
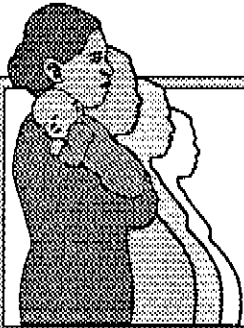


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**MATERNAL HEALTH
AND SAFE MOTHERHOOD PROGRAMME**

**HUMAN RESOURCES DEVELOPMENT FOR
MATERNAL AND NEWBORN HEALTH
AT THE HEALTH CENTRE LEVEL**

Report of a joint FHE/HRH Task Force Meeting
25-29 October 1993



World Health Organization
Division of Family Health
Geneva

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1. EXECUTIVE SUMMARY

A Joint FHE/HRH Task Force on Human Resources Development for Maternal and Newborn Health at the Health Centre Level met 25-29 October 1993 in Geneva. Its main purpose was to examine ways of strengthening capacity at the health centre level in provision of services to decrease maternal and newborn mortality. The examination of the above issues was intended to provide guidance to the World Health Organization (WHO) Maternal Health and Safe Motherhood Programme (MSM), including WHO regional and country officers, and to provide support to countries in implementing safe motherhood action plans.

The task force built upon work carried out by a Technical Working Group which met in July 1993 to examine Care of Mother and Baby at the Health Centre, as well as a draft *Mother-Baby Package. A safe motherhood planning guide.*

The principle accomplishments of the task force meeting were identification of:

- trends affecting the provision of health care at the health centre
- priority tasks related to management, clinical services and the community at the health centre level
- skills, knowledge and attitudes to accomplish priority clinical tasks
- principles for effective capacity strengthening at the health centre level
- a framework for strengthening the capacity of the health centre
- general recommendations for support of health centres

2. BACKGROUND

In response to the global Safe Motherhood Initiative, WHO has sponsored three task force meetings in order to address the human resource needs for safe motherhood. The first was held in Geneva in 1990. The conclusions of that meeting were as follows:

- continuing education of already qualified health workers in maternal health must be done in the context of the district health team
- national and/or regional mechanisms must be developed to coordinate this training on an ongoing basis
- pre-qualification training must also be revised if this training is to have long term effects

- 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
- WHO headquarters, working with 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.

Following the XXII Berzelius Symposium on "Maternal Health Care in an International Perspective," a working group meeting of the Task Force on Human Resources Development for Safe Motherhood was held in Stockholm in 1991. The group focused upon a single problem: many women do not avail themselves of conventional health services for social and cultural reasons. The major conclusion was that the health services and the community which they serve must remain in dialogue and work together to seek solutions to problems identified by the community. Furthermore, training of health workers, including traditional birth attendants, will not be sufficient to address the problem of maternal mortality. Training programmes and learning materials need to be developed for the community itself.

This third meeting of the Task Force on Human Resources Development based its work primarily upon two recent documents: draft report of a Technical Working Group which met in July 1993 to examine the "Care of Mother and Baby at the Health Centre" (expanding work done previously that identified "Essential Elements of Obstetric Care at the First Referral Level"), as well as a draft *Mother-Baby Package. A safe motherhood planning guide*. The technical working group for Care of Mother and Baby at the Health Centre specified the essential elements of comprehensive care for mothers and newborns at the health centre level, elements of developing and maintaining a functional referral system, institutional support mechanisms, community support systems and monitoring and evaluation of health centre performance. Essential drugs and equipment for maternal and child health/family planning care were delineated. The *Mother-Baby Package* focused on strategies for implementation of specific interventions which will have the greatest immediate impact on maternal and infant mortality, as well as essential components of effective programmes at the national, regional and district levels.

3. OBJECTIVES AND EXPECTED OUTCOMES OF THE TASK FORCE MEETING

The original objectives of the task force meeting were to examine the human resource needs at the health centre level to ensure that training will be relevant to the tasks required, to develop a framework for training health care professionals and to examine components of a regulatory framework for midwifery tasks.

Initially, the group discussed the proposed objectives and agreed that training, alone, was not the answer. Rather, it was agreed that "capacity building," later revised to be "capacity strengthening," which includes training, a nonrestrictive regulatory framework, and many other components, is the key to providing acceptable, effective health services at the health centre.

