

Promoting the health of mothers and newborns during birth and the postnatal period

Report of the Collaborative Safe Motherhood
Pre Congress Workshop

International Confederation of Midwives
Brisbane, Australia, July 21 - 23, 2005



World Health
Organization



Department of
Making Pregnancy Safer

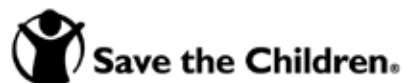
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The death of a woman (and often her unborn/newborn child) is always a disaster, an unnecessary and wasteful event which carries with it a huge burden of human grief and pain. It is outrageous when it is realised that the death need not have happened. It could have been prevented. Realising this, the International Confederation of Midwives (ICM) determined to enhance the contribution by midwives to the achievement of the goals of the Safe Motherhood Initiative. Since 1987 ICM and its member associations have been addressing Safe Motherhood issues through international and regional workshops focusing on different aspects of the Safe Motherhood Initiative. The international workshops are conducted before each international triennial congress as a pre congress workshop. The regional workshops to date have been carried out before each executive committee meeting in a developing country. So far the pre congress workshop themes have been

- 1987: Women's Health and the Midwife: A Global Perspective
- 1990: Midwifery Education: Action for Safe Motherhood.
- 1993: Midwifery Practice: Measuring, Developing and Mobilising Quality Care.
- 1996: Strengthening Midwifery within Safe Motherhood Country Plans – Women's Health, Midwives and Public Policy.
- 1999: Frontiers of Midwifery Care: STDs/HIV/AIDS in Safe Motherhood.
- 2002: The Role of Midwives in the Prevention of Gender Based Violence among Adolescent Girls and Women: A Safe Motherhood Intervention.

This year's theme (2005) was "Promoting the Health of Mothers and Newborns during Pregnancy, Birth and the Postnatal Period". This topic was intended to bring back senior midwives: midwife educators, administrators and midwife managers, to basics. It is basic midwifery care which makes the difference to the health outcome of mothers and newborn babies. In the face of repeated complications, the tendency is to strengthen skills to handle the abnormal, occasionally at the detriment of the basic skills. Doing that would unfortunately deny a midwife the full utilisation of the midwife's unique position in the community and the health care system. The uniqueness of the midwife's position stems from the fact that the midwife chose to prepare herself/himself to be "with women" at the most crucial time of their lives. The midwife accepts through education and training, the responsibility of caring for women throughout their reproductive years and to concern themselves with promotive and preventive health action in families and communities. Basic midwifery skills are the ones that make the midwife the best person to attend a birth - a skilled attendant.

The intention of this report was to collate, synthesise and disseminate the valuable information and thoughts that came out of this important two day meeting. We welcome any questions, comments and suggestions. Please direct these to the author of this report, Nester T. Moyo, ICM Programme Manager at n.moyo@internationalmidwives.org.

The International Confederation of Midwives is sincerely grateful to all those who contributed in some way or another towards the success of this workshop. Although it is not possible to have all the names of those people appear below, we do wish to acknowledge the following:

ICM Partner Organizations who collaborated with us on this Workshop:

- World Health Organization (WHO) for financial and technical support
- United Nations Population Fund Headquarters for financial support
- Prevention of Postpartum Haemorrhage Initiative for technical and financial support
- Saving Newborn Lives/Save the Children for technical support and sponsorship of participants

Other organizations and agencies who generously contributed to the Workshop:

- The Ministry of Foreign Affairs of the Netherlands for financial support
- United Nations Population Fund-DASE for participant sponsorship
- United Nations Population Fund-Pacific Office for technical support and participant sponsorship
- Johnson and Johnson Worldwide Baby for the educational grant to support participants
- American College of Nurse-Midwives participant sponsorship
- PHRplus for participant sponsorship
- Ministry of Health Solomon Islands for participant sponsorship

Individuals:

- Mr Michael Head, Vice-President Johnson and Johnson Baby Worldwide for the key note presentation during the official opening
- Dr Monir Islam, Director of Making Pregnancy Safer, WHO Headquarters Geneva for the key welcoming and opening speech for the workshop and his support throughout the workshop.
- Dr Wame Baravilala of UNFPA-Pacific Office for his presentation and encouragement during the official opening and his support throughout the workshop
- The Workshop facilitators for their support and work throughout:
 - Della Sherratt Regional Adviser for Gender and Women's Affairs, WHO Regional Office for South-East Asia (SEARO)
 - Debra Armbruster, Director Prevention of Postpartum Haemorrhage Initiative
 - Frances Ganges Midwife Consultant
- ICM volunteers who worked tirelessly throughout the workshop and provided support in every possible way: Margot Bubbert and Marion Overduin

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There is mounting evidence demonstrating the benefit of midwifery care in the reduction of maternal and newborn mortality. It has been shown in different documents and presentations that when the number of midwives increase, the number of women who die decreases. It has also been demonstrated that women's satisfaction with care is linked to utilisation of services and reduction of mortality. To maintain and enhance such a positive impact it is of paramount importance for the skills of midwives to be at their best when they come in contact with women. This workshop was designed to update and strengthen the basic skills of midwives and to remind them about the value of basic midwifery care in the reduction of maternal and newborn deaths. It was geared towards reminding midwives about ethical care and the philosophy of midwifery care. The workshop reaffirmed the midwives' confidence in their competencies and standards of care which are paramount to saving lives of women and newborns. The workshop facilitated midwives to design strategies for change and improvement in midwifery practice in their countries. The participants reflected, self assessed, shared information and ideas and produced action plans to be implemented in their countries.

Goal and expected outcomes

The title of the workshop was: "Promoting the Health of Mothers and Newborns during Birth and the Postnatal Period". The Goal was to update the knowledge, skills and behaviours of midwives to promote the health of mothers and newborns during birth and the post natal period.

At the end of the workshop the midwives:

1. Identified key strategies that, when used appropriately, promote normal progress of labour and a safe birth.
2. Demonstrated the technique of active management of the third stage of labour for the prevention of postpartum haemorrhage.
3. Demonstrated techniques of immediate newborn care that promote a healthy transition to extra uterine life and support the well being of the mother and the newborn.
4. Identified key strategies to keep the mother and newborn together during the early post natal period.
5. Developed an action plan to address ongoing education and advocacy strategies for promoting the health of mothers and the newborns in their countries.

Participants

There were 43 participants from 29 countries. Thirteen participants were from the Pacific Islands, 10 from Africa, 8 from the Middle East, 5 from Asia, 4 from Europe, 2 from the West Indies and one from Argentina (Appendix 1). This was the first time the pre congress workshop had participants from the Middle East. It was a pleasure to interact with midwives from Afghanistan, Lebanon, Yemen, and the United Arab Emirates. It was an enriching cultural exchange and a great learning opportunity for both the participants and the facilitators.

Facilitators

Expert midwives facilitated the workshop: Nester Moyo the ICM Programme Manager, Debbie Armbruster the Director of Prevention of Postpartum Haemorrhage Initiative (POPPHI), Della Sherratt the WHO South-East Asia Regional Office (SEARO) Advisor for Gender Issues and Women's Health and Frances Ganges an Independent Midwife Consultant who has been working for years in the area of newborn health.

Proceedings

Official Opening

The official opening was an encouraging exchange of pledges and support for midwives from the sponsors. Mr Michael Head, ice President of Johnson and Johnson World Baby Franchise related the philosophy of Johnson and Johnson and stated that Johnson and Johnson (J&J) will always be there for health professionals especially nurses and midwives. They will always be there to support the efforts of midwives as they take the lead as front line workers in the move to reduce maternal and newborn mortality and morbidity.

