The African Maternity Link

Report on visit to Freetown

Sierra Leone- February 2016

This trip is planned as a feedback and evaluation follow up, completing objectives set at the end of the November 2015 workshops. This evaluation visit is funded in part by Life for African Mothers with whom we have partnered for training workshops.

Whilst workshops are an effective teaching tool here in Sierra Leone, bridging the gap between theory and practice and making sure our teachings are being implemented in the clinics and hospitals is an essential means to reducing the maternal and neonatal mortality and morbidity rate.

We must work alongside our fellow midwives here in Sierra Leone to observe practice and help educate in the clinical setting when necessary. We are hoping that healthcare professionals, who have attended our workshops, have cascaded their training to others in their unit. It is essential to visit the units in which the attendees work in order to establish a support network, analyse their working practices, supervise and to assess what needs they have. Many small units may not have vital equipment, space or staff to do midwifery to a basic standard. Many units have one midwife with healthcare assistants and students supporting them. These women do assist at deliveries and need to be taught a basic level of midwifery regarding obstetric emergencies and neonatal resuscitation.

Another area that requires emphasis ‘early referral’. This is referral from home or a peripheral health unit (PHU) before a problem becomes too severe. Community education is something that we are presently discussing and planning. We believe good understanding of the partogram will aid midwives in this.

Objectives of visit - February 18th-28th 2016

- Aim to visit 2 units a day in the Freetown area, visiting midwives who attended workshops in November. Performing follow up questionnaires to gather data for monitoring and evaluation.
- Visit Magburaka government hospital - liaise with MSF staff regarding current midwifery training programme and deliver teaching session on neonatal resuscitation, the partograph and other topics requested
- Neonatal resuscitation update sessions in all the units.

Travelling personnel

Oli Jeacock - NHS midwife
Helena White - NHS midwife
Robin Woolgar - Freelance photographer

Day One
Travelling.
I always enjoy the journey to Sierra Leone as without a doubt you will meet some interesting people and good contacts. Today we met a chap called Ian from Atlanta, US, who ran one of the Ebola treatment centres during the crisis, he is now here working with the survivors. He himself is a survivor of the deadly disease, having been on dialysis in an induced coma during his recovery. Now he is healthy but suffering terrible complications following the disease, including momentary blindness leading to cataracts, sleep deprivation, metabolic problems, joint problems and organ damage. The list goes on and I'm sure further problems
will surface as the long-term effects are unknown. He very interestingly talks about the virus lying dormant in the eyes, semen and also breastmilk. There is some research into placental carrying of the virus and working with survivors who are now carrying children. All is very interesting from our maternity point of view. Hopefully we will catch up with Ian later on in the week for more discussion.

Once at Family Kingdom resort we meet with Morlai our charity liaise to discuss plans for the week.

Day 2
Today we travel to Magburaka, 3 hours into the country, to spend two days, driven by our trusty friend Pina. We visit Magburaka government hospital, which is the main referral hospital for a wide radius, some women are travelling for hours to get here. Helena and I have been here before and are once again extremely impressed with the cleanliness. A huge IPC protocol has been adopted within the last year and has clearly made a difference. MSF are currently working out here in maternity and paediatrics to improve practice, and we meet with a few of their doctors to briefly discuss their short few weeks here so far and their upcoming plans. On visit to the maternity ward we see one woman who had delivered earlier that morning, with severe eclampsia, still suffering from high BP of 160/110. She has the magnesium sulphate regime running and is clearly quite ill and exhausted. There are also some twins being cared for by the midwives with milk provided by MSF. They are 8 days old. Their mother unfortunately died from severe eclampsia, PPH and DIC following the delivery in theatre, leaving behind other children as well. It is unclear what will happen with these children, a stark reminder to us of the lottery of life.

Our friend and fellow midwife Kumba asked us to do some small teaching sessions, so we gather the midwives (5) and maternity healthcare nurses (MCHN) for neonatal resuscitation. Using practical scenario based participation we teach and discuss resuscitation using different situations that may arise. People get to simulate and practice their skills, including calling for help. It is obvious that not one person is confident in this skill and definitely needed the update. Many did know parts of resuscitation but not necessarily to an effective use. MSF have recently brought in case reviewing meetings on a Thursday with the midwives, it has been suggested for a short neonatal resuscitation practice after each meeting, to imbed these skills further into their knowledge base.
Day 3
Returning to Magburaka government hospital today we teach the partogram as Kumba felt this was something that they needed help with to enable effective use, particularly with twins. After some discussion it seemed that the midwives knew how to plot on the partogram but other healthcare nurses were in need of some help. We discussed a scenario where a woman made slow progress immediately but then with conservative management had a normal labour and delivery. Conservative measures such as relieving a tachycardia with iv fluids, ensuring a woman mobilises and keeps eating and drinking to prevent slow progress weren't clearly understood as first line management. 'Call the doctor' and 'rupture her membranes' were phrases used before it was necessary. However, the knowledge base of these professionals was good and with a little guidance and practice of skills and drills they will become much more competent in these areas. We followed by teaching shoulder dystocia using a mama pelvis. Shoulder dystocia is rare in African countries as most African women have good obstetric pelvisses, but undiagnosed diabetes, malpresentation, abnormality, obstructed and prolonged labour are risk factors and extremely pertinent. Using the HELPERR mnemonic we conducted a scenario with plenty of discussion and demonstrated the manoeuvres, allowing them to participate by demonstrating afterwards.
It will be interesting to see what difference MSF's training has made when we next visit Magburaka. The possibility of working alongside, observing practice and initiating update workshops on the next trip over a few more days may be a possibility.

