**Freetown, Sierra Leone – Follow Up Visit, August 2016**

**Background**
In November 2015 four, two-day workshops were held in Freetown, and a further one in January 2016, led by UK-based midwives. The workshops are aimed at any staff who provide maternal and neonatal care, be they midwives, Maternal and Child Health Aides (MCHA), State Enrolled Child Health Nurses (SECHN) or Clinical Health Officers (CHO).

The purpose is to refresh and strengthen previous training inline with the aims of the Ministry of Health (MoH). We also encourage attendees to cascade the training to their colleagues, so widening the reach of the workshops. The overall goal is to contribute to improving maternal and neonatal mortality rates in Sierra Leone.

These workshops have practical sessions, supported by relevant theory, on management of emergency situations, such as haemorrhage and neonatal asphyxia. Also covered is the use of the partogram (or partograph), to aid recognition of slow labour which may require referral to the next level of care (secondary or tertiary centre); delayed referral is one cause of maternal/neonatal death.

Follow up of attendees is as important as the workshops themselves, as this helps us know what has been retained and put into practice, and whether or not knowledge has been cascaded, so we can change our approach if required. It gives us chance to see the particular difficulties and limitations that people face in the workplace so we can adapt teaching to real world Sierra Leone. Also personal visits strengthen relationships, and help identify people who are, or might become, change-makers in – or even beyond - their own setting.

In February 2016 Helena White and Oi Jeacock began the follow up from the November and January workshops; this trip aims to complete that task, visiting the remainder of the attendees in their health centres.

**Objectives of Visit – August 19th-31st 2016**
- Visit two units a day in the Freetown area
- Perform questionnaires with workshop attendees to gather data for monitoring and evaluation, particularly relating to cascading of training
- Neonatal resuscitation (NNR) update session in each unit visited

**Travelling Personnel**
Liz McSporran-Bates – NHS midwife (retired)
Gina Short – Senior midwifery lecturer (until Friday 26th August)

**Day One 19th August**
Travelling from Gatwick in the afternoon, overnight, with long layover in Casablanca.
Day Two 20th August
We arrived at about 0600hrs without hitch, in possession of our 4 cases of supplies, plus hand-luggage with our own necessities. Family Kingdom, where we stay, is unique and almost defies description. It is a safe, clean place and the staff will do anything to help. It is also a fantastic place to network with a wide variety of development workers from around the world staying there.

After a short rest, we met with Morlai, our local co-ordinator to confirm plans for the coming 11 days. Some plans were already in place, others not yet set. Morlai had kindly arranged a driver for us for the whole time, as requested. It wasn’t possible to have a clinic visit today, given our arrival time; however in the afternoon we walked to Aberdeen Women’s Centre, run by Médecins Sans Frontières (MSF). This developed as a centre for fistula repair, and now also has a maternal and child health service; it is an encouraging place to visit, as standards are very high and care exceptionally good. Unfortunately no senior staff were present; we weren’t able to visit at a later date due to the busyness of our programme.

Day Three 21st August
Hamilton Beach Community Health Centre
Oli and Helena had visited here in February, and left a resuscitation training doll with Elizabeth, the MCHA in charge. She had dearly used this to practice, and to demonstrate NNR to her colleagues, two of whom were present. Gina, with Elizabeth, did further demonstration of NNR and all three staff practiced again.

A discussion indicated that Elizabeth does use the partogram as part of her normal practice.

On checking the ambubag, it was noted that a medium sized mask is needed; unfortunately we did not succeed in getting one to her, as we had insufficient for the need on this trip. Checking the NNR equipment, and replacing as necessary was part of what we aimed to do in each unit.

MCHA x3 trained/refreshed

On return to Family Kingdom we discussed what we had learned, used this to inform our following day’s plans, and prepared a selection of supplies (eg single use delivery packs and instruments, single use speculums, packs of sterile swabs, gloves, baby clothes) for the two units to be visited. This would be the pattern for the remainder of our trip.

