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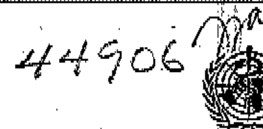

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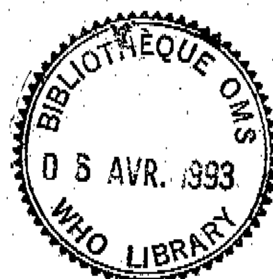
World Health Organization
Maternal and Child Health & Family Planning
Division of Family Health, Geneva

HUMAN RESOURCE DEVELOPMENT FOR MATERNAL HEALTH AND SAFE MOTHERHOOD

REPORT OF A TASK FORCE MEETING
GENEVA, 2–4 APRIL, 1990



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HUMAN RESOURCE DEVELOPMENT FOR MATERNAL HEALTH AND SAFE MOTHERHOOD

REPORT OF A TASK FORCE MEETING
GENEVA, 2 - 4 APRIL 1990

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1. EXECUTIVE SUMMARY

The task force meeting on human resources development for maternal health and safe motherhood took place from 2 to 4 April 1990. It was composed of seven temporary advisers, two representatives of related non-governmental organizations and 10 members of the WHO secretariat. The main purposes of the meeting were to examine training needs for the Safe Motherhood Initiative (SMI) and make recommendations for the development of a training strategy for the Initiative. This strategy would be implemented as quickly as possible to support the SMI's other facets: country support, operational research, and information analysis, dissemination and advocacy.

During part of the meeting, participants met in three working groups of about six persons each to address three particular issues in detail: essential obstetric functions (EOF), midwifery, and training and educational methodology. After small group discussions, each working group presented its findings to the large group for further input. The remainder of the meeting was conducted in plenary with active debate among members. As a result of this process, there emerged a general consensus on the essential elements of a training strategy for SMI.

The total training effort for SMI, the group found, will have to address a broad spectrum of training activities. It has to start in the community, where women themselves need to learn how to participate effectively in the maintenance of their own health. It must include the retraining of maternal health teams at district level, using modern methods, to be able to handle pregnancy, labour, delivery, postpartum and family planning care and to perform essential obstetric functions (EOF) in a way which responds to the community's needs and is sensitive to its values, attitudes and beliefs. It will extend also to the retraining of physicians, both generalists to perform EOF as needed, and obstetrician/gynaecologists to back the teams up with services for complicated problems.

Pre-qualification training will require attention as well, and training programmes for all levels of providers of maternal health services will have to be examined and revised in terms of both content and methodology. This will include training programmes for midwives, traditional birth attendants (TBAs) and other health auxiliaries, and medical students. Attention will also have to be paid to the training of trainers for these categories. Along with this, countries will need to develop community- or country-specific learning materials to support their training activities.

The group concluded that WHO's best approach to support this training and retraining effort would be to strengthen regional training resources which would in turn reinforce countries' training capabilities. These resources for training may be interregional or regional training centres, WHO collaborating centres, national centres able to support their region, or others. Where such resources do not exist, they will have to be created. These centres should train trainers, develop or adapt maternal health learning materials, consult with countries on the performance of needs assessments, the development and institutionalization of systems of national SMI training and the revision of curricula, and assist countries with the performance and evaluation of training.

2. BACKGROUND

As a result of the Safe Motherhood Initiative, the issue of maternal health is receiving attention for the first time as one of the major inequities in the health system yet to be redressed. It is a complex issue situated presently in an adverse social, cultural and economic climate. A brief look at the problems reveals, among other things, that:

- training for maternal health has become compartmentalized and uncoordinated;
- there has been a worldwide decline, and in some countries a disappearance, of the intermediate level provider of maternal care, usually the midwife or nurse-midwife, with no provision for her replacement;
- women are unable to participate in the process of their own health care due to lack of essential information;
- in many countries there has been a failure to identify and train a category of personnel at the first referral level to perform essential obstetric functions (EOF);
- TBA training and service is not integrated into the overall health care system, but rather is growing up quite separately.

At the Meeting of Interested Parties concerned with safe motherhood which met in Geneva on 19 and 20 June 1989, four elements essential to the success of the Safe Motherhood Initiative were identified: 1) advocacy and dissemination of information, 2) technical cooperation, 3) research, and 4) training. It was further recognized that none of the first three elements could be put effectively into operation without addressing the fourth one, training. Consequently a task force was formed to examine training issues with a view to the development of an integrated safe motherhood training strategy.

The task force meeting, of which this is the report, was held from 2 to 4 April 1990.

