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MotherCare

John Snow, Inc., 1616 N. Fort Myer Drive, 11th Floor, Arlington, Virginia 22209
Tel. (703) 528-7474 ▪ Fax (703) 528-7480 ▪ Telex 272896 JSI WUR

DRAFT

NIGERIA TRIP REPORT # 5

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Margaret Marshall CNM, EDD, MPH
MotherCare/American College of Nurse Midwives

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Appendices B through CC are on file at the American College of Nurse-Midwives. Those wishing to see any appendix may do so by a request to ACNM.

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The MotherCare staff- Mrs.'Lola Payne, Mr. USA Nnanta

Mr. Gene Chiavaroli, Dr. John Mc William and their staffs at USAID and Family Health Services.

The Life Saving Skills trainers and Course Coordinators at the training centers at Bauchi Specialist Hospital and Adeoyo Maternity Hospital.

ABBREVIATIONS

ACNM	American College of Nurse-Midwives
AIDS	Acquired Immuno-deficiency Syndrome
CHO	Community Health Officer
FHS	Family Health Services Project
FMOH	Federal Ministry of Health
HIV	Human Immuno-virus
IC	In Charge
IEC	Information, Education, Communication
LGA	Local Government Area
LSS	Life Saving Skills
MCH	Maternal Child Health
NERDC	Natl. Educational Research Development Commission
NMC	Nursing and Midwifery Council
PHC	Primary Health Care
PIH	Pregnancy Induced Hypertension
PPH	Post-partum Hemorrhage
POP	Public Opinion Polls, Inc.
PSM	Problem Solving Method
SMOH	State Ministry of Health
SNS	Senior Nursing Sister
TBA	Traditional Birth Attendant
VVF	Vesico-vaginal Fistula

I. EXECUTIVE SUMMARY

DRAFT

This six week trip for traveller Margaret Marshall accomplished the following activities:

1. Both training sites for the Life Saving Skills trainings were visited. Inputs needed were discussed with staff and state level Hospital Management Board and Health Department personnel.

2. Two doctor's conferences were held (one in Bauchi State and one in Oyo State for Oyo and Osun physicians):

   -to update their knowledge regarding the scope of the problem of maternal mortality worldwide with emphasis on Nigeria,

   -to teach the modern management for prevention and treatment of the five major killers,

   -and to assist to develop a personal commitment of attending doctors to work actively in their own areas to decrease mortality.

3. The first Life Saving Skills training for the northern training center at Bauchi Specialist Hospital was held. Due to the four and a half week national job action (strike), only the theoretical portion of the program was held. The trainees were called back the Monday following settlement of the job action.

4. Arrangements were made to replace the faulty surgical instruments received with a higher grade of steel.

II. BACKGROUND

The MotherCare project is a collaborative effort among the Federal Ministry of Health Nigeria, the several state ministries of health, and the centrally funded USAID project named MotherCare. The project is funded from March of 1992 through August of 1993. The aim of the project is to address the high maternal mortality ratio seen in Nigeria by 1) updating and expanding the skills of midwives to address obstetrical emergencies, and 2) to address the information needs of communities so that they may better prevent and treat maternity health needs and eliminate barriers to good care.

Several needs assessments were conducted seeking two states whose personnel are committed to improving maternity care. The state also had to have a maternity service with sufficient volume of antenatal clients and deliveries to permit clinical continuing education for midwives.

The program then introduced the concepts to national policy makers, finished development of the needed curriculum, obtained consensus that the curriculum already developed fits the education needs of midwives in Nigeria, and started to fit the designated training centers with needed equipment and supplies. Additionally, trainers were identified, a training schedule developed, and equipment ordered. Forms were printed and new forms developed to address evaluation, record keeping, and trainee handouts.

III. PURPOSE

The purpose of this visit was to:

1. Assist the MotherCare Coordinator and project staff in modification of the workplan.

2. Provide support and supervision to the new Life Saving Skills trainers in the conduct of the first training to be held in Bauchi, Bauchi State from February 15th through March 5th.

3. Assist with the planning, conduct, and evaluation of two continuing education workshops to be held for physicians working with the LSS midwives at the training centers as well as the sub-centers. The workshops were held March 3-5 in Bauchi and March 9-11 in Ibadan.

IV. ACTIVITIES

A. ADEOYO TRAINING CENTER

Due to some delays in raising the standards of the maternity unit to permit it to serve as a model for midwives coming from other areas, the January training for Adeoyo Maternity Hospital was delayed pending certain improvements. Mrs. Payne, MotherCare Project Coordinator has made multiple trips to Ibadan over the past eight months to urge progress both at the policy makers level and the hospital level. Areas of ongoing concern were:

1. Poor level of hygiene and aseptic technique particularly in the labor and delivery areas.

2. Lack of provision for on-site emergency blood blank services.

3. Lack of emergency drugs on the labor and delivery units and no ongoing system for replenishment of same.

4. Lack of system for identification and special management of very high risk antenatal clients.

5. Lack of implementation of the antenatal risk assessment forms (with attendant protocols). Use of these was taught at the site preparation workshops.

6. Lack of implementation of the partograph forms (with attendant protocols). Use of these was taught at the site preparation workshops in October-November, 1992.

Progress has been noted in the first three areas. A new disinfection/decontamination system has been put into place and the autoclave is now working. A transit blood bank is now ready to receive donated blood. It will be necessary now to put serious efforts into recruitment, as donating blood is not a highly held cultural value; and people are afraid to donate.

A start has been made to put an emergency drug revolving fund on to labor and delivery. At this point only methergine and pitocin are available on the ward. We have been assured that apresoline, diazapam, and other drugs will be added to the stock within the next week or so.

No progress has been noted in special identification and close

management of high risk antenatal patients. Meetings were held with hospital management to address this urgent need. Progress towards points 5 and 6 are addressed next under this section.

A random sample of twenty charts was chosen for review of quality of filling the forms and quality in carrying out the management protocols for patients with problems related to pregnancy induced hypertension and anemia. Findings were as follows:

1. Plots gestational age based on LNMP- 20% correct, 50% incorrectly, 30% did not fill in.

2. Plots up and down single line- 70% did it correctly.

3. Plots blood pressure, weight and uterine growth every visit- 25% (single visit) correct.

4. If elevated BP 140/90 checks and records reflexes-75% not applicable, 25% not done inspite of elevated blood pressure

5. Plots growth on proper week gestation-20% correctly

6. Checks hemoglobin first visit-0% !!

7. Checks hemoglobin every visit until up to 8 Gms or 55%-85%, not done, 15% not applicable.

8. Fills history portion of graph completely- 85% done correctly.

9. Records drugs ordered/given-35% done correctly.

10. Refers to physician when abnormality noted- 10% referred, 20% should have referred. 70% not applicable.

A review of use of the partograph was also made. A random sampling of labor and delivery records was selected from December 1992. This allowing observations to be drawn from a time period when the Oyo trainers had returned home and the job action had not yet occurred. Please note that two more site preparation workshops have been taught by the Oyo trainers to labor and delivery staff on use of the partograph after this sampling period.

Ninety-nine charts were reviewed from December 2,8,16,20, and 30, 1992. Of the 99 charts only 21 had used a partograph. Twenty partographs were reviewed with the following findings:

1. Starts the partograph correctly- 80% correct with dilatation but only 45% correct with descent.

2. Plots cervical dilatation 4 hourly in active phase of labor-

65% correct.

3. Plots decent of head 2 hourly- 0% did it.

4. Plots fetal heart at least 2 hourly- 30% did it.

5. Plots contractions at least 2 hourly- 35% did it.

6. Completes partograph at delivery- 50% did it for dilation, 0% for descent.

7. Gives appropriate latent phase labor management before 8 hours- 0%, 90% not applicable.

8. Give appropriate latent phase management at 8 hours (action line)- 0% correct, 90% not applicable.

9. Fives appropriate active phase management on or left of alert line- 30% correct, 50% not applicable, 20% not correct.

10. Gives appropriate active phase management between alert and action line- 30% correct, 55% not applicable, 15% not correct.

11. Gives appropriate active phase management at/beyond the action line- 5% correct, 70% not applicable, 25% not correct.

In summary, at this point in time neither the antenatal risk assessment nor the partograph are being used with consistency or correctly. The trainers and administration will need to provide ongoing intensive support to improve functioning in these two areas.

B. BAUCHI TRAINING CENTER

It was not possible to watch site preparation workshop graduates in action as they were all observing the strike. It was possible however, to review the antenatal risk assessment form used by reviewing the antenatal cards. From the primigravida antenatal clinic 175 charts had no antenatal risk assessment form in use. Twelve charts did have the form. From the multigravida antenatal clinic 216 charts contained no antenatal risk assessment form. One hundred and seventeen (117) charts did contain the form. In total, in only thirty-four (34) percent of the charts was any attempt made to use the antenatal risk assessment tool.

A random sample of twenty charts was chosen for review of quality

of filling the forms and quality in carrying out the management protocols for patients with problems related to pregnancy induced hypertension and anemia. Only one form of the twenty was filled out properly. This was for a woman having only one visit. Findings were as follows:

1. Plots gestational age based on LAMP- 5% correct, 40% incorrectly, 55% did not fill in.

2. Plots up and down single line- 35% did it correctly.

3. Plots blood pressure, weight and uterine growth every visit- 5% (single visit) correct.

4. If elevated BP 140/90 checks and records reflexes-5% not applicable, 85% blood pressure not even recorded at one or more visits

5. Plots growth on proper week gestation-5% correctly

6. Checks hemoglobin first visit-100% did it !!

7. Checks hemoglobin every visit until up to 8 Gams or 55%-25%, not done, 75% not applicable.

8. Fills history portion of graph completely- 65% done correctly.

9. Records drugs ordered/given-35% done correctly.

10. Refers to physician when abnormality noted- 0%, 30% should have referred. 70% not applicable.

In summary, there is no objective evidence that the antenatal risk assessment site preparation workshops or training of trainers has resulted in any improvement in the quality of antenatal care rendered at Bauchi Specialist Hospital. The intent was to create a model training environment which would serve as a model to rural midwives coming for training.

The above findings were discussed with the training team. A plan has been developed to schedule trainers in the clinic to help to motivate clinicians to improve their practice. The chief trainer will also consult with the Chief Nursing Officer about rotating "dead wood" out of the clinic. There is a surplus of senior officer working there who are reluctant to work in other areas of obstetrics and rotate shifts. The need for community outreach for high risk women who do not keep clinic appointments and team conferences to develop management plans for high risk women was again addressed both with the trainers and at the doctors' conference.

As the hospital was closed for the strike, it was not possible to access the medical records room. The man with the key is a labor leader. He was put in jail and thus we could not enter the medical records room. Therefore, a convenience sample of the nine available charts sitting in the matron's office ready to be sent to the records room was used for review. The results were as follows:

1. Starts the partograph correctly- 3 of the 9.

2. Plots cervical dilatation 4 hourly in active phase- 5 of the 9 were done correctly.

3. Plots decent of head 2 hourly- 7 of the 9 not done, 2 of the 9 not applicable.

4. Plots fetal heart at least 2 hourly- 5 of the 9 did it.

5. Plots contractions at least 2 hourly- 6 of the 9 did it.

6. Completes partograph at delivery- 1 of the 9 did it.

7. Gives appropriate latent phase labor management before 8 hours- none were applicable.

8. Give appropriate latent phase management at 8 hours (action line)- none were applicable.

9. Gives appropriate active phase management on or left of alert line- 7 of the 9 done correctly.

10. Gives appropriate active phase management between alert and action line- 5 of the 9 done correctly, 1 not applicable.

11. Gives appropriate active phase management at/beyond the action line-7 of the 9 not applicable, 1 done correctly

Clearly the partograph is being used as a management tool. Some work still needs to be done in teaching its plotting and appropriate management though clearly a good start has been made.

C. FIRST TRAINING BAUCHI

A national strike of the civil service workers started on February 2nd lasting four and a half weeks and crippled maternity services in the Bauchi Specialist Hospital. Inspite of the major obstacles, the theory portion of the training continued.

Due to the national strike, creative solutions were called for. Staff were told that they entered the hospital area "at their own risk". Labor leaders were jailed without being charged. Others went

underground awaiting the governor's resolution to the wage dispute. Therefore, the training started off in the Presidential suite of the local hotel-safely away from the hospital. After several days, the hotel conference room became available and the training moved there. As the strike continued and it became clear that no demonstrations or riots were occurring near the hospital, the training was moved to a small house across the street from the hospital.

Only emergency services were being rendered. The labor and delivery unit was ably staffed by the LSS trainers. Tremendous credit is due them for the tremendous commitment they displayed in the face of great difficulties. They received all gynecology and pediatric emergencies as well. No support services were available-blood bank, laboratory, emergency surgery, etc.

The theory portion of the LSS training was taught to six midwives from Bauchi, and three midwives from the sub-center hospitals in the periphery. This was the first training the new LSS trainers have taught. They performed extremely well. Several have never taught before yet their management of a class environment, use of audio visual aids, involvement of trainees, ability to field questions, and general organization was very good. Daily trainers meetings were held to evaluate how the day had gone, what we would do differently next time to strengthen the training, and what should be done again the same. Eleven days were used to teach the theoretical portion of the LSS training including the IEC communications piece. Trainees were then sent home and asked to return after the strike action was settled to complete the clinical portion of the training. A trainers' report will be forthcoming which will contain clinical experience gained by trainees, pre and post test scores, and problems encountered with solutions tried.