Day Four 22nd August
Sierra Leone Red Cross Community Health Centre
Total staff:
CHO x 1
SECHN X 3 - all present
MCHA x 2 - 1 present
Volunteer X 4 - 3 present
Cleaner X 1
The two most senior members of staff were absent.
One SECHN had attended a workshop. She reported having done NNR in-house demonstration; she repeated the procedure to me, but there were many points of confusion. She also reported passing on her new knowledge around assisting birth by having an inexperienced member of staff with her at delivery.

We proceeded to NNR demonstration in two groups. There was no discernable evidence in practice of there having been any dissemination. However, we need to take into account that it is between 7 and 9 months since the workshops. Three people showed very good grasp of the method; the remaining five less so. Zainab, from the workshop, did greatly improve her knowledge and technique, showing that there was a foundation on which to build.

The senior staff member present had difficulty with the required precise but delicate handling of the bag and mask; this was a frequently recurring issue, and is probably due to the type of activities which young people do. This is easy to understand when considering that there is traditionally little work or play which develops fine motor skills, such as playing with small bricks, or learning early to handle crayons or pens; rather, it is doing the laundry by hand and planting vegetables, for instance, which develop power and strength. This is another reason why practical demonstration and patient coaching is so important.

Two ambu bags with appropriately sized masks were left with staff, and positioning in the delivery room shown – it needs to be out, checked, clean, ready to use before the birth in case of unexpected need.

**Susan’s Bay Community Health Centre**

This CHC is in the very centre of the city, and was reached by a long, brisk walk through the large market; our return walk to the car was marked by a typical rainy season deluge.

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<td>MCHA</td>
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<td>SECHN</td>
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Total no of staff not known

Approx 35 deliveries/month

Isata, a MCHA attended a November workshop; she was acting midwife until a qualified midwife was transferred to this CHC. Its current MoH policy to have at least one midwife per CHC, whereas until recently they have been very unevenly distributed, thus many have been moved in recent months.

Isata completed the questionnaire, stating there had been dissemination of training on 4 subjects: misoprostol (medication to control PPH), NNR, shoulder dystocia, post-partum haemorrhage (PPH).

Of the 6 staff members present, 5 participated in NNR training (Isata did not). There was no evidence of dissemination having been successful/effective. However, 3 people showed real grasp of the principles and practice of NNR. One was moderately effective, the other (again the most senior person) had significant dexterity issues with bag and mask.
We gave a brief explanation of the cause and management of shoulder dystocia to the midwife, at her request, and to a MCHA; given time constraints and degree of understanding demonstrated, we limited the management to McRobert’s manoeuvre and moving to all-4s.

Two ambu bags and masks of appropriate sizes left in situ with other ambu bag already appropriately positioned in delivery room

**Day Five Tuesday 23rd August**

**Ross Road Health Centre**

This is a very well run clinic, with a very pro-active CHO. CHOs are the senior and most broadly trained member of staff in this setting; they have specific training in management of a health unit, as well as diagnostic and treatment skills with adults, children and, to a lesser degree pregnant women.

Ross Road is in central Freetown, so has quick access to the tertiary centre, Princess Christian Maternity Hospital (PCMH), also known locally as ‘Cottage’; PCMH has a very limited special care baby unit (SCBU) and also a paediatric unit on the same site. There is also proximity to pharmacy and equipment central supply departments. The CHO works hard to keep the centre stocked with essentials, with a member of staff almost per manently visiting central supply departments. Even so, items such as suture material are frequently unavailable, and the midwife in charge buys some herself.

Midwives 2 – both present
MCHA 1 – present
Other staff numbers not obtained

The senior midwife, Kezia Cole had attended Nov ’15 workshop run by Pat and Katie at PCMH. She readily stated that she had done no cascading of training, due to time constraints - her own, and that of other staff being available.