As a result of these initial deliberations by the task force, it was agreed that discussions should focus upon the means of strengthening capacity at the health centre level in order to provide services which decrease maternal and newborn mortality.

The participants of the group identified the following expected outcomes of the meeting:

- Identify priority tasks at the health centre level to decrease maternal and newborn mortality:
 - community related tasks
 - clinical services
 - management tasks.
- Define the skills, knowledge and attitudes to accomplish the priority tasks at the health centre.
- Identify alternatives/options in order to build capacity needed to accomplish the tasks.
- Develop an action framework for addressing the above within country realities at the district/health centre levels and as an integrated part of primary health care services.
- Identify the factors at the central level that influence practice at the health centre/village levels, e.g. legislation, human resources development policy, civil service.

During the course of the meeting the objectives were further modified. General trends which affect the environment in which health care is provided at the health centre were identified. Furthermore, the group elected to identify the general principles upon which health centre capacity strengthening activities should be based.

4. INTRODUCTION

Following the opening of the meeting the terms of reference were reviewed and two considerations were presented to guide the subsequent deliberations. First, it is recognized that the person with midwifery skills in some cultures is not called midwife or nurse-midwife but rather, for example, lady health visitor. The word midwife used in the meeting discussions, therefore, refers to all health personnel with midwifery skills. Second, it was agreed that the word "health centre" would be used to refer to all levels of health facilities below the district hospital, including the dispensary, health post and health sub-centre.

WHO secretariat then provided a brief update on the problem of maternal and newborn mortality and the contents of the *Mother-Baby Package. A safe motherhood planning guide*. There are still estimated to be 1/2 million maternal deaths each year with

the vast majority occurring in the developing world. Additionally, there are approximately 4.3 million deaths of newborns (during the first 28 days of life) each year. The risk approach has not been completely successful since many women who are not identified as being at increased risk do develop serious complications and die. Nevertheless, application of existing technology can greatly reduce the number of deaths. Rapid decline in maternal deaths has occurred with the introduction of antibiotics, blood transfusions, management of pregnancy induced hypertension and timely caesarean section. This decline has been well documented in England and Wales earlier in this century and in Sri Lanka more recently.

Findings of the Technical Working Group Meeting on Care of the Mother and Baby at the Health Centre were then presented. In this presentation it was pointed out that integration of health services can be seen in a variety of ways: across the life span, vertically from community to health centre to hospital, and horizontally to include all reproductive and child health services.

In order to emphasize the need for horizontal integration and to increase awareness regarding the multiple WHO programmes which demand the attention of overstretched nursing/midwifery personnel, presentations were made by secretariat representatives of the following WHO programmes: Expanded Programme on Immunization, Diarrhoeal Disease Control, The Sick Child Initiative, Acute Respiratory Infection, Global Programme on AIDS, Family Planning and Population, Healthy Woman Initiative, Health Learning Materials, Action Programme on Essential Drugs, Breastfeeding, Nutrition and Strengthening of Health Services. Presentations focused on achievements, lessons learned and linkages with other programs. The conclusions served as a basis upon which to formulate principles and recommendations.

5. TRENDS AFFECTING THE PROVISION OF HEALTH CARE AT THE HEALTH CENTRE

The environment in which health care is provided at the health centre is profoundly affected by patterns and trends over which persons based at the health centre and in the community have little or no control. However, these trends need to be taken into account in planning at all levels. They include:

- Decline in the numbers of qualified midwifery personnel at the health centre level due to a variety of reasons including:
 - migration of midwives and nurses from poor to rich countries all over the world;
 - movement of midwifery personnel from rural areas to richer urban centres;
 - employment of midwives by the private sector;
 - retirement of midwifery personnel at a younger age;
 - second career opportunities taken by midwives