3. OPENING, ORGANIZATION AND PROCEDURES

3.1 Opening session

The meeting was opened by Dr Mark Belsey, Chief, Maternal and Child Health, Division of Family Health of WHO/HQ. It was attended by seven temporary advisers each with experience in training for maternal health, but in differing sub-fields and from different parts of the world. Also represented were the International Federation of Gynaecology and Obstetrics and the International Confederation of Midwives. The group was completed by ten members of the WHO secretariat from the Maternal and Child Health programme, Division of Family Health and Division of Human Resources for Health Development. One invited temporary adviser, Dr. Amin Nasher, President of the Central Cooperation for Scientific Research of Aden, Democratic Yemen, had died in an automobile accident a few days before the start of the task force meeting. His loss was deeply regretted by the group. The complete list of participants is found in Annex 1.

3.2 Organization and procedures

It was decided that the meeting would be chaired by Dr Belsey with two members of the secretariat serving as rapporteurs. The draft agenda (Annex 2) was amended and then accepted by the group. It was decided to place Draft Agenda Item 4, Priority areas for global, regional and national action, at the end of the meeting as a part of the conclusions and recommendations.

Regarding the meeting's format, the group agreed to plenary discussion of most of the agenda items after an initial introduction by a member of the task force. However, it was felt that Agenda Item 5, Approaches to be considered, could be discussed best in small groups after the introductions in plenary. Consequently, the task force was divided into three working groups of approximately six persons each, with the special interest areas of 1) essential obstetric functions and health team management, 2) midwifery, and 3) training and educational methodology. Each working group addressed the issues in Agenda Item 5 with particular reference to its interest area. They then prepared a brief report of their findings, which were presented and discussed in plenary session. The working group reports are found in Annexes 3, 4 and 5.

4. DISCUSSION ITEMS

4.1 Human resources needs in maternal care (Agenda item 3)

4.1.1 A country case study

Most countries have information about their health systems which has never been analyzed in a systematic way. Authorities in one Asian country, aware that this was the case, determined to see what could be learnt from the available data. Since the task force was interested both in the results obtained and in the method itself as a possible model for other countries, it decided to study that country's case in some detail.

Taking about 12 person/months and working from a base of both political and technical support at national level, authorities of the country under study discovered, among other things, deficiencies in the quality of care at peripheral and referral levels, problems in the training of personnel from the standpoints of both adequacy and relevance, lack of technical support, especially in the periphery, and a dysfunctional distribution of work responsibilities among the personnel. As a result of this analysis, authorities are now taking steps to redress the situation and four of the country's nearly 60 districts have been recently targeted for the first phase of this activity.

As this country and others like it seek to overcome obstacles to the effective delivery of maternal health services, they may be able to aid others along the way by demonstrating solutions to problems or showing the methods by which problems were solved. The task force thought that the MCH programme of WHO/HQ could be instrumental in getting this process started in four to six coun-

tries and in disseminating the results to other countries which wish to do the same.

In the area of training, some of the lessons which the country under study has already learnt, include the following:

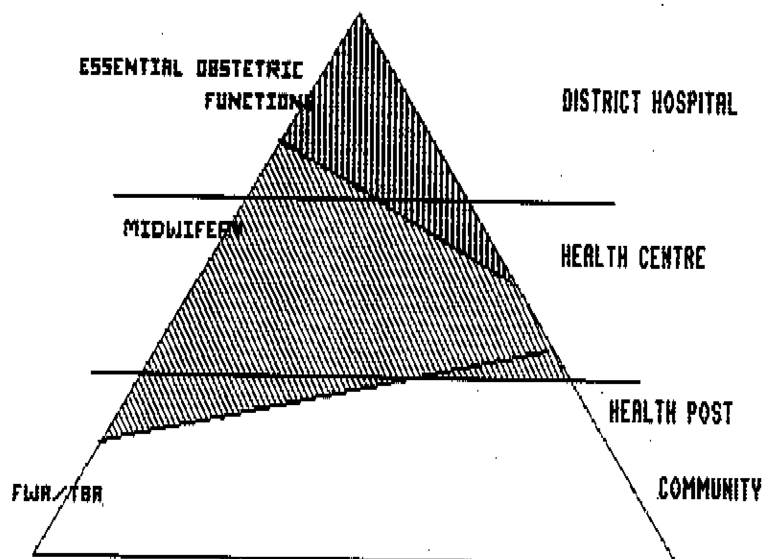
- solutions to health worker training problems must be sought within the social and cultural context of the country,
- when adequate training is not feasible within a country, it should be obtained as close to home as possible,
- a functioning mechanism, integrated into the country's overall health and/or educational infrastructure, must be developed to plan, organize, implement and evaluate the ongoing training of health workers,
- this mechanism must include a built-in process for the transmission of information in both directions (centre to periphery and periphery to centre),
- midwives have been shown to be effective in filling the gap in functions at the intermediate level; this solution should be further institutionalized and exploited.