75 deliveries per month
H V pos case 1/month

No maternal deaths in the 3 years since Sr Kezia working there. This is indicative of strong use of decision-making tools, such as partogram and Sr Kezia’s supervision of all labours, plus ease of transfer to PCMH. (One positive outcome of Ebola is that a number of ambulances donated during that crisis have been redeployed to general health purposes – availability of money for maintenance and fuel will determine the longevity of this bonus.)

Due to busyness of clinic, we did NNR training with the three maternity staff; all showed existing knowledge, and real confidence in their own ability afterwards. We left a resuscitation doll with the sister to cascade training to remaining clinic staff. She had said she would like to train staff, and for time to be set aside for this, eg at end of a shift. Morlai communicated this to the CHQ in sister’s presence. We sense that there is a strong likelihood of this training being realised.

Several staff from Ross Road will be invited to next workshops.
Given hand-written flowchart of process of NNR to put on wall as aide-memoire.
Lakka/Ogool Farm Community Health Clinic

CHO 1 (not present)
Midwife 1 (present)
MCHA 6
SECHN 4

Deliveries 15/month

We were delayed arriving, so staff had finished work and were rather tired and some hungry. So our visit had to be brief and to the point.

The midwife had attended a workshop in November with Helena, Ol and Liz. However, she had been unwell (and seems to still have health problems) and was unable to stay until the end of each day.

Questionnaire: some cascading of training was done with staff on NNR and partogram

NNR Training
Initially all said they would resuscitate an asphyxiated baby, but found it hard to know where to start, most wanting to begin with cardiac massage (this was a frequently repeating theme).

Trained - 6
3 were very good, 1 got it with persistence, 2 not good

Midwife did not participate.

A flowchart of NNR was written in midwife’s notebook.

Day Six  Wednesday 24th August

Signal Hill Maternal and Child Health Post

This is a tiny place, in a mess – probably due to lack of space, very difficult location attached to a steep hill down a flight of steps, with very enthusiastic staff.

Midwife 0
MCHA 5
Volunteers 7 (Volunteers=trained staff who have not yet been allocated a RN by MoH; they work unsalaried to maintain skills/gain experience until a RN allocated, usually a year or more)

Deliveries 20-30/month No maternal deaths in last year

Workshop 2 MCHAs attended in November; one was very quiet, the other (the senior) was very outgoing.

Questionnaire - reported cascading training through discussion and through supervision of others during deliveries, though not obvious when doing NNR training.
Trained – 6, all became very proficient.

At Gna’s suggestion several recorded the demonstration on their own phone so they can use this as a reminder or to teach others. (after this, in each place visited we suggested recording, and usually at least one person did).

Macaulay St Government Hospital

Greeted by the doctor in charge; Matron Irene excused herself from a meeting to greet us and answer the questionnaire. Helena had provided her with a USB stick containing training material from the workshop for her to use in her own setting; unfortunately this has been lost. She expressed concern about midwives’ clinical skills, eg with breech birth, and would appreciate relevant training videos.

When discussing number of deliveries, she explained that, due to proximity of PCMH, many prefer to go there.

Also, since Ebola crisis the hospital no longer has a functioning operating theatre. So in effect, other than having a doctor (NB not an obstetrician) on site, Macaulay St functions as a midwife-led unit, not a secondary level care facility.

Midwife 5 (incl matron)
Other staff not obtained, but approx. 12 in total

Deliveries 35/month (difficult to obtain)

Workshop Matron and senior midwife attended.

Questionnaire - Due to other responsibilities, Matron’s time for training is limited; however a whiteboard with some partogram teaching was seen in her office. The senior midwife had done minimal cascading.

NNR Training 9 staff (SECHN, MCHA, plus 1 RN who is HIV counsellor and spends time in the dept); Matron and senior midwife returned to their meeting without participating in training, and another midwife declined to participate.

All were effective after training.

Delivery room – In contrast with the light and airy 8-bedded ward, the delivery room was small; we suggested removing unnecessary items to allow more space. This would free a surface for NNR with equipment accessible.

