Background

In 2017, the neonatal mortality rate for Eswatini was 17.4 deaths per 1000 live births; infant mortality rate was 40.8 deaths per 1000 live births; and under-five mortality rate was 53.9 deaths per 1000 live births. In one regional hospital, between April 2018 and March 2019, 105 deaths were recorded. The mothers normally did not receive any form of psychosocial support or grief counselling following the death of the child.

When a child dies, the mother is usually shocked, confused and experiences self-blame and grief, which can produce negative psychological effects if neglected. Support is needed as she goes through bereavement since the stress experienced increases the risks for psychopathology and relationship issues. Caring for mothers who has lost a baby or a child, presents a challenge that can be addressed by the interprofessional team. Hence, this quality improvement initiative was conducted in an effort to provide holistic interprofessional care to these mothers.

Purpose

The purpose of this project is to provide holistic care to mothers who have lost a child as a stillborn, a neonate, or a child under the age of 5 years in the regional hospital in Eswatini.

Method

The quality improvement project was based on Kouzes and Posner’s Leadership Model (2017). According to the Leadership Model there are five exemplary leadership practices, namely model the way, inspire a shared vision, challenge the process, enable others to act and encourage the heart. The quality improvement project was initiated to address the lack of support to mothers who have lost a child. The interprofessional team was formed and comprised doctors (2), a mental health nurse (1), nurses (14), midwives (15) and a hospital-based social worker (1). As there was no counselling being done prior to the project, no baseline data was collected. A tool was developed to measure the level of bereaved mothers’ coping. The project team was trained on how to conduct the grief counselling sessions. In the event a mother lost her baby, the doctor explained the cause of death and then the midwives and nurses counselled the bereaved mothers and followed them up. Those found to require further psycho-social support were referred to the social worker. A questionnaire was developed to collect data from midwives post intervention to determine the knowledge the midwives had gained about counselling. The team received feedback and encouragement throughout the process.

Results

Following training, the interdisciplinary team demonstrated a high level of knowledge on grief counselling. From April 2018 and June 2019, the results indicated that 40 mothers received grief counselling immediately after delivery. From these, fifteen (n=15) were referred to the social worker for psychosocial care and ten (10) were also visited in their homes for further support. A developed tool was used to measure the level of coping. Mothers who were found to be coping and moving towards acceptance were not visited at their homes, but supported telephonically. Some mothers expressed gratitude with the support they received during their difficult period and were able to cope and accept the loss.

The Leadership Model certainly proved to be a valuable tool for a quality improvement initiative to improve child health.

Conclusion

Interprofessional collaboration can effectively facilitate provision of holistic care to mothers who have lost a child as a stillborn, a neonate or a child under five years. Leadership and a formal quality improvement initiative is needed to drive the process.

Implications

A standard procedure was developed and will be used by nurses and midwives in counselling mothers who have lost their children up to age five. The next stage is developing related institutional guidelines. The Kouzes and Posner Leadership Model proved to be a valuable tool to improve maternal and child health outcomes.

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