- retrenchment and curtailed recruitment of midwives by governments due to declining economic conditions and structural adjustment programmes.
- Midwifery personnel often lack adequate skills to work effectively with communities or deal with the major causes of mortality and morbidity due, in part, to:
 - multiple vertical programmes which make unrealistic demands on overstretched personnel;
 - training which is too short, non-experiential, or in an environment removed from the realities of the health centre, so that learners cannot master core knowledge and skills and develop appropriate attitudes;
 - inordinate focus upon the biomedical approaches without active involvement of the community and focus on the problems perceived as most important by the community.
- Legislation and regulations which do not allow personnel located at the health centre to perform life saving functions.
- Worsening situation, in some countries, with respect to supplies, equipment and drugs, due to unchanging or reduced health care budgets in the face of expanded population and rising costs.
- Direct and indirect toll of AIDS as health care workers die or use their limited energies to care for family and community, as well as provide expanded HIV/AIDS services.
- Decentralization of health care systems before local governments are prepared to adjust to the increased demands decentralization places on them.
- Increased health consciousness with concomitant increased needs for health education and social mobilization.
- Increasing importance of the private sector in providing care for a limited portion of the population.
- Potential for improved communications (mass media, facsimile, telephone, etc.) while infrastructure, in some countries and regions, remains weak and so reliance on traditional methods (village meetings, word of mouth, etc.) must continue.
- Urbanization with resultant differing definition of "community," as well as additional health problems related to lack of the most basic services in urban slums, the dissolution of close family and community support, as well as environmental hazards, such as noise, air pollution and stress.

- Transformation of the life and activities of women as they marry later, add responsibilities of paid employment and become subject to both the positive and negative aspects of industrialization.
- Increase in refugee and migrant populations, as well as female labour in housework and sex work, which does not benefit from the necessary protection, security and remuneration, such as health insurance and pension rights.

6. PRIORITY TASKS TO DECREASE MATERNAL AND NEWBORN MORTALITY AT THE HEALTH CENTRE LEVEL

Based upon the draft report of the health centre technical working group and the *Mother-Baby Package*, priority tasks for workers at the health centre were identified. These are considered to be especially important where maternal and newborn mortality is high. Training which has only clinical emphasis will not be sufficient, just as supervision which has only managerial emphasis will be inadequate. All services performed should meet the identified needs of the community, and there should be community involvement from assessment through evaluation.

6.1 Clinical tasks

Clinical tasks should include:

- Providing family planning counselling and services which include a choice from a range of available methods including hormonals and intrauterine devices;
- Providing prenatal, intranatal and postnatal care including:
 - identification of those whose history and/or examination suggest special risk;
 - recognition and treatment of complications including abortion, anaemia, haemorrhage, prolonged and obstructed labour, hypertensive disorders of pregnancy and sepsis, according to a standard protocol;
 - performance of clean, safe deliveries;
 - performance of skills/procedures including use of the partograph, catheterization of the urinary bladder, episiotomy, repair of episiotomy and lacerations, vacuum extraction/low forceps delivery, manual removal of the placenta and evacuation of the uterus;
 - administration of intravenous fluids and oral and parenteral medications including tetanus toxoid, iron, antimalarials, antibiotics, anticonvulsants, antihypertensives, sedatives, oxytocics, analgesics and local anaesthetics;
 - provision of maternal resuscitation.

- Providing neonatal care including:
 - prevention and detection of complications including neonatal asphyxia, hypothermia and low birth weight according to a standard protocol;
 - performing the following: neonatal resuscitation including rewarming, manual mucous extraction, cutaneous stimulation, ventilation with bag and mask and external cardiac massage;
 - referral of both mother and newborn to the hospital for all conditions that can not be treated at the health centre;
 - promoting and supporting breast-feeding.

All staff carrying out these tasks should have received training in their application and performance. The above tasks should be performed with respect for the patient and in a culturally sensitive manner.

6.2 Management tasks

Management tasks should include:

- Assessment of community health and health-related priority problems and needs related to maternal and newborn mortality;
- Development of plan of work in line with community priorities, resources and orientation of safe motherhood programme;
- Allocation of tasks and resources among members of health centre team and community health workers;
- Organization of periodic review meetings with team members including all health workers at health centre and community level;
- Organization of the supply, storage and distribution of materials, drugs, equipment and supplies;
- Organization of the logistics of the referral system within the district;
- Ensuring appropriate maintenance of facilities and equipment;
- Ensuring supportive supervision, appraisal and development of all health care workers in the community;
- Participating in training of all health care workers to decrease maternal and newborn mortality, as appropriate;
- Keeping regular and accurate records related to activities to decrease maternal and newborn mortality taking place both in the health centre and the community;

- Collecting information required to monitor implementation of safe motherhood activities and their effect on maternal and infant mortality;
- Utilization, after simple analysis, of information collected and/or registered to make appropriate decisions;
- Preparation of reports on safe motherhood activities using appropriate format;
- Transmission of above-mentioned reports to the appropriate level observing appropriate timing.