Day 4
Visit to Hamilton PHU to see the midwife there, Elizabeth. She works and lives in a very small unit that covers a wide area. Often a labouring woman wakes her in the night. 'On call' every night and is running clinics each day, some of which are outreach appointments to neighbouring villages. These include antenatal and neonatal vaccination treatments. Saturday and Sunday are reserved for emergency only appointments at Hamilton PHU. Elizabeth does a fantastic job. She is in fact not a midwife, or a nurse but a community health worker. She has received some midwifery training from workshops but is not qualified. She works alongside 2 other CHW's who work shifts. It is amazing to see how well she does there and her knowledge base is fantastic considering. We carried out a neonatal resuscitation session
with Elizabeth to refresh her skills and we provided a new ambubag and mask. We will ensure that Elizabeth and other health workers from this unit attend the next African Maternity Link workshops in Freetown.

Afternoon off

Day 5
Macauley Street Government Hospital and PCMH

Macauley Street is a small hospital that treats medical patients as well as maternal and child health. Irene Sesay, the matron, came to our workshops in November alongside 2 other midwives. There are 3 midwives at this facility and a number of MCHN's helping them who also facilitate deliveries. Unfortunately she was unable to meet us but we met with another midwife, Kadiatu, who discussed with us her practical use of our training. She said that training has been cascaded during quiet times in the unit and continues to be when possible. She has taught others how to manage shoulder dystocia and PPH. This training we were glad to hear has come in great use as they have had a shoulder dystocia recently in which McRoberts position was adopted and the baby was born in good condition. Irene has been very keen to train the other healthcare workers in the maternity unit so we left her our presentations, a USB with training films from 'Medical Aid Films' and a resuscitation doll, which we will recover at a later date. The maternity unit is incredibly small. A pathway acts as a waiting room, which you must squeeze past pregnant women waiting to enter the
antenatal clinic room. Directly beyond this room is postnatal ward, which leads to the labour room. Postnatal ward is a beautifully light large space with 10 beds all lined up laden with colourful cloths ready prepared for the next woman. The labour room is so small. A delivery bed just about fits inside without a bottom on it. There is some water buckets for washing and cleaning and a small broken metal trolley with equipment inside. Neonatal resuscitation takes place in the postnatal ward and if another woman needs the labour room a spare bed is used in the corridor. Despite these difficulties they manage and are lucky enough to be able to refer women to PCMH main referral hospital, which is close by.

PCMH is the largest hospital in Freetown. The main referral unit and high risk care unit. They have 8 midwives, many nurses and students. The matron, Daphne attended our workshops in November alongside 3 other midwives. This is a very busy hospital and maternity is always very busy. Daphne conducts monthly training with her staff and we are hopeful that she has cascaded our training. 3 midwives are on duty per shift with MCHA’s and students assisting. As this is the main referral hospital they often have emergency situations which many times are referrals from the community when problems arise from home deliveries. Many women deliver at home with a traditional birth attendant despite being encouraged to deliver in the PHU’s or hospital. When problems arise they come to the hospital too late and usually there is mortality or severe morbidity involved. We stress in our workshops about early referral from the PHU’s and we have had positive feedback that this has been happening. Extra partogram sessions have been asked for, especially as the students find it difficult to understand. Hopefully this will be rectified as more people attend our workshops. Neonatal resuscitation training is also being carried out every week for 30
minutes by paediatric registrars working with WHO. A SCBU is available at PCMH. It's a large unit, which is consistently busy, due to most referrals from small PHU's being because of complications that arise during pregnancy or birth. When we visit it looks full. 3 sections break off the nursing babies, the babies in need of some special care and the intensive care babies. Intensive care has no incubators, no temperature controls, low infection prevention and one oxygen cylinder that is manually pumped through nasal airway. Premature babies, babies with abnormalities, HIC and various other problems were seen here in cots with no NG feeding tubes, breathing or regulated support because it's not available. Many of them luckily had IV access but so many were incredibly ill. Prioritising care and equipment to those most likely to survive is the only way they can cope in this unit. We see one baby with severe abnormalities whilst we are there. A twin born a few hours previously with one leg, no anus and its placenta imbedded into its intestines through its umbilicus. Though her SATS were low, there was no airway support available and you could clearly see that this baby was struggling with its respiratory effort. That was not the only baby that was dusky and struggling, the majority in the intensive care section looked incredibly ill with no support available to them.