They have only one set of delivery instruments; three single-use sets were provided.

Day Seven Thursday 25th August

Due to a much delayed start this morning, we were late in reaching both of today’s locations; this was very disruptive for the second CHC visited, but staff stayed and attended training, which was a reflection of their commitment.

Kissy Community Health Centre

The midwife was busy arranging a referral to PCMH for a woman with constant abdominal and back pain, hard abdomen and no fetal heart sounds. A vaginal discharge
had led to a possible diagnosis of infection (urinary tract, vaginal or amnionitis); we tentatively suggested placental abruption as cause, and there was a hint of recognition that this may be the case.

A second year midwifery student was on a 16-week placement; when asked if she was able to look up a topic, such as placental abruption, she replied that she had no text book of her own as they are hard to get and very expensive, but could browse online — if she ever had credit.

Staff — total staff not known

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Deliveries 38/month

Workshop Attendee transferred elsewhere
Sr Kargbo was transferred here in June 2016 from the provinces, and while still there she had attended a workshop with Liverpool School of Tropical Medicine (LSTM), including NNR. She had a good base in NNR which was brought to fluency with this refresher.

Questionnaire - None

NNR Training
4 staff plus 1 student: 2 good, 3 satisfactory

Grafton Community Health Centre
Total staff not known

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HIV couns 1

Deliveries not obtained

Workshop Sr Kpaka attended while working at Wilberforce

Questionnaire — stated cascading training at Wilberforce, had use of a doll for NNR; also covered PPH/misoprostol.

NNR Training
8 staff trained
Most were satisfactory, and two were very good

Visited delivery room; the midwife did not think there was an ambu-bag, but one SECHN eventually found it; cleanliness, functionality and readiness were discussed and demonstrated. A new ambu-bag was provided, plus 3 sets of ‘single-use’ delivery instruments.
The SECHN who know there was an ambulance bag showed considerable interest, awareness of gaps in her knowledge and persistence in plugging those gaps through her questions, e.g., difference between lungs and heart – and therefore what we are assessing in NNR procedure! This is a common issue.

This was the first centre visited where Infection Control and Prevention (IPC) measures (hand washing) were not in force at the entrance.

Day Eight Friday 26th August

Gina returned to UK earlier than planned due to her weekend flight cancellation. As Liz was now working alone, adjustment to the work schedule was attempted, with limited success, due to a variety of factors. The greatly delayed arrival of Morla and driver on this day made it a very difficult one.

Godrich CHC

Clinic was in full swing on our arrival, so it was some time before Sr Naomi Hyde (midwife) was free to talk, and staff were free for training.

CHO 1 (not present)
MIdwife 1
MCHA 1 (plus 1 still not yet upgraded by MoH since SECHN training)
SECHN 7 (some non-RN)

Delivery 35-50/month
Partogram clearly used; written in red if not used
IPC very good IPC practice seen – use of aprons, hand-washing between activities/patients, gloves where appropriate, etc.

Workshop Sr Naomi attended in November 2015. She has a PGD from Liverpool School of Tropical Medicine (LSTM), and regularly does some work with them.

Questionnaire

Cascade of training reports having done some on various subjects, particularly on misoprostol. However, there was no hard evidence, but staff appear well trained, with good attitude towards learning. (The positive side of having to wait to talk to Sr Naomi was the opportunity to observe normal work going on around me.) NNR has not been covered; she did not know if there was an ambulance bag, but one staff member did and located it – the mask was mouldy. A new one was provided, and availability during delivery discussed.

Remisoprostol: she talked about using it for augmentation of labour, but commented that their women don’t need this (she did sound a little disappointed!). There has been no PPH where this has been required. MoH leaflets, printed last year, have not been distributed; she has received only the copy given at our workshop (this was reiterated in
conversations with other attendees). She would like more training on use of this drug for herself and staff.