6.3 Community tasks

Community tasks should include:

- Identification of community organization, structures and resources (material, financial, individual, group) likely to support or inhibit safe motherhood activities;
- Determination, based on information collected from community assessment, of areas in which collaboration with individuals, families and groups is needed;
- Preparation of a plan of work with the community in areas of common concern;
- Provision of relevant information and appropriate feed-back to the community on activities and their implementation;
- Provision of appropriate support to the community for resource mobilization and management through participation in their health and development committees;
- Provision of appropriate support to the community for the monitoring of their health-related activities;
- Setting up a local mechanism for periodic communication with community leaders and decision makers;
- Involvement of community in collection of data and in evaluation related to safe motherhood activities;
- Ensuring that women in the community are involved in all safe motherhood activities;
- Mobilizing men in the community to participate in safe motherhood activities;

- Ensuring that traditional healers are involved in safe motherhood activities, where appropriate.

Attitudes

All contacts with mother, newborn, relatives, the community (including community health workers) and with or between staff should respect human dignity and cultural sensitivity. All clinical tasks ask for a broad range of cognitive, manual and interactive/communication skills.

7. PRINCIPLES FOR EFFECTIVE CAPACITY STRENGTHENING AT THE HEALTH CENTRE LEVEL

The following principles should underlie efforts to strengthen the capacity of health centre personnel and communities in order to reduce maternal and neonatal mortality:

- Effective capacity strengthening is based upon country identification of needs and assessment of resources.
- The district is the focal point for effective capacity strengthening.
- Effective capacity strengthening involves the community (women/men/consumers) and the health centre of which it is a part.
- Effective capacity strengthening centres on a team (health centre staff and community health workers) rather than on an individual.
- Effective management, crucial to capacity strengthening, implies:
 - clarity of job descriptions;
 - supportive rather than controlling supervision which is ideally carried out by a person involved in the training;
 - delegation of tasks, with corresponding responsibilities and authority
 - integration of training programmes;
 - establishment, building and strengthening of linkages between community, health centre and hospital.
- Training programmes are most effective when they:
 - focus on priority tasks related to major health problems;
 - use a problem-solving approach;
 - take place at or under conditions that resemble as closely as possible those at the place of work;
 - emphasize "hands on" or experiential learning;
 - provide access to a clinical site with sufficient caseload and clinical expertise;

- provide the opportunity to observe and practice in an environment where high quality care is provided;
 - train a team rather than individuals;
 - reinforce partnership rather than provider/recipient relationships with community or adversarial relationships with community health workers;
 - build a positive learning environment with rewards for questioning and experimentation;
 - emphasize respect for human dignity;
 - incorporate current standards of practice utilizing essential list of drugs;
 - build competence to understand the language, beliefs and world view of women and their community;
 - utilize performance oriented assessments of learner accomplishments in the areas of clinical competence, management of time and resources, and collaborative spirit in work with the health centre and the community;
 - involve national and district levels.
- Effective capacity strengthening occurs within a local and cultural context and requires an understanding of local language, knowledge and perceptions, as well as the ability to bridge the gap between traditional and biomedical approaches.
 - The health centre team is accountable to the community for the quality of service provided, including accurate and timely dissemination of information.
 - Effective capacity strengthening includes monitoring and evaluation at and by the community, the health centre and the first referral level; indicators should be identified which evaluate the performance of the health centre staff, the system of services and the acceptability of services to the community.
 - Effective capacity requires district-based action plans which make the effort to integrate the work and activities related to all PHC services.

8. FRAMEWORK FOR STRENGTHENING THE CAPACITY OF THE HEALTH CENTRE

Effective district based action plans put emphasis on support of health centres. The variability of resources between large and small health centres is great. It is preferable to have health centre staff and members of the community they serve participate on any district committee to identify and tackle problems. Whether large or small, the health centre requires the support from all other levels (district, regional/provincial and central) in order to strengthen effectively their own capacity to provide services that meet the needs of their community.