It is clear that the training team in Bauchi works well together, are willing to share the workload very flexibly depending on day to day circumstances, and are well able to assume the responsibility for which they were trained. See Appendix CC to see the clinical experience gained after their Training of Trainers workshop.

D. BAUCHI STATE PHYSICIANS' MEETING

A three day meeting for physicians was held March 3-5 at the Midwifery Training School Conference Room in Bauchi. A total of 19 physicians attended from Bauchi Specialist Hospital (12), Azare Hospital (2), Gombe (2), Darazo (1), Misau (1), and Toro (1). Bauchi Specialist Hospital sent doctors from surgery, medicine, pediatrics, and obstetrics.

The conference concentrated on:

1. Creating an awareness of how great a problem maternal mortality is in Nigeria and how a large majority of the deaths are preventable.

2. Providing an update on the five major killers of women with suggested protocols and procedures for handling same (hemorrhage, sepsis, unsafe abortion, obstructed labor, and pregnancy induced hypertension).

3. Giving special emphasis to the introduction of the partograph for the early recognition and management of obstructed labor and the antenatal risk assessment tool for dealing with anemias and pregnancy induced hypertension.

See appendix M for a copy of the program and appendix Q for a list of participants by specialization.

Special consultants for the conference were Dr. Joseph Taylor (Obstetrician) from Ghana and Dr. Shola Franklin (Obstetrician) from Adeoyo Maternity Hospital, Ibadan. These two men contributed tremendously to the richness, practicality, and high scientific level of the conference. Dr. Taylor has been involved in backing a sister Life Saving Skills training program in Ghana which has been functioning for over two years. He spoke eloquently to the value of teamwork and addressing the problem from an orientation of focusing on the problem of maternal mortality, rather than traditional professional boundaries of practice. He also made several of the technical presentations and used break times well to discuss a wide variety of topics with the participating physicians.

Dr. Franklin is the backing physician for the LSS training program in Oyo. Having informal time to relate to Dr. Taylor was another valuable product of the conferences.

The participants were asked a number of questions on their registration and final evaluation forms. The compiled results on the registration forms are as follows:

1. Do you care for pregnant women? Yes-15, No-4

2. Do you perform cesarian sections? Yes-13, No-6

3. Do you perform hysterectomies? Yes- 12, No-7

4. Do you perform vesico-vaginal fistula repairs? Yes-10 No-9

5. Are there skills you wish to learn to render better care to women and newborns? Yes-16 No-3

If yes, which skills?

Repair of VVF-3
Ob/Gyn specialization (residency) program-1
Resuscitation and emergency care of the newborn-5
more practical experience-1
Keilland forceps-1
vacuum extraction-1
Manchester repair-1
Care of the critically ill patient-3
Use of modern and improved technology-1
Cardio-pulmonary resuscitation-1
Improvised exchange blood transfusion-1
Cardiac catheterization-1
Intrauterine fetal monitoring-1
Hysterectomy-1
In vitro management of premature and low birth weight infants-1
States yes, but skills desired not specified-1

6. Please estimate how many maternal deaths occur in your institution per month. The range given was 2-12 with several stating they don't know.

7. Please estimate how many newborn deaths occur in your institution per month. The range given was 1-20 with quite a few stating they don't know.

8. What inputs do you need to render better care to pregnant women?

better trained support staff/midwives-8
vacuum extractor-4
emergency drugs-1
transport for home visits/follow-up-1
basic obstetrical instruments-1
suction machine-1
better organization with coordination and cooperation-1
anesthetic nurses-1
intensive care nurses-1
resuscitation kits-3
delivery sets with accessories-3
detailed antenatal record-1
D and C (instrument) sets-2
weighing scales-1
BP apparatus-2
height measurement scale-1
fetal monitoring devices-1
surgical materials for emergencies-1
hemoglobin testing materials-1
urine testing materials-1
emergency supplies-1
practical knowledge in problem solving-1

regular team review of care mortality/morbidity-1

9. What continuing education needs do you have?

seminars on maternal and infant mortality-1
postgraduate diploma in maternal and infant mortality-1
more obstetrical skills-1
regular seminars/workshops/short courses on various topics-9
Journals-4
Obstetrical residency training program-2
Workshop for intensive care/care of the critically ill patient-1
Workshop on management of pediatric problems especially with available, affordable, and accessible facilities (low technology inputs)-1
Seminar on antenatal care techniques-1
review of basic medical knowledge-1

On the final evaluation form physicians noted the following:

What was the most valuable part of this conference for you?

Section on high maternal mortality in Nigeria-2
Need to draw protocols for midwives practice-1
Film on Why Did Mrs. X Die?-2
Discussion of the partograph-3
Segment on Maternal Mortality worldwide-2
Various topics-1
all-5
group discussions-1
discussions of practical problem solving-1
How to reduce maternal mortality with low technology-1
Management of hemorrhage-1
Management of PIH-1
Vacuum extraction-2

What was the least valuable part of this conference for you?

none-15
lunch-1
didactic lectures-1
discussion on interpersonal communications-2

All participants rated the venue, food, technical guest speakers, choice of topics, handouts, and audiovisual aids. All were rated good to excellent with two exceptions. Several of the physicians working at Bauchi Specialist Hospital felt the venue would have been better outside the hospital premises. Several remarked that the sound quality of one of the video films was poor.

Suggestions for future continuing education topics included:

Incentives for physicians working in the LSS program
VVF
All areas of obstetric practice.
Involve all the doctors in the workshop.
Role of AIDS in LSS
Diarrheal diseases in children.
Infant mortality rate.
Socio-cultural factors that effect health.
CPR
Interpersonal communication between health workers
Discuss systems problems.
Do practicals.
Management of abortion, ectopics, and VVF.

How could this conference have been improved?

Do practicals instead of theoreticals.
Cover topics in allotted time.
Bring in more doctors from other parts of the country.
More time needed.
Midwives from the periphery should have been included.
Doctors should have participated more.
Add two or three days more; extension of duration.
Bring in some policy makers to appreciate the dangers women have.
Notify us of the course at least a week in advance.
include practicals.
Include bureaucrats at the sessions.
By following up on what was taught at the designated centers.
Include more experts with a greater variety of opinions.

What can you do in your own work site and community to reduce maternal mortality?

Encourage the use of the partograph.
Adopt LSS in our center.
Share my knowledge of LSS training program with my health workers and at the LGA.
Use the skills.
Involve everybody in the reduction of maternal mortality.
Show more concern for the plight of the pregnant woman.
Have a more positive attitude at work.
Use preventive methods through PHC
Give public education.
Hold mortality audits.
Be more committed personally.
Liaise with the LGA and NGOs to promote this idea.

Educate new staff in the use of the partograph.
Propagate family planning.

E. OYO STATE PHYSICIANS' MEETING

A three day meeting for physicians was held March 16-18 at the Adeoyo Maternity Hospital conference room. A total of 19 physicians attended from Adeoyo Maternity Hospital (9), St. Peter's Maternity Hospital (1), Jericho Nursing Home (1), Eruwa District Hospital (1), Iwo State Hospital, Osun (3), Oshogbo State Hospital, Osun (2), Ilesa State Hospital Osun (1), and Ife State Hospital, Osun (1).

The conference concentrated on:

1. Creating an awareness of how great a problem maternal mortality is in Nigeria and how a large majority of the deaths are preventable.

2. Providing an update on the five major killers of women with suggested protocols and procedures for handling same (hemorrhage, sepsis, unsafe abortion, obstructed labor, and pregnancy induced hypertension).

3. Giving special emphasis to the introduction of the partograph for the early recognition and management of obstructed labor and the antenatal risk assessment tool for dealing with anemias and pregnancy induced hypertension.

See appendix Q for a copy of the program and appendix R for a list of participants.

The participants in this second doctors' conference were on the whole younger and more urban in orientation than the doctors from the Bach Conference. They tended to expect "the system" to provide needed inputs for solving the crisis of maternal mortality and had more difficulty perceiving potential roles for themselves in helping to solve this crisis. Sessions were very animated and excellent intellectual arguments were held on clinical management in the controversial areas of obstetrical management (e.g. prophylaxis in PROM, management of sepsis, etc.).

The participants were asked a number of questions on their registration and final evaluation forms. The compiled results on the registration forms are as follows:

1. Do you care for pregnant women? Yes-19, No-0

2. Do you perform cesarian sections? Yes-8, No-11

3. Do you perform hysterectomies? Yes- 6, No-13

4. Do you perform vesico-vaginal fistula repairs? Yes-3 No-16

Feedback regarding inputs needed for their hospitals and continuing education needs were very similar to those reported at the Bach Conference. Please see the section titled Bach Doctors' Conference for a detailed report.

F. EVALUATION

In an attempt to evaluate how much progress has been made since the Training of Trainers workshop in October/November of 1992 several evaluation tools were utilized. Due to the national strike, it was not possible to do direct observation of clinical skills as they were practiced.

Work rosters were reviewed to determine if trainers had in fact spent their time since training consolidating the skills they had learned. Review of the rosters was not helpful in that they do not give an indication as to whether work time was spent in administration, clinical practice, or a combination of the two. Therefore each trainer was interviewed as to how her time had been utilized from November 17 through March 17th. The results are as follows:

Bauchi Trainers

Sambo, Salome
No vacation taken.
60-70% of time spent in clinical area.
worked throughout the national strike period very very long hours.

Mahmood, Hafsa Sugra
6 weeks vacation taken.
of remaining 10 weeks 60 % time spent in administration (principal of the midwifery training school) and 40% in own clinical practice.
Worked clinically during the strike.

Ikpe, Dorcas
3 weeks vacation taken.
of remaining 13 weeks time was 60% administration and 40% clinical.
Worked clinically during the strike.

Medina, Emily
2 weeks vacation taken
of remaining 14 weeks worked clinical 90% and administration 10% of time.
worked clinically during the strike.

Akanet, Paulina
4 weeks vacation taken
of the remaining 12 weeks 100% of time spent clinically.
Worked clinically during the strike.

Oyo Trainers

Akindele, Comfort
did not work the 4.5 weeks of national strike
1 week vacation
of remaining 10.5 weeks time 50% of time spent in administration and 50% time in own clinical practice.

Oyediji, Ebun
did not work the 4.5 weeks of national strike
1 week vacation
of the remaining 10.5 weeks about 25% time spent in own clinical practice and 75% in administration and teaching midwifery

Adekogba, Jumoke
did not work the 4.5 weeks of national strike
2 weeks vacation
of remaining 9.5 weeks spent about 80% of time in clinical practice and 20% in administration.

Olojede, Matilda
did not work the 4.5 weeks of national strike
of remaining 11.5 weeks worked almost 100% clinically-2 weeks in labor and delivery and 6 weeks in antenatal clinic

Sanda, Clara
did not work the 4.5 weeks of national strike
worked 11.5 weeks in labor and delivery almost 100% time clinical practice.

The trainers were also administered a post-test of three case studies, and asked to record both quantitatively and qualitatively their practice between the TOT and first training. A listing of the skills practiced by each trainer can be found in Appendix CC.

Only one of the ten trainers kept the Incident Reporting Forms which addressed qualitative issues of training. Therefore, they were asked to do so between now and the end of training. These forms will be evaluated during the final project evaluation.

Please see sections A and B under activities for an in-depth review of use of the antenatal risk assessment and partograph at the two training sites.

G. MEETINGS WITH OTHERS

USAID STAFF

Mrs. Bunmi Dosumu, Mrs. Lola Payne, and Peg Marshall met for a briefing meeting on February 5th. Objectives for the visit were shared and Mrs. Dosumu noted she will try to attend the physician's continuing education workshop in Ibadan. The desire to continue with maternal care in the new AID project was discussed.

OYO MINISTRY OF HEALTH

A formal meeting was held with the Honorable Commissioner of Health to sign the Memorandum of Understanding and to request a person from PHC who can serve as the day to day course coordinator for the Oyo trainings. Mrs. Elizabeth Adejuwon will replace Mrs. Ladipo in the day to day runnings of the program. Attendees at the signing included The Honorable Commissioner for Health Mr. Bankole, Dr. Ladeinde Director of Medical Services for the Health Management Board, Dr. Ogundiji Zonal PHC Coordinator for the FMOH, Dr. Iyun Medical Superintendent Adeoyo Maternity Hospital, Dr. Shola Franklin Senior Medical Consultant Adeoyo Maternity Hospital, Mrs. Ladipo Deputy Director PHC, Mrs. 'Lola Payne MotherCare Project Coordinator, and Peg Marshall.

It was stressed that though significant progress has been made at Adeoyo Maternity Hospital, that efforts must continue. If Adeoyo is to remain a training center in any follow on project, it is essential that changes which have begun become institutionalized. See Adeoyo Training Center under the Activities section for a full discussion of changes in progress.

AVSC

A brief meeting was held with Dr. Adetungi, regional director for AVSC and Mrs. Lola Payne, and Peg Marshall. We discussed how MotherCare and AVSC can be more supportive of one another in the field and how we might collaborate more closely in the future. The difficulty of getting family planning information to the women of

the north in a palatable form was discussed at length.

V. FINDINGS AND RECOMMENDATIONS

Several recurring themes pervaded the previous visit of September through November 1992. They were: need for accountability in clinical management of patient care, poor aseptic technique, lack of use of AIDS precautions, and lack of awareness of the scope of the problem of maternal mortality in Nigeria.