Dr Wame Baravilala of United Nations Population Fund (UNFPA) pledged support and respect for the work of midwives and shared that when he was learning his clinical obstetrics he benefited from working closely with senior midwives. He praised the efforts of ICM in educating midwives so that they are able to carry out their responsibilities more effectively for the benefit of women and children of the world. He stayed for the whole period of the workshop. His support was appreciated.

Dr Monir Islam, Director of the Making Pregnancy Safer Department of the WHO Headquarters Geneva, gave a presentation demonstrating the life saving value of midwives and midwifery skills. He stated that Traditional Birth Attendant or no Traditional Birth Attendant is no more a question. The public health strategy now for saving women and newborn lives is skilled care at every birth. He reaffirmed that the midwife is the prototype of the skilled attendant. Therefore we need more midwives to save lives. Maternal and newborn mortality are silent tragedies. Every minute 380 women get pregnant, 190 of them face an unplanned pregnancy, 110 women experience pregnancy related complications, 40 have an unsafe abortion, 5 babies are born dead, 5 newborns die and 1 woman dies. The Department of Making Pregnancy Safer has as its goal, reduction of these tragedies. The causes of maternal and newborn mortality have not changed over the past decades. Neither have the causes of newborn deaths. Most of the deaths are preventable. Evidence shows that skilled care can prevent these deaths as shown by the declines experienced in the USA, Malaysia, Sri Lanka and Thailand when skilled midwifery was introduced and increased. Evidence clearly shows that the higher the proportion of deliveries attended by a skilled attendant in a country, the lower the country's maternal mortality ratio. Therefore every country needs enough midwives, a functioning system with adequate transport systems, effective management and supervision, supportive policies and adequate equipment, supplies and drugs. There is no doubt that midwives play a central role in making pregnancy safer. There is need for advocacy, support in organising midwives at country, regional and global scales and taking part in setting up policies and providing technical support so that midwives move from taking part in activities to being activists. We should all make every mother and child count. No more poor options for poor people. Developing countries are not rich enough to invest in cheap ideas and strategies. Dr Islam stayed for the whole workshop. His support was appreciated.

The Sessions

Assessment

Before the workshop started a short questionnaire (Appendix 2) was given to the participants to give the facilitators an idea of what practices for normal midwifery were taking place in the different countries. This was analysed before the sessions started. The responses showed a great variability of processes and procedures and this gave the facilitators the confidence to share whatever information they had prepared.

Self Reflective Cycle

The participants were taken through the self reflective cycle (Appendix 3). Self reflection was a process they were encouraged to go through after each session.

Definition of reflection

Reflection is a process for reviewing an experience of practice in order to describe, to analyse, and so inform learning about or on the practice.

Steps

The process has definite steps.

One starts off by describing the experience followed by identifying the feelings and thoughts that were evoked during the experience and then evaluation i.e. determining what was good or bad about the experience. Analysis is when one decides what sense one can make out of the situation. A conclusion is drawn by answering the question: so what? What else could one have done? After reaching a conclusion the last step is to put down an action plan. What will one do when one gets back to the experience? If the situation arose again what would one do?

This process can be used in combination to the frame work for situation analysis and identifying needs to strengthen Midwifery in - country (Appendix 4).

The partograph

The new approach to the use of the partograph was shared. Participants agreed to introduce the new approach to their colleagues back home. The current suggested partograph does not have the first eight hours of the latent phase. Recording should only start when the woman is in active labour i.e. when the cervix is four centimetres dilated.

Diagram 1 below shows the current partograph as it looks without the initial 8 hour period.

Discussion

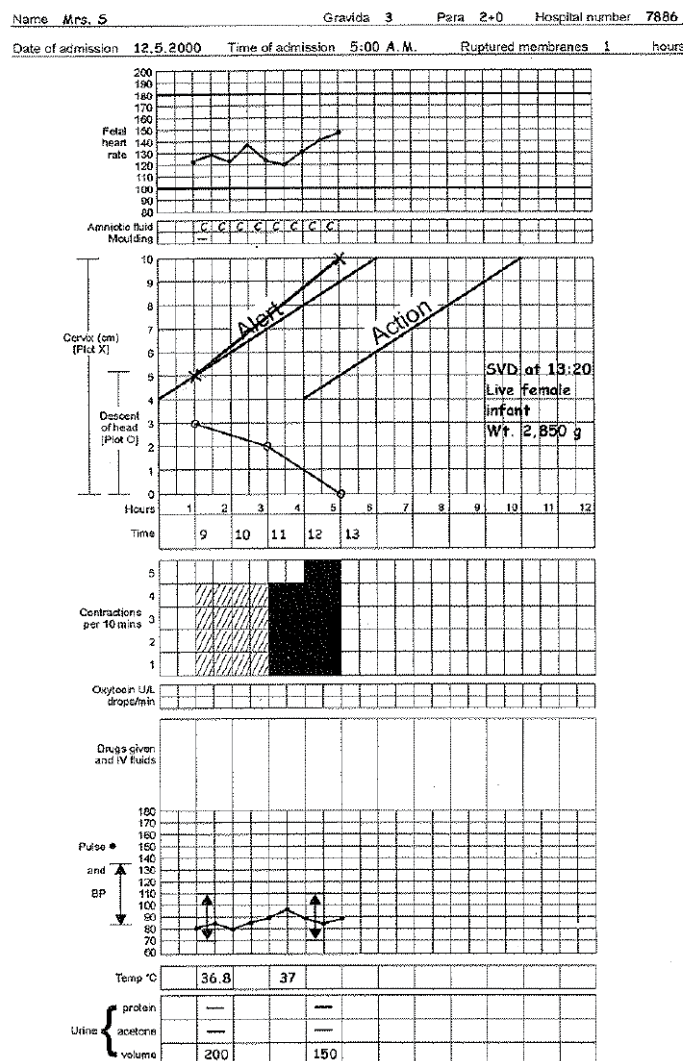
A discussion followed the introduction of this approach. Some participants pointed out that in those countries where this partograph has been introduced, women are being left alone because “they are not yet in the active phase of labour”. This is risky because then the prolonged latent phase and such conditions as cervical dystocia can go for a long time undiagnosed. After a thorough discussion, it was agreed to go back home and encourage colleagues that the fact that the recordings are not being plotted on a graph does not mean that the woman is not monitored. Midwives should be encouraged to monitor the women’s conditions and the progress of labour as before. The only difference should be that the findings are only recorded on the partograph when cervical dilation is 4 centimetres and above.

Diagram 1 Partograph

Normal labour and childbirth

C-69

FIGURE C-11 Sample partograph for normal labour



Practices during labour

In some countries a labour companion is not allowed for cultural or other reasons (policy does not allow, place too crowded, no privacy, bad advice from companion etc). It was discussed and agreed that there is need for midwives to use their knowledge and scientific evidence available to influence policy to ensure that in those countries where companions are not allowed, this can be considered. In those countries where the companion is allowed but not permitted into the labour ward because they give bad advice, the midwives were challenged to ensure that the companion is given adequate information before the labour starts so that the companion becomes more positive and helpful during labour. The outcomes of the discussion were captured in Appendix 5.

