Report of Second Midwifery visit to Mongolia, December 2008

Background

In April 2008, two community Midwives travelled to both urban and rural areas in Mongolia to gain an understanding of Midwifery provision and practice, to meet with health professionals in order to discuss practice issues and to discover whether a small educational project would be useful and desirable.

The purpose of this return visit was to achieve some of the new goals, as set out below, that came out of the original findings.

Objectives

- To contact the midwifery education centre in Ullanbaator and gather information on the current education programme and, if invited, to carry out some interactive workshops.
- To target two units already visited, Ullanbaator and Murron and to work alongside midwives and doctors.
- To begin a small education programme and maintain ongoing links with professionals.
- To focus initially on education and skill development in 2 main areas:
    1. Fetal heart monitoring in labour.
    2. Use of upright and kneeling positions in labour and delivery, returning to the traditional Mongolian birth pose, which are currently used successfully in the UK leading to more comfortable birthing for the women and fewer vaginal tears, which in turn reduces the need for suturing lessening the chance of infection.
- Gather information about other projects in the area of pregnancy, childbirth and the post-natal period running

Visit

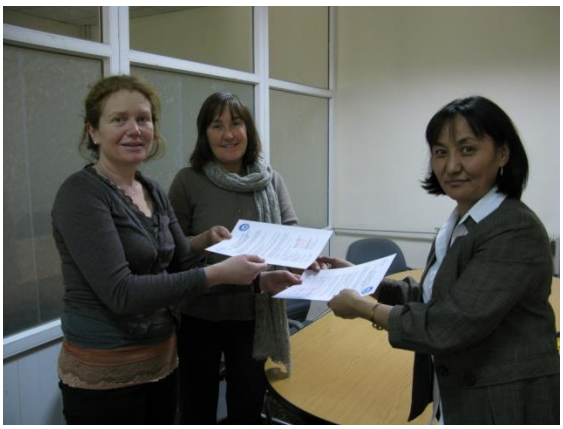
The visit took place between 29th December 2008 and 8th January 2009, in the heart of the Mongolian winter with temperatures as low as minus 32 degrees Celsius! We were accompanied by Dr Usukhbayar Ariunbold who acted as our translator, filmmaker, Mongolian expert and friend throughout and was responsible for making contact with clinicians in the different hospitals. He helped set up all the meetings and enabled us to manage the more formal exchanges with the appropriate and required etiquette.

Ullanbaator

We spent 5 days in Ullanbaator and our focus was on initiating relationships with the Midwifery Association of Mongolia and senior clinicians in the country's capital. We also ran the workshops for professionals in the Number 1 Hospital and worked alongside a number of the participants in the following days.

Meetings in Ullanbaator:

In order for the project to begin well and have the right profile several meetings were set up with individuals who have an interest in and influence over maternity services. We will maintain ongoing links with those that we met since such connections are likely to help us cascade out the knowledge and practice that we are sharing, making our interventions more sustainable.



1. The first meeting was with the General Director of the First Maternity Hospital, Professor Purevsukh and his deputy director and midwife manager. We had the opportunity to talk about BirthLink (see appendix), its objectives and where it operates and to talk about our findings from the first visit and what we would be focussing on in the workshops. We had 2 further meetings with the Professor and his team, to sign a document to set out the co-operation between the No 1 Hospital and BirthLink and we were given a Certificate of Appreciation. We also gave one of our handheld sonicaid devices to support the practice of fetal monitoring.
2. The second group that we met was the Mongolian Midwifery Association and we were able to speak with the president and secretary who are keen to organise a joint seminar at a future conference of the Midwifery Association.
3. Our third formal meeting was with the Project Coordinator for the Maternal Mortal Reduction Project, Ministry of Health, Mongolia, who is also the incumbent president of the Midwifery Association. This meeting took place at the end of our 2 weeks so we were able to share ideas and reflect on the experiences and outcomes of our visit. We also signed a certificate of co-operation between Birthlink and the Mongolian Midwifery Association.

Our sense from these meetings is that we were welcomed in Mongolia and that we have begun to establish some useful connections, which will smooth the way for future visits.