1. Need for Accountability in Clinical Management of Patient Care

There is a problem at both training center hospitals regarding distribution of midwives over the various shifts and need for assignment of patients in labor and the antenatal clinics to a specific midwife or team of midwives. Dr. Barbara Kwast will be working with the training team at Adeoyo Maternity Hospital during their first training and will be placing emphasis in this area. In review of antenatal clinic charts and patient flow, it is clear this area has not yet been improved. See evaluation section for details.

2. Poor Aseptic Technique

Significant progress at both training sites has been noted in this area. Both sites now have a system for decontamination and high level disinfection in place. Both have made arrangements for obtaining bleach in an ongoing arrangement. Oyo now has a working autoclave and Bauchi will have within the next two months when renovations on the gynecological operating theater (operating room) are complete.

3. Lack of AIDS Precautions for Health Workers

Significant progress in this area has been noted. The decontamination- high level disinfection system mentioned above has been institutionalized at both training sites. Both states have petitioned for basic inputs for the training centers which will permit good technique (e.g. perineal sheets, scrub gowns, surgical towels, etc). These are now in place at the Bauchi training site and are being made by the tailor for the Oyo training site. The inputs not available locally (e.g. goggles) were purchased in Washington and brought in.

4. Lack of Awareness of the Scope of the Problem of Maternal Mortality in Nigeria.

Clearly staff at the state and local levels are often not aware of 1) their own levels of maternal mortality, 2) levels for Nigeria as a whole, 3) how this compares with other parts of Africa and the

World, and 4) how much of this death is preventable. It is important that the state level policy meetings (listed in the work plan as IEC strategy meetings) include as many personnel from the state and sub-center levels as possible. Until people become aware of the scope of the problem, they will not become shocked and outraged. This process precedes organizing an effective local action plan. Much progress has been made over the past several months through the state level planning the meetings, the two doctors' conferences held this trip, and through Mrs. Payne's ongoing contacts with the state level officials at both training sites. A matrons' conference in schedule in April for both training states to continue this process of seeking support and heightened awareness of the maternal mortality reduction project.

Based on this visit, the major recommendations in order of importance are:

1. Acquisition of Life Saving Skills is clearly already making a difference. Anecdotal review of cases managed by the new LSS trainers notes much improved resuscitation of newborns, improved management of post-partum hemorrhage, and earlier recognition of obstructed labor on the part of the midwives. It is critical that as in-depth an understanding as the trainers now enjoy is transmitted to the rural midwives working so alone in facing disastrous emergencies.

2. There is an ongoing and urgent need to strengthen referral centers with basic facilities or inputs to be able to perform essential obstetric functions e.g. blood pressure cuffs, hemoglobin testing equipment, weighing scales, laparotomy instruments, evacuation sets, etc. Collaboration and planning for this with appropriate governmental agencies is critical. This is an appropriate role for the MotherCare Policy Advisory Committee to assume.

3. There is an urgent need for all institutions offering maternity care to institute regular periodic maternal and perinatal death audits with the aim of improving care and decreasing future maternal deaths. Formats for death audits are well established in other places and should provide constructive strategies for improvement, not punishment for inadequate care rendered.

4. In the follow-on project money and time should be budgeted for the development and implementation of a Maternal Mortality module which would be taught at all Nigerian Medical Schools as a way of getting issues regarding maternal mortality into pre-service education. Where possible, this module would be accompanied by classes or a conference where the partograph and antenatal risk assessment would be taught. Mr. Rudolph Thomas noted that a group is currently working on developing family planning lessons for medical students. Mrs. Lola Payne will investigate whether or not

we might be able to collaborate on this project.

5. There must be a state level ongoing commitment to the reduction of maternal mortality. Included in this commitment must be efforts to provide periodic continuing education for doctors, midwives, and other members of the health care team. Efforts must also be made to help doctors become more public health oriented in their care and outlook.

APPENDICES

A. PERSONS AND INSTITUTIONS CONTACTED

United States Agency for International Development

Mr. Eugene Chiavaroli, AID Affairs Officer
Mr. Rudolph Thomas, Program Officer AID
Mrs. Shitta-Bey, Senior Program Analyst
Mrs. Bunmi Dosumu, Senior Program Analyst

Family Health Services

Dr. John Mc William, Project Administrator
Dr. Akin Akinyemi, Deputy Project Administrator

Mrs. Abimbola ('Lola) Payne, MotherCare Project Coordinator
Mr. Uzoma S.A. Nnanta, Administrative Secretary

Mr. George Oligbo, Director, Operations Division
Mr. Lukmon Kalejaiye, Store Officer
Mr. Mordi Goodluck, Transport Officer
Mr. Celestine Onwuyali, Expediter
Mr. Innocent Chukwu, Expediter

Mrs. Susan Krenn, Director IEC
Mrs. Data Phido, Program Officer IEC
Mrs. Mini Soyoola, Program Officer IEC
Mrs. I.V. Mako, Consultant IEC

Mr. Nosa Orabaton, Acting Director Program Evaluation
Mr. Michael Egboh, Director, Pathfinder Int.

Federal Ministry of Health

Dr. Ogundeji, Zone B PHC Coordinator

Africare

Dr.J.Howard Teel, Nigeria Country Representative

Oyo State

Mr. Bankole, Honorable Commissioner for Health
Dr. Ladeinde, Director of Medical Services Health Management Board
Mrs. A.O. Ladipo, Deputy Director PHC, SMOH
Mrs. Elizabeth Adejuwon, Asst. Chief Health Sister PHC, SMOH

Adeoyo Maternity Hospital, Yemetu, Ibadan

Dr. Iyun, Chief Consultant (Radiologist)
Dr. Shola Franklin, Senior Consultant Obstetrician
Dr. (Mrs.) Williams, STD clinic
Dr. Williams, Chief Consultant Obstetrics and Gynecology
Mrs. Ronke Apatira-Jawando, Principal Hospital Secretary

Mrs. S.T. Akinwale, Senior Matron
Mrs. R.O. Fadare, Matron
Mrs. Juliana K. Ayansola, Matron IC, Labor and Delivery
Mrs. D.O. Onipede, Matron, Labor and Delivery
Mrs. C.F. Akindele, Matron Labor and Delivery
Mrs. D.O. Peters, Matron Labor and Delivery

Mrs. C.A. Adewusi, Senior Sister IC Antenatal Clinic
Mrs. M.A. Oladoja, Senior Sister IC Postnatal Clinic
Mrs. A.O. Akindeji, Senior Sister IC AP Lying In Ward
Mrs. S.M. Animashaun, Matron IC C/S Lying In Ward
Mrs. E.O. Fawole, Senior Sister IC, Premies Ward
Mrs. C.E. Ogundele, Senior Sister IC, GYN. Septic Ward

School of Midwifery Yemetu, Ibadan

Mrs. E.F. Oyediji, Principal Midwifery Training School
Mrs. V.F. Hanson, Vice Principal MTS

Oshogbo, Osun State

Dr. Adeyefa, Director PHC

Bauchi, Bauchi State

Dr. Danjuma Sulai, Executive Secretary, State Health Management Board
Dr. Dauda, Director, Health Services State MOH
Dr. Magaji Mohammad, Medical Officer, Health Management Board
Mrs. Helen Jammal, Asst Chief Health Sister PHC
Mr. Caleb Maina, State Coordinator for PHC
Mrs. Habiba Ali, MCH Coordinator

Mr. Lynn Marshall, Bauchi MOH Strengthening Project, Chief of Party

Dr. Ike Orokon, Epidemiologist
Mr. Bongs, Computer Specialist
Dr. Christopher Schwabe, Health Economist

Bauchi Specialty Hospital, Bauchi

Mr. Kuli B. Tula, Chief Nursing Officer
Mr. Alhaji Mohamed Danhali, Deputy Chief Nursing Superintendent
Dr. Jorge Jorge, Obstetrician-Gynecologist
Dr. Chima, Senior Medical Officer

Mrs. Salome Sambo, Chief Matron IC Maternity Services
Mrs. Sintiki Henry, Chief Health Sister, ANC
Mrs. Regina Lee, Asst. Chief Health Sister, IC Gyn ward
Mrs. Dorcas Ikpi, Principal Nursing Sister,IC Maternity
Mrs. Hannatu Yarang, Reg. Nurse Midwife,IC Antenatal Ward
Mrs. Talatu Sani, Nursing Sister, IC Postnatal Ward
Mrs. Grace Pariola, Asst. Chief Nursing Sister,IC Postoperative Ward

Mrs. Halima A. Abdulsalam, Nursing Sister, Labor and Delivery
Mrs. Agnes Knight, Principal Nursing Sister,IC Labor and Delivery Ward

Midwifery Training School, Bauchi

Mrs. Hafsa Sugra Mahmood, Principal
Mrs. Gidado, Midwifery Tutor

Others

Miss Elizabeth Crane, PATH, IEC Consultant
Mr. Peter Weymann, Senior Associate, Saffitz, Albert, and Assoc.
Miss Colleen Conroy, Deputy Director, MotherCare, John Snow, Inc.
Dr. Pepe Solari, Private Sector Initiatives
Dr. Patterson, Private Sector Initiatives
Mrs. Margaret Bodede, Consultant, Private Sector Initiatives
Dr. Stella Goings, Johns Hopkins Policy Group
Ms. Charlotte E. Hord, Program Officer, IPAS
Mrs. Joanne M. Weinman, Regional Training Officer, AIDSCAP
Mrs. Grace Ebun Delano, Consultant FP Services
Dr. Adetungi, AVSC

Addresses and Phone Numbers

Family Health Services
Plot 1601 , Adeola Hopewell Street.
PO Box 554

Victoria Island, Lagos, Nigeria
Telephone: 612-815;619-952 (Dr. Mc William direct)
Fax: 011-234-1-612-815
Mr. Chiavaroli telephone 613-825

PHC/Family Health Division
8, Harvey Road, Yaba

Telephone: 868-185

Nursing and Midwifery Council
6, Mobolaji Bank Anthony Way
PMB 21194
Ikeja-Lagos, Nigeria

Telephone: 961-554,553,552,or 650

Africare
Africare House
45 Ademola Street, Ikoyi SW
P.O. Box 52839
Lagos, Nigeria

Telephone 685-400
FAX 685-400

University of Ibadan College of Medicine
or University College Hospital
Department of Obstetrics and Gynecology
UCH, Ibadan, Nigeria

Telephone: 022-400-010 through 29, ext 2450/2154

Mrs. E.F. Oyediji, Principal
School of Midwifery Yemetu
PO Box 7866 Secretariat Ibadan
Ministry of Health
Yemetu, Ibadan, Nigeria

Adeoyo Maternity Hospital
PMB 5115
Dugbe, Ibadan, Nigeria

Telephone: 022-400-220 through 9

Mrs. A.O. Ladipo, DD PHC
Ministry of Health
Directorate of Primary Health Care
Secretariat, Ibadan, Nigeria

Telephone: 022-41-4041

Ministry of Health
P.M.B. 4421
Oshogbo, Osun State, Nigeria

Telephone: 232-460 through 65

Bauchi Specialist Hospital
PMB 005
Bauchi, Bauchi State

Toro General Hospital
PMB 010
Toro, Bach State

School of Midwifery, Bauchi
Bauchi, Bauchi State

Telephone 42-632

NATIONAL CONCORD, Thursday, February 18, 1993

Topical Talk

Horror of childbirth in hospitals

WITHIN the past few weeks, four women, all of whom were pregnant and looking forward to smooth deliveries, ended up with horrifying experiences in our hospitals.

Today, two of those women are dead. The other two are alive but bereft of the babies they expected after nine months of pregnancy.

The dead women and those who survived, lost their lives and babies during childbirths in our hospitals.

The experiences of the survivors provide an insight into the ordeal many women go through in our hospitals today.

One of the women Remi, whose pregnancy was her first, lost her baby after being left in labour for about 36 hours in a public hospital in Lagos.

Remi, who decided to deliver in a public hospital due to her confidence in the quality of the nurses and doctors recalled that during labour, the nurses ignored her warning, when she alerted them, that her baby's struggle to come out was getting progressively weakened. They also ignored her first request for a caesarian section and further abused her for crying out in pain during labour.

When finally they sectioned her, the baby came out dead. It was bruised and exhausted. The second woman, who also lost a first pregnancy, patronised a private hospital in the belief that they are better than public hospitals. A few days before her labour started, she went for a scan and the baby was found in a proper position. When labour came, the baby's position had changed and she was heading out feet first. No doctor was immediately available. By the time the doctor came the baby was close to birth and it was delivered in that manner with the doctor pulling it out by its feet. The baby, when it emerged, had its umblical cord wound round its neck. This the doctor said, caused its death.

These two women have been told that they are lucky to be alive. This is because so many others who go in for seemingly normal births, whether in private or public hospitals, end up losing their lives.

For many women now, especially pregnant ones, childbirth is a highly feared experience. This fear is rooted not only in the lack of facilities at the hospitals but in the attitude and service given by the hospital staff. There is today, an incredible level of negligence and callousness on the part of many nurses in our hospitals. Many of them abuse and maltreat women in labour as well as patients generally.

All over the country there is a stupendous number of maternity homes and private hospitals stalking the streets. Most of them have only one or two doctors and a flood of ill-baked and ill-tutored women in various uniforms called nurses. These hospitals receive a large number of patients but whether they treat them successfully or not nobody knows and it seems nobody cares.

In the past few weeks, many groups and individuals have continued to expand their energy on whether abortion should be legalised or not. Abortion,, it is said, is responsible for the high incidence of maternal deaths in this country.