4.1.2 Special problem areas

Issues concerning the training of midwives, the training of maternal health teams in essential obstetric functions (EOF), the rational distribution of tasks to the various members of the team, and the relationships among the team members, were seen as important problem areas.

A schematic model was proposed by the group to represent the relation between midwifery and the providers of EOF at the three most peripheral levels of any country's health system. It is reproduced in Figure 1, below.

Figure 1



As can be seen in the diagram, the group did not feel that there could be a clear definition of roles corresponding exactly to the various levels of the system. While midwifery services are delivered primarily at the health centre level, they can also be found at the district hospital and in the community. Likewise, while many EOF (e.g., surgical functions and those requiring general anaesthesia) are performed by team members at the referral hospital, others may be done by different members at the health centre.

Although not shown in the diagram, there was consensus that team members performing EOF at the first referral level (e.g., district hospital) would not be limited to a maternal health role. For practical and economic reasons, these functions should be assured by hospital staff who also provide services in other domains.

Another point discussed which could not be illustrated on the diagram was the general agreement that midwifery functions and EOF were not at all mutually exclusive. Many EOF are normally performed by midwives, and in some countries midwives may be the appropriate category of worker to perform all EOF. In the case of a country where at least some EOF were assured by non-midwives, the group agreed that both the providers of EOF and midwives should be members of the maternal health team.

The task force felt also that the maternal health team could not be separated conceptually from the primary health care (PHC) team. Rather it must be either identical to it or a subset of it, depending on the circumstances in the country, region or district. It was accepted that the team leader should be a person central to the team and aware of the roles of each member, but the group felt that the person with the highest level of technical skill was not necessarily the person best qualified to be team leader.

Training of already-practicing personnel should be done in the context of the district team itself, the group believed. This would help assure complementarity of roles. Planning and organization of this training, however, would be done best at a level more central than the district (i.e., second referral level or higher) to afford some economies of scale and to allow for a broader exchange of ideas and experiences. Other roles of second referral level providers, vis-a-vis those of the first level, would be to treat patients with problems referred from the first level, and to provide technical support to that level.

Another point emphasized at this part of the discussion was that a system of continuing education, however dynamically mounted to remedy gaps in training of already-qualified workers, cannot substitute for the simultaneous revision of the basic curricula of health provider training programmes so as to bring future health workers up to the new skill level by the time they qualify. The individuals revising both pre- and post-qualification curricula should also bear in mind the need for the training to be community

oriented. This can only be done by taking the students into the community to learn.

During final discussion of this topic, the group underlined the concepts that both pre- and post-qualifying training must be:

- pragmatic,
- based on the needs of the communities which the trainees will serve and sensitive to the attitudes, values and beliefs of those communities,
- no longer than necessary, but long enough for trainees to learn judgement in the provision of antenatal, obstetric and postnatal care.

4.2 Approaches to be considered (Agenda item 5)

Each of the three sub-groups, working separately, developed independent sets of recommendations. These are summarized in the three subsections below. A synthesis of all the groups' recommendations is presented in the Conclusion section, paragraph 4.3.3.

4.2.1 Essential obstetric functions and health team management

This group first explored the concept of multidisciplinary teams as providers of EOF. It was felt that these teams had to be an integral part of the primary health care system in any country, and located at, for instance, a district hospital or health centre. They should interact with providers at the community level, and be a support to them. In turn the teams would receive support from more central levels (e.g., the regional hospital) to which they would also refer their problem cases and from which they would receive in-service training. The composition of the team in any given country would depend on the human resources for health available in that country. The working group felt, however, that prior to the establishment of teams in a country which did not yet have them, a fact-finding exercise should be performed to assess the existing manpower, skills and resources available and identify any deficiencies in the infrastructure. This would permit a more logical structuring of the teams.

Turning to specific training issues, the group agreed that coordination of training programmes for district teams should be done from a more central level (within one country or even among several countries, depending upon circumstances). The creation at this level of a mechanism to institutionalize the planning, organization, implementation and evaluation of training, which would be integrated into the overall health structure, was seen to be an indispensable element in assuring the success of the idea. The development of this permanent system for training should be done in harmony with, and at the same time as, the development of an integrated, holistic maternal and child health service. The training team within this system should be a part of a maternity service made up of both specialist obstetrician/gynaecologists and midwives. Similar training would also have to be incorporated

into the basic curricula of those schools preparing individuals to perform EOF, and students should be exposed to the relevant issues early in their training.