Workshops in Ullanbaator:

Topics:

1. ***Fetal Monitoring in Labour***
2. ***Alternative Posistions for Labour and Birth***

We had organized to do 2 presentations for the doctors and midwives on fetal monitoring and alternative positions for labour and birth. We also showed the group a video of different birth positions which caused a lot of interest, as all women in Mongolia are delivered on their backs with legs in stirrups, which is a legacy of the Russian system. The presentations were delivered in English with Dr. Ariunbold translating. The materials and handouts included much illustration in order to overcome language barriers. See Appendix 2 and 3 for the Presentations.

There were 28 people who attended these workshops. There was a lot of interest and many questions asked. It was apparent, on our previous visit, that there was no monitoring of the fetal heart in labour, so our teaching concentrated on current best practice of assessment of fetal well-being. The baby's heart can be heard in a variety of ways, including the traditional Pinnard Stethoscope, which requires no batteries and is available in all Mongolian Clinics, therefore teaching in this area is simple to introduce and sustainable. During our last visit we also noticed that no monitoring was performed alongside the use of syntocinon so we made particular emphasis of this. We encouraged practitioners that gaining a picture of the baby's well-being in labour is an important aspect of care. Where the heart rate is not reassuring, simple manoeuvres can be put in place, which don't necessarily require further technology. In the UK, the first thing midwives would do is change the mother's position to encourage maternal-fetal blood flow and this often resolves the situation. Furthermore, if fetal compromise is suspected, anticipation and readiness is always important as it minimises time loss for intervention at delivery. Finally, in the larger hospitals, there is the technology to expedite delivery if needed. So education on fetal heart assessment would provide Mongolian practitioners with a useful tool.

Our choice of teaching on Positions for Labour and Delivery again focuses on an intervention that is free of technology and therefore free from structural hurdles, in terms of implementation in a developing country. Labouring and delivering in an upright position maximises placental-fetal blood flow and increases the space in the maternal pelvis which facilitates descent of the fetus through the pelvis. Women are more able to push in an upright position and report feeling more in control. There is also a reduced risk of perineal damage,

which therefore leads to less suturing, thereby reducing the risk of infection – an area of concern in Mongolia.

The traditional birthing position in Mongolia was to kneel and lean over an upturned dung basket (dung is used as fuel and fire, as in many places, is sacred to Mongolians, so the dung basket is an object of great importance). In our presentation, we emphasised that we were not introducing them to anything new but rather encouraging them to return to the Mongolian way abandoning the system introduced under Russian influence. This idea was not only grasped instinctively but also appealed to national pride!

To end the presentations, we showed a video of a waterbirth. This is not something we intend to introduce at this stage but we knew that there was a lot of interest in this method and we felt that the group would enjoy widening their knowledge of current practice. The video also illustrated very well the effectiveness of upright birthing positions and we used it to consolidate the theory of the previous presentation.

There was much discussion after the workshops among the participants, which was really important to see. We were also asked many questions about practice in the UK – there appeared to be genuine interest to learn.

Shared Practice in Ullanbaator:

Over the next few days we went to work in the No 1 hospital. We found that the midwives were a little reluctant to let us actually do anything, they wanted us to observe them. We did manage to do some physical caring of the women by taking them drinks and rubbing some backs, one woman was very appreciative of this care, we felt that if the midwives observed us doing this that they may be encouraged to feel free to copy, we also encouraged the women to changed their positions, they were very appreciative of this. It was lovely to watch the 2 women that we were caring for chatting about what we were doing and supporting each other. This is a very positive aspect of the women labouring together, as they do not have their partners or family with them. Being in such an open area might not suit British women, but we could see the advantages of this companionship!

The other observation we made was that 8 out of 10 babies that we saw delivered were born with meconium. We believed this could be due to the practice of giving syntocinon in the second stage. We were told this is to prevent bleeding. This made for a rapid delivery in the 2nd stage and appeared to cause stress to the baby. As the heart beat is not listened to they had no way of knowing if the baby was coping with the much stronger contractions. Babies tended to have lower Apgar scores at delivery, appearing more shocked with less tone, a poorer colour and needing a full minute to give the first cry. We believe this could be due to overuse of syntocinon.

The least positive things that we observed were that there was very little hand washing between doing procedures to different women. In order to minimise the transfer of infection, hand washing before and after contact with each woman is essential. This is something we could look at on a return visit. General hygiene in this hospital was not well maintained either. We noted blood spots around some of the tables and on walls and although care assistants did clean, they tended to use the same cloths over a large area rather than

thoroughly and regularly rinsing the cloth. In this way bodily fluids can be spread rather than contained.

