Report of the 5th BirthLink Midwifery Visit to Mongolia

23rd March – 9th April 2011

Introduction

The fifth midwifery visit took place from 23rd March to 9th April 2011. Our focus for this visit was to develop the education and continued professional development of midwives through delivering a 'train the trainer' course in Ulaanbaatar. In order to achieve this we brought with us culturally relevant and Mongolian translated materials from the UK. All these materials have been produced by us and our focus has been to create simple, precise resources, which are evidence based, meeting international and WHO guidelines and are pitched at the right level.

Objectives

- To deliver the train the trainer package to 5 midwives, including one from Erdenet, Orkhon province.
- To maintain links with Erdenet Hospital, Orkhon province and develop satellite education project through the trained midwife.
- To meet with the working party at First Maternal Clinic to take the project forward.
- To strengthen the relationship with the WHO (Mongolia) who are in the strongest position to influence the Ministry of Health and thereby make changes to midwifery practice.
- To continue our connection with the University of Health Sciences and to deliver some teaching to student midwives.
- To evaluate the progress in establishing the Education Room.

- To review English language development in our key midwives to facilitate their own research and ease of communication with us and with a view to their visit to England.

Outline of work

Since the start of this project the philosophy behind all our work is to enable midwives to develop highly effective, evidence based, practical skills in line with this WHO observation,

"There is a widely shared but mistaken idea that improvements in newborn health require sophisticated and expensive technologies and highly specialised staff. The reality is that many conditions that result in perinatal death can be prevented or treated without sophisticated and expensive technology. What is required is essential care during pregnancy, the assistance of a person with midwifery skills during childbirth and the immediate postpartum period, and a few critical interventions for the newborn during the first days of life." (Turmen, WHO, 2006)

All our experience shows this to be true for both mother and infant. Expensive equipment is impossible to service and maintain in both isolated, rural areas and even in the major cities. Donated equipment lies unused and wasted, not only when broken down but also because clinicians are not experienced in their use. At the same time essential skills promoting the normal and the avoidance of complications are underdeveloped.

In order to help develop these critical skills we developed resources and arranged workshops to enable 5 experienced midwives to become trainers through practice and delivery of a range of essential educational updates for other midwives. Each trainer was given a complete pack of powerpoint presentations (soft copy), charts, handouts, learning aids, DVD materials, questionnaires and evaluation forms. The topics included were on Normal Childbirth, Fetal Heart Assessment including basic cardiotocograph understanding, Management of Obstetric Emergencies, Infant Resuscitation, Handwashing and Documentation.

The train the trainer programme that we scheduled would be for 5 days of theory based learning, teaching practice, practical skills development, peer group assessment and evaluation. Our aim was for the trainers to familiarise themselves with materials but in owning the project, for them to come up with ideas of how they will roll out the education and monitor attendance and compliance and evaluate its effectiveness.

To safeguard the development of this programme we built in certain objectives that have to be met in order for the trainers to be certified by us. The first stage to include 6 hours of teaching practice, some photographic evidence and a reflective report on the teaching – this will achieve a Level 1 Certificate. As an incentive to continue, we asked the trainers to go on to deliver all the topics at least 2 times and again to write a report with supporting photographic evidence. This will achieve a Level 2 Certificate and we will donate a small sized doll and pelvis, which is an excellent and transportable teaching aid.

We also planned to work at the University of Health Science, delivering some presentations to midwifery students and to see how curriculum developments were progressing.

Events and experiences

First Maternity Hospital Ulanbaataar

Since our last visit there have been some changes with local members of the project team. Our excellent project co-ordinator and translator Dr Usukbayar has departed for Australia to do a PhD. We were therefore more reliant on the First Maternal Hospital's Head of Nursing and Midwifery, Amarjargal, and we had to find a new translator. These changes were not without teething problems. Although Dr Usukbayar is still supporting us remotely and helping with some of our translation needs , communication with Amarjargal proved to be difficult and this led to some misunderstanding. Despite our expressed objective that she should become proficient in basic English, and an offer of funded classes which was not taken up, her English remains poor. Though the programme was sent to both Usukbayar and Amarjargal, significant changes were made to the schedule without our prior knowledge. This may have been through misunderstanding or due to Amarjargal holding a different agenda – we will follow this up in our evaluation with her and Usukbayar.

An agreed action point of the Working Party at First Maternity Clinic was that Birthlink UK should develop a Train the Trainer package and bring this to UB in April 2011 and for trainers and Birthlink to share the delivery of education to First Maternity Clinicians and midwives from other UB hospitals.