The truth of the matter is that sheer negligence and nonchalance, on the part of medical staff in our hospitals, both private and public, are also responsible for a great many maternal deaths. True, we need to provide adequate facilities in our hospitals and pay our workers well but we also need to monitor those hospitals, the behaviour of their staff and the type of services they give. Until we do that childbirth will continue to be a fearful and fatal experiences for most women.

NATIONAL CONCORD, Tuesday, February 23, 1993

NATIONAL CONCORD, Tuesday, Februarv 23, 1993

Economic Insight

States deserve more money

By S.M.O. Aka

THERE is a greater need now more than ever before to allocate more funds to the states to enable them cope with their ever-increasing duties and obligations. Perhaps, a brief look into the recent past will help to buttress the point that the state really deserve more money now.

For instance, when President Babangida came into power in 1985, there were just 19 states in the Federation. He later created two additional states - Akwa-Ibom and Katsina - which increased the number of states to 21. Military governors were then in charge at the state level.

The interesting point to note is that when there were only 21 states, the revenue allocation to the states from the Federation Account was 30 per cent. Unfortunately and very, surprisingly, today when the states have since increased in number from 21 to 30, the revenue allocation to the states has, by some curious logic or strange reasoning "which passeth all understanding", been reduced from 30 to 24 per cent.

Now that there are more states with greater needs and obligations, the revenue allocation logically ought to have been increased; but instead of the expected increase, it was inexplicably reduced to 24 per cent, thus turning the states virtually to perpetual beggars.

The 45 per cent salary increase granted by President Ibrahim Babangida to workers at the Federal level is quite justified, considering the hardships and high prices faced by workers.

But why should the 45 per cent salary increase be limited to only workers at the Federal level? Do workers both at the Federal and State levels not go to the same market?

Why did the President not take the state governors into confidence or call them into a meeting before making such an increase.

Perhaps, the relevant question now is, have the states enough money to pay the 45 per cent salary increase to all their workers? Practically all the state governors have cried out loudly that they do not have enough to pay.

Some voices at the Federal Government say that the state governors should have enough money to pay. Comrade Pascchal Bafyau, the Labour Union leader, even went as far as accusing the civilian governors of being extravagant and that many of them were already millionaires, erecting mansions in the cities and in their villages.

It may be true that some of our governors have become millionaires so soon at the expense of the suffering masses who voted them in, but that notwithstanding, the truth still remains that most of the states do not have enough funds to pay.

The on-going nation-wide strike which has caused (and still causing) so much havoc, losses and hardships, should be regarded as a serious emergency that requires an urgent solution. Thus when President Babangida summoned all the state governors to Abuja for a meeting on the issue on Friday, February 5, our hopes were high that the solution would come out of that meeting.

Nigerians were, however greatly disappointed when President Babangida and the governors came out of that meeting only to announce a 20 per cent cut of their salaries. Not a word was said about meeting the workers' demands and thus bringing the strike to an end. It was indeed a huge joke.

Our leaders should please not take the workers for a ride. The workers deserve what they are asking for. The workers' strike has dragged on for too long, so an urgent solution must be found.

The truth is that the states certainly deserve more money, particularly now that in addition to the 45 per cent pay rise, they will also be responsible for the payment of salaries of primary school teachers.

What is needed urgently right now is a new revenue allocation which, in my view, should be 38 per cent to the Federal Government, 32 per cent to the States, 20 to the Local Governments and 10 per cent to the oil-producing communities and other emergencies. The earlier this suggestion is implemented, the better for us all.

★ Aka writes from Benin-City, Edo State.

'The interesting point to note is that when there were only 21 states, the revenue allocation to the states from the Federation Account was 30 per cent. Unfortunately and very surprisingly, today when the states have since increased in number from 21 to 30, the revenue allocation to the states has, by some curious logic or strange reasoning "which passeth all understanding", been reduced from 30 to 24 per cent.'

'The truth is that the states certainly deserve more money, particularly now that in addition to the 45 per cent pay rise, they will also be responsible for the payment of salaries of primary school teachers.'

Sunday Tribune 21 February 198[illegible]

FG, states cautioned on workers' strike

By
Ademola Adeyanju

THE federal and state governments in the country have been cautioned to stop playing politics with the sovereighty of the nation as a result of the current public servants' strike.

Expressing this concern was the president, Nigerian Association of Alaqura Churches (Inc.) Most Reverend Dr. Olapade Agoro who noted that such attitude could destroy the great agacy of a country handed to us by our forefathers.

Dr Agoro told the *Sunday Tribune* in Ibadan at the weekend that the administrative machinery of the government has been on holiday for the past three weeks due to the series of industrial strikes and was indicative of a nation on a sick-bed

The full implementation of the workers' demands which include 45 percent salary increment and backdating the increment to six months, according to Dr Agoro, will instigate similar demands by other workers with the consequential result of the already hyper-inflated economy getting overheated

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Strike

Continued from Page One

and possible burst.

He therefore advised the workers to show restraint in the pursuit of their demands because "no nation has ever gone this far and survived".

While chiding the federal government for unilaterally increasing by 45 per cent salaries of its workers without due consideration of its bandwagon effects on the states and other sectors of the economy, Dr. Agoro said that solution to the present impasse lay in concilliatory approach.

As a way out of the current problem, the prophet called on workers and governments at various levels to meet at a dialogue table, with the possibility of eminent citizens

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Sunday Tribune 21 February 1993

Lack of tools may cripple hospital

By Idowu Adelusi and Ademola Osunmo

LACK of basic amenities which has constituted a clog in the way of performance of the Jericho Orthopaedic Hospital Ibadan in Oyo State, may cripple the hospital.

The latest of such problems, is the non-availability of anesthestic machine which grounded four months ago.

Following the break down, the Sunday Tribune learnt that a number of patients penciled for surgical operation were languishing in the hospital wards.

However, the current workers' strike has warranted their release from the hospital.

It was further gathered that work had paralysed at the theatre ward due to the grounded machines.

It was also gathered that the hospital has neither physiotherapy nor X-ray units as the x-ray unit whose installation started a couple of years ago is yet to function.

Speaking with our reporters, some of the patients who claimed to have been delayed by the faulty machine, said they were very sad.

According to them, the hospital may have been

See Hospital on Page 14

Hospital

Continued from Page One

neglected by the government.

Efforts made by the *Sunday Tribune* to see the Chief Consultant Dr Olaseinde and his deputy, Dr Ayansola on Wednesday and Thursday last week failed as they were said not to be available.

The Sole Administrator, State Health Management Board, Dr W G Lawal was also sought after last Friday, but the secretary informed Sunday Tribune that he has travelled.

It would be recalled that the Sunday Tribune ran a story on Jericho Orthopaedic Hospital in November 1991.

What followed, the Sunday Tribune gathered, was harrassment of the staffers by the then state Military Government. Jericho Othopaedic Hospital was established in July 1987 by Major General Adetunji Idowu Olurin (then a Colonel and Military Governor of the old Oyo State.

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Vol. 13 ★ No. 707 February 21, 1993 Ramadan 1, 1413 A.H.

Strike Must Continue Till... -- JCC

★ BAFYAU: Sidelined

By MOSHOOD ADEBAYO and JOSHUA IWEBUKA

LEADERSHIP of the joint unions involved in the current nation-wide civil service strike has resolved to continue the action in those states where the governors have declined to pay the controversial Federal rate.

Hope of calling off the workers' strike in some states over the 45 per cent salary increase was dimmed last Friday as the meeting of the National Joint Consultative Council in the Public Service ordered that the action should continue in those states where the governors had declined to pay the wage increase.

Mr. Sylvester O.Z. Ejiofor, secretary, Joint Public Service Negotiating Council, said the strike will continue in those states until the governors are ready to reason with workers.

The meeting, which was attended by all representatives of the workers in the public service of the 30 states, expressed dismay at the attitude of some state governors.

"They behave like tin gods, forgetting that workers contributed to their election. Labour peace will elude their states until they agree to our terms," Mr. Ejiofor said.

Citing the decision to pay the 45 per cent increase in Lagos and Yobe states, Mr.

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NEWS

Strike Continues

Continued from Page 1

Ejiofor said that no state government in the Federation is economically comfortable but the two states have only succeeded in negotiating on terms agreeable in their workers.

"The problem is that some state governors are rigid in their approach to issues, he said, adding that "no amount of intimidation would force the striking workers back to their respective offices until their demands are met.

Giving insight on why striking workers would not go back to work until their demands are met, Mr. Ejiofor hinted that in the past pledges made by some state govenors were not met, adding that some governors were behaving immaturely. "It is a matter of regret and serious concern that some state governors were not able to avert the industrial action," he added.

Warning on the implications of retrenching workers as threatened by some state governors, Mr. Ejiofor said that such action would only aggravate the situation. He said that implementation of the 45 per cent wage increase costs far less than the cost of retrenchment as such would lead to colossal payment of entitlements to workers so retrenched.

On allegation of incitement of workers by the NLC, Mr. Ejiofor said that it was lamentable that some state governors had chosen that option adding: "we are patriotic enough not to involve ourselves in such act. The truth of the matter is that state governments put up different claims in order to solicit public support on the on-going industrial action.

Meanwhile, salaries of Non-academic Staff of Universities who have a first class or a second class upper degrees are to be reviewed upwards to match the salaries of their counterparts in academic.

Education and Youth Development Secretary, Professor Ben Nwabueze who disclosed this in Lagos on Friday at a meeting with Rectors and Provosts of Federal institutions said that it was a further concession to the striking non-academic staff.

He said that the ministry decided to review the salaries of holders of the two classes of degrees because they are the qualifications required for teaching.

The Education Secretary said that although government had granted parity in salary scale to the non-academic staff, they wanted the parity in actual salary.

"I thought that we have made concessions one would be expected to make under the circumstance without aggravating the circumstance, but the workers are still not satisfied," he said.

Professor Nwabueze stated that the parity granted to the non-teaching staff had not in any way violated the earlier agreement with ASUU, adding that the only difference was that it was no longer exclusive to them.

MIM
HEALTH & VITALITY
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SESSION I

BARRIERS, MOTIVATORS, AND ENABLERS TO CARE

A barrier is defined as something which "holds apart, separates or hinders." In the context of Maternal Health, barriers are those customs, preferences, economical, political, geographical, educational and technical constraints which separate women from safe, satisfying, accessible healthcare. A recognition of the barriers which hinder clients from benefiting from healthcare services and also the midwife from providing quality care should be the first step in the drive towards the reduction in maternal mortality rates. Motivators are the factors that "move" someone to action. Enablers make this action possible. In maternal health, it is the balance of these barriers, motivators, and enablers that determine the extent to which we are able to influence our own situation.

Objectives:

Participants will be able to:

A. Define and identify barriers to maternal health care
B. Define and identify "motivators" and "enablers" in maternal health care
C. Recognize and categorize barriers, motivators, and enablers to maternal health care in the clinical environment.
D. State implications of barriers, motivators, and enablers to maternal health care
E. Identify a possible solution for each barrier identified.

Time: 3 hrs. 45 mins

Sections covered: (a) Barriers, motivators and enablers to maternal Health care

(b) "Fresh Eyes, Fresh Ears" Exercise.

Preparation: - Prepare and plan a brief visit to the maternity ward with matron in charge ahead of time.

Training Aids: - Flipcharts and markers or board and chalk

Hand-outs: - Hand/out: "Maternal Health Care Services in Nigeria"

Reference materials: - Videos: "Why did Mrs X Die?" and "Vital Allies"

Time	Objective/ Evaluation indicator	Content	Method/Activity
30 mins	A. Define and identify barriers to maternal health care	<u>Possible responses</u>: 1. Hindrances, obstructions, obtacles, constraints 2. Lack of communication between spouses, between parents and children, inadequate finance, etc. 3. Poor communication, lack of incentives, knowledge deficit, etc. <u>4. Definition of barrier:</u> Barriers are issues, factors, beliefs, behaviors,etc. that prevent contact or interaction between one thing and the other. In human terms, a barrier prevents someone from DOING something. Barriers may be political, cultural, customary, economic, geographical, or educational in nature. Barriers to maternal health care are factors which make it difficult for clients to obtain quality health services.	1. Ask participants to brainstorm on what a barrier is. List their responses. 2. Extend the brainstorming on the definition by asking for examples of barriers in our domestic lives and how these affect us. 3. Brainstorm further on barriers in the workplace and how these might affect our output/achievement. 4. Present the definition of barrier under "content" at left. Explain its meaning in the context of maternal health care. Mention that barriers could be categorised under political, socio-economic, cultural, and geographic content.