Communication to the women during procedures was very poor. They were told little about what was being done to them even though staff continued to speak freely on their mobile phones while caring for these women. We observed one caesarean section for a breech baby and even in theatre, mobiles were ringing regularly and yet the woman herself was not addressed or reassured during the delivery. One woman's baby was taken to special care after a difficult resuscitation and she was given no information on where he was.

No abdominal palpations were done before a vaginal examination, which is an important assessment tool for working out externally what the position of the baby is and the extent to which he or she is descending through the pelvis. Furthermore, in the UK it is routine to listen to the baby's heartbeat after a vaginal examination to check fetal wellbeing and this was not done here. Occasionally the fetal heartbeat was listened to with a pinnard, but this was not done regularly enough or for long enough to assess properly the wellbeing of the fetus.

The women were delivered on narrow metal couches on plastic sheets with their legs in stirrups sometimes, four women in the same room. In another room however there were some much more modern delivery beds, but we were told that these were used for the women to rest on in early labour. This would be a good objective for our next visit, to encourage the use of these beds, which would be much more comfortable for the women to use as they would be more able to change positions on them.

There is a lot of stretching of the vagina by the birth attendants when the women are pushing, and the birth attendant pushes hard against the baby's head as it is being born. This was practiced in England in past years, but is discouraged now and we did note that although there seemed to be intact perineum's there was a lot of vaginal and labial tearing, which required suturing. With all suturing, especially in conditions where maintaining a clean environment is difficult, there is a concomitant risk of infection. Bringing down the rates of suturing would be desirable and something we could focus on in the future, though, practising

the upright delivery position also reduces perineal trauma and was addressed in the workshop.

We did observe a baby being resuscitated. The way in which this was done was dated relative to UK practice and included a lot of suction to the baby's mouth and airways, an intervention which is discouraged in England now, as it over stimulates the baby and can increase the level of resuscitation needed.

Our overall experience at the No 1. Hospital was that it had been challenging and that the culture was disheartening. There appeared to be a lack of motivation in staff to pay attention to standards and to give proactive care to the women. Midwives spent much time in the staff room together and only came out to perform a procedure on a woman, rather than be with her throughout her labour. Many changes could be made here, mostly changes in attitude and behaviour, which would increase the level of care a woman receives and would help midwives be more in tune to the progress of labour. Tackling this would probably demand a longer stint of working alongside practitioners as well as further education on specific practices such as hand washing.

Muron

We flew from Ullanbaator to Muron in the North of Mongolia, close to the Russian border. Muron hospital serves the region and is therefore busy with over 1000 deliveries per year, including higher risk births. Muron Hospital was a lovely hospital, it was cleaner, better organized and had much better equipment than UB. There was Telemedicine set up for the use with the scan equipment and the CTG and Doppler machines. This had been donated by the Swiss government, and they have had a large amount of financial support from the Luxemburg government who donated new equipment for the theatres. This equipment has been well cared for and appears to be properly used, and it was noticeable that the aseptic techniques were excellent here in the theatres.

The behaviour of staff was also noticeably different. Mobile phones were largely switched off except in the more public areas, if they were answered, it was done discreetly. The staff appeared behave as a more cohesive team, communicating courteously and in gentler tones with one another. The atmosphere in the operating theatre was quiet and peaceful and the woman was communicated with.

We were shown round by several members of the team and it was clear that the Doctors and Midwives were proud of their unit, happy to show us everything and keen to be with us to exchange ideas and knowledge. We also met with the director of the hospital and she suggested that we would go back to meet with her at the end of our visit to give feedback. The staff didn't seem in any way threatened by our presence and were very open with us. This extended to our shared practice with them. The experience here was very different from in Ullanbaator. Perhaps, because the unit had already received funding and equipment from abroad, they were more open to foreigners.

Presentations in Muron

We did our presentation on the first day and it was extremely well attended. Our presence had been well advertised, we were shown a noticeboard which advertised the workshop stating that all staff were to attend. In fact, even one of our taxi drivers had heard that English

Midwives were coming to Muron to do some lectures! It was a lively audience, many taking notes and lots of interested questions. There was a specially dedicated education room and the atmosphere felt very purposeful and it seemed that all present were keen to learn. One of their main concerns was about the risk of infection, which they thought would be greater if the women were more mobile. We were able to reassure that this is not the case and to argue the point that the less we intervene and touch, the less chance there is of infection.