Active management of the third stage of labour

Postpartum haemorrhage is one of the five major causes of death among women in child birth contributing 14 million deaths per year to the total maternal mortality. Evidence shows that active management of the third stage of labour reduces the risk of postpartum haemorrhage (the Bristol trial and the Hinchingsbrooke trial: Appendix 6). It was emphasised that in some women any amount of blood loss leads to the deterioration of the condition of the woman even if the amount lost is considered to be very little. Even a small amount of blood loss can be life threatening for anaemic women. The benefits of active management of the third stage of labour include: reduction in quantity of blood loss; reduction of emergencies and related costs and reduction of the need for blood transfusion and the related costs. The drugs commonly used were outlined i.e. oxytocin, ergometrine and misoprostol.

The challenges to the practice of active management of the third stage of labour include the fact that the procedure is an intervention by skilled attendants yet 50 % of births occur at home. There is a variety of definitions of active management of the third stage of labour both stated and practiced. The availability of drugs and the facilities for their storage and acceptance of the procedure are still a challenge in some countries. There are still controversies among practitioners on the practice. The Prevention of Postpartum Haemorrhage Initiative is prepared to work with midwives on the practice either as a whole training programme or as an update for midwives in order to save women's lives.

There was a demonstration of the procedure followed by return demonstrations. The return demonstrations helped midwives to share a common skill on the procedure.

The Newborn

The presenter emphasised that essential newborn care is basic care for all newborn infants to promote newborn health. The care starts preconception when the midwife ensures that the mother is in optimum health at the time of conception and continues during pregnancy, labour and delivery. Then there is immediate care of the newborn soon after birth. It follows the basics principles. The baby must establish breathing. Birth asphyxia causes one third of all neonatal deaths. Most causes of asphyxia can be prevented. Five to ten percent of newborns will need resuscitation. Sometimes the midwife can predict that the baby who is going to be born will need resuscitation, sometimes not. Therefore it is important to prepare for resuscitation for all births. The methods used include mouth to mouth and bag and mask. Incubation should not be the first thing that the midwife considers when the baby is not breathing. Most babies will start to breathe spontaneously with effective use of bag and mask.

The newborn section stimulated a lot of discussion on breast feeding and bathing of the newborn with participants sharing the cultural barriers to breast feeding in some countries.

Skin to skin contact and bathing

Despite the proof provided by the best available evidence, in some countries the baby may not be given to the mother (skin to skin) before the placenta has been delivered. In some countries, the baby MUST be bathed "cleansed" soon after delivery or at latest during the first day to make him culturally acceptable and in others the baby is NOT bathed until the cord has separated. The diversity of culture in the face of scientific evidence gave fertile ground for discussions. Some of the prevailing practices were captured in Appendix 7.

Policy issues, negative professional culture and the culture of the populations served were all analysed with participants sharing ideas of how best to influence policy and introduce and maintain culture change for the benefit of the mother and the newborn. There was general agreement that these issues should be emphasised in the midwifery curricula and that there is need for effective continuous programmes for the continuing education of midwives in all countries. How each country was going to do this was captured in the individual country action plans (Appendix 8).

Strategies for keeping mother and baby together

For midwives to work out strategies for keeping mother and baby together they need to acknowledge that BOTH mothers and babies NEED skilled care. Half a million women are still dying due to pregnancy related complications. More than 8 million perinatal deaths occur annually. Fifty percent of babies are stillborn and 10% deaths occur as early neonatal deaths. The availability of a skilled attendant able to offer skilled care has been shown to go a long way in reducing this excessive and sometimes preventable loss of life. The discussion then focused on who is the skilled attendant and what is skilled care.

Skilled attendant and skilled care

A skilled attendant is a care provider who has a work ethic, is competent (knowledge, skills and attitudes), is regulated and supported by the community and other health care providers, especially medical physicians. To provide skilled care there is need for an enabling environment i.e. there is logistical support, supportive policies, back up and referral systems, transport, supportive supervision, incentives and a functioning facility for management of obstetrical complications. If midwives are the prototype of skilled attendant then there is a need to ensure that the midwifery skills are maintained at optimum level and that midwifery and midwives are strengthened.

Strengthening midwifery

Some of the ways of strengthening midwifery include the creation of regulations and licence to practice, the definition of competencies and continuing education facilities. There is also need to strengthen midwifery by increasing the numbers, improving their education and practice and enhancing the enabling environment and recognition by politicians, society and others in the maternity team. This needs advocacy for midwifery and midwives, documentation and dissemination of evidence and the setting of clinical, managerial and professional standards.

Policy makers must put systems in place to improve provider performance. Improvement of provider performance benefits all: mothers, babies, communities, families and health care systems and the profession.

Women's satisfaction with care has been shown to positively correlate with the utilization of care and subsequent reduction of mortality. To know what women want, midwives need to learn from the women. This is best done if care is provided in partnership with women. One way of strengthening partnerships between midwives and women is through midwives starting local initiatives which bring midwives closer to women. In the process midwives must think strategically and take into consideration the context within which they practise. They should not forget to include other stakeholders. Midwives CAN make a difference if they concentrate on providing midwifery care. This is what saves women's and newborn lives.

Action plans

At the end of the workshop all participants produced action plans (Appendix 8) which they will implement in their countries. Afghanistan, Djibouti, Egypt, Indonesia, Lebanon, Philippines, Tuvalu, Vanuatu and Yemen will work on active management of the third stage of labour. Fiji, Tonga, Trinidad and Tobago and Zimbabwe will work on regulation of practice and licensing. Cook Islands, Ethiopia, Kiribati, Solomon Islands, South Africa, Viet Nam and Yemen will work on immediate care of the newborn. Kenya and Russian Federation will work on supportive care during labour and Afghanistan, Argentina, Kenya, Samoa, Solomon Islands and South Africa will work on the partograph and Vanuatu will work on strategies to keep mother and baby together. Participants were encouraged to network with each other and share ideas with those who were working on the same area with them. Each of them was given a list showing who was working on which area.

Evaluations

During the end of workshop oral evaluations the participants voiced that the workshop went well. The two from Italy asked if the workshop could be repeated in their country in the near future. One of the biggest benefits of the workshop, the participants said, was that controversies came out and were discussed. In the written evaluations, (Appendix 10) the participants wrote that they learnt a lot and were able to consider the policies of their country in relation to the health of mothers and their newborns. They found the workshop to be an opportunity to go back to basics and revisit what midwifery is, what it stands for and what the role of individual midwives is in providing care and using their skills for the benefit of mothers and newborns during the period surrounding birth. One participant wrote that this topic was poorly chosen and inappropriate for the level of participants we had, that is, directors in schools of midwifery and several leaders in different aspects of midwifery. The rest of the participants indicated that the discussion of basic midwifery, which

forms the reason for the profession's being, has been long overdue. Now is the time for midwives to reclaim their turf as specialists in normal child birth and re-establish their value and capacity to improve the health outcomes for mothers and newborns through influencing policy and the environment and through the use of effective communication with other professionals and families.

Follow up

The action plans have been compiled and a follow up programme initiated. We hope to receive the first reports of implemented action plans in January 2006.

Conclusion

This was a fruitful workshop. The objectives were met. The midwives had an opportunity to return to basics – the normal and to realise that that is what midwifery offers – specialist care in normal birth. The support of the obstetrician colleagues from WHO and UNFPA helped give the other side of issues and facilitators ensured that the discussions remained focused on the mother and the newborn and their health. Professional turf was not the issue.

Recommendation

Millennium Development Goals 4 and 5 are about the reduction of mortality and morbidity among newborn babies, children and women. The ICM should have more workshops on basic midwifery care so that as the global leader of midwives and midwifery it steers the course towards the re - realisation that midwives are the specialists in normal birth and that their skills save lives. Midwives themselves need to be convinced of this and be able to practice with confidence and enthusiasm if midwifery is going to contribute to the attainment of the global Millennium Development Goals.