The working group recommended that WHO assist those countries which so request and have the potential to develop an effective training programme in EOF within the next five years. It felt that WHO activities should be concentrated in the fields of coordinating regional training, preparing teaching/learning materials and promoting the establishment of training within the context of primary health care. Once this is accomplished in several countries, WHO should prepare relevant guidelines for the definition of training and service strategies, and for the evaluation of EOF training and of the overall performance of the maternal health care system.

4.2.2 Midwifery

This group first reflected on the role of the midwife as a member of the maternal health team. It felt that as a part of the midwife's provision of antenatal, labour and delivery, postnatal and family planning care, she would be performing a significant number of EOF. In addition to this, she would also provide social and psychological support, counselling and education to clients, families and communities, and offer leadership in matters of safe motherhood.

Numerous problems were identified, however, in the optimal use of the midwife for the provision of maternal care. These centred around the absence of training programmes for midwives in many countries, the poor quality of many existing training programmes, the gravitation of highly trained midwives away from the periphery and toward capital cities, the loss of clinical skills by many trainers, the loading of midwives with non-midwifery responsibilities leaving them insufficient time for midwifery functions, and the fact that many midwives do not understand the problems of maternal mortality.

Addressing the training issue, the group found that in order to assure effective midwifery training, laws and regulations should be written which would support the performance of essential functions by the midwife. There would also have to be at least a minimum number of centres providing high quality care to be used as training sites and midwifery tutors would have to be trained or retrained in clinical techniques and other subjects appropriate for work both as a trainer and in the community.

Broad strategies proposed by the group included assessing communities, providing information to communities, performing situation analyses of TBA, health auxiliary and family welfare visitor training and service, and developing or revising training programmes for them. Short term strategies for midwives would include clinical refresher courses developed in the context of the needs of the communities in which they serve, as well as the con-

tinuation of safe motherhood workshops in collaboration with the International Confederation of Midwives and the promotion of study tours to permit teams to see model programmes. Long term solutions would be found in legislation, curriculum revision, training materials development and the training of tutors.

The group suggested that WHO's involvement centre around the reinforcement of support to midwifery by the addition of midwives to the MCH and HRH teams at WHO/HQ and to the HRH teams in the regions, and the establishing of a working group on midwifery to: 1) organize training at all levels, 2) promote and/or perform situation analyses of midwifery services and training, 3) develop training materials and 4) reinforce training teams. They also recommended the restructuring or re-establishing of midwifery tutor education programmes.

During the discussion which followed, a suggestion was made as to the appropriate role of the midwife in the Safe Motherhood Initiative. In this proposed role, the midwife would be the person initially responsible for antenatal care, delivery services (even of high risk patients), postnatal care and family planning. The specialist in obstetrics/gynaecology for his/her part, would support the midwife, provide backup, and care for those patients with complicated or abnormal problems. Thus the midwife would have important leadership functions on the maternal health team, assuring most of the necessary intermediate-level services. In this role, she could shift the focal point of midwifery services away from the referral centre and out to the community. The group strongly endorsed this envisaged role as an appropriate one to accelerate achievement of safe motherhood objectives.

4.2.3 Training and educational methodology

This group started with the identification of problems in the field of maternal health training. They found that trainers were frequently inadequately trained themselves, that trainees often had a passive approach toward learning which worked against their learning of new skills and attitudes, that rigid statutory requirements made it impossible for trainees to utilize newly acquired skills, and that training itself was often irrelevant, insensitive to actual needs, performed in inadequate or inappropriate sites, and presented from perspectives poorly aligned with the existing situation. General problems, such as resistance to change and the imbalance between resources and needs, further compounded these difficulties. Like the other two groups, this one also underlined the necessity of identification of needs and also of resources available to meet those needs, both in the traditional sector and in the conventional health sector.

Suggested broad approaches included a focus on the training of trainers and the training of district health teams. It was felt that, as a minimum, all trainers should be able to redesign training programmes, address management issues related to training and collaborate in the production of health learning materials as well

as utilize modern educational methods. Regarding training of the district teams, the group affirmed the need for an integrated, national mechanism responsible for training which is adequate in quantity as well as quality, and is provided on a permanent basis. This mechanism must include provision for two-way movement between the central level and the periphery in order to assure that the training remains relevant, adequate and effective.

The working group proposed that WHO's strategy for reinforcing maternal health training should focus on the strengthening or development of interregional, regional and national training centres which would, in turn, strengthen the capacity of countries to assure the delivery of appropriate and high quality maternal health services by their district health teams. They would do this by assisting requesting countries to develop integrated, national mechanisms for training. Once in place, these national training units would produce continuing education programmes for teams and develop or adapt country- or community-appropriate learning materials for local use. With a view to having medium- to long-term impact, the training centres would consult with requesting countries on the revision of curricula of their health professions training schools and on the training of trainers at a national or sub-national level.