SD. She has seen only one in 4 years; the birth register showed that nearly all babies weighed over 3kg, with no noticeable effect on incidence of SD or CPD (cephalo-pelvic disproportion) rate.

Edema/preeclampsia: MoH provide regular supplies of MgSO4 (magnesium sulphate, to prevent convulsions in this condition) and calcium gluconate (antidote to MgSO4 in case of overdose).

Learning: very limited access to reading/study materials. She has a copy of the textbook ‘International Maternal and Child Health Care’, produced by a Scottish NGO (Non-governmental organisation), an excellent and comprehensive text, many copies of which we were given and distributed during previous visits. She keeps this at the diric so all staff can use it.

She commented on how lack of electricity, therefore of light, at home limits the ability of people to study at home. An interesting point was how the oral culture affects learning; people want to be taught, rather than study themselves. This tied in with a discussion with Nicki Brown, a UK midwife with USAID who recounted how one group of MCH workers have developed their own means of learning through recounting personal learning experiences, unconsciously applying principles of reflection. How can we foster this?

TBAs (Traditional Birth Attendants): outreach in community reveals frequency of use of TBAs versus CHC, and TBA practices, which vary from good to very bad. TBAs are encouraged to come into the CHC to work with staff; one was present at our visit, attended NNR training and did very well, even helping some of the younger staff.

NNR Training
7 trained, including sister and TBA cleaner also present. One or two were hesitant, but overall satisfactory.

Kingshorn Road Hospital
We arrived here after 3pm, well after the 2pm shift-change time. Delivery suite staff were in theatre for a cervical tear repair. Of the two people who had attended a workshop, one had already left after her shift. The second had been delayed, but stayed even longer to respond to the questionnaire.

Unable to obtain staff numbers and delivery numbers.

Workshop:
Macdalynne EGGIE, SECHN, attended the January 2016 workshop. At that time she worked on labour ward, but now is Family Planning (FP) nurse.

Questionnaire
Cascading of training: supported by the other staff member who attended, she had effectively changed some practices on labour ward – presence of husband or other family member now permitted in labour, if the woman wishes it; also if the woman wishes to
stand or crouch instead of lying on the bed, she now can. The timing of oxytocin has now been delayed, but it was unclear precisely what had changed.

She and her colleague had discussed NNR, and demonstrateduse of the ambu bag, although there was no evidence of this, or of the outcome of that demonstration.

Help requested – to further train other staff. Unfortunately, due to my full programme I was unable to return on the following Monday, as requested.

This lady is very enthusiastic; it is easy to see how she had managed to change practice in quite a big unit. She is one to keep in touch with as she is clearly a change-maker.

**NNR Training**
Postnatal ward sister, who was present throughout our discussion, and Macdalynedaughter attended NNR training – satisfactory.

**Day Eight Saturday 27th August**

*Regent Community Health Centre (just on other side of mountain, so closer to Rokupa Hospital)*

We were received by a very good, young CHO

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<td>MCHA</td>
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<td>SECHN</td>
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**Deliveries** 20-30/month

**Workshop** Staff who had attended a workshop were not present today, so no questionnaire completed. However, had a helpful discussion with the CHO.

FP service is very popular with students (18 years and over) and with mothers of 3-4 children. The implant is the most popular method.

She stated the CHC has a good relationship with TBAs in the community; however, it was difficult to understand how their actions had a long-term positive effect.

OJT has so far been attended by about 8 staff; this covers NNR; also the CHO who had attended our workshop, had done at least one session of NNR training with other staff.

The CHC was clean, tidy, spacious and well staffed. Good IPC practice was observed.

**NNR Training**

| SECHN | 6 |
| CHO | 1 |

Very good session, good questions, including “what Apgar score would this asphyxiated baby have?” asked by the CHO. This led to a discussion of Apgar, what it means, how the score is achieved, and the limits of its usefulness in such a situation.
Lesson learned: 7 in one group is too many! Split the into groups of 3 or 4 at a time, so they don’t get bored.