Promoting the Health of Mothers and Newborn Babies during the Birth and the Postnatal Period

List of participants

Number	Name	Country
1	Pashtoon Azfar	Afghanistan
2	Toorpekay	Afghanistan
3	Alicia Gomez	Argentina
4	Upoko Takau Matapo	Cook Islands
5	Safia Elmi Djibril	Djibouti
6	Neven Abd Rab Elnaby Mohamed	Egypt
7	Zeleke Haregu Yalemwork	Ethiopia
8	Silina Waqa	Fiji
9	Jule Friedrich	Germany
10	Susanne Raetz	Germany
11	Harni Koesno	Indonesia
12	Patrick Kimani Wairiri	Kenya
13	Maoto Metai	Kiribati
14	Nayla Doughane	Lebanon
15	Sabine Abou Malham	Lebanon
16	Evelyn W. Zimba	Malawi
17	Lennie A Kamwendo	Malawi
18	Meena Sharma	Nepal
19	Patricia M. Gomez	Philippines
20	Edna A. Beguia	Philippines
21	Svetlana Efimova	Russian Federation
22	Sara Filemu	Samoa
23	Teja Zacksec	Slovenia
24	Kathleen Gapirongo	Solomon Islands
25	Relma Harrington	Solomon Islands
26	Vaine Kuma	Solomon Islands
27	Jessie Larui	Solomon Islands
28	Judith Seke	Solomon Islands
29	Sikhonjiwe Masilela	South Africa
30	Elgonda Bekker	South Africa
31	Diana du Plessis	South Africa
32	Ana T. Kavaefiafi	Tonga
33	Debrah Lewis	Trinidad and Tobago
34	Emerald Williams	Trinidad and Tobago

Number	Name	Country
35	Atf Gherissi	Tunisia
36	Alaita Taulima	Tuvalu
37	Fatma Ghanim Obaid Al Shamsi	United Arab Emirates
38	Mary Angela Mento	Vanuatu
39	Phan Thi Ngoc Thach	Viet Nam
40	Fauzia H. Yousef	Yemen
41	Huda Jahlan	Yemen
42	Fatoom Ali Nooraldin Alwazer	Yemen
43	Judith Audrey Chamisa	Zimbabwe

Introductory Questionnaire

Please hand this back before the end of the evening July 21st.

Name: _____

Country: _____

Please tick the appropriate box.

No.	Question	Yes	No
	Are the following practices done routinely in your country?		
	Use of the partograph		
	Giving women food during labour		
	Giving women fluids during labour		
	Letting women move around during labour		
	Letting a woman adopt a position of her choice during labour		
	Letting a woman adopt a position of her choice during delivery		
	Letting a woman have a support person during labour and delivery		
	Third Stage		
	Active management of the third stage of labour for all women.		
	The Newborn		
	Drying the baby immediately after birth		
	Delivering the baby onto the mother's abdomen		
	Practising skin-to-skin contact as soon after birth as is possible.		
	Assessing the baby's Apgar score		
	Putting the baby onto the breast during the first hour after birth		
	Assess the baby's condition within the first hour after birth.		
	Counsel mothers about HIV and AIDS in relation to breast feeding.		
	Resources		
	Do you have access to the following resources?		
	Essential Competencies for Basic Midwifery Practice.		
	Strengthening Midwifery Toolkit		
	The Critical Role of the Skilled Attendant		
	International Code of Ethics for Midwives.		
	Integrated Management of Pregnancy and Childbirth		
	ICM/FIGO Joint Statement on Prevention of Postpartum Haemorrhage		
	Policy Issues		
	Do policies in the hospitals in your country support the following practices:		
	Rooming in (Mother and baby sleep in the same room)		
	Bedding in (Mother and baby sleep in the same bed)		
	Baby Friendly Hospital Initiative		

No.	Question	Yes	No
	Mother and Baby Friendly Initiatives		
	Exclusive breast feeding		
	Actively encouraging mothers to breast feed.		

Please note that this is not a test. This is information to give the facilitators some insight in the practices in the different countries.

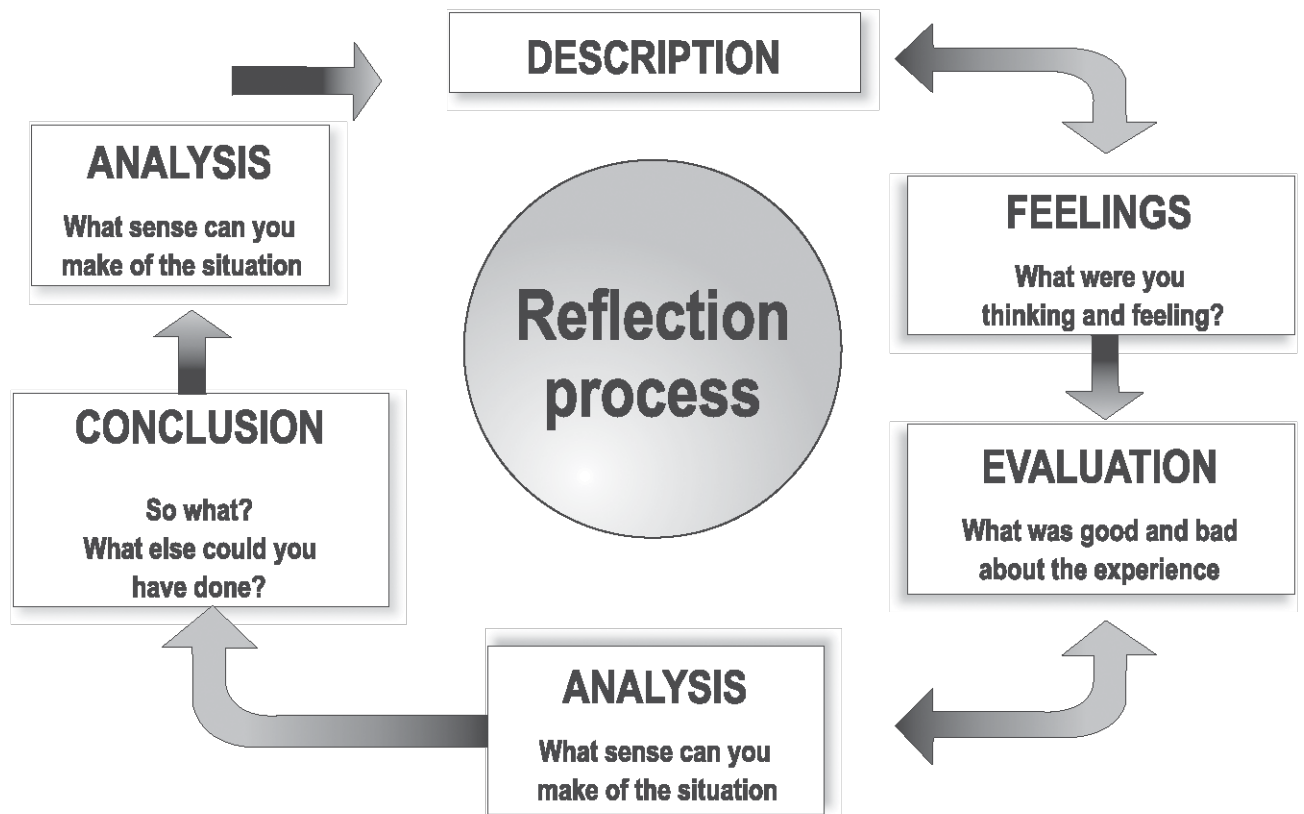
Please turn this questionnaire in before you go to your room.