Besides promoting the development or reinforcement of these resource centres, WHO's immediate interventions could also include 1) contracting for the development of health learning materials, making use of national and regional capabilities and utilizing all appropriate media, and 2) identifying and cataloging existing health learning materials so as to facilitate the tailoring of them to specific country needs.

Discussion of the working group's presentation pointed up the problems in development of community-specific training materials. In view of the vast number of communities which need such materials, the task was seen to be overwhelming. A suggestion was made that these materials should be developed on a region- or continent-wide basis and then adapted to individual countries or communities. The difficulties already encountered in this type of adaptation were noted, however. It was suggested that the WHO learning resource centres, of which there are already three in Africa, could be instrumental in this effort.

The large group also stressed that the training process must be institutionalized at the district level, while being coordinated more centrally. It pointed out the need for ongoing evaluation to be built into any system for training, and the consequent necessity of training health workers and their trainers in research and evaluation methods. Finally, participants urged governments to build on the bases which exist, and to strengthen training step by step.

4.3 Conclusions and recommendations (Agenda items 4 and 6)

4.3.1 Preparation for Meeting of Interested Parties

In discussing the approach which should be used at the next Meeting of Interested Parties on 18 and 19 June 1990, the group recommended that the topic of training should be introduced by a panel using a media presentation. It was felt that this approach could put across most clearly the depth and complexities of maternal health training issues. Members specified that this introduction should cover three main areas: 1) a presentation of the present situation, exposing the problems, 2) individual elements of a recommended solution, and 3) a strategy for integrating the elements into an overall plan.

The group noted that cost estimates must be included as part of the presentation, and that the efficient use of resources of the proposed solutions should also be demonstrated. Assurances should be given, supported by specific projections, of the probable payoff of these solutions within a reasonable period of time and guidelines on how individual elements may be implemented should also be presented.

4.3.2 Other recommendations

In considering future task force process, the group recommended that:

- additional human resources be added at WHO/HQ and in the target regions; as had been discussed previously, the need for more midwives was felt to be particularly acute;
- a project document be drafted to obtain funds for the support of further safe motherhood activities;
- a working group of the task force be created to review the task force's work and promote its recommendations.

Human resources not currently represented on the task force, which might be beneficial, include:

- an expert in evaluation technology as applied to training;
- a health planner;
- a health economist;
- a health learning materials development specialist;
- a midwife specializing in clinical services;
- one or more categories of social scientists;
- an expert in training of trainers; and, perhaps
- experts in nutrition and public health.

Finally, it was re-emphasized that **training for safe motherhood must be carried out in the context of existing, horizontal, primary health care programmes, and should not be developed within a new, separate, vertical structure of its own.**

4.3.3 Conclusions

As a result of its discussions, the task force succeeded in taking concrete steps toward the development of a safe motherhood and maternal health training strategy. It had also looked closely at the issues of essential obstetric functions, midwifery, and training and educational methodology as applied to the Safe Motherhood Initiative. By the end of the three day session, it had endorsed the following elements which it considered essential to the SMI training strategy:

1) Continuing education of already qualified health workers in maternal health must be done in the context of the district health team.

   - In order to do this, situation analyses must be performed and team members' roles must be clearly defined.
   - Training must be geared to equipping team members with the necessary skills to fulfill those roles.
   - This training must be provided to all categories of maternal health workers from TBAs to midwives to physician generalists and specialists.
   - All levels of workers will need updating in technical skills appropriate to their level, and many will require training in management, research and information/education/communication skills.
   - Special attention must be given to the identification of the appropriate team members to perform essential obstetric functions (EOF) and the training of these workers to perform them.
   - Special emphasis will also have to be placed on the preparation of midwives to fulfill their leadership functions.

2) National and/or regional mechanisms must be developed to coordinate this training on an ongoing basis.

   - Systems must be institutionalized within the health and/or educational infrastructure of the country or region.
   - They must ensure back and forth communication between the central level and the periphery.
   - They must give serious attention to the training of trainers as an early priority.
   - These trainers' primary role should then be to assure the training of district level health teams.
   - Trainers should also participate in the development or adaptation of appropriate maternal health learning materials.

3) Pre-qualification training must also be revised if this training strategy is to have long term effects.

   - Midwifery training, particularly, requires serious attention. It must be reoriented towards clinical practice

and the learning of skills, and geared to the needs of the community served. It must emphasize the development of judgement and must include an element of management training to prepare the midwife to assume her leadership role within the maternal health team. The key role that the midwife plays at the intermediate (first referral) level must be stressed.