With the health centre serving as focal point, the following action framework can be implemented:

8.1 District level

Supportive activities at the district level (to be developed in coordination with regional/provincial and national levels) are

- Establishment of a capacity building committee including health centre personnel, community health workers and the community;
- Assessing needs in relation to safe motherhood (e.g. skills, drugs, equipment, transportation, communication, facilities, personnel) with community participation;
- Assessing available resources in relation to the planning of safe motherhood activities (e.g. skills, drugs, equipment, transportation, communication, facilities, personnel) and develop innovative approaches to mobilize additional resources with community participation;
- Ensuring integration of safe motherhood activities at district level with other activities in the primary health care system;
- Development of a plan of action on the basis of the needs and resource assessment which contains:
 - activities related to improvement of services, e.g. skills, drugs, equipment, transportation, communication, facilities, personnel,
 - mobilization of resources for activities,
 - scheduling of time, personnel and facilities,
 - development of a protocol for monitoring and evaluation,
- Implement and monitor the plan of action;
- Evaluate and modify the plan with the participation of the community.

8.2 Regional or provincial level

Supportive activities at the regional/provincial level include:

- Providing technical assistance to the districts on capacity strengthening which may include:
 - financial support,
 - trainers/facilitators,
 - pre-service and in-service training programmes,
 - development of Information, Education and Communication (IEC) materials.

- Conducting operational research to test training and implementation plan approaches.

8.3 National level

Supportive activities at national level include:

- Establishing a national intersectoral planning committee on safe motherhood with representation of women from the community;
- Analyzing regulatory policies and national health policy with respect to the objectives and needs of safe motherhood;
- Setting regulatory policies to support full delegation of priority management, clinical and community tasks at the health centre;
- Including safe motherhood in national health care policy (5 year plans, medium-term plans, etc.) and budget;
- Including appropriate maternal and newborn information as an integral part of the primary health care data base and ensure regular analysis and feedback to all levels including the health centre;
- Coordinating and building consensus on safe motherhood activities with international organizations, nongovernmental organizations and donors;
- Providing guidance to districts in safe motherhood activities.

9. GENERAL RECOMMENDATIONS FOR SUPPORT OF HEALTH CENTRES

While action plans should be district based, there are many enabling actions which may be taken at the central level to coordinate and support the work of the districts and the community health centres:

- Health care should be viewed not just as an expenditure but as an investment and, therefore, the consequences of not educating and adequately compensating health workers should be considered;
- All programmes to reduce maternal and newborn mortality should be horizontally integrated into broad primary health care programmes;
- Priority tasks to decrease maternal and newborn mortality should be integrated into the regularly updated pre-service curricula of medical, nursing and midwifery schools whose programmes should include a rural health centre experience which lasts a significant period of time and includes

learning from traditional health care workers, such as traditional birth attendants, and other members of the community;

- Curriculum changes should be accompanied by a comprehensive programme which preserves and enhances the status of midwives by attracting them to, and retaining them at the health centre through:
 - remuneration (with additional payment for remote areas)
 - housing,
 - respect for social mores,
 - provision for security,
 - career structure and development,
 - deployment to home village/locale,
 - in-service education;
- Legislation and administrative regulations should enable health care providers to undertake life saving procedures in an emergency;
- Standards of practice, which may be referred to as standard operating procedures, protocols, guidelines, etc. (and may be included in institutional regulations, circulars or handbooks), should be developed, approved, distributed and regularly revised.
- Effective plans to reduce maternal and neonatal mortality and morbidity must include provision for financing the programme;
- Trainers and tutors should be given regular retraining with a focus on modern teaching methodologies;
- In-service training should be provided to ensure the opportunity for all health care providers to keep up-to-date, as well as to provide time for team building and rejuvenation of commitment;
- Supervision, an essential aspect of quality care, should be planned and budgeted with recognition that it should be carried out only by those persons who have actually done the kind of work that they are supervising and preferably by those who have been involved in the training;
- Training and deployment of health care personnel should be made with sensitivity to community preferences related to male and female workers;
- The special needs of both rural and urban health centres need to be taken into account in planning training and services;
- Evaluation of programmes should involve integrally all those concerned including community representatives, service providers and trainers;

- Support and activities of international organizations, nongovernmental organizations and donors should be well-coordinated and should support the country plan.