In the event, the schedule proposed and promoted in Ulaanbaatar by Amarjargal was for us to do all the teaching with a large group of midwives, rather than focus on the trainers. Furthermore, our 5 days had been shortened to 4, despite agreement from her that we would work together on Day 5, which was a Saturday. This was unacceptable to us so a compromise was reached of 2 days larger scale teaching with midwives and 2 days working with the group of 5 trainers. We are conscious that this has been a setback to our objective for this visit and left the trainer programme under developed. An additional setback was that the 4 midwives that had been named and put forward to us were reduced to 3 and 1 was unavailable for the first 2 days, which had less impact than it might have, due to the fact that we were now working only with the trainers on day 3 and 4.

Our two days of teaching went well and was delivered largely to a new set of midwives but also as an annual update to First Maternity Midwives who have participated before. Such annual updates are absolutely aligned with UK practice. Our teaching of the materials also gave the opportunity for the trainers who attended, to revisit and familiarise themselves with the content and teaching style of our package.

Our shortened Train the Trainer course ran as successfully as it could, given the time constraints. The midwives had time to work with the materials, refine all the translations using our translator and to understand fully all the content and theory. We also emphasised the importance of evaluation – both self, peer and participant evaluation – so that the materials can be amended and developed as appropriate. There was some opportunity to do the teaching practice and peer evaluation but this was limited and there was no time for teaching practice with a larger group of midwives. We stressed the need for them to take this on in our absence and we placed Amaraa in charge of structuring and monitoring this, suggesting that they start with teaching small groups. We will monitor this ourselves by evaluating their reflective reports and photographic evidence. When the trainers are more proficient and confident we will encourage them to develop a programme of education that can be taken out of the city. We are aware that this is a big challenge for this small group of midwives but, if successful, will achieve our ultimate goal of Mongolian midwives sustainably driving forward their own professional development.

The Education Room at Frist Maternity has had some setbacks. The allocated room was recently moved to make way for a Doctors' Training Room and funded for gynaecological purposes. Amarjargal has been given a replacement room. Dr Govind, of the WHO, encouraged Amaraa to make a proposal for midwifery equipment from them. We have stressed to her the importance of using this room with the trainers for regular updates and making it open access for midwives.

We requested a debrief meeting with the Deputy Director of the First Maternity Hospital to ask for feedback on this visit and to ask for their ideas on how they wanted the project to develop at their hospital and our role within it. The Deputy Director is only six months in post but claims to have a strong mission to increase practice development, especially in her midwives so that they are enabled to take greater responsibility in normal birth and also to improve standards in documentation and hand washing – both areas that we have identified. She was keen that, at present, we do continue to return whilst the education programmes are developed and to lend weight to the initiatives.

Erdenet Hospital, Orkhon Province

Our ambition to develop the satellite project in Erdenet through training Bayarhu, their midwifery manager, became one of the biggest successes of this visit. At our first meeting with Bayarhu, her enthusiasm persuaded us to make an unplanned visit to Erdenet. Since we were now free on Saturday, we agreed to use the weekend to go to Orkhon province but impressed upon her the need to organise it properly as it is a long way to go for 48hours. Our visit last July had been so successful that Bayarhu's team of midwives were eager for us to return.

After a very early start, and a 6 hour journey, we arrived at lunchtime and went straight into a fully packed timetable and a crowded room full of midwives and doctors, several of whom had travelled from remote soum villages. Bayarhu had certainly kept her promise and her efficiency of organization and planning thoroughly lifted our morale. In just 2 days, whilst she was still in UB and with the help of her team in Erdenet, she put together a full programme and rallied 45 clinicians to attend. It was touching to see how warmly Bayarhu was greeted by her colleagues after being away for a week and clearly demonstrates what a highly regarded leader she is.

We had several lively sessions, with much interaction and simulated practice. Bayarhu planned the sessions and delivered some of the materials herself, taking our project forward exactly as we had hoped. The hospital employs an English-speaking Education Co-ordinator who gives English classes to Doctors and helps facilitate educational visits from outside. The teamwork and organization between her and Bayarhu was outstanding and enabled the clinicians to benefit as much as possible from the weekend. It is clear that the culture in this hospital is forward thinking and values professional development greatly. An example of the organization was that a register of attendance was kept throughout and each participant was given a signed certificate at the end. This attention to detail and record keeping is excellent and promising.

The buildings, facilities and equipment at this hospital may be limited in comparison to the First Maternity Hospital but the appetite for solid, internationally accepted knowledge and practical skills is far greater. We made one recommendation for the clinical environment. Though staff understood the need for hand washing, most of the basins had no soap bars since these are often stolen. We stressed the need for soap and suggested that wall mounted soap dispensers be placed at each basin – whilst the outlay is expensive, the cost of antibiotics as a result of infection is far greater. Bayarhu agreed to this and said she would take it to the Hospital's Director the next day at their debrief meeting from the weekend.