- Medical school curricula must be revised also, with particular emphasis placed on training students in the community so as to better understand and meet community needs.
- TBA training programmes and training methodologies need to be revised and coordinated with the training and service activities of all the other members of the maternal health team.

4) Interregional, regional and national training centres should be created or reinforced so as to be able to support countries in putting the above plan into operation.

   - These centres should provide for the training of trainers and participate in the development of learning materials for maternal health in addition to supporting countries directly.
   - Centres should identify one or two "flagship" countries within their region and support them as they go through this process.
   - They should then document and disseminate the results obtained in these countries so they can be used by others seeking solutions to their own problems.

5) WHO/HQ, working with the regional offices, should be involved primarily at the level of the above-mentioned centres, strengthening those which already exist and promoting the development of more where needed.

   - HQ should support these centres in their efforts to identify flagship countries, perform needs assessments, carry out retraining activities and document and disseminate the results.
   - It should also support them in the development, adaptation and dissemination of health learning materials.
   - In addition, WHO/HQ should serve as a focal point for information exchange among the centres, support the development of guidelines for human resources planning in maternal health, perform policy reviews, and collaborate in the development of performance indicators, as needed.

Annex 1

LIST OF PARTICIPANTS

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Annex 2

AGENDA

1. Opening and background to the Task Force

2. Objectives of the Task Force and of the Meeting

3. Human resources needs in Maternal Health Care

   3.1 A global assessment and projects
   - different settings and stages of development
   - categories of health workers relevant to maternal health
   - policies
   - training capacity and organization

   3.2 Country needs/case studies
   - needs for an holistic approach

   3.3 Special problem areas
   - midwifery and traditional birth attendants
   - essential obstetric functions

4. Priority areas for global, regional and national action

5. Approaches to be considered for the development of programme priorities

   5.1 Situation and policy analysis

   5.2 Human resource development planning
   - Boelen: "RADICAL" Method for Optimizing Human Resources for Health

   5.3 Support to education and training, including continuing education

   5.4 Support to curriculum and learning material development

6. Conclusions and recommendations

Annex 3

REPORT OF WORKING GROUP ON ESSENTIAL OBSTETRIC FUNCTIONS AND HEALTH TEAM MANAGEMENT

1. BROAD APPROACH TO THE PROBLEM

The availability of essential obstetric functions (EOF) at the first referral level is an appropriate approach to reduce maternal mortality and morbidity. This is a pragmatic method to deal with emergency situations in primary health care, particularly in countries/regions with limited resources. It should be considered as an interim measure to cope with the current crisis. The approach is not applicable in countries where there are highly specialized services available to everyone.

1.1 Multidisciplinary teams as source of EOF

- a multidisciplinary team should provide EOF and be located at a primary care unit which could be a district hospital or health centre
- the team should interact with community health care providers and be a support to them
- the team should be an integral component of the primary health care system
- the coordinator of the team must take responsibility for its direction, implementation of its functions and accountability; he/she must have skills and experience in management
- the composition of the team providing EOF will depend on the manpower resources available
- the team approach should be pursued not only in the provision of services, but also in training and evaluation of performance

1.2 Essential maternal health functions to be performed by the team:

- antenatal assessment to identify and manage women at risk
- attendance of normal labour and emergency interventions in life-threatening situations, including neonatal care
- postnatal care of delivery complications
- fertility regulation

1.3 Prior situation analysis is essential

- central to the planning of an effective programme is an evaluation of existing manpower, skills and resources available and the identification of any deficiencies in the infrastructure
- a strategy for training will depend on the results of this fact-finding exercise

1.4 Role of the secondary level

- at the second referral level (specialist level) there should be a mechanism for referral of cases, a system of continuing education and a means of support to the more peripheral levels

2. TRAINING OF MATERNAL HEALTH TEAMS IN EOF

2.1 Training issues

- training will depend on the available case load and on the trainers
- trainers will need to be identified from among available specialists
- trainers themselves may need to undergo a training programme to acquire the necessary behaviours and skills to be effective
- trainers themselves should participate in ongoing educational activities
- the training programme for the team should occur in a facility not dissimilar to those in the location where they will work
- coordination for the training programme should be regional (either within a country or among several countries depending on geographical and cultural circumstances)
- the existence of an appropriate infrastructure at this regional level will be an essential requisite

2.2 Special considerations

- this training proposal does not preclude or limit the development of an integrated, holistic, maternal and child health service as part of the health care planning of the country concerned
- this integrated service should be developed simultaneously and on a long term basis
- countries should be encouraged to ensure that medical students have early exposure to issues of relevance (an important one of which is EOF) in their undergraduate medical training
- it is in a country's interest to plan an integrated maternity service made up of both specialist obstetrician/gynaecologists and midwives

3. PROPOSED WHO ACTIONS

- the working group is of the opinion that WHO should respond to invitations for assistance to those countries which have the potential and the will to achieve an effective programme within five years
- WHO's role should be:
  - to coordinate training within the regions concerned,
  - to prepare appropriate teaching aids, materials and programmes,
  - to facilitate the establishment of relevant training facilities within the context of primary health care
- it will be necessary to obtain donor support to fund these activities
- coordination with appropriate experts, organizations and institutions of the country concerned will be essential to implement the above
- this would enable the preparation of relevant guidelines for the definition of strategies for training and service, and for the evaluation of EOF training and of the overall performance of the maternal health care system.