There was also a lot of notetaking and questioning when we delivered the presentation on fetal heart assessment. We suggested that we could do some practical assessments with the practitioners using the sonicaid that we would leave with them on pregnant and labouring women. This way we could ensure that practitioners had adequate training with the sonicaid and could become competent while we were with them, making it more likely that they would use it after we had gone.

Shared Practice in Muron

When we returned next day there had just been a delivery and we were pleased to see the baby was skin to skin with the mother.

We asked if we could look at their delivery beds with a view to trying out the all four Mongolian traditional position for birth. With several of the midwives and doctors present, we adjusted their delivery couch and tried the position for birth ourselves, demonstrating how the baby would be delivered. This seemed to catch their imagination and the doctors and midwives were keen to practise this with us on a woman as long as it was not her first baby and if we gained consent.

We then demonstrated the use of the sonicads that we had bought with us as gifts. We spent a long time going through the importance of the right interpretation of what they were listening to. We had decided that we would not give them until we were sure that they had gained the correct technique.

Our first birth in Mongolia was with the midwives and a lady having her 3rd baby. We did the Mongolian birth position with them. The midwives were very excited by this birth and the mother declared that it was a much more comfortable way to deliver. The midwives also saw that because we did not try to enlarge the vagina with our fingers, but allowed the perineum to stretch slowly without touching, there was no damage to the vaginal wall and therefore less risk of infection to the mother.

We did a second birth with a young Mongolian poet having her second baby. She told us she had had a difficult first birth with extensive tears and a lot of stitches. She was keen to deliver in the all fours position because this was, for her the traditional Mongolian way and also we explained that it may lead to fewer stitches. Her husband was very interested when we updated him about what was happening and they both wanted him to be present at the birth, something that does not happen in Mongolia, but she had read about it.

The doctor agreed. We progressed to a beautiful birth with no stitches and again all agreed that their traditional position was a much more comfortable way to give birth. The woman felt she had been much more in control and could manage the birth much better in an upright pose. Her husband, also, was so proud to have seen his baby born. He was even offered the

opportunity to cut the umbilical cord, which is always offered to fathers in England, and he did this as well.

During this birth we had used the sonicad, and had managed to demonstrate its correct use, and how easy it is to listen to the heart beat even with the mother in the traditional Mongolian pose. This woman was also on an intravenous infusion of syntocinon as her contractions had been weak. Ordinarily in Mongolia, women on a drip will remain bed bound until delivery. Again we were able to show that it is possible to stay mobile with a drip in and that being upright would maximise contractions.

Throughout this time at Muron we managed to demonstrate easy techniques for supporting women through labour and birth, getting the women off the couches, being more active in their labour, and demonstrating massage techniques. We successfully taught the use of using the sonicaid in labour, and the most effective way of counting and assessing the fetal heartbeat. We showed that even with their current delivery beds it is possible to deliver in the upright pose, returning to the Mongolian traditional birth position, which is largely accepted in the UK as superior to the recumbent position. In a small sample of women who had delivered in both positions, we demonstrated that they found it more comfortable and in all cases, no stitches were required and babies were delivered in very good condition, needing no resuscitation. During our last night, the hospital had a further delivery and, though we were not there, she was delivered on all fours, with all good outcomes – a strong indication that in this hospital, the learning that they had acquired was being put into practice, independent of us.

On the last day we returned to meet with the Director of the hospital to give some feedback from our visit. We were very complimentary about the cleanliness of the hospital and the excellent equipment that they had. We also said that we were very impressed with the strong team work, and that the doctors and midwives were very keen to learn new techniques and to learn of new developments in the care of women during labour and birth.

We briefly talked about the difficulty of correct hand washing and the lack of availability of soap and towels. It was uncommon to see anyone wash their hands between mothers and babies. The director did not seem to really take this on board and tried to suggest that infection rates differ between the UK and Mongolia. Again, all our observations point to this as being an important topic for the future.

Overall our visit to Muron was highly successful. We felt that we had really worked together and that we were able to deliver some education in the workshops that we then helped practitioners to put into practice and which, as we departed, they were beginning to consolidate. There is a strong desire by them for us to keep the contact going and to return in the future for more co-operation and learning. The senior obstetrician clearly leads a strong team, who are very committed and he would like the unit to be a forerunner of good, up-to-date practice in Mongolia. We would very much like to continue to support this unit with further educational material and joint practice.

