Reintroduction of Emergency Obstetric and Newborn Care (EmONC) in Liberia: Training in Ebola Recovery Phase

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Background

- Maternal and neonatal mortality at 741/100,000 and 55 per 1,000 (World Bank)
- Health workers in maternity wards were at high risk for Ebola virus exposure
    - Many hospitals and maternity wards closed during the height of the epidemic
- Infected pregnant women and newborns had high mortality rates in the face of the virus – creating more fear and stigma around birth
    - Many pregnant women stopped coming for care
    - Census at the main maternity hospital in Bong County (CB Dunbar) decreased from an average 175 births/month (January – June, 2015) to an average of 84 births/month for the following 6 months

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Background

Shifting from Emergency to Recovery Phase

- International Medical Corps opened an Ebola Treatment Unit outside Monrovia in August, 2014
- IMC opened a second ETU and training center to train providers on Ebola treatment and other topics including infection prevention and control (IPC)
- Re-activating the hospitals became the focus of an ECHO funded grant supporting EmONC training and specialized care for EVD survivors and referral systems
- 7 month project

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EmONC Activities

- Target facilities: 4 referral hospitals in Bong and Nimba Counties
  - 3 government run and 1 privately run hospitals
  - Building on existing health programs including IPC
- Target audience: **Midwives, nurses, physician assistants** in maternity, pediatrics, emergency department, and operating theatre
- Objective: **Provide EmONC training** to the target audience at each hospital with accompanying **mentorship**
  - Original proposal stated that MOH mentors would be used
- Engagement of local medical directors and County Health Officials (CHOs) in project development; however, some relevant national level MOH decision makers were not informed

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Liberia: Targeted Hospitals

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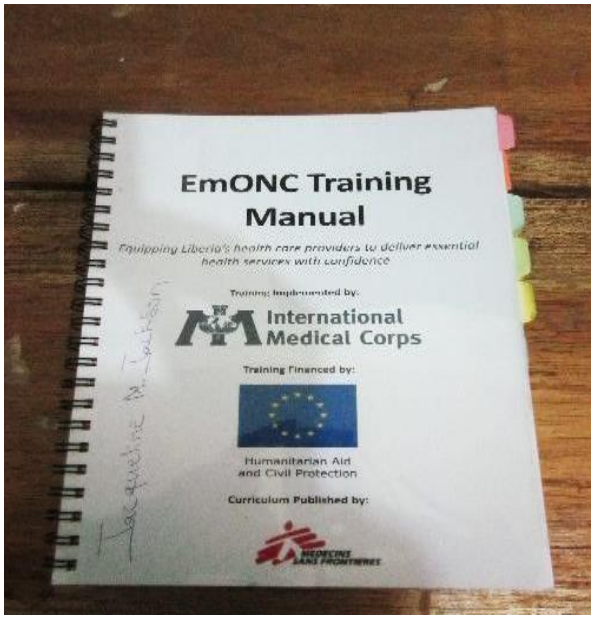
Curriculum Development

- Consulted the MOH RH department, the hospital directors, County RH team, RH working group – there was **no standardized curriculum**
- Training needs assessment in each hospital
  - Need for basic midwifery training with EmONC
  - **2 week curriculum** with 8 days of lecture and 2 days practice on models
- Utilized the trainer's previous experience of working with MSF curriculum
  - MSF's *Essential Obstetric and Newborn Care Handbook* (provided to trainees)
- First training started in September



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Training

- Curriculum approved by County RH team
- Piloted the first training with both midwife trainers training together
- After first 2 weeks, trainers split and went to separate counties to train
- Midwife/nurse from each hospital were unable to assist with the trainings as originally planned
- Members from the county RH teams were selected and paid to assist with training

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Mentorship

- The donor provided additional funds to hire 2 more midwives as mentors

- Goal of Mentorship: provide hands on training to reinforce the didactic trainings
  - Act as a resource for hospital ward supervisors/managers
  - Track learning through mentorship

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Challenges

- Logistics: Insufficient number of health workers in each hospital
  - More time required to train staff - only a few could be released at a time
  - Most of those who did come to the training during the day then had to work the night shift
- Mentorship:
  - The facilities would have preferred that their staff be hired to provide mentorship vs. someone external
  - In the hospitals with the lowest morale and staff shortages, the mentor often filled in as a staff nurse, detracting from her role as a mentor

Challenges

Due to the short time frame:

- Unable to show impact of teaching or mentorship through performance or on maternal / newborn outcomes
- Prevented training national midwifes/nurses for mentorship positions

Results

- Trained 128 nurses & midwives
- Training package handed over to MOH Division of Family Health, County Health/RH teams, and hospital directors
- Provided 6 month supply of RH Kits
- Providers reported increased confidence and technical ability
- Approach designed to transition to comprehensive reproductive health programming

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Results

Analysis Pre-Post Tests EmONC Trainings (RAISE Tests)					
	Training Group	**County**	**Pre-Test**	**Post-Test**	**Percent Change**
1	1	Bong	63%	68%	4%
2	2	Bong	64%	69%	5%
3	3	Bong	64%	87%	23%
4	4	Bong	61%	83%	22%
5	5	Bong	68%	86%	18%
6	6	Bong	66%	89%	23%
7	1	Nimba	66%	66%	0%
8	2	Nimba	71%	70%	0%
9	3	Nimba	77%	76%	-1%
10	4	Nimba	45%	75%	30%
11	5	Nimba	68%	70%	2%