10. CONCLUSIONS

Because of the magnitude of the problem of newborn mortality and the complementarity between interventions to decrease maternal and neonatal mortality, there has been implicit acceptance of the expansion of safe motherhood programmes to include interventions to decrease newborn mortality.

Since 1990 the focus of WHO in support of human resource development for safe motherhood has been on the district and health centre levels with support from regional/provincial and central levels within a given country.

There is agreement that training alone is not the key to human resource development for improved health services; rather, there needs to be broader capacity strengthening which includes not only such supports as a nonrestrictive regulatory environment, but, more importantly, promotion of job satisfaction which comes with being paid and housed well and receiving appreciation for good work done through supportive supervision.

While model centres for training and service do not represent actual conditions of the community, there is recognition that one of the factors to improve the performance of midwives and nurses is to provide opportunity to observe and practice in an environment which provides high quality care and has an adequate caseload.

The importance of integration of maternal and newborn care into primary health services has been emphasized by the Maternal Health and Safe Motherhood Programme, but the actual implementation of integration is not yet evident within WHO as a whole. The presentations of persons representing various WHO programmes at the task force meeting were well received but the desire was expressed by certain programme representatives and task force members to do more to find consensus and actualize the concept of integration.

There may be *de facto* "integration" at the health centre level because there are few personnel who must perform all services. However, despite the multipurpose nature of their work, they may have numerous supervisors and reporting mechanisms which overstretch the limits of their competence and commitment.

The absolute necessity of understanding and working with women and men from the community, not just professional representatives of the community, is a recurring theme; the implementation of this concept beyond the local level is rarely realized.

ANNEX I

JOINT FHE/HRH TASK FORCE MEETING ON HUMAN RESOURCES
Geneva, 25-29 October 1993

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ANNEX II

JOINT FHE/HRH TASK FORCE MEETING ON HUMAN RESOURCES

AGENDA

Monday 25 October 1993

Opening of meeting

Appointment of co-chairpersons and rapporteurs

The Mother-Baby Package: a tool for safe motherhood
- *Dr R. Johnson, MSM*

Recommendations of the Technical Working Group Meeting on Care of Mother
and Baby at the Health Centre - *Mrs C. AbouZahr, MSM*

Adoption of agenda and expected outcomes of meeting

Trends which affect the provision of health care at the health centre

Tuesday 26 October 1993

Community health care in Zimbabwe - *Mrs J. Mutambirwa*

Health centre care in Egypt - *Dr N. Kamal*

Priority tasks related to management, clinical services and the community
at the health centre level

- Expanded Programme on Immunization - *Dr F.L. Gasse, EPI*
- Diarrhoeal Disease Control - *Dr S. Aboubaker, CDR*
- The Sick Child Initiative - *Dr J.L. Tulloch, CDR*
- Acute Respiratory Infection - *Dr S. Gove, CDR/ARI*
- Global Programme on AIDS - *Dr E. van Praag, IDS/HCS*
- Family Planning and Population - *Dr J. Kierski, FPP*
- Healthy Woman Initiative - *Mrs A. Haaland, TDR/SER*
- Health Learning Materials - *Mrs J. Smy-Murdoch, HRH/HLM*
- Action Programme on Essential Drugs - *Mrs M. Helling-Borda, DAPI/COL*
- Breastfeeding - *Dr F. Savage, CDR/CDD*
- Nutrition - *Dr D. Benbouzid, FUN/NUT*

Wednesday 27 November 1993

- Strengthening of Health Services - *Dr G L Dorros, SHS/DHS*
- Health Care in Tanzania - *Dr M Hirschfeld, HRH/NUR*

Principles for Effective Capacity Strengthening at the Health Centre Level

Thursday 28 October 1993

Priority Tasks Related to Management and Clinical Services (continued)

Skills, Knowledge and Attitudes to Accomplish Priority Clinical Tasks

Framework for Strengthening the Capacity of the Health Centre

Friday 29 October 1993

Framework for Strengthening the Capacity of the Health Centre (continued)

Recommendations for Central Level Support of Health Centres

Closing of the Meeting