Calabeh Town CHC
Met by CHQ Alfred Momba; as time was short, discussion was limited.

Staff and delivery numbers: not obtained. However, there is no midwife allocated here.

Population served: 22,000 – much larger number than most we visited, which is salutary in the light of there being no midwife.

The healthcare worker (Hc W) who had attended a workshop was transferred here from another CHC, but was not working today, so no questionnaire was completed.

NNR Training
SECHN 7
MCHA 4
(Unfortunately the CHO did not participate, though present throughout)

As a woman was in active labour when training finished, I was unable to see the delivery room. I was informed there was no ambulance bag here so one was provided.

Lesson learned: crew were hungry as had not eaten before coming to Family Kingdom so they were anxious to get away from work to get food. So ensure they have eaten/get some food at some point, otherwise they are pulling in a different direction (ie Mbrâi, driver etc)

Day Nine Sunday 28th August

Gray Bush Community Health Centre
Met by CHQ who was very welcoming; he had done resuscitation training with LST M who donated adult and baby resuscitation dolls. The baby doll was not so good for neonatal ventilation demonstration, but heful for staff practice at a later date. Misoprostol is not available; however the CHO still asked about its use and application and a very helpful discussion ensued, particularly regarding the risks when used to augment labour. It again highlighted the need for training and monitoring of misoprostol use.

Staff:
CHO 2 (+ 1 non-RN)
CHA 4
Midwife 1
MCHA 9 (+2 non-RN)
SECHN 5 (+5 non-RN)

Deliveries 25-30/ month
Maternal deaths – CHO reported one in last year, which occurred after transfer to PCMH, where he said that no action was taken for many hours after transfer.
Partogram clearly used. CHO has a very good grasp of its use and application, as we were looking through a pile of them he picked out one with a problem and at once took aside the relevant MCHA to explain the problem.

Workshop  
Ai sha Sheriff, MCHA (non-PIN), attended Jan’16.

Questionnaire  
Ai sha stated that she had cascaded some training relating to Misoprostol (though not available at this CHC, so not so relevant), partogram and NNR, though no evidence of this.

NNR Training  
Unknown designation - 4  
3 were satisfactory, 1 was weak.

Day Ten  
Monday 29th August

Wilberforce Community Health Clinic

Staff:  
CHO  3 (Senior CHO Osman Kamar, present today - new in post)  
CHA  2  
Midwife  1 (Zainab Masey, under 2 months in post)  
MCHA  9  
SECHN  17 (inc non-PIN)  
HIV counsellor  2

Deliveries  20-22/month  
HIV pregnancies approx. 6/yr  
Population  14,661

Workshop  
Two midwives from here attended workshops but have since been transferred, both visited during this trip, one at Susan’s Bay, the other at Grafton.

Questionnaire  
None

NNR Training  
Trained 13 - 2 CHO, 1 midwife, 1 student midwife, HIV counsellor, SECHNs and MCHAs. Each did get some personal time practicing with me, but with only one doll and trainer, it was difficult to ensure each had enough practice. However, a couple of staff did video the demonstration and were encouraged to review this, practice, and demonstrate to others.

Due to time restraints it was not possible to see the delivery room, check register or partograms. An ambulance bag and mask was given.

Mordaick discussed the supply of Misoprostol.
Rokupa Government Hospital

This was a very interesting and informative visit. The length of the day's first visit, and distance to Rokupa, meant that we arrived late, but two midwives, Umujabbi (senior midwife) and Hawa Tarawally had both waited to meet us.

Staff:
- Midwife: 4
- MCHA: 4
- SECHN: 4
- AIDS: 3
- Obstetrician: 1
- Deliveries: very variable, numbers still recovering after Ebola; as the hospital was a treatment centre, women were afraid to go there, but are now returning.
- Pre-Ebola: 90-100/ month (though with seasonal variation)
- 2016: 40-90/ month

Maternal death - 1 in May, a referral to them 3 weeks postnatal, following persistent, irregular bleeding. On arrival, the woman’s Hb (haemoglobin) was 3.5; a blood transfusion was arranged with PCMH but delayed due to the family not being able to donate blood as payment (4 donors to replace 2 units of blood). The patient died within minutes of the transfusion being commenced.
Rokupa hopes to have its own blood bank very soon.