Thank you for taking your time!

Self-assessment - Reflective cycle

Definition of reflection

Reflection is a process of reviewing an experience of practice in order to describe, to analyse, and so inform learning about/on practice.



WHO Making Pregnancy Safer Strengthening Midwifery Toolkit

Framework for Assessing Situational Analysis and Identifying Needs to Strengthen Midwifery In-Country

Current Status	0	1	2	3
1. Rules/ Legislation in place that frame/define Licence to Practice Midwifery	No legislation covering right or license to practise midwifery	Rules in place but not functioning	Rules governing license to practice functioning but ineffective.	Legislation for license to practice is defined and International Definition of the Midwife in place and assessed as operating well.
2. Re-Licensing procedures ensure competency is maintained	No re-licensing procedure in place	Re-licensing procedure in place but is not linked to demonstrating competency to practice	Plans being developed/ implemented to ensure re-licensing procedure linked to practice.	Re-licensing procedures linked to continued competency to practice operating and assessed as being effective.
3. An accreditation process in place to ensure practitioners fit for practice – meet minimum competencies	No accreditation process specified.	Accreditation framework but weak and not functioning	Clear transparent accreditation process functioning but not been evaluated or has some weaknesses.	A clear and transparent accreditation process in place that is compiled by all and respected by the profession and national authorities.
4. Curriculum is based on Fit – for – Purpose* approach	No central standards established for midwifery curriculum	Central standards established for curriculum but no evidence that they meet current needs of country	Revised in line with fitness for purpose but awaiting approval or implementation.	Curriculum based on fitness for purpose updates, implemented and regularly reviewed.
5. Evidence Base Standards (E-B) established for midwifery practice (Competency based)	EB standards of midwifery care not established	EB standards not developed, or no system in place for regular up dating or audited	EB Standards currently being developed / implemented.	EB Standards in place and are regularly audited and action taken based on audit findings.
6. Clinical areas assessed and provide quality service (care based on evidence based standards) and appropriate clinical experience for students to gain competency in midwifery	No assessment made of clinical area	Clinical areas do not provide quality care or the experiences required for developing competent midwifery teachers	Clinical areas assessed and able to provide quality midwifery care but do not provide the full experiences required for developing competency.	Clinical areas provide quality midwifery care and all experiences required for students of midwifery including supportive supervision of students.

*Fitness-for Purpose means the curriculum has been designed to meet the specific socio-ethnographic and epidemiological needs of the country, as well as professional competency (See Sherratt DR. 1998. Improving Women's Health in South East Asia: the needs for Midwifery Trained personnel)

Current Status	0	1	2	3
7. Realistic norms established for number of midwives needed in each district.	No staffing norms established for districts, or norms for midwives not generally known at district level.	Norms are established but current establishment is below that required to meet the needs of the women and newborn in the district/country.	National plan is being developed / revised to establish norms required to meet the current needs.	Norms established and being met in all districts with only minimal shortfalls of midwifery staffing in some areas.
8. Number of midwives in clinical posts (both private and government) known and mapped according to actual place of work.	No mapping of midwives in clinical practice undertaken recently, no real knowledge of total number of midwives currently working (including in private practice)	Numbers of midwives in clinical practice known, but many vacant posts exist and no realistic plan in place to address the shortfalls.	Mapping of midwives in clinical practice is taking place as part of a national plan to address needs and shortfalls.	Realistic map of all midwives currently in practice known at national and district level and special efforts are in place to meet the needs of the hard to fill/long term vacant posts.
9. Sufficient midwife teachers in place- based on norms set for Student: Teacher ratio	No student: teacher ratio agreed or student: teacher ratio unrealistic.	Realistic student: teacher ratio established but not in place in many areas.	Currently plan being developed based on realistic student: teacher ratio to address shortfall of midwife teachers.	Realistic student: teacher ratio established and being met in most places.
10. Programme of preparation of midwife teachers is in place to ensure midwife teachers are competent in all aspects of midwifery practice and education, including teaching and learning strategies, and have been adequately prepared for their post.	Numbers of midwife teacher posts required not determined and or posting as a midwife teacher is not determined by successfully completing a specialist teacher preparation programme/ educational course.	Very few teachers of midwifery have received training and been assessed as competent in all aspect of midwifery as well as competency to teach.	Currently plan being developed/implemented to ensure all teachers of midwifery are competent to be teachers of midwifery.	All teachers of midwifery have successfully completed specialist preparation as midwife teachers.
11. Quality teaching and learning resources available.	No or very few teaching and learning resources available in all midwifery schools/educational institutions.	Limited teaching and learning resources available in most centres but many out of date.	Currently plans are in place to develop in country appropriate quality teaching and learning material to be available in all centres.	Sufficient and varied teaching learning materials of good quality are available and being used in all centres.

Current Status	0	1	2	3
12. Job description of midwife at all levels of service (including community), is regularly updated/ revised, and included within in this is the minimum standard required by the post holder.	No specific job description is available for the person who provides midwifery care, or job descriptions are not prepared for all levels of the service.	Job descriptions of clinical midwives too vague, do not specify the particular needs of midwifery, or are out of date.	Job descriptions being reviewed/up dated to ensure specifics of midwifery practice are covered including EB standards of care and practice.	Job descriptions specifying particularly midwifery practice required based on provision of EB standards of care, is in place in all areas, including the community.
13. In-service /updating programme is in place.	No provision for up dating providing in-service and on-the-job training.	Limited up dating available to some midwifery practitioners in some areas.	Plans being developed to implement regular up dating programme for all midwifery practitioners in all areas including rural hard to reach areas.	All midwifery practitioners participate in regular up dating programme. All have received some up dating in the last three years.
14. Provision for continuing education programmes for strengthening midwifery services, in country, capacity of midwives to provide leadership and for career enhancements is in place and operating well.	No or limited provision for midwifery practitioners to participate in Continuing Education Programmes/ advanced education programmes, and/or research development, management, policy. Leadership programmes.	Making provision for continuing education programmes / advanced education programmes, including midwifery management and research.	Currently plans are being developed/implemented that will increase access to Continuing Education Programmes/Advanced Education Programmes including midwifery management and research.	Midwifery practitioners at all levels of the service have the opportunity to fully participate in continuing education programmes/ advanced Education Programmes including specialist midwifery studies at both Masters and PHD level and specialist programmes for midwifery leadership, management, research development and policy-making.

Total Score: _____

Date Assessment taken. _____

Labour practices

Outcomes from group work

Group 1 Countries:

Afghanistan, Vanuatu, Solomon Islands, Zimbabwe and Kenya

Group 2 Countries:

Egypt, Lebanon, Trinidad and Tobago, Djibouti, Russian Federation, Tunisia and South Africa.

Group one and two: The Partograph

1. Do you use the partograph in your countries?

Response: All countries "Yes"

2. Who decides when the woman's labour process should be monitored through the use of the partograph?

The midwife in all countries. It is routine if the labour is taking place in a hospital.

3. Who actually makes the record (filling in the record)?

The midwife in all countries. The doctor at times

4. Who interprets the findings?

The group did not respond to this question

5. How much information and advice does the woman receive during labour and from whom?

Only what she asks for or when there is deviation from normal does she get information. Otherwise the next information she receives is when she is actually delivering and is advised to push or pant as is necessary.