Day 6
Driving 1.5 hours out of Freetown to Tombo PHU. We are amazed that the two midwives who work here travelled so far to attend our workshops in November. This unit has 1 midwife (the second has been moved to another unit where there isn't one at all), 9 MCHN's with 3 people per shift. The antenatal clinic room is a communal space with a desk and couch placed in between the smallest delivery room and a newly built postnatal ward. The delivery room just about fits two beds in placed up against the wall, about one metre separates the two. The postnatal ward once furnished should hold perhaps 4 beds, however this relies upon donations of beds by NGO's. The healthcare workers here seem quite proactive and we have a great neonatal resuscitation session where we not only update the skills of the workshop attendees but the untrained staff. They have been cascading the training we gave in November and I'm quite impressed with their feedback and knowledge. Luckily they have had very few severe PPH's and state that usually rubbing up a contraction and expelling any
clots tends to settle the bleeding well, despite the high rates of pregnancy anaemia here in Sierra Leone. They have asked for more training on the partogram and obstructed labour that is something we may be able to work on in the next workshops along with eclampsia.

Waterloo is our next unit. This is a new larger maternity unit alongside a government hospital. It boasts a large delivery room, bathroom, theatre space (although not complete) and postnatal room big enough for 4 beds. There are 2 midwives here, both of whom came to our workshops and 6 MCHN's. As this unit is yet to be finished it is barely furnished. There is one delivery bed and a clean area where the delivery instruments are kept. No resuscitation area, however they do have an ambu bag and stethoscope ready. When speaking to the midwives, they both have been cascading the training we gave, teaching the MCHN's neonatal resuscitation, PPH and the misoprostol protocol. They asked for blood loss estimation posters as they have been using a water bottle in training to assess amounts. To hear that our training has not only been useful and helped save lives, but that is has been cascaded throughout was so pleasing. We did a neonatal resuscitation session whilst we were there with the 6 MCHN's who all participated in the scenarios. They were really eager to learn and interested which always makes active participation much more fun.
Hastings is a small PHU about 45 minutes from Freetown. We meet one of the CHO's (Community HEalth Officer - some medical training background) there who explains that they cover a wide population offering maternity and under 5 care including vaccinations. Unlike other PHU's, Hastings treats minor child injuries too, has family planning and contraception clinics, treats women with incomplete abortion or complications from illegal abortion, as well as HIV and TB testing. They have 40-50 births per month and unbelievably have no midwives working there at all; only MCHN's who are not trained midwives and cannot make decisions on care when issues arise. This is shocking news and should not be the case as each unit must have at least one trained midwife employed. The CHO explains that the midwife they had a few months previously had been moved to work somewhere else. This really is worrying so we gathered all of the staff who were on duty (around 15) and taught neonatal resuscitation with the baby Anne doll, as most said they needed help and were not confident. Only one MCHN from Hastings came to our workshops, with another CHO, so cascading training had been difficult for them. It became apparent to us just how important it is to ensure all healthcare professionals attend our workshops and are updated regularly, not just midwives.