Misoprostol: none in stock. Sr Jabbie has experienced considerable difficulty in getting further supplies from Reproductive Health, and this, plus her account of the drug being used in the community for unregulated abortions, indicates that there is some 'leaking' of stocks from government sources. When available, misoprostol is used for PPH and induction of labour (IOL) following intra-uterine death (IUD).

There have been similar difficulties in obtaining oxytocin, and she has resorted to buying supplies, clearly marked 'free government supply', from someone who walked into the hospital offering the m for sale.

Manual vacuum apparatus (MVA) was supplied by a NGO and Sr Tarawally trained in its use; she then trained Sr Jabbi. Its purpose is to evacuate retained products from the uterus, whether after incomplete abortion/ miscarriage, or following term birth (thereby preventing further bleeding). They also know how to use an intra-uterine balloon, as well as basic skills and knowledge (emptying bladder, repairing tears etc). This hospital is better placed than many to handle maternal bleeding, mainly because of the commitment and skill of the staff.

Workshop - it was unclear if anyone from here had attended

Questionnaire: none

NNR Training
The first part of training was an unexpected opportunity to assist with resuscitating a baby born as we were having our discussion. This was a real-time demonstration of the initial actions – neutral position jaw thrust, which enabled respiration to start. There was evident initial good practice; the baby had been moved to a good work area, a bag and mask was in place (though slightly perished – a new one was provided). As the baby clearly had respiratory distress, the local protocol was implemented and so he was given a combination of antibiotics and a steroid, kept warm and observed; if no better, he would be referred to PCMH the following day. Resuscitation was demonstrated to 6 staff, but only the two midwives practiced.

This is a potential training base to reach out to CHCs who refer into Rokupa.

Day Eleven Tuesday 30th August

Kumtolo Community Health Centre
Met by midwife Elizabeth M Cole.

Staff:
CHO 2
Midwife 1
MCHA 11 (+3 non-PIN)
SECHN 3 (+7 non-PIN)

Deliveries 27-37/month
Maternal death: 1 this year – PPH 2hrs post-partum, only oxytocin available, no balloon or misoprostol (not yet supplied)

Workshop the previous midwife attended, but is now at Waterloo.

Questionnaire - none. Sr Cole had received NNR training from another NGO, and she had a good basis of knowledge; also several staff members had attended MoH programme, OjT which includes NNR.

NNR Training
Midwife 1
MCHA 4
SECHN 4

Most had a reasonable grasp of procedure. The senior CHO arrived towards the end of the visit; he had a good question regarding use of, and timing of steroids. It was explained that nothing will work without good NNR practice first; steroids can be of use later if required.

An ambu bag was available, but only 250ml; the mask was broken, so disposed of. A new 500ml ambu bag and mask was provided.
Day Twelve Wednesday 31st August

0030hrs was the start of the 16 hour return journey to Gatwick, via Casablanca.

Summary

This visit has been very productive, gathering useful information, developing contacts and learning more of the environment in which people work day to day, besides doing NNR training with 109 people in 17 units. However, as is evident from these notes, this does not mean that the job is done in these places, with the people encountered. Rather, we have put another brick in the wall of learning.

We came away with further thoughts on how we could reach staff in health centres and posts in a more limited area, in order to have a more concentrated impact, rather than the scattered impact we have had until now. This would have a much more long-lasting effect on people’s knowledge and practice, and therefore on the safety of childbirth than having one, relatively brief encounter with perhaps only one follow up session. Given that TAM has no one permanently in the country, it is vital to consider how we best do this, making the most of the resources at our disposal, both in terms of personnel and funding.