6. Who is responsible for the care of the woman?

The midwife, the labour companion and any midwife assistants if there are any.

7. Any challenges you face in the use of the partograph?

Recording is a problem in most countries.

8. Do women have a companion during labour?

Only in Vanuatu women have a companion at birth, in the other countries, some do and some do not. It depends on where the woman is having the baby. In private hospitals conditions are different from those in public hospitals; the private hospitals are more liberal than the public hospitals.

9. Who decides whether they can have a companion or not?

In all the countries, hospital authorities make most of the decisions. The woman, the relatives and sometimes the midwife contribute to the environment.

10. What do women prefer at birth?

The presence of a relative but some prefer to be alone.

11. Who is acceptable to the women as a companion?

Usually a female companion or the spouse. In Afghanistan the spouse is not acceptable at delivery.

12. What does the midwife prefer?

One companion, not a whole family. In most countries the midwife's preference is guided by policy.

13. What are the challenges of having company at birth?

Crowding of the delivery room. Interruptions/disturbance. Companion giving incorrect advice and cultural restrictions.

14. What are the suggested solutions?

Home birth with a skilled attendant would solve all the problems including cultural restrictions because the birth would be conducted the way the woman and the culture of that place accept. The midwife needs to have communication skills and develop a relationship with the companion to ensure that they give the same advice. There is need for the introduction of mother friendly care so that the woman has a chance of taking part in the decision making process.

*Group three and four: Food and fluids***1. Do you give women food and drink during labour?**

Three countries – No

Two countries - Yes

2. Who actually gives the woman food or drink?

The relatives.

3. Who decides whether the woman will have food or drink?

The relatives. They do not consult the health staff.

4. Any challenges you face in your country in relation to giving food and drink to women in labour?

The three countries who do not give: Relatives sneak in with food and give it to the woman.

5. What are suggested solutions?

Educate the midwives and community on food and drink in labour. Also incorporate the information from this workshop (Women should be allowed to eat light foods and drink fluids).

Evidence of effectiveness of Active Management of the Third Stage of Labour

Active vs. Physiologic Management: Postpartum Haemorrhage

	Active Management	Physiologic Management	OR and 95% CI
Bristol Trial	50/846 (5.9%)	152/849 (17.9%)	3.13 (2.3-4.2)
Hinchingbrooke Trial	51/748 (6.8%)	126/764 (16.5%)	2.42 (1.78-3.3)

Prendeville et al 1988; Rogers et al 1998.

Group Work Outcomes

Newborn care Practices

Group 2 Countries

Egypt, Lebanon, Trinidad and Tobago, Djibouti, Russian Federation, Tunisia and South Africa.

1. Are midwives taught resuscitation?

The 7 countries agreed that they teach resuscitation in pre-service training.

2. Are there regular updates on resuscitation?

Lebanon: There are workshops for midwives through the university twice a year.

Djibouti and Tunisia: Updates are through the Safe Motherhood programme.

Russian Federation and Egypt: Through the Ministry of Health projects every year.

Trinidad and Tobago: Updates are through in service training held by hospitals.

Group 3: Prevention of Hypothermia

Countries: Ethiopia, Yemen, Malawi, Fiji, Tonga and Tuvalu

1. Preparation: Room temperature for deliveries.

Warm cot with hot water bottle or warmer. Incubator where available or steaming (wet).

2. Do you practise Skin to Skin Contact?

Yes for all.

3. Do you practise Kangaroo Care?

Yes in Ethiopia it is cultural so all babies are kangarooed. In Malawi the process is starting following the Saving Newborn Lives Programme.

4. Do you bath babies at birth?

On average three to four hours after delivery. In Ethiopia baby not bathed until the cord has separated.

5. Who baths the baby?

The nurse midwife, the obstetric nurse, grand mother. The bathing is done with warm water or water at room temperature. Cord care is practised according to the procedure manual.

6. Weighing, cord and eye care

In The Pacific Islands, the baby is weighed before the bath. In Malawi the baby is weighed one hour after birth.

7. Cultural practices

Professional culture – separation of mother and baby and paying more attention to the mother and not drying the baby adequately.

8. Community culture – removal of vernix caseosa and repeat washing to remove vernix.

During home delivery, no-one touches the baby until the placenta is delivered.

Group 6

Vanuatu, Zimbabwe, Kenya, Solomon Islands and Afghanistan

1 Who breastfeeds?

All women breast feed.

2. When does breastfeeding start?

Soon after birth. In some countries within the first three hours or within the first day in remote areas.

3. Any birth companion? Who if yes?

The woman's mother in law, the midwives, mothers themselves and relative birth attendants.

4. Are babies fed colostrum?

a. Encouraged professionally.

b. Believed to cause diarrhoea. Cannot satisfy baby's hunger and believed to cause constipation.

5. What else, if not breast milk, are the babies fed on?

Ghee, butter, tea, honey, warm water, glucose water, formula milk.

6. What would make a woman stop breastfeeding?

Cultural beliefs, tiredness, shy to breastfeed, inadequate milk let down, lack of knowledge on how to fix on breast and misperceptions.

Participants Action Plan

Objective	Activity	Person Responsible	Time frame	Resources required
Afghanistan: Pashtoon Azfar and Toor Pekay				
To train 80% of the midwives	* Work with MOPH regarding policies and strategies of oxytocin and partograms	Pashtoon Azfar Toor Pekey Nawab NAWAB AMA Officers	Aug 2005	- standards - supplies - human resources - incentives for staff
* Use of the partogram and			Sept 2005	- Support from MOPH, REACH, ACCESS, JHPIEGO, AMA, WHO, UNICEF, PHOs, Hospital Directors.
* active management of the third stage of labour.	* Establish a system of keeping oxytocin cool		Oct 2005	
	* Baseline assessment in the big cities hospitals		Oct 2005	
	* establish a committee for regular monitoring in each level		Oct 2005	
	* reassessment		Feb 2006	
Argentina: Alicia Gomez				
Plan in Spanish. Awaiting translation				
Cook Islands				
1. To be able to increase skills and knowledge of midwives in resuscitation of the newborn for 18 midwives.	1. Meet with DoN, CNS, and Midwives to identify and to discuss training needs of midwives in resuscitation of the newborn.	Facilitator U.T Matapo	10 – 14 Oct 2005	Partners – CNS, paediatrician, anaesthetist, neonatal nurse. Support – Charge Midwife, Secretary for Health.
2. To develop knowledge and skills of 2 nd and 3 rd year diploma student nurses in the effective use of the partogram.	2. Training is carried out in the school of nursing and the neonatal unit.	Clinical Nurse Specialist		Supplies – PCPNC Guidelines, stationery, resuscitation equipment, manikin. Funding – RH, UNFPA, MOH
	1. Carry out training in the school of nursing using the standard form that is already in use.	Self and Clinical Nurse Specialist.	15 to 16 th August 2005	
	2. Carry out an assessment after the session to measure knowledge and skill gained .			