Time	Objective/ Evaluation indicator	Content	Method/Activity
30 mins	B. Define and identify "motivators" and "enablers" in maternal health care	<u>Possible response</u>: 1. A motivator is anything or anyone, for example, knowledge or incentive that "moves" us or makes us want to do or achieve something. 2. An enabler is a fact or condition that makes it possible, or "enables" us to do something. 3. Some motivators: ▪ Knowledge that an immunized baby is more likely to survive ▪ Praise for coming to the clinic for a prenatal visit (the friendly or gentle but knowledgeable midwife) ▪ The desire to "keep up with the Joneses" ▪ Awareness that eating certain foods during pregnancy decreases the chance of hemorrhage during delivery ▪ Good rapport (a trusting relationship) between the midwife and community members 4. Some enablers are: ▪ Placing the clinic within the community	1. Ask participants to define "motivator". 2. Ask participants what an "enabler" is. 3. Continue by asking participants to give examples of motivators and enablers in health care. 4. Ask participants to suggest some enablers in maternal health care.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		▪ Clinic hours that are flexible to accomodate the communities' schedules and activities ▪ Access to regular supply of basic delivery tools and perishables ▪ A husband's permission , willingness, and support in taking his wife to care.	
			5. Explain to participants that identifying barriers, motivators, and enablers is crucial to the provision of quality care.
60 min	C. Recognize and categorize barriers, motivators, and enablers to maternal health care in the clinical environment.	"Fresh Eyes - Fresh Ears" Exercise: A walk through the Maternity Unit. This is to assess the clinical situation and sensitize the trainees to their feelings of what they saw or heard.	1. Take participants on a tour of the antenatal, labour, delivery, post-partum, septic, gynae and neonatal wards. They should tour all of the facility, including equipment, drugs, examining rooms (with client's permission). They should be free to tour at their own pace, stop, question, and observe as they wish. Instruct participants beforehand to look at the clinic from the viewpoint of the provider and the client.

Time	Objective/ Evaluation indicator	Content	Method/Activity
			Explain that they should ask themselves the following from each point of view: *Provider:* a) What do I see? How do I feel about what I see? b) What are the barriers to providing good health care? c) What are the enablers to providing good health care? d) What are my feelings regarding the patients and their relations? e) As a provider, how do my feelings about what I see affect my treatment of the patient? f) What motivates me to do my job? g) What does the client want from me?
		Possible Responses: b) happy, afraid, disraught, strange, uncomfortable?	Client: a) What do I see? b) How do I feel about the clinic environment? the

Time	Objective/ Evaluation indicator	Content	Method/Activity
			provider? myself? c) What barriers do I face in obtaining health care? d) What enabled me to obtain health care? 2. Convene all participants in the classroom. Ask participants: a) to discuss their experiences during their visit to the clinic. b) what barriers, motivators, and enablers existed from the clients' point of view? Categorize their responses underthe headings of geographic, political, socio-economic, cultural/religious, and logistical, managerial, professional.
		Possible Responses: *Client Factors* - Geographic/logistical: Access to clinic: transportation, location of health centre/hospitals and hospital schedules. - Cultural/social/religious: purdah, gender preference in providing health care, awareness about danger signs, traditional food customs, beliefs about personal integrity that prohibit taking blood transfusion, drugs, and assisted delivery. - Economic: ability/inability to afford	

Time	Objective/ Evaluation indicator	Content	Method/Activity
		medical care and supplies, food, education *Provider Barrier* - Geographical/logistical: distance from home to clinic, transport to dispensary. - Professional: attention to/lack of regard for clients' need for confidentiality, privacy; skill/knowledge about medical procedures; authority to take urgent decisions; staffing - Social/cultural/religious: local language skill; ethnic/religious affiliation; familiarity with or disrespect for local customs and beliefs	c) what barriers, movivators, and enablers existed from the provider's point of view? Also categorize these under headings as before. 3. Have participants brainstorm other barriers to care they know, but might not have observed during the walk-through exercise.
2 hrs.	D. State implications of barriers to maternal health care	1. Negative: - Health providers' negative attitude frightens women in need away.	1. Ask participants to discuss some of the effects of identified barriers on maternal health services.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		- Clients do not receive antenatal care because they have to travel over long distances to reach the clinic. - Cultural values and ideals related to modesty enforce unattended delivery, e.g. "KUNYA." - TBAs are afraid to refer women in need because midwives talk harshly at the women. 2. These are obstacles to care because they separate the women from the provider. Most often as a result of these: at-risk mothers are not screened and helped towards safe delivery.	2. Ask why these factors are considered as obstacles?
	E. Identify a possible solution for each barrier identified	*1. Possible Solutions:* *Midwives need to:* a] improve their interpersonal communication skills. b] understand the values of their patients and how their own	1. Explain that now that they have identified factors contributing to the health situations they found in the clinic--the barriers, motivators, and enablers, participants should identify what they as midwives can do to address every identified

Time	Objective/ Evaluation indicator	Content	Method/Activity
		personal values and biases get in the way of good interaction with their clients. c] go beyond providing clinical services to greater interaction with the community. d] develop problem-solving skills that encourage initiative and "go-getting." **POINT TO EMPHASIZE:** These problems can be overcome through carefully packaged programs and increased community awareness and participation on the part of the midwife.	barrier.
		2. The Video, "Why did Mrs X Die" analyzes the issues relating to maternal mortality from a multi-dimensional perspective.	2. Show participants the film, "Why did Mrs X Die?" Allow participants time to watch this video in order to gain a sense of the broader issues relating to maternal mortality.
		Many of the barriers enumerated in the film "Why did Mrs. X die?" and through their own assessment of the maternity	3. Lead a discussion on the video. Ask participants: a) How does what you just saw

Time	Objective/ Evaluation indicator	Content	Method/Activity
		environemnt may seem out of proportion with what is manageable by the midwife. However, others are within the midwives power to change.	in the video corroborate your experiences in the "Fresh Eyes, Fresh Ears" exercise? b) Randomly ask participants to name one barrier to maternal health care and its implications. 4. Summarize by asking clients to discuss which barriers might by addressed by midwives and which are beyond her power and why they feel as they do.

HEALTHCARE SERVICES IN NIGERIA

Background Information:

One clear trend in the development of health care facilities in Nigeria is that health care services are more concentrated in the urban areas. But in the past five to six years carefully planned steps have been taken to bring health facilities to the rural settlement in order to promote the health of the rural populace too. These efforts could be seen in the Primary Health Care programme, provision of child survival services e.g. Expanded Programme on Immunization [EPI], and Oral Rehydration Therapy [ORT]. Others include family planning, health education and maternal health services.

Despite these efforts, it has been discovered that very little has been achieved in reducing maternal deaths in rural settings.

According to the World Health Organization [WHO] report (1990) and the Federal Ministry of Health of Nigeria, 800 [WHO] to 1,500 [FMOH] mothers die every year out of 100,000 live births in Nigeria. In some particular areas, 90 - 95% of maternal deaths are cases from the rural areas. This may be attributed to lack of access to prenatal care and delivery with a trained health worker. For instance, less than 50% of rural women attend antenatal clinic while only 30% of them deliver in the health facilities. In view of this it is necessary to identify barriers which affect patients/clients and health care providers; that may stand between the rural women and health care facilities with a view to suggesting solutions to the barriers.

Factors Affecting Health Care Services

Health is defined by the World Health Organization [WHO] as a state of complete physical, social and mental well being, not merely the absence of disease or infirmity. In Nigeria, programs like MAMSER and Better Life for Rural Women contribute to this health goal. In the health sector, services are provided at different levels--Primary, Secondary and Tertiary levels--to achieve this state of health.

Despite the government effort to meet the health needs of the people, it is observed that many people, especially in the rural community, do not have access to health care. The aim of this paper is to identify those barriers to health care and introduce problem solving techniques which could be used to remove identified barriers.

A barrier is defined as something which "holds apart, seperates or hinders." In the context of maternal health, barriers are those customs, preferences, and economic, political, geographical, educational, and technical constraints which seperate women from safe, satisfying, accessible healthcare.

These barriers could be directly related to the clients or the health care providers. Barriers as they affect the clients include:

- *Inaccessibility to clinic:* This may be due to transportation difficulties, location of clinic/hospital and hospital fees/schedules.

- *Cultural/religious beliefs.* For instance some religious groups do not believe in using hospitals or medication, while others would hesitate to come to the hospital if they will be attended to by male staff alone.

- *Socio-economic status.* Low socio-economic status could lead to poverty, ignorance and subsequently malnutrition. These factors to a great extent can hinder clients from benefiting from health care services. For instance in a state of extreme poverty both housing and nutrition which are essential to maintenance of good health may not be affordable.

- *Lack of awareness* of available health services for health care provision often lead to under utilization of health care facilities.

- *Differences in values :* This may result from diversity in cultural and/or religious background. Values are ideas that are shared by members of a community about what is good and desirable (Abdurraham 1991). According to Abdurraham, traditional African values include group supremacy over the individual, discipline, respect for elders, honesty, sharing and helping the less opportuned, and conformity to another in planning and delivering health care services to people. Most of the identified African values are stressed in the Code of Ethics for Nurses. Differences in values, whether they originate from differences between colonial and traditional African culture or differences between ethnic or religious groupings can forge a seperation between caregivers and clients resulting in inability to provide optimal care.

It is not enough to see the distance between the rural women and health care services only from the

socio-economic status and environment of the woman. A further look into the quality of services and health personnel offering these services may afford us a comprehensive or a broad outlook. This approach can guarantee positive effects for intervention strategies. Factors such as knowledge deficit, lack of drugs and equipment, poor aseptic technique, poor interpersonal relationships and managerial problems such as lack of monitoring and evaluation, poor motivation, poor record management, and low levels of responsibility are enough to increase the barrier already observed.

KNOWLEDGE DEFICIT:

Good performance and productivity depend largely on the knowledge, skills, and attitudes possessed by the health care personnel. A sound background knowledge is essential for effective health care delivery. The basic training health care providers received is therefore not enough to cope with the increasing health care demand of the society. As the societal demand changes, the health care providers have to expand their knowledge and skills, through training and retraining, and by reading current books and journals to keep abreast of the developments in health care services. Failure to do this will lead to gross knowledge deficit and poor quality healthcare. Gradually, the personnel will become incompetent and lack confidence. This also affects the relationship with their clients as the client bound to loose confidence in the health care provider.

It is therefore pertinent for every health worker to develop a positive attitude to learning and become research minded. Research is defined as an attempt to increase available knowledge by discovering new facts through systematic, scientific enquiry (Clerk and Hockey 1981).

Research involves careful observation and documentation of facts from which inferences could be drawn. For health care practice to be improved, providers must try to carry out studies which will provide them with feedback on their strengths and weaknesses, effectiveness of working tools, and management. Providers must also involve themselves in assessing the community problems to determine the community barriers to effective health care/needs.

It is not enough to collect and analyse this information (data), but efforts must be made to solve the identified problems through any means possible.

Health care providers must become acquainted with knowledge and skills of Problem Solving, Communication and Interpersonal relations and research. Research is very beneficial as it widens the scope of knowledge, and keeps provider abreast of current changes. For instance, it is through research that knowledge on benefits of exclusive breastfeeding, AIDS awareness and precautions, increased maternal mortality rate; and the need to go into the community to provide care at grassroots level became apparent. Inadequate exposure to research information often leads to incompetence and shying away from responsibilities.

In any provision of healthcare we must evaluate:

- ***Lack of Drugs and Equipment:*** Inadequate equipment and drugs in the health centres and hospitals may lead to sub-standard care or no care at all. Some equipment can be improvised while others cannot. Drugs cannot be improvised. Lack of needed supplies make clients lose confidence.

- ***Unethical Conduct:*** Failure to observe professional ethics in discharging professional responsibilities could be strong barrier to health care provision. Where clients needs for confidentiality, respect, and consideration are not recognized by the health care provider. They may not attend such clinics.

- ***Managerial Problems:*** Managerial problems may include factors such as lack of monitoring and evaluation of health care services, inadequate managerial skills of health workers, poor staff motivation, and poor record management.

Monitoring is needed to ensure the *MAINTENANCE* (continuous functioning) or correction of strategies adopted for an identified goal on one hand. Monitoring means keeping track of how the process is going towards achieving the goals. *EVALUATION* on the other hand is the process or collection of processes used to determine the extent to which the goals have been achieved; that is, whether the program has had the desired impact. The importance of monitoring and evaluation is actually to give feedback on how the efforts into health care services are yielding results and what may be needed to correct them. It may help to answer questions like "how many pregnant women attended our clinic last month?" "Where are they from?" "How many have been attending our clinic in the past six months?" "What was the nature of their problems?" "How many mothers died in our clinic yearly?" "Why did they die?" "How many mothers lost their babies at delivery?" "Why did the babies die?" "How well are we caring for our patients?" "Do we have enough drugs?" "Why are they not enough, if they are not?" "Do we treat our patients with respect?" "Why is there a drop in our client flow?" "How effective are our solutions to their problems?" "Can we easily obtain past information on our clients?" and so on.

Very often our inability to answer these questions is due to the fact that health workers are not adequately trained in how to obtain information from clients or that they are not adequately motivated [moved] to obtain them. Equally important is the evaluation of duties due to poor supervision of services and responsibilities by the superior officers [Matron in charge of a Unit or Unit Heads]. In other words, nobody cares where and how documents/equipments are kept, whether they are kept or not, and who is expected to keep and give out information when needed. It is necessary to assign responsibilities and to check daily, weekly, monthly, randomly as the case may be as to whether they are being carried out the way they are expected. The systematic recording of

information will enable the clinic to retrieve information when needed.

SESSION II

VALUES CLARIFICATION

Values are the "social principles, goals or standards held by an individual or group." Values have their influence on the individual's daily activities relating to good health, family, position, career and marriages.

Our values are often so ingrained that we are unaware of them until we are confronted with situation that challenge them.

By understanding her own values, the midwife is better able to appreciate and respect the various experiences that shape the values and belief systems of her clients. By appreciating that her own sensibilities may differ from those of her clients, the midwife allows the client's need to be met with the commensurate quality of care.