Day 7
A breakfast meeting to begin the day with Francis Kaikumba, country director for Kings Health Partners. An incredibly useful contact as the KSLP does so much work within the health sector here in Sierra Leone. They are hoping to branch out into maternal health whilst working in partnership with other charities and organisations. One of the president’s main delivery targets is to reduce the maternal mortality rates in the country so we are hoping that working with the government will help collectively reach those goals with government backing and support. We have begun to work with Dr Conteh and Matron Mary Fullah from the reproductive health unit, who draw up the maternity policies and guidelines. Francis helped us by giving us useful contacts and it was fantastic to talk about both our charities progress and future plans.
The afternoon was spent in Kroo Bay. As always a longer period of our time is spent here. This welcoming community steals the hearts of all who visit. Situated on the 'rubbish tip', Kroo bay and its pigs, is an extremely poor and populated area. Sewage and rubbish is everywhere, the smell is horrific and the people live so close together they may as well be all under one roof. However these smiley people do their best, their small tin huts are always clean and they help each other consistently in times of need—which is pretty often. Kroo Bay PHU is set right in the heart of the community. Down the small dusty pathways, past people's huts and make shift stalls (selling some of the tastiest homemade biscuits) is a small unit where approximately 40 births per month take place, antenatal clinic, vaccinations and under 5's clinic. Without electricity and with very little government funding this place functions with one midwife and a handful of MCHN's. Kroo Bay unfortunately was badly flooded in the last rains leaving many people homeless until the weather improved. The PHU was also flooded with the sewage water, leaving the whole place a very dirty, damp mess. The walls and flooring, furniture, doors and toilet facilities still remain, however incredible filthy and broken no matter how much cleaning takes place. All equipment, drugs and documents were swamped including the fridge freezer, which held the children's vaccinations. Since then The African Maternity Link together with Life For African Mothers have donated furniture, equipment, mattresses, cleaning supplies and a brand new fridge freezer to the unit. In November, Martha, the midwife and one of the MCHN's came to our workshops. Martha always has been very good, very keen and does a brilliant job, furthermore never shy to ask for help with obstetric emergency skills and the partogram. We did a session this visit on neonatal resuscitation with 10 healthcare practitioners from Kroo Bay. Some evidence of the basics was seen, however the session was very much needed. The women seemed much more confidant afterwards. Martha had told us how she successfully has resuscitated many babies since attending our workshop, including a baby with abnormalities that she had to then refer to PCMH.

Day 8
A UK midwife with an extensive background within MSF runs Aberdeen women’s centre. Although initially set up as a fistula clinic it has been running as a maternity unit as well for the past 5 years. This unit is well run, follows a UK approach to policies, guidelines and the general running of the unit. We met with Olivia, clinical director, the new midwife taking on the role of running the women's centre, who showed us around each area and discussed with us upcoming changes and plans. Aberdeen Women's Centre really highlights what can be done in this country with the right funding, supervision, management, equipment and trained staff. This is somewhere that prototypes what The African Maternity Link are dreaming we can achieve in every unit in Freetown eventually; it shows possibility and is a very positive experience.
Murray Town PHU is beautifully placed on the edge of the sea with a stunning view and lovely sea breeze. There is a big polio vaccination campaign being carried out in Freetown this week and most MCHN's have been assigned the role of vaccinating in the community, therefore leaving most maternity PHU’s with only one member of staff working. This is the case in Murray Town. We meet Virginia Williams the only midwife working at this unit; she is supported by 11 MCHN's. 3 members of staff on each day shift and 4 on the night. With only one midwife this means that most shifts are ran by MCHN's with Virginia being 'on call' for emergency situations. We were incredibly impressed with Virginia, she had attended our training in November and not only has been cascading training on normal labour and neonatal resuscitation to her support staff, but has been producing prompt posters of some of the things we had taught. We saw posters on the use of misoprostol, third stage of labour, blood loss estimation, neonatal resuscitation and care of the newborn. The delivery room here was a good size, clean, tidy and with two delivery beds in good condition. A resuscitation area was clearly identified and a privacy screen was readily available. The room was bright and led on to a small room with two postnatal beds in it, which are also used for early labour. Virginia seemed knowledgeable and keen to learn, however we had some concerns over the use of half a tablet of misoprostol to prevent prolonged labour. Leaflets that were produced by the reproductive health unit were supposed to be distributed to all maternity units last Nov/Dec, so we must ensure that all units receiving misoprostol are also receiving the leaflet as it compliments our teaching of the drug.
Day 9
Travelling home.

Overview
We managed to visit 9 of the units covered in November, with another 11 left to be visited the next trip. Feedback was very positive from all units. We have ideas on future workshops, training, handouts and promotional material. Discussing what issues midwives and healthcare workers have in their own individual units was extremely beneficial for our understanding and for them to realise we would like to work together and not only improve practice but improve facilities and care supervision. Each unit was updated on neonatal resuscitation and given a new ambubag. Unfortunately, due to a community wide polio vaccination drive being promoted we were unable to meet with the reproductive health unit to discuss some future plans we have and working together. Hopefully via email we can communicate better before our next visit.

Future visits
- Ensure neonatal resuscitation areas are available with equipment needed ready in each unit.
- Size 1 and 0 facemasks are needed.
- Continue plans for community early referral film.
- Visit the next 11 units
- Workshops with more members of staff from each unit attending
- Posters, handouts for units walls
- Update the workbook so it can be used, including partogram scenarios. Call it a 'reference document'.
- Work with CHO's, matrons and people with supervision capabilities to promote responsibility and accountability for all maternity workers.
- Pre eclampsia in the workshops
- Sepsis in the workshops
- Find out what units have anti hypertensives readily available for antenatal women and what are the protocols.
- Observation and documentation of tears and grazes? Do they Suture? Is it Sterile?

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