

It’s complicated...: Views of clinicians in Kenya on Assisted Vaginal Births

Fiona Dickinson¹, Helen Allott¹, Paul Nyongesa², Charles Ameh¹

¹ Dept Int. Public Health, Liverpool School of Tropical Medicine, UK. ² Moi Teaching & Referral Hospital, Kenya.

Introduction

In Kenya, maternal mortality was estimated to be 362/100,000 live births[1], far from the target of 70/100,000 under the Sustainable Development Goals[2]. Skilled and equipped healthcare workers, can provide life-saving emergency obstetric and newborn care (EmOC) including caesarean section (CS) and assisted vaginal birth (AVB), and reducing unnecessary deaths.

Assisted vaginal birth is a method of expediting the birth of an infant following full dilatation of the cervix. This study sought to explore the views of clinicians and managers in five counties in Kenya, regarding assisted vaginal birth-(AVB) and reasons for non-performance.

Method



Doctor receiving AVB training as part of LSTM MNH programme in Kenya

From eight high-volume, healthcare facilities supported by our ongoing maternal and newborn health programme in Kenya, we identified senior obstetricians (OB), medical officers (MO) and nurse-midwives (MW), who were involved in providing emergency obstetric care to women during labour or overseeing maternity services.

Following informed consent, qualitative, key informant interviews were conducted using an online platform, to explore the views of the purposively selected sample of doctors and nurse-midwives. This approach allowed us to explore individual clinician’s perceptions, experience and practice of AVB. The interviews were recorded and transcribed, and a framework approach was used to analyse the data.

Key findings

Key reasons for non-performance of AVB included:

- Lack of functional equipment
- Staffing levels inadequate or trained staff rotated to other departments
- Insufficient pre-service training
- Lack of support/training/mentorship within facilities

Results

In total we interviewed 20 clinicians, 9 nurse-midwives, 5 medical officers and 6 consultant obstetricians.

Results cont.

AVB beliefs and performance

Although most clinicians believed that more assisted vaginal births should be performed and agreed that increasing the number of AVBs could result in a reduction in second stage CS, with the attendant morbidity, they were sometimes reluctant to take the initiative to bring about the required changes in practice.

When asked about the views of their local communities, many stated that women had little knowledge or understanding of the AVB procedure. Interviewees thought they would accept whatever procedure was recommended, particularly if it was advised by the doctor, hastened the birth or avoided surgery.

“The majority don’t understand.” (KII11, MW)
In this community... the ones who want to give birth to fifteen children, they want to avoid caesarean section as much as possible because they know that is going to limit the number of children they are going to get. (KII8, MO)

However, if the healthcare workers were not confident in performing the procedure, women were unlikely to opt for it even if they are given the choice.

“Most of the population they just have the basics of education and all this, now the issue comes in the Doctor’s perception towards AVD So if you find a doctor who doesn’t like they will like despise it.” (KII6, OB)

When questioned about having the procedure for themselves or their wife, responses varied from *“excited” (KKI14, MW)* to *“I wouldn’t let it to get to that, I would have delivered her by caesarean before.” (KII6, OB).*

Equipment

Our routine programmatic data demonstrated a 0.31% AVB rate in 2020, with 3 of the 8 facilities not performing any AVB, despite staff having received training previously. Key reasons given for non-performance included lack of functioning equipment, with the preferred, single-use Kiwi devices regularly being reused to reduce costs and difficulty in getting replacements.

“They are washed and stored but they are not discarded, because we are in a poor setting whereby you can’t afford to just [discard it]. If it is something that can be sterilized and packed again, we would rather do that.” (KII18, MO)

Reuse of the AVB devices up to *“ten times” (KII19, MW)* could lead to them not functioning correctly when needed and failed procedures.

Staff issues

Staffing issues were also cited as reasons for not performing AVB, such as insufficient trained staff on duty or trained staff being rotated to other departments.

“I would say maybe, on average twice a year, you have some staff, though not all the staff, but you could have some staff transferring to another department, or you could get staff transferred to another facility once or twice a year.” (KII9, MO)

“At times we only have two nurses covering the maternity. By maternity I mean, the two nurses are in charge of the antenatal, they are in charge of the labour, they are in charge of the postnatal.” (KII6, OB)

Results cont.

Other issues related to lack of staff confidence, and experience.

“Some of the staffs have got fear of using Kiwi despite of them knowing how to use it... ‘I am afraid I don’t know how the outcome will be, so I cannot do it without a medical officer being around’.” (KII1, MO)

“Some of them have been trained, others have not but what is lacking in most of them, it is just confidence” (KII11, MW)

Training

A lack of basic training was given as a reason for not performing AVB by one MO, particularly when monitoring labour, and a few doctors stated that they had received minimal AVB teaching and practice prior to qualification.

A consequence of inadequate pre-service training might have been that subsequent short EmOC courses were insufficient to give the confidence and competence to perform AVB without additional support in the facilities, without additional mentorship.

The continuing medical education (CME) that was described seemed to be largely theoretical. Some staff did practical on-the-job training with colleagues, but this was often limited by low staffing levels. Staff rotation was also a disincentive to provide in-house training.



AVB training as part of LSTM MNH programme in Kenya

“You train this medical officer or this nurse or this midwife but after training them, they become experienced and then they are moved and taken away from that department.” (KII1, MO)

Conclusions

The skilled use of AVB has the potential to reduce the number of second stage CS with their associated morbidity. Generally, staff seemed to be open to the use AVB, particularly with the Kiwi device. However, practical aspects of non-functioning equipment, insufficient staffing and lack of regular, sustainable and practical refresher training seemed to be barriers that need addressing at facility, county and national level.

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2. WHO (2019) Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.