Objectives: Participants should be able to:

A. Identify differences in values
B. Define values and identify four factors that influence them
C. Explain how values influence our perceptions and actions

Time: 1 hr 30 mins.

Topics Covered: A] "Assumption Vs Knowledge" Exercise.
B] Summary.

Preparation: N i l

Training Aids: Newsprint and markers or chalk and board.

Reference Materials: N i l

Time	Objective/ Evaluation indicator	Content	Method/Activity
45 min	A. Identify differences in values	*1. Assumption Vs Knowledge Exercise* This exercise helps trainees to focus on the problems and interests of their clients and their families. Are their perceptions similar to those of the people with whom they work? This activity demonstrates how hard it is to make assumptions of what someone else's interests really are and how easy it is to make incorrect assumptions.	1. Divide participants into two equal groups A & B. Each member of Groups A should choose a partner from Group B. 2. Tell partner pairs that they must not speak to each other. Ask them to list the three things they think their partner is most interested in doing after today's session and to rank these in order of importance to their partner. Then have them list three things they themselves would be interested in doing after the session. (Partner pairs should sit together, face-to-face, but no speaking.) 3. Ask each member of group A to read aloud her list describing her partner's imagined interests. Next, the partner from group B reads aloud her own list of actual interests. Continue until everyone has shared their list. 4. Discuss the following questions: a) Did any member of Group A correctly or almost correctly identify the main interests of

Time	Objective/ Evaluation indicator	Content	Method/Activity
			her partner?
		Possible Responses: b) ▪ Similar educational background ▪ Same sex ▪ Same cultural background ▪ Same religion ▪ Knew each other before ▪ Had discussed this before ▪ Had observed her	b) If so, how do you think this was possible?
		c) Even though you know some one, you may still be unaware of that person's real interests or concerns unless special efforts are made to learn what these may be.	c) Why do you think some of you did not identify the interests of your partners correctly?
		d) If we had been allowed to talk together. Ask her. If we had time to observe each other for some days before the exercise.	d) What would have assisted you in correctly identifying your partner's interest?
		e) Felt resentful, surprised, misjudged, amused, lost respect for person making assumptions. It was more difficult to then tell the truth or felt need to defend self. Felt devalued as person.	e) How did it feel to be told what your interests were, or what you were going to do? How did you feel when you were prejudged or misjudged?
		If you had difficulty guessing a fellow midwife's real interests	Summarize with the content at left:

Time	Objective/ Evaluation indicator	Content	Method/Activity
		(with the commonalities you share) think how even more mistaken about the needs and problems of the community residents about whom you may know very little.	
30 mins.	B. Define values and identify factors that influence them.	1. Exercise: Survey of Attitudes This exercise illustrates how individuals can have different priorities in life even though they may all live in the same community and have similar backgrounds.	1. Explain to participants that you are now going to take a poll of their views on certain subjects. Explain the rules as follows: a) There is no right or wrong answer to any question. b) They must either agree or disagree with each statement. c) If they agree with the statement, they should stand at the right side of the room; if they disagree, they should stand at the left.
		4. STATEMENTS a) TBAs should be given more responsibility in giving care to women. b) It is the couple's right to determine their reproductive needs (fertility).	4. Read statements from the list presented at left:

Time	Objective/ Evaluation indicator	Content	Method/Activity
		c) Men should beat their wives less during pregnancy. d) A woman's worth is defined by the number of children she has. e) Women should be virgins when they marry. f) Men should be virgins when they marry. e) If a baby dies because a woman comes in too late to deliver, it is the woman's fault. g) A pregnant woman's husband should decide how money is spent on health care.	
		b) Age, ethnicity, personal experience, family pressures.	Process this exercise by asking participants: a) Were you surprised by the reactions of some of your colleagues? b) What explains the differences in your attitudes toward some of the statements made?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		c) These might depend on the barriers, motivators, and enablers present in their lives. These might be very different from what we assume.	c) Supposing your clients had the opportunity to list their major problems in order of importance, how would these resemble your own ideas of their problems?
		d) Listening to women and their families would give us a better idea of how we can best communicate our ideas to them. One of the best ways to know someone's real interests is to talk directly to that person.	d) How can we become more familiar with the value systems and ideas of our clients and their families in order to communicate more effectively with them?
		2. <u>Definition:</u> Values are the ways the individual sees or looks at life or things important to him in order of priority.	1. Ask participants to brainstorm the definition of "values". Modify the definition and write on the board the definition at left.
		3. Factors that influence values: ▸ Family ▸ Peer groups ▸ Religion. etc. ▸ Educational background ▸ Community ▸ Experience	3. Ask participants to list some of the factors that influence their values.
		4. Family: We seek our parents approval, respect, so we adopt their views and beliefs.	4. Ask participants give a few examples to explain how these factors influence our values.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		Education: We internalize facts learned from teachers, media IF the source is credible to us. Peer groups: We seek acceptance among those we perceive as being like us. Experience: We may encounter experiences that run contrary to what we have learned or observed in our homes. This can lead to a growth or change in values or actions that are in conflict with our values.	
		5. Values are closely tied to our self-concept, our sense of worth, and our sense of belonging to our community, our family, our environment.	5. Ask participants what conclusions we can draw about values and the role they play in our lives?
		6. Participants should use their own examples, such as: a) Call home: desire to maintain closeness with spouse, children because family welfare is important. b) Review notes from training:	6. Refer back to the first game and ask participants in the first game, what values might have been influencing peoples plans for what they would do after work?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		learning, education, self-improvement is important to self esteem. c) Check in at office: Success at work gives a strong sense of accomplishment, worth. 7. Not usually, especially if we are not well acquainted.	7. Can we easily anticipate each others' value systems?
	C. Explain how values influence our perceptions and actions	1. Note to trainer: If people have difficulty, give them the example (kunya, high parity) and have them identify the associated value/perception. **Possible examples:** "Kunya": Women perceive assisted delivery as shameful because within their culture, modesty is valued very highly. If they have assisted delivery, they are less valued as women. High parity: (1) Women perceive children as god's gift which cannot be denied and so see fertility control as opposing god. (2) Women know that their value to their husband depends on large numbers of sons so they perceive limiting as dangerous to their future and their	1. Ask participants to think back to the first section on barriers, motivators, and enablers. From the clients' point of view, what were some of the factors affecting perception of health care and how did their values affect these perceptions?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		marriage. Unsafe abortion: Unmarried women know that if they seek abortion from a public health provider, it will be evident that they are sexually active, which is against community values, so they seek clandestine services or delay abortion until it is very dangerous instead. Nutrition: Certain protein foods are thought to make children thieves or cause upset stomach in the pregnant woman, so women avoid them during pregnancy even though they actually need more protein at this time. Early breastfeeding: Women want to ensure purity in their newborn; colostrum is thought to be impure, so women do not feed it to the new baby. **POINTS TO EMPHASIZE:** ▪ Even in a group of people from similar backgrounds, educational levels and professions, a wide variety of attitudes and values may persist. If health workers	2. Conclude this session by summarizing the points at left.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		can recognise their own biases first and understand where these come from, they are better prepared to deal with the different beliefs and behaviors their clients hold. ▪ We would probably have more success in our work with the members of the community if we first tackle the problems <u>they</u> saw as important. ▪ We must first be aware of our own values so as to ensure that we do not impose them on our clients. Better understanding of our values as well as those of the client will help providers deliver more relevant, appreciable care in ways that do not come into conflict with their clients' values.	

SESSION III

INTERPERSONAL COMMUNICATION

Interpersonal communication [IPC] is the face-to-face, person-to-person, verbal or non-verbal exchange of information, feelings or opinions between individuals. Because of the direct and immediate nature of this interaction, IPC is at the core of all human relationships.

Objectives:

Participants will be able to:

A. Define Interpersonal Communication
B. Give examples of IPC
C. Identify health activities that require IPC
D. Identify IPC Skills
E. Demonstrate nonverbal interpersonal skills and explain their effect on clients
F. Demonstrate verbal communication skills and explain their effect on clients

Time: 2 hours

Topics Covered:
A. Definition of IPC
B. IPC in helping clients
C. Verbal and non-verbal communication.

Preparation: Write emotions on slips of paper and put in a "lucky dip bag."

Reference Materials: Handout on Interpersonal Communication.

Time	Objective/ Evaluation indicator	Content	Method/Activity
10 mins	A. Define Interpersonal Communication	1. <u>IPC Roleplay</u> The purpose of this role-play is to expose participants to the meaning and effects of interpersonal communication. As the "provider", you will open the session by addressing each of three "patients" using the same phrase, but a different tone, with each.	1. Start out the session with a short role-play. Before the session begins, ask three participants to act the part of "maternal health clients." Have each "client" enter the room and approach you at your desk. To each one, you will say the phrase, "Yes. What can I do for you?" Vary the tone in which you deliver the phrase (compassionate, angry, indifferent) to include a range of emotions.
		2. ▪ Compassionate: secure, happy, confident ▪ Angry/hostile: frightened, angry, defensive, stupid ▪ Indifferent: unsure, frightened or nervous	2. After all three "clients" have been "greeted," ask each "client" how she felt when she was spoken to in a particular tone.
		3. The provider is uninterested in us, put upon, annoyed with us.	3. Ask the group as a whole what each of these greetings seemed to say to the "client."
		4. The sound of the voice, facial expression, position of body,	4. Ask the group what about the provider led them to these conclusions.
		5. **Possible responses:** ▪ Person-to-person communication ▪ Verbal communication of feelings, information	5. Ask participants to define interpersonal communication (IPC).

Time	Objective/ Evaluation indicator	Content	Method/Activity
		▪ Nonverbal communication of feelings	
		<u>Definition of IPC</u> Interpersonal Communication is the face-to-face, verbal and nonverbal exchange of information or feelings between two or more people.	After recording their various responses, present the complete definition at left.
10 mins	B. Give examples of IPC	1. Hissing, calling, eye contact (staring, glaring, gazing, looking away, rolling eyes), hand-holding, hand-shaking, nudging, kicking, crossed arms, facial expressions (frowning, smiling, furrowing our brow), laughing, waving, speaking, shouting, crying, etc.	1. Ask participants to list as many ways as they can think of that we communicate our feelings, information, and emotions or attract or give attention. Write these on Newsprint and categorize under "Verbal" and "Nonverbal" headings.
		2. **Possible examples:** ▪ In some cultures, direct eye contact is not appropriate, especially between members of the opposite sex or between a younger person and an older person. ▪ Hand-holding among men is common in some cultures as a sign of casual friendship. But in other cultures, only homosexual men would hold hands.	2. Ask participants which of these they think are "universal" and which are "local." Why or why not? What can happen when health care providers are unaware of or insensitive to local forms of expression or local taboos against certain expressions. Give examples.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		POINT TO EMPHASIZE: People communicate on many levels, using many cues, both verbal or nonverbal. These signals may be formal and culturally defined or very basic or subtle.	3. Summarize using the content at left.
10 mins	C. Identify health activities that require IPC	1. <u>Possible Responses</u>: • Community needs assessment • Antenatal/Postnatal health education at the clinic. • Motivation/promotion advocacy efforts. • Counselling in private homes or in the clinic. • Meetings and discussion groups.	1. Ask participants to list types of activities they carry out during the course of their work that call for interpersonal communication. Write responses on board.
10 mins	D. Identify IPC Skills	1. Verbal and Nonverbal Communication Exercise	1. Ask participants to form pairs. Person A should talk for 2 minutes non-stop about some concern of hers. Person B should try to communicate interest, understanding and help in any way but must not talk. 2. After 2 minutes, have

Time	Objective/ Evaluation indicator	Content	Method/Activity
			couples switch roles and repeat the exercise for 2 minutes also stop them. 3. Allow pairs 2 minutes to talk freely to each other. 4. Discuss and process what happened.
		a) good, free, relieved	a) How did it feel to talk for 2 uninterrupted minutes?
		b) Frustrating, difficult	b) How did it feel to be prevented to speak?
		c) Expression, body movement, eye contact - leaned forward, looked at me, etc.	c) Did you feel your partner understood you? How did you know?
		d) Holding, hugging, patting, eye con-tact, leaning forward, "m-m-m-m, ah-hah."	d) What specific body behaviors communicate understanding, support, help?
		e) Leaning back, cross arms, chin pulled down, frowning, shaking head, "tut-tutting."	e) What specific body behaviors communicate disagreement, unwillingness?
		f) Confusion, uncertainty mistrust, indication that someone feels unhappy but does not feel free to communicate these feelings freely or verbally.	f) What happens when nonverbal behavior does not match verbal message?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		g) Saying "Yes" and frowning.	g) Give an example of contradictory verbal/ non-verbal messages.
		h) ♦ shuffle papers ♦ avoid eye contact ♦ look at watch ♦ laugh or frown at what they say thus showing judgment or contempt.	h) Ask participants to mention some negative nonverbal emotions or cues that service providers/nurse midwives sometimes use when communicating with mothers/clients.
	E. Demonstrate nonverbal interpersonal skills and explain their effect on clients	1. <u>Nonverbal Exercise</u> (Feelings CHARADE) Suggested emotions should be written on separate pieces of cardboard before session begins: Anger, pride, pain, impatience, happiness, misery, boredom, empathy.	1. Give a lucky dip of slips of paper with different emotions written on them to participants. Have participants act out the chosen emotions. Other participants should try to guess the emotions being communicated.
			2. Process the exercise by asking the following questions:
		a) ▪ Frustration at home ▪ Frustration with commuting from home to work.	a) What factors (barriers, motivators, enablers) may lead to displays of these emotions?
		b) Negative nonverbal communication can be a barrier to health care: Clients may be frightened away from the	b) What do you think is the impact of our nonverbal communication on our clients' behavior (negative/positive)