Objective	Activity	Person Responsible	Time frame	Resources required
Ethiopia: Zeleke Haregu Yalemwork				
To strengthen the practical attachment area in relation to the theory achieved especially on the newborn care and life saving care.	<p>* Call a meeting with members of the executive committee of the Ethiopian Midwives Association and association of obstetricians</p> <p>* Approach Ministry of Health , the university through the committee members.</p> <p>* By planning and implementing workshop and refresher course for the hospital midwives.</p> <p>* By making alliance and trying to get some top up for the hospital midwives and monitoring after implementation.</p>	<p>Education and training</p> <p>Midwives association</p> <p>Ministry of Health</p> <p>Hospital Midwives</p> <p>Finding funding agency or ministry of health</p>	Two years	<p>Ministry of Health</p> <p>Midwives Association</p> <p>Any funding agency</p> <p>Association of obstetricians.</p>
Malawi: Lennie Kamwendo				
To disseminate workshop discussions to key stakeholders to gain support by Oct 2005	<p>Organise a meeting with key stakeholders to discuss the following:</p> <ul style="list-style-type: none"> - use of the partogram and other labour management tools. - Making pitocin readily available for AMTSL. - Ensuring essential newborn care to all newborns. - Need for regular renewal of midwifery licensure 	Lennie Kamwendo	Oct 2005	Partner Evelyn Zimba
To raise political interest in maternal and newborn health so that more money is committed for improvement of maternal and newborn health in the next financial year.	Arrange a meeting with parliamentarians to sensitise them on the status of maternal and newborn health in Malawi and suggesting the way forward.	Lennie Kamwendo	July 2005	Partner Evelyn Zimba

Objective	Activity	Person Responsible	Time frame	Resources required
Philippines: Patricia Gomez				
1. Advocate for upgrading midwifery education by hosting a national conference of educators to present a four years curriculum	* Meeting with the officers of the association of Philippines School of Midwifery.	A Esmrle – com. Chair. Educ	Aug 2 2005	IMAP Office address, IMAP Sec. Office supplies C/o IMAP
	* Writing of position paper to com. On higher education	P. Gomez President IMAP	August 31 2005	
	* Workshop of different stake holders on course syllabi	R. Castilo – Chairman. Tech. com on mid. Education	Sept 5 2001	
	* Finalisation of output	P. Gomez IMAP office	Sept 21 2005	
	* Presentation of the output to different schools of midwifery	R. Castilo. Chairman	Oct 21 2005	
2. To update midwifery law by introducing amendments to the following sections	* Meeting with the following stakeholders: IMAP, BOD, BOM, PPC and other midwives org.	P. Gomez – IMAP Dr Mandisla – BOM Cleo Estrada (NCR) P. Gomez – IMAP	August 2 2005	IMAP office IMAP Secretariat
a. composition of the member board	* creation of a com.	Dr Beguia – BoM	August 15 2005	Office supplies
b. giving of oxytocin in the third stage of labour instead of the fourth	* Workshop on the amendments.	Dr Roque POGS P. Gomez – IMAP	Sept 15 200	
	* presentation of output to legislators	R. Castilo APSOM	Nov 2005	
	* Lobbying with legislators for support	Dr Beguia – BoM P. Gomez – IMAP	Jan 2006	C/o IMAP
	* Passing of the bill	Senator ManRoyas	Dec 2007	
South Africa: Sikhonjiwe Masilela				
* Training	* Train health workers in judicious use of the partogram	Masilela/Tsotetsi	March 2006	Partners- Wits/UP, MEDUNSA, GcoM
	* Train health workers in neonatal resuscitation	Masilela/ Tsotetsi	March 2006	JJPI Finance ADM Drs
	* Facilitate implementation of national maternity case records in all districts	Masilela/ Tsotetsi	March 2006	Manuals
*Quality assurance				

Objective	Activity	Person Responsible	Time frame	Resources required
Trinidad and Tobago: Debra Lewis				
To have continuing education for midwives mandatory for re-licensing within two years	Work with the regulatory body The Nursing Council of Trinidad and Tobago- to make continuing education mandatory for re-licensure	Trinidad and Tobago Association of Midwives	TTAM Executive and members , Nursing Council of Trinidad and Tobago, Ministry of Health, School of Midwifery	Follow up – In 6 months when ICM makes follow up, TTAM will have had several meetings with resource partners
Tuvalu: Alaita Taulima				
To facilitate and support midwives in using the international guidelines for AMTSL in their practices	<ul style="list-style-type: none"> * Identify key people to adapt and adopt these guidelines (DOH, Obstetrician) * Conduct refresher workshops amongst midwives and nurses yearly * get a national policy on these guidelines so as to support service delivery 	Self and other interested midwives	By end of 2005 or beginning of 2006	<p>Partners with Tuvalu Nurses Association/DOH and also the obstetricians to be involved.</p> <p>Support by the MOH.</p> <p>To be funded or to seek funds from donors – UNFPA, WHO, UNICEF</p>
United Arab Emirates: Fatoom Ghanim Obaid – Sharjah				
1. To train midwives in the active management of the third stage of labour	<ul style="list-style-type: none"> * Share the new information I got form the ICM workshop with them * Convince the in charge of the department to change the protocol and policy. Bring the latest research. Meet her and discuss 	Self	October 2005	
Viet Nam: Thank Thi Ngoc Thach				
Open training class for midwives on infant massage method.	<ul style="list-style-type: none"> Open infant massage class. Pregnancy massage class Do home grown study on benefit of infant massage 	Chief midwife Director	October to Dec 2005	<p>Room for training facilities, video</p> <p>Head of paediatrics</p>

Objective	Activity	Person Responsible	Time frame	Resources required
Yemen: Fatoom Ali Nooraldin Alwazer				
Training midwives to take care of the newborn	Conducting refresher course for 60 midwives on Saving Newborn Lives from birth. Each workshop will be 5 days long	Fatoom and colleagues at work	Sept 2005 to Sept 2006	Ministry of Health, Local Midwifery Association
Yemen: Huda Gehalen				
Train midwives on Newborn care	Workshop for midwife. Each workshop 2 days long	Huda and colleagues	Start Nov 2005	MOPH, GTZ, Midwifery Association
Yemen: Fauzia H Yousef				
To update the training curricula of midwives in the area of SMTSL and resuscitation of the newborn by the end of 2006 to contribute in improving the quality of midwifery services	<ul style="list-style-type: none"> * Invite the directors of the two main health institutions and midwives association to discuss the need for reviewing the curricula * Provide the institutes with the evidence based information on the success and advantages of the approach followed in AMTSL and resuscitation of the newborn. * Develop a plan of action with the institutes for reviewing and developing a training programme for training trainers. * Follow up the implementation of the process * Report on progress 	<p>The Directors of the two main health institutes</p> <p>Midwifery trainers</p> <p>Reproductive Health Department at the MOPH</p>	By the end of 2006	<p>WHO Document. UNICEF Consultant, MOPH support in approving the reviewing and training of trainers.</p> <p>Supplies: Midwives to do the training of trainers</p>

Objective	Activity	Person Responsible	Time frame	Resources required
Zimbabwe: Judith Audrey Chamisa				
To work towards possible change of name from Zimbabwe Nurses Council to Zimbabwe Nurses and Midwives Council	<ul style="list-style-type: none"> * Sensitise the Zimbabwe Confederation of Midwives members about the need for change of name. * Build a consensus among midwives themselves * Write a position paper to Zimbabwe Nurses Council explaining the association's intentions * Negotiate for a meeting to discuss the issue 	The Zimbabwe Confederation of Midwives President (self, national executive, provincial executive and branch executive)	August 2007	Resources- * Partners – President of Zimbabwe Nurses Association, Registrar of Zimbabwe Nurses Council, Members of Zimbabwe Confederation of Midwives, Schools of Midwifery, Health Science Universities – University of Zimbabwe, Open University of Zimbabwe * Support – Psychiatric nurses and Theatre nurses * Funding – by association Other – Zimbabwe Medical Association. Society of Obstetricians and Gynaecologists of Zimbabwe

Workshop outline

Title:

Promoting the Health of Mothers and Newborns during Birth and the Postnatal Period.