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RH Kits

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Participatory Evaluation

- External consultant led
- December 6 – 15, 2016
- Methodology:
  - KIIs (12 conducted with 18 respondents
  - FGDs (3 conducted with 23 participants)
    - Selected from: Training participants, IMC project staff, MOH leadership
- Review of program documentation
- Site visits for observation

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Evaluation Findings

- Community health teams and trainers approved of curriculum
- Length of training – divergent views – just right, too long - due to some participants continuing shifts during training
- In general, low use of signal functions
  - vacuum extraction in 1 out of 4 facilities
  - High c/s rates
- Trainees liked new MgSO4 protocol and MVA procedure

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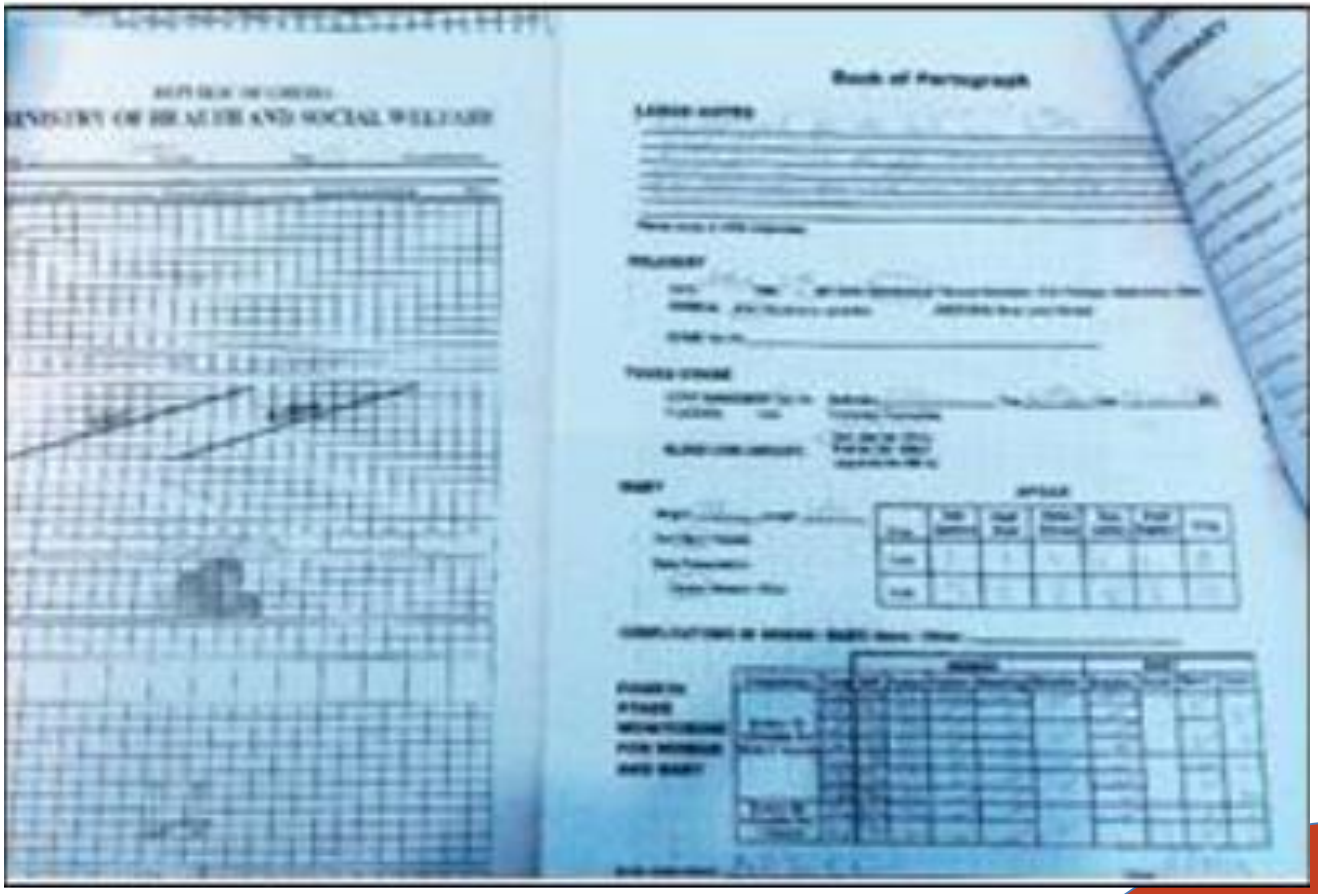
Evaluation Findings: Partograph



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Evaluation Findings

- Neonatal resuscitation reported to be improved
- Mentors highly appreciated

Evaluation Recommendations

- Dedicated EmONC project in similar settings
- Train doctors and primary health care staff at same from different facility levels in consideration of referral patterns
- Supervision/mentoring is a recommended practice – needs to be implemented directly by MOH staff (County RH or Health Team)
- Ensure timely provision of supplies

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Evaluation Recommendations

- Need consensus on who, how and when to use checklists for mentoring and supportive supervision
- Set up data base for monitoring performance from the start
- Comprehensive post-training follow-up is needed at 3 and 6 months
- Integrate EmONC into pre-service training

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Thank You!

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