Time	Objective/ Evaluation indicator	Content	Method/Activity
		clinics. Clients will lose confidence and trust in our care. Positive nonverbal communication: can be a motivator enabling care by creating trust, confidence on the client's part. c) ▪ Become aware of our nonverbal responses whilst interacting with clients. ▪ Plan and arrange our schedules to avoid tensions. ▪ Practice positive nonverbal cues.	c) How could we as Nurses/midwives enhance and improve the effect of our interactions with clients?
10 minutes	F. Demonstrate verbal communication skills and explain their effect on clients	1. <u>Verbal Communication Exercise</u> **Sentences:** Client:"Nurse, I have been waiting for the past one hour" Provider: "Someone will see you in a minute" **Suggested emotions:** anger, panic, boredom, disgust, disinterest, impatience, concern, compassion, interest,	1. Write the sentences to the left on cardboard. Enlist two participants at a time to act out the exchange of phrases using any emotions they choose. One participant should play the role of the client and one the role of the nurse. Tell the rest of the class to guess the emotion being exhibited.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		pleasure. a) ▪ Calm ▪ Friendly ▪ Polite b) ▪ Act distracted ▪ Permit interruption by others ▪ Interrupt clients as they talk ▪ Use abrupt manner of speech ▪ Put words in their mouths c) ▪ Watch for nonverbal cues ▪ Listen to tone of voice ▪ Look for discrepancies between what they are saying and how they are behaving d) ▪ Shake hands (if appropriate) with smile ▪ Introduce yourself ▪ Speak in the person's language and at the person's level ▪ Use simple language ▪ Show patience ▪ Allow the client to finish	Repeat the exercise with a few other participants. 2. Process the exercise by asking the following questions. a) What tone of voice would you prefer a provider to speak to you with if you are in the clinic for help? b) Ask participants to think of ways service providers/nurse midwives show negative emotions or feelings to clients whilst interacting with them. c) Ask how we can interpret responses of those we are communicating with or observing? d) Ask participants: What are some of the behaviors that we can adopt in our interactions with our clients to convey concern and interest?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		her thoughts ▪ Make eye contact ▪ Don't discuss other clients ▪ Choose a private place to discuss ▪ Ask other clients and staff to give you time ▪ Show empathy verbally ("oh, that must have hurt you") and nonverbally (touching, sympathetic facial expression) ▪ Paraphrase and reflect ▪ Praise and encourage	
	Summary	**POINTS TO EMPHASIZE:** ▪ There are many facets of interaction between individuals communication, both verbal as well as nonverbal. Midwives must pay close attention not only to people's verbal cues but to their nonverbal behavior as well. ▪ The verbal and nonverbal cues we send to others can have far-reaching effects on what we hope to achieve. If we expect compliance with safe health practices, such as return to the clinic for delivery, proper	3. Summarize and stress the key points under contents.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		eating habits, immediate breastfeeding, and we must first communicate trust and concern to clients. For this reason, midwives need to be attuned to their own behavior as well as that of their clients.	

INTERPERSONAL RELATIONSHIPS

Relationship according to the Oxford dictionary is the connection between people and/ or things.

In a health care setting, there exists different kinds of relationships: Midwife-patient, midwife-Nurse, midwife-Doctor, midwife-allied professionals and midwife-community relationships. The quality of these relationships to a great extent affect health care provision. Where poor relationships exist there will be no cooperation among the workers themselves, and both clients and the public suffer. This is clearly reflected in the following statements made by a journalist in the Nigerian Tribune: "One cannot imagine the cruel treatments nurses give to patients either when they are in the hospital for prenatal care or when they want to put to bed." He also said that "If Florence Nightingale was to be so cruel as some of today's nurses, she could not have been able to reduce the death rate in the hospital at Scutari."

Definitely, maternal health care providers do not like the public to perceive them as being inhumane and insensitive when they are supposed to be offering humanitarian services. Health care providers must therefore improve their communication skills and maintain good human relationships with clients and their relatives.

In interacting with the community, health care providers must recognize individual differences and treat each individual differently. Their values, likes, and dislikes, as well as perceptions must be understood and respected.

Determinants of Positive Relationship:

Indices of good relationship include:

- Greeting clients in ways acceptable to them
- Friendliness
- Taking time to listen to them
- Answering their questions satisfactorily
- Being patient even if they ask questions repeatedly.
- Other attitudes which signify a positive relationship include trust, caring, empathy, mutual understanding and allowing the clients greater participation in their care.

The attitude of trust is built through experience from childhood. If one grows up in a trusting environment, one would learn to trust and expect the same from others. However, experience of mistrust could reverse the attitude and clients may learn not to trust health personnel or vice

versa.

Characteristics of a trusting person:

i. acceptance of others as they are without attempting to impose change on them.

ii. consistency between words and actions

iii. openness in interaction.

These characteristics can be utilized for self assessment and improvement and for helping the clients as well as the community to develop a trusting attitude.

Definitions:

Empathy is the ability to perceive another person's situation or feelings. This attitude is necessary in understanding the clients/community's problems. Constant and close interaction between health care provider and the community could promote an attitude of empathy. This is because empathy grows gradually and spontaneously through a progressive relationship (Othman, 1914).

Caring: Most often health care providers are described by the public as callous and uncaring. This is because the care we give does not seem to go beyond a mechanical one (e.g. giving injections, medications or dressing). Health care personnel come in contact with people who are sick, sad, depressed, afraid or anxious. A caring attitude like gentle approach, respect, listening, physical touch and provision of companionship will go a long way in relieving the patients' anxiety and providing her/him with sense of security.

Participation: Clients and their relatives should be allowed to participate in decision making concerning their care. This promotes cooperativeness and compliance which form basis for successful health care provision.

Rev. 12/2/93

SESSION IV

C O U N S E L L I N G

Health providers come into contact with the public, clients and their families everyday. They are expected to motivate, educate and counsel members of the community.

The most intimate of these interactions, counselling is a process of defining feelings, providing unbiased information and empowering clients to make their own decisions. The interpersonal skills a health care provider brings to communicating with and counselling her clients make up the quality of care she provides for her clients.

Objectives: Participants will be able to:

A. Explain "levels of response" model for helping in decision-making
B. Define Counselling
C. Identify basic counselling concepts and techniques
D. Describe the key components of the counselling process
E. Demonstrate counselling skills and use of observer's guide using feedback

Time: 6 hours

Topics Covered:
A] Levels of response
B] What is Counselling?
C] What am I? Motivation/Education/Counselling Game
D] Counselling Skills
E] Counselling Practice and use of observer's guide

Teaching Aids: Newsprint and markers

Preparation: Prepare a story about a problem of yours for "levels of response" (See A).

Reference Materials: Hand/Out Numbers.

Time	Objective/ Evaluation indicator	Content	Method/Activity
20 mins	A. Explain "levels of response" model for helping in decision-making	1. **Possible story:** Today I started out for work. Just as I was leaving, my neighbor came running to me. She wasn't feeling well. One of the children had fever and she thought maybe he had malaria. She wanted to know if I could look at him, or had Panadol. Her husband was out of town and she couldn't get to the clinic. 2. Possible levels of Response: ▪ give advice ▪ disclose sympathetically (the same thing happened to me...) ▪ ignore ▪ order, direct, command ▪ warn, scold, threaten ▪ moralize, preach ▪ persuade, implore ▪ judge, criticize ▪ "butter up," pamper ▪ insult, shame ▪ analyse ▪* reassure, sympathize, console ▪* question ▪ distract, joke ▪* reflect, summarize feelings accurately: "You sound as if you're worried.." ▪* identify problem, help confront	1. Tell the participants a story about a problem of yours or you may use the story at left. 2. Ask participants to list all the responses, either positive or negative, that might be offered to the friend, neighbor, or client with a problem. 3. Using the case above, ask the group which responses they would find helpful if they were the neighbor. Why or why not? Highlight the helpful responses. 4. Explain that a person is ready and able to deal with the situation or problem only after his or her feeling is acknowledged. We can only counsel when we are fully prepared to learn and respond to our client's needs.

Time	Objective/ Evaluation indicator	Content	Method/Activity
20 mins	B. Define Counselling	1. <u>WHAT AM I ? GAME</u> This game will help participants to learn the differences and similarities between motivation, health education, and individual counselling. Most of the time, health workers mix all three activities and act as if they are interchangeable. <u>Definitions</u> <u>Motivation/Promotion</u>: encourages a client and their families to adopt a new health behavior such as visiting a clinic or trained birth attendant. Through motivation, the client is persuaded to be more favorably disposed to the formal health sector. <u>Education</u>: provides specific information and gives information that state the facts objectively. Education assists clients in making decisions by expanding their knowledge base.	1. Have participants read out statements of activities from the list in reference material # 1. As each participant reads, ask others to identify the person being described as a counsellor, educator, or motivator. Chances are that there will be much discussion, disagreement or ambivalence about most of the options. Have participants brainstorm the definitions of motivation; education and counselling. List of statements of activities. "What am I." Guide participants in reaching a good working definition that accommodates the essence of what is under contents.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		<u>Counselling</u>: a person-to-person interaction in which the provider gives adequate information which will enable a client to make an informed decision about her health. Counselling helps the client to understand her feelings deal with her specific, personal concerns. Effective counselling empowers a client to make her own decisions. <u>Points to Emphasize</u> • Counselling, Motivation and Education all require interpersonal communication skills. • Counselling is the ultimate end of these three processes. <u>Possible Response</u> Ante-natal or MOH clinic, health talks conducting medical examinations, taking health history, home visits, counselling a bereaved relative, consultations at home and rehabilitation.	Have participants brainstorm on the various areas of their work that call for counselling.
1 hr	C. Identify and demonstrate skills and techniques of	1. <u>Skills</u> • Praise and encouragement	1. Have participants brainstorm the skills needed for counselling. Write the

Time	Objective/ Evaluation indicator	Content	Method/Activity
	counselling	• Questioning • Paraphrasing and summarizing • Active listening • Coping with special needs • Use of support materials • Observation • Explaining in language client understands • Reflecting • Nonverbal responses • Clarification	list on board. Review the list and come up with the skills areas listed under "content." Talk briefly about some of the skills areas mentioned.
		2. Exercise: Skills Practice	For each of the skill areas, discuss what each skill involves and why. Demonstrate the skill using examples at left. Ask one or two pairs of participants to to demonstrate each skill area. Encourage participants to bring out local examples. Refer back to the session on verbal and nonverbal communication and why these skills are paramount to good counselling.
		a) <u>Praise & Encouragement</u> What: Speaking to a client using words that motivate and assure a client that you approve	a) Ask participants to come up with examples of praise and how that encourages clients to listen and practice good health behavior.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		of her. Why: Praise and encouragement help build a client's confidence and reinforce desired behavior. Praise elicits self-worth in clients which in turn empowers them to make the right decision or execute the right task with enthusiasm. **Example:** A client comes in after several hours of labour. Possible responses: Nurse: "You did well to come here for help," "Well done." Other examples for different situations: "Good, you are pushing well." b) <u>Questioning</u> What: Questioning is a technique for learning from the client specific information or general feelings and concerns. Why: For screening, good questioning skill is important. For education sessions, questioning helps determine whether clients understand what	b) Refer to the handout on types of questions. With participants, discuss the different types of questions. Ask participants to give examples of each type of question and when they would use it. Have a few participants make statements and ask other

Time	Objective/ Evaluation indicator	Content	Method/Activity
		they are being told. Good questioning skill is needed for community assessments. In counselling, questioning helps uncover fears and concerns, preferences, and areas of knowledge deficit. **Example:** Client: "I'm so tired." Nurse: "Oh? Tell me, why do you think you are feeling so tired?" Client: "I don't know, I seem to sleep plenty." Nurse: "How much sleep are you getting?" "What have you been eating lately?" (Other follow-ups would include questions about bleeding, other conditions that might lead to her being tired.)	participants to respond with a follow-up, probing question. See examples at left.
		c) <u>Listening and Response</u> What: Active listening is the art of hearing and trying to interpret your clients' words. Why: Often we think we listen, but we aren't really <u>hearing</u> our clients responses. Paying attention to uninterrupted responses are one of the best ways we can come to know our	c) Two trainers should role-play the example under "content." Then have participants form pairs and engage in "active listening." The rules follow: One partner starts with a statement. For one minute, the second partner "listens" and makes responses. The listener must repeat (paraphrase) their

Time	Objective/ Evaluation indicator	Content	Method/Activity
		clients and make <u>appropriate</u> responses to their questions and concerns. **Example:** Client: I think a woman should have as many children as God gives her. Possible response: Nurse: You think a woman should have as many children as God gives her. Do you think God wants you to stay healthy to take care of your children? Client: It's my duty to care for them. Nurse: You see it as your duty to care for your children. What are some ways we can make sure you stay well to help your children grow well? d) <u>Paraphrasing and summarizing</u> What: Repeating back to client what you heard her say. Why: To make sure you	partners' statement and add a comment or a probing question. They must respond to the "client" in a nonjudgmental way. Some examples for practice: ▪ The role of polygamy in Nigeria ▪ The importance of waiting between births ▪ The advantage of early breastfeeding After this exercise, ask participants the following questions: ▪ What happened during your listening sessions? ▪ Was it difficult to follow the rules? Why/why not? ▪ What are some qualities of a good listener? d) Follow the same process in this skill area as in "listening and response." Refer to H/O #2 for more examples on paraphrasing and