This unplanned visit proved extremely worthwhile, and our setback in First Maternity paved the way for success in the so-called satellite version at Erdenet. We are satisfied that one of our four trainers is fully committed, confident and will certainly drive the education project forward locally. To help her, we left a full-sized doll and pelvis, which is one of the most useful tools for demonstration and simulated practice.

Relationship with the W.H.O

We had two meetings with Dr Salik Govind, the first was to increase the collaboration between WHO, First Maternity Clinic and BirthLink – the 3 strands of the working group - and was attended by ourselves and Amarjargal. Dr Unurjargal, a First Maternity Clinic Doctor, also on the Working Group, was away so could not attend.

We discussed the Train the Trainers programme in progress and showed him a sample of the materials in the trainer pack. He was very impressed with our resources. He told us that WHO is developing a new initiative to take training programmes out to 26 Soums (remote towns and villages). These programmes are to develop practice in essential healthcare, including maternity services. In his quest for summaries of brief, suitable training programmes and essential equipment from Mongolian Doctors, he was presented with long, complicated documents and the need for many drugs and a range of expensive equipment. Our training package exactly meets his criteria as the materials are short, succinct, highly visual, practical and problem based. He was extremely enthusiastic about our work and was excited by our shared vision. He invited us to return the next day to meet some of his Mongolian staff to demonstrate our materials as a model for their whole programme and explore avenues of mutual support.

Dr Govind had also met with the Director of the University of Health Sciences to discuss the development of a more robust midwifery curriculum that will prepare midwives to deliver total care to women in normal childbirth. Only then will it be possible to put forward a strong case to the Ministry of Health to raise the profile of midwives. We feel that this may have been influenced by our previous discussions on the curriculum and our delivering of the complete Oxford Curriculum to the University. He suggested that we met with the Director ourselves during our visit to the University.

Health Science University

Our final piece of work was the visit to the University. Unfortunately we were not able to call a meeting with the Director. We delivered our lectures as planned to the whole cohort of 50 students. They were lively, appreciative and the feedback we received was that our interactive presentation style was much more easy to assimilate than their usual lectures. Teaching at this level has an added benefit of being able to influence the thoughts, possibilities and practice of future midwives before they become entrenched in the culture of outdated midwifery practices.

Reflections/conclusions

All projects in developing countries will have setbacks. In the event, our experience in Erdenet, though unplanned, exceeded our expectations of Bayarhu's development as a trainer. We are confident that one of our trainers has been enabled to work with the materials and we have had the opportunity seeing her teaching running a training event.

We are wiser about local personnel and the need for excellent organizational skills at the planning and preparation stages. With this in mind, there is also the need for us to scrutinise such planning in our future collaborations.

Our initial experience at the First Maternity Hospital was disappointing but we would like to continue to support Amarjargal and will be expecting and requesting regular updates on the progress of her trainers. We recognise that Amarjargal is working in a difficult environment where there is much professional conflict and she is lacking in support making leadership and motivation more of a challenge. Change will inevitably be slower there. We will also continue to take an interest in the development of the Education Room.

Both Bayarhu and Amarjargal have done little to develop their English language skills. Bayarhu has found a teacher and we suggested that she makes a proposal for funding to us. We will suggest the same to Amarjargal.

Our strengthening relationship with the WHO will benefit the project and gives us confidence that our philosophy dovetails precisely with current needs in Mongolia. Our continuing relationships, built up over several years, and growing understanding of maternity care and working conditions give us some expertise and insight into the reality of delivering maternity services in Mongolia. It may be that the project is at a crossroads of being able to be extended across Mongolia, with the endorsement of the WHO and our sharing of local knowledge. Our knowledge of local expertise has also enabled us to recommend some midwives as champions for the future of midwifery services.

We feel very positive that the University looks set to move their curriculum forward and at the same time influence changes in government thinking. We will continue to support these developments in curriculum changes by sharing our knowledge of UK education and will also share our teaching resources.

Action points for the future

- A thorough evaluation of our work in the Train the Trainer programme
- Continue to develop and refine our training materials
- Strengthen communication with midwives when we are UK based
- Plan our timeline for returning to monitor progress
- Plan to do more practical based teaching in the hospital clinics, delivery rooms and postnatal areas.
- Begin to make decisions on an exit strategy subject to a review of the developments in the next few months.

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