Goal:

To update the knowledge, skills and behaviours of midwives to promote the health of mothers and newborns.

Expected Outcomes:

At the end of the workshop the participating midwives will be able to:

- Identify key strategies that, when used appropriately, will promote normal progress of labour and a safe birth including the promotion of the midwifery model of care.
 - Demonstrate acquisition of knowledge and skills to actively promote the active management of the third stage of labour for the prevention of postpartum haemorrhage and immediate newborn care that will promote a healthy transition to extra-uterine life and support the well-being of the mother and newborn.
 - Identify key strategies to keep the mother and newborn together during the early postnatal time
- Develop an action plan to address ongoing education and advocacy for change to promote the health of the mother and the newborn in their countries.

The Programme

21 July: Evening

- Registration and questionnaire to be handed over before the end of the evening.
- Official opening of the workshop.
- Introductions, objectives and expectations of the participants.

22 July: Morning

Welcome

Introduction of elements of ethics, competency, self-assessment and advocacy for the participant's plan of action.

Outcome 1: Key strategies for normal labour and birth

- Use of partograph
- Food, fluids, mobility during labour
- Positioning during labour and birth
- Pushing behaviours

Small group activity:

- Use of partograph, etc
- Discussion of cultural issues related to food, fluids, mobility, positioning during labour and pushing behaviours and birthing positions
- Treating women with respect
- Support for people in labour

Begin self-assessment plan. Begin thinking about what to include in the action plan for maternal care during labour and birth

Afternoon

Outcome 2: Active Management of Third Stage of Labour

- Background and evidence
- Competencies and regulation

- Components: uterotonics, controlled cord traction, uterine massage following delivery of the placenta
- Issues and challenges of Active Management of the Third Stage of Labour

Small group activity

- Demonstration and return demonstration of AMTSL
- Discussion of cultural issues impacting on third stage of labour.

Continue preparation for plan of action for third stage actions

23 July: Morning

Outcome 3: Immediate newborn care (low tech).

- Airway – techniques and evidence.
- Warmth – drying, skin to skin (radiation, conduction, convection, evaporation).
- Initial assessment – physical exam, APGAR scoring.
- Nutritional needs including issues of HI and breast feeding.
- Bathing.

Small group activity:

- Demonstration of key competencies.
- Cultural issues impacting on newborn care and newborn health. (Early discharge, home deliveries).
- Continue preparation for plan of action for newborn care.

Outcome 4: Key strategies for keeping mother and newborn together

- Creating mother-baby friendly environments (initiating breast feeding, rooming in, bedding in).
- Early and continuous breastfeeding policies (exclusive breast feeding).
- Support of family interaction.
- Addressing cultural practices.
- Environment/system practices that promote or hinder healthy mother/baby dyad.

Afternoon

Outcome 4 continued: Changing the environment

- Regulations, policies and practices impacting on the environment.
- Human resources issues.
- Changing attitudes.
- Advocacy strategies.
- Ongoing competency development.

Small group activity:

- Discussion groups on strategies/advocacy needed
- Continue preparations for plan of action for advocacy/policy activities

Outcome 5:

- Ongoing competency development and updates.
- Development of action plans.
- Share action plans.
- Way forward.

Closing remarks

Participants' evaluation form

We would like all the participants at the workshop to fill in and return this evaluation form by the time the workshop is closed. Your comments will help us in planning future workshops.

- | | | |
|--|-----|----|
| 1. Were the arrangements for your travel satisfactory? | Yes | No |
| If 'No' please say what would have improved them: | | |
| a) | | |
| b) | | |
| c) | | |
| 2. Were the arrangements when you reached Brisbane satisfactory? | Yes | No |
| If 'No' please say what would have improved them: | | |
| a) | | |
| b) | | |
| c) | | |
| 3. Have the domestic arrangements in the hotel been satisfactory? | Yes | No |
| If 'No' please say what would have improved them: | | |
| a) | | |
| b) | | |
| c) | | |

4 ABOUT THE PROGRAMME

21 July

Setting the stage:

4.1	The introductory session made the objectives and expected outcomes of the workshop clear	Strongly Agree	Agree	Disagree	Strongly Disagree
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 Comments:

July 22: Morning

4.2	By the end of the session the speaker and group work had helped me to achieve outcomes 1, of the workshop.	Strongly Agree	Agree	Disagree	Strongly Disagree
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 Comments:

4.3	By the end of this session I was clear about the evidence relating to the active management of labour and the competencies I require and the technique.	Strongly Agree	Agree	Disagree	Strongly Disagree
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 Comments:

4.4	The facilitator in our group helped me to get a grasp of the impact of professional culture in different countries on the promotion of the health the health of mothers and newborns	Strongly Agree	Agree	Disagree	Strongly Disagree
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 Comments:

July 22: Afternoon

	Outcome 3: The speaker facilitated the session well and helped me to understand the immediate care of the newborn including nutritional needs.	Strongly Agree	Agree	Disagree	Strongly Disagree
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 Comments:

July 23: Morning

4.6	The group work and report back sessions provided a good opportunity to discuss and learn from other midwives and identify the competencies I need to strengthen or develop in order to effectively promote the health of mothers and newborns.	Strongly Agree	Agree	Disagree	Strongly Disagree
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 Comments:

4.7	Outcome 4: The speaker facilitated the session well, and provided me with a clear understanding of strategies to keep the mother and newborn together during the early postnatal period and how I can contribute to changing the environment in my country.	Strongly Agree	Agree	Disagree	Strongly Disagree
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Comments:

July 23: Afternoon

4.8	The session on strategies and advocacy needed helped me realize my role as a midwife in promoting the health of mothers and newborns during birth and the neonatal period.	Strongly Agree	Agree	Disagree	Strongly Disagree
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Comments:

4.9	The report from the action plans gave a valuable insight into the work which I will be doing when I go home.	Strongly Agree	Agree	Disagree	Strongly Disagree
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Comments:

5 ABOUT THE PREPARATION OF YOUR ACTION PLANS – OUTCOME 5

5.1	I will return home with an action plan which will help me in my work to address the promotion of the health of mothers and newborn during the postnatal period.	Strongly Agree	Agree	Disagree	Strongly Disagree
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Comments:

5.2	The content of the workshop guided me in the preparation of my action plan	Strongly Agree	Agree	Disagree	Strongly Disagree
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5.3	If I asked for it I was given useful help with the preparation of my action plan	Strongly Agree	Agree	Disagree	Strongly Disagree
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Comments:

6 GENERAL COMMENTS

6.1	The review of the previous day which took place each morning was useful	Strongly Agree	Agree	Disagree	Strongly Disagree
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6.2	I was given every opportunity and encouraged to express my views and ask questions throughout the workshop	Strongly Agree	Agree	Disagree	Strongly Disagree
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6.3	I found attending a workshop with midwives from different countries a good experience	Strongly Agree	Agree	Disagree	Strongly Disagree
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6.4	The workshop was well organised	Strongly Agree	Agree	Disagree	Strongly Disagree
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Comments on statements 6.1 to 6.4:

6.5	Overall, the workshop has been a valuable Experience
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7	Do you have any other comments either in support of your experiences or which would help us to improve future workshops?	Yes	No
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If 'Yes', please make them here:

a)

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b)

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c)

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d)

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e)

.....

Name/Signature (only if you wish).....