Annex 4

REPORT OF WORKING GROUP ON MIDWIFERY

1. ROLE OF THE MIDWIFE

The midwife is a person who:

- by her/his training has the competence and skills to provide reproductive health care as an independent and interdependent practitioner in the maternity care team.
- by regulatory mechanisms is entitled and protected to practice in the spheres defined by the content of midwifery.

2. CONTENT OF MIDWIFERY

This content also can be tailored to fit other cadres of health care personnel who will be used in certain countries to carry out midwifery functions. It includes:

2.1 Provision of care of high technical competence:

- antenatal
- labour and delivery
- postnatal
- family planning
- newborn
- infant

2.2 Provision of the following essential obstetric functions:

- repair of vaginal and cervical lacerations
- perform and repair episiotomy
- vacuum extraction
- administration of IV fluids, blood
- emergency evacuation of uterus
- manual removal of placenta
- emergency treatment of severe pre-eclampsia, eclampsia
- administration of IM and IV antibiotics
- family planning functions: prescription of oral contraceptives, insertion of IUD and Norplant

2.3 Provision of social and psychological support, counselling and education to clients, families and communities, based on norms and values appropriate to the society.

2.4 Provision of leadership in matters of safe motherhood including the areas of:

- administration
- management
- leadership
- research

3. AVAILABILITY OF PERSONNEL TO CARRY OUT MIDWIFERY ROLE

3.1 There is wide variation in personnel among countries.

3.2 Personnel, especially at the community health level, are largely lacking:

- those with degrees have left for more prestigious posts
- many others prefer to work in cities where better housing, education and amenities are available.

3.3 Where personnel are available they vary widely in education, including:

- polyvalent health workers whose training in midwifery is rudimentary
- nurse-midwives trained in an integrated system where midwifery has disappeared
- nurse-midwives with varying amounts of time devoted to midwifery (6 months to 2 years)
- midwives where, in some cases (e.g., francophone Africa), delivery skills may have been completely lost due to the separate vertical systems of antenatal and delivery care
- auxiliary nurse midwives
- enrolled, grade II midwives, which have been phased out now in many countries

3.4 Where personnel are available, they have been trained in and have practiced services with varying quality (in some cases very poor) so that their own standard of care may be low.

3.5 Where personnel are available, they are largely ignorant of the problems of maternal mortality.

4. TRAINING

Problem: There is a dearth of midwifery tutors, and those who are available are out of touch with clinical practice. Their time is taken up in out-dated teaching practices such as lecturing.

4.1 Pre-conditions for training:

- laws/regulations which are supportive (or at least not restrictive) of performance of essential functions.
- service which is providing high quality care.
- tutor training.

4.2 Prerequisites for midwifery tutor:

- trained midwife (nurse-midwife)
- postgraduate clinical and community experience
- sensitive to and knows how to assess community's perceptions and needs.

4.3 Components of midwifery tutor training:

- additional theoretical knowledge in midwifery and practice in extra clinical skills (including selected essential obstetric functions)
- sociology, anthropology, epidemiology, research, etc.
- specialization in education

5. STRATEGIES

5.1 Short term

5.1.1 Community

- assessment of community perceptions and ethno-cultural belief systems regarding reproduction, with intersectoral collaboration (maternity care team)
- provision of appropriate information concerning self care, community responsibilities

5.1.2 TBAs

- assessment of TBAs' perceptions of antenatal care and safe delivery
- definition of targeted training needs for prevention of haemorrhage, sepsis, obstructed labour, ruptured uterus
- retraining in the village

5.1.3 Health auxiliary, family welfare visitor

- guidelines for refresher in-service (hands-on) courses based on working group plans

5.1.4 Enrolled nurse-midwife, auxiliary nurse-midwife, registered nurse-midwife, registered midwife

- ten-day to two-week inservice <u>clinical</u> refresher courses which include:
  - providers' and community's perceptions of causes of maternal mortality
  - additional theory and clinical experience in essential obstetric and maternity care functions
- continuation of collaborative International Confederation of Midwives/WHO intercountry team workshops on safe motherhood
- study tours for teams to see model programmes
- promotion of community midwifery experience in current midwifery training programmes

5.2 Long term

- curriculum review
- legislation
- materials development (self-study, etc.)
- tutor training

6. APPROACH BY WHO

6.1 WHO/HQ should appoint 2 additional midwives in MCH for midwifery training for safe motherhood.

6.2 A working group on midwifery should be established for:

- preparation and organization of in-service training at all levels;
- situation analyses of midwifery services, particularly in regard to their:
  - quantity,
  - distribution, and
  - quality;
- development of training materials;
- building up of a regional teams with nationals and midwifery experts.