Reflections

How far did we meet our objectives?

Fetal heart rate monitoring

It was our aim to run workshops to teach midwives and doctors the correct methods of listening to fetal hearts.

We ran successful workshops that were well attended but more importantly managed to work with the staff so that, particularly in Muron, they gained a better insight into the importance of the techniques we were teaching.

We donated 2 sonicads to the units that we visited

Delivering in the upright, all fours position, the traditional Mongolian birth position.

We demonstrated 2 births in this position in Muron, all the staff and women seemed to understand the advantages of this method for birth. The staff in Muron successfully delivered one further woman in this position on the night of our departure.

The work in Muron was undoubtedly more successful. It was a smaller unit with a positive, forward-looking and open culture. There was a keenness to learn and an open attitude to support from other countries. Attitudes and culture in Ullanbaator were more closed, and there appeared to be less motivation to change working practices, though attendance and enthusiasm in the theory sessions were high. However, we were successful in Ullanbaator in contacting the Midwifery Association and the Ministry for Health and the contacts we have made are important and returning to the capital to deliver workshops during a national conference, for example, would raise the profile of our work in Ullanbaator and could break down barriers in clinical practice.

Observations and reflections on further educational topics:

Use of Syntocinon

The use of syntocinon is extensive. We noted that it was being used without a drip counter or monitoring of the baby. This is a powerful drug that can cause fetal distress and rupture of the uterus. We had seen old CTG machines in UB that were not being used, and one hand held doppler again this was used only occasionally.

Babies whose mothers had received syntocinon were delivered in a poorer condition than would be expected of normal labouring mothers. Education focussing on appropriate use of syntocinon and the optimal regime surrounding its use would be extremely valuable.

Hand washing

There appeared to be poor understanding of the importance of hand washing as well as a lack of resources for good hand hygiene, ie shortage of water, soap, hand towels.

Understanding of this procedure as an essential component of good care in the UK is something that has relatively recently gained a much higher profile in the drive to reduce hospital acquired infections such as MRSA. Hand washing between each and every contact with patients is now mandatory in the UK and failure to follow this procedure is disciplinary. This is certainly an area that we could focus on as a future topic.

Infant rescuscitation

Our observation of resuscitation procedures in Ullanbaator was that some outdated and potentially harmful techniques were still being used. We would like to develop an interactive workshop based on the guidelines from the Resuscitation Council (UK) which is a nationally accepted and practiced protocol in the UK.

Next steps

- Ullanbaator contacts are keen for us to return to run joint workshops and seminars, especially through the Midwifery Association
- We would like to organize for a midwife to come to visit some maternity units in England
- Return to Muron to assess the impact of last visit and to return with new topics, which we would like to plan with the staff there
- We would like to return to Tsetserleg with workshops. We went to this hospital on our first visit and the staff there were keen for us to return. It serves a broadly similar population to Muron. Given our success in Muron we feel that a unit of this size would be good to target as the impact could be greater than in a larger institution. It was reported to us that Tsetserleg has a relatively high rate of infant mortality and morbidity so work on fetal heart assessment and infant resuscitation would be valuable to focus on.
- Add further workshop on the use of syntocinon, neonatal resuscitation and hand hygeine

Appendix 1:

BirthLink

Our activities are aimed at all healthcare professionals involved in maternal and neonatal care from the start of pregnancy until six weeks after birth.

BirthLink was established to provide support and education for all caregivers involved in maternal and newborn care. We seek to work with traditional and professional caregivers, and share ideas and practices, to develop skills in our day-to-day work and clinical roles for the benefits of mothers and babies everywhere.

Objectives

- To facilitate learning and development for safer midwifery, obstetric and neonatal practice by running skills sharing, interactive workshops and emergency skills training.
- To support neonatal departments through training, and improve basic facilities for low birthweight and sick babies.

BirthLink workshops are centred on key care principles embedded in The UN Millenium Project:

Goal 4: Reduce Child Mortality

Goal 5: Improve Maternal Health

www.birthlinkuk.org

Appendix 2:

Add presentation on Fetal Heart Assessment

Appendix 3:

Add presentation on Positions for labour and birth