6.3 Existing training colleges should be assessed with regard to the preparation of midwifery educators.

6.4 Midwifery tutor education programmes should be restructured and/or (re-)established. This will require consultants who will feed their results back to the working group.

Annex 5

REPORT OF WORKING GROUP ON TRAINING, EDUCATIONAL METHODOLOGY

1. WHAT ARE THE PROBLEMS?

- inadequately trained trainers
  - lack of exposure to real-life work settings (community and clinic)
  - overemphasis on didactic teaching methods
- passive attitude and expectations of trainees
- imbalance between resources and needs
- resistance to change
- insufficient and inappropriate locations for training
- rigid statutory demands
- inadequate or inappropriate perspectives
  - women's perspective
  - community perspective
  - caste, class
  - white coat mentality
- irrelevance and/or insensitivity of current programmes

2. IDENTIFICATION OF NEEDS, RESOURCES

2.1 Needs identification

- what are the problems, needs in the local system?
- what do the learners want to learn? It is important to know this so as to overcome resistance and generate motivation to learn, as well as to satisfy the need for rewards and recognition (incentives).

2.2 Resource identification

- what are resources to be found in the traditional sector?
  - conditions
  - normal labour and birth
  - local knowledge system
  - clients/patients
  - practices
- what are to be found in the conventional health sector?

3. BROAD APPROACHES TO RESOLVING PROBLEMS

3.1 Training of trainers

3.1.1 Training programmes for trainers should include:

- updating of technical skills,
- introduction to community-defined concerns and the ethno-medical system,
- purging learners of conventional educational methods and retraining in educational skills with an emphasis on problem-solving, placing the teacher in the role of consultant, facilitator and collaborator.

3.1.2 Newly trained trainers should be able to:

- redesign training programmes,
- address management issues related to training such as optimal ratios of students to trainers,
- collaborate in the production of appropriate teaching materials.

3.2 Training of the district team

3.2.1 An integrated, national system must be developed in order for countries to provide training which is adequate in quality and quantity on a continuing basis. This system must include:

- human resources (coordinator, supervisors),
- materials,
- means of meetings to identify needs and to evaluate.

3.2.2 There must be two-way movement between the community/district and the central coordination levels. Training needs must be fed in from the periphery, and centrally coordinated programmes must return to the periphery for implementation.

4. SPECIFIC RECOMMENDATIONS

The capacity of district health teams must be strengthened to deliver appropriate and high quality maternal health, safe motherhood care. This should be done primarily through the intermediary of interregional/regional/international centres which will be mutually supportive and will have two main functions:

4.1 Training of trainers at international (regional or interregional) level, so that they will be able to:

- teach (facilitate learning) effectively,
- develop appropriate curricula,
- develop appropriate learning materials.

(Trainee trainers can be from any health profession [physicians, nurse-midwives, midwives, etc.] and can be taught to train in any domain which is needed and for which they are qualified [e.g., technical skills, education of the community, management])

4.2 Consultation with, and assistance to requesting countries to develop an integrated system of national training of district health teams in maternal health and safe motherhood.

4.2.1 National activities to be undertaken which will have short-term impact:

- programmes of continuing education for all members of the district health team
  - based on identified needs,
  - culturally and scientifically appropriate,
  - accomplished through a system established by the country to assure continuity, and
  - subject to evaluation.
- development of country- or community-appropriate learning materials (this will take some time).

4.2.2 National activities with medium/long term impact:

- revision of curricula of health professions schools,
- training of trainers at national or sub-national level.

5. PRIORITY WHO/HQ INTERVENTIONS

5.1 Promotion of the development and/or reinforcement of the inter-regional/regional/international resource centres, fostering mutual support among them. (A number of centres already exist, e.g., Kigali, Singapore, Mauritius).

5.2 Issue contracts for the development of health learning materials. These should be developed using any appropriate medium and should make use of knowledgeable nationals for their development.

5.3 Identify, obtain and catalog existing health learning materials with a view to their "tailorability." This activity would also have a clearinghouse function, channelling materials to potential sources of adaptation.

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