Time	Objective/ Evaluation indicator	Content	Method/Activity
		understood her, to show her you are listening, and to help her clarify her feelings. This is most needed when trying to get information from the client, e.g. during history taking or when she seems concerned about something. **Example:** Client: "I've been having some blood, but my mother-in-law says don't worry because everyone sees blood during pregnancy. It comes often and sometimes I just need to rest but there's hardly time to lie down. I don't know what it means." Possible response: Nurse: "It sounds like you've been seeing this bleeding for awhile and you think the bleeding might be a cause for concern. You've made a good choice to come and tell me about it." e) <u>Reflection acknowledgemen</u>. What: Similar to summarizing and paraphrasing, reflection is a process of reflecting clients emotions back to them.	summarizing. e) Follow the same process as in last two skill areas. Have participants role-play reflecting feelings using the following examples at left.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		Acknowledgement is a verbal recognition of fears, concerns, or satisfaction. Why: Reflection and acknowledgement validate the client's feelings and show empathy and respect on the part of the provider. **Example:** Client: "I feel like I am being torn in bits with my husband, the new baby and little boy wanting me to do things." Possible Response: Nurse: "You sound confused by competing responsibilities. It seems as if there are a lot of demands in your life." **Example:** Client: "This clinic is too far away. Why can't you people build one in my village? I had to look for someone to take care of my children, and I had to cook for three days and I had to wake up in the middle of the night to begin my journey here." Provider: "It sounds like you are anxious about your family and tired from the work and	

Time	Objective/ Evaluation indicator	Content	Method/Activity
		travel. These hardships are frustrating. You did well to come." **POINT TO EMPHASIZE** The midwife may reflect words or feelings expressed so long as they are the clients words and feelings, not what the midwife thinks she should say.	
		f. <u>Observation</u> What: Looking and listening to the client's behavior, reaction, physical appearance. Why: A midwife will benefit from developing high sense of awareness of her client as a complex human being. This is done consciously or intuitively and helps us to evaluate her educational level, socio-economic level, state of mind (distressed, agitated, calm and the degree of pain she is in and whether she has family support.	Ask participants to give some examples of what the nurse is looking for. They may bring up medical conditions, but also be sure to refer to verbal and nonverbal clues the client is exhibiting,
		g) <u>Translating into Simple Language</u> What: Making a complex concept or procedure comprehensible to the client according to her level of education and	g) Ask participants to give their ideas on what this skill involves and why it might be important. Have participants translate the medical terminology in the

Time	Objective/ Evaluation indicator	Content	Method/Activity
		informational needs. Why: Clients will be less fearful and better prepared to take decisions to benefit their health if they fully understand what has happened, what is going to happen, what is being required of them, and why. **Example:** The fimbrae of the Fallopian tubes capture the ovum for transfer into the uterus. <u>Possible Response</u> The finger-like ends of the woman's ropes take the egg into the womb. **Example:** The primigravid woman presents with cephalo-pelvic disproportion, requiring a cesarian section. <u>Possible Response</u>: A woman is pregnant for the first time does not have room enough in her waist to deliver the baby. So she will need the doctor to deliver the baby safely by an operation on the woman's womb.	example at left into simple language. Trainers may come up with more examples from the LSS or any midwifery manual.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		Point to emphasize Use the following acronym to emphasize this point: K-eep I-t S-imple S-ensible h) <u>Coping with special needs</u> What: Coping with special needs means being able to handle special problems or clients whose situations are unusual without imposing one's own values or judging the individual. Examples: • 12 year old pregnant school girl • patient with VVF • incomplete induced abortion • women on labour who has an STD (or is HIV positive) • High risk mother • Prostitutes	h) Ask participants whether there are any clients to whom they would have difficulty providing services or who would present special problems. Why? What reactions do they anticipate in themselves? Explain that later they will do roleplays that include such cases.
30 mins	D. Describe the key components of the counselling process	1. Acronyms GATHER, ROLES, CLEAR and GATHER explaining basic counselling techniques and processes.	1. Write the acronyms ROLES, CLEAR and GATHER on the flipchart. Take participants through these acronyms, explaining every step.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		G- greet the client politely, warmly A- ask her about herself T- tell her what is going to happen during her visit H- help her to be comfortable, to understand her situation, to make a decision or find a solution to a problem E- explain any post-procedure care or instructions R- return visit or REFER client as needed	Explain that GATHER represents the overall counselling process.
		R- relax O- open up L- lean forward E- eye contact S- sit squarely (and smile where appropriate)	Explain that ROLES represent the non verbal communication skills that make up effective counselling.
		C- clarify L- listen E- encourage A- acknowledge R- reflect and repeat	Present the CLEAR acronym and explain that CLEAR represents the verbal communication components of effective counselling.
		POINT TO EMPHASIZE: For effective counselling a provider must make a conscious effort to incorporate the processes and techniques as explained in ROLES, CLEAR and GATHER.	

Time	Objective/ Evaluation indicator	Content	Method/Activity
4 hrs 10 mins	E. Demonstrate counselling skills and the use of feedback using observer guide.	1. Counselling demonstration: During an outreach session in the community: An antenatal woman, 26 weeks pregnant, with anaemia.	1. Take the part of an effective counsellor. Give one of your participants or a co-trainer the case at left to act out in a roleplay of good counselling. Ask clients to comment on what they saw. Ask them to discuss the how the counsellor identified the problem, discussed it with the client, helped her to explain her situation, and assisted her in finding a solution.
		2. Counselling roleplays in the large group. Participants should play especial attention to the use of the components of the counselling process and the skills employed to put the client at ease, show empathy, and listen for barriers, motivators, and enablers expressed in her speech and actions.	2. Ask three or four participant pairs to volunteer to role-play a client/provider situation in front of the group. Use examples found in the reference material. Following each "session," allow the group to make observations about the strengths and weaknesses of the counselling sessions.
		3. Counselling practice and the use of observer's guide. Every participant should have	3. Divide participants into groups of three. Participant A plays the counsellor/provider, participant B, plays the

Time	Objective/ Evaluation indicator	Content	Method/Activity
		the opportunity to play the part of observer, client and provider.	client, and participant C, plays the observer. Use case studies provided in Trainer's Reference Material #2.
		4. <u>Rules for Giving Feedback</u> ▪ Observers should be nonjudgmental ▪ Give positive feedbacks before negative ones ▪ Finish feedback with positive observations.	4. Introduce the observer's guide (HO #2) and explain that each participant will have a chance to use the guide. Ask observers to use the observer's guide to identify the nonverbal and verbal communication techniques as well as the counselling steps used. Give participants the rules for providing feedback at left.

WHAT AM I?

Motivator/Educator/Counsellor
Sample Situations

* I have conduced a survey of husbands' attitudes and have arranged to visit a cattle or ram market to discuss the benefits of antenatal visits for mothers. What am I?

* I am talking to a group of women in the TBA's compound. I ask them about the health problems that they and their children have. Then I tell them about the benefits of eating energy and vitamins and rich food during pregnancy. What am I?

* I am on the gynae ward of a local hospital talking to an 18-year old university student who is recovering from a septic abortion. I am asking her about herself, her future plans, and her need for avoiding unwanted pregnancy after she has recovered from this abortion. What am I?

* I am in a private home, talking to the mother-in-law of a newly wedded girl, 16 years of age. I am discussing with the mother-in-law why her daughter-in-law might want to wait a little while before she starts having babies. What am I?

* At the village square I am meetig with all TBAs. I am talking to them about the importance of referring pregnant mothers to the clinic when labour has lasted for 8-12 hours. What am I?

* At the MCH clinic, I am meeting with a mother who has had her baby through cesarian section. I am showing her a chart explaining reporductive anatomy and explain what happens to the body during pregnancy. I offer to help schedule a clinic appointment to discuss family planning. What am I?

* I am asking a group of pregnant women waiting for services at the antenatal clinic what rumours they have heard concerning tetanus toxoid vaccine (TT). What am I?

* I am explaining the breastfeeding technique to a mother who is worried that her baby does not suck well and that her breastmilk does not satisfy her baby. What am I?

* I am talking to a group of young teenage boys at the secondary school about STDs, their symptoms, how they are transmitted, and how they are prevented. I have a box of condoms to distribute after the talk. What am I?

OBSERVERS GUIDE

	USUALLY	SOMETIMES	RARELY
R- relaxes **O-** opens up to client/nonjudgmental **L-** leans forward towards client **E-** establishes eye contact **s-** sits squarely			
VERBAL COMMUNICATION SKILLS **C-** clarifies **L-** listens **E-** encourages and praises client **A-** acknowledges **R-** reflects and repeats.			
GATHER = Counselling PROCESS **G-** greets clients **A-** asks open ended and probing questions **T-** tells client about the benefits of prenatal care/reproductive system/medical examinations and specific issues. **H-** helps client to make her own decision **E-** explains use and side effects of drugs, nutritional contents of local foods, nutritional needs of prenatal client. **R-** return visits referral follow-up explained.			
Observers Comments Observer's Name _____ Date: _____			

TYPES OF QUESTIONS

Open-ended Questions	Closed-ended Questions	Probing Questions	Leading Questions
Open-ended questions give opportunity for answers in various ways. This allows for explanation of feeling and concerns. **Examples:-** - How do you feel about getting the baby's layette ready? - What are your concerns during pregnancy? - What do you think of this?	Closed-ended questions are useful for obtaining basic factual information, especially if there is a limited time available, as in an emergency, and in taking a medical history. Require a brief and exact reply; often elicit "Yes" or "No" response. **Examples:** - How old are you? - When was your last period? - How many children do you have?	Probing or clarifying questions encourage the respondent to give further information, and to clarify an earlier point. Require tact in the wording and tone used. Probing questions should be asked gently and nonjudgmentally. **Examples:** - What is it about the care you are receiving that you don't like? (In response to a statement that the care is not good.) - Why do you prefer to deliver at home?	Leading questions encourage the respondent to give an expected response. It is suggestive and puts ideas into the respondents heads. **Avoid using leading questions.** You will not get much useful information when you use this type of question. **Examples:** - Don't you think Midwives are wonderful? - Is this not pretty? - Doesn't this hurt?

Reflection Exercise, paraphrasing and summarizing (Examples)

1. **Client:** My life is going very well. We are just expecting out second baby and my husband is very anxious to make sure the layettes is ready for the baby.

   Midwife: You sound content with your situation.

2. **Client:** My mother in-law is always nagging me. Nothing I do is right.

   Midwife: It sounds like you are feeling frustrated and angry with your mother in-law.

3. **Client:** My husband beats me whenever I do something wrong. I don't like it but, he is right to do it.

   Midwife: I am hearing that you feel guilt of things you do wrong.

4. **Client:** This clinic is too far away. Why can't you people build one in my village? I had to look for someone to take care of my children and I had to cook for three days and wake in the middle of the night to begin the journey to this place.....

   Midwife: It sounds like you are anxious about your family and tired from the work and travel. You did well to come....

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ROLE PLAY I

A teenager is admitted to OB/GY ward with incomplete abortion. The doctor performed an evacuation. Her parents do not want to see her. They refused to bring food to her in the hospital. The girl has been seen crying.

ROLE PLAY II

Mrs Salt has just been told that she has delivered a baby girl. She is worried because her mother-in-law threatened to get another wife for her husband if she comes home with a baby girl.

ROLE PLAY III

Mrs Idowu has cephalo-pelvic disproportion. Her child has been damaged in delivery. Her husband has refused to allow her to return home with the baby, saying that the situation is bad luck and bad omen for the family.

ROLE PLAY IV

A woman 26 years old in third pregnancy. She is brought in by husband with the baby's head on the perinium.

ADDITIONAL ROLE PLAYS:

A 44 year old woman, 32 weeks pregnant, first pregnancy, making first visit to the antenatal clinic.

An antenatal mother 26 weeks pregnant with anaemia.

A newly delivered woman with four children driven out of her husband's house because she could not tolerate a second wife.

A 32 year old woman, 8th pregnancy (how many weeks). Has 10 children alive do not want more children but husband very uncooperative.

A 25-year old pregnant woman in antenatal with symptoms of STD.

A multiparous woman booked for caesarean section, 12th pregnancy 32 year old, 6 children alive.
A woman delivered twins undiagnosed.

Primip who has refused to breastfeed her baby.

A woman with pre-mature baby.

A woman 22 year old sits at the antenatal clinic with her hand at her right jaw looking sad and uninterested in what was going on. It was finally discovered that she is worried because she thinks her husband wants to marry another wife.

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SESSION V - PROBLEM SOLVING

Problem solving skills are among the most urgent and meaningful skills a health worker should master. The ability to master a situation carefully, analyze what problems exist, and determine steps to ameliorate or improve the situation is a prerequisite to provision of complete quality care.

If midwives are to develop a sense of responsibility to the community, they need problem-solving skills because most of their interaction would involve the assessment of needs and the proffering of solutions.

Objectives: Participants should be able to:

A. Identify common or frequent problems facing midwives in practice
B. Explain and apply the steps in a problem solving method (PSM)
C. Apply the problem solving method to maternal health problems
D. Define problem-solving skill and explain its relevance to midwifery
E. Apply the PSM to problems of maternal health.
F. Develop positive personal responses to "hopeless" situations

Time: 2 Hours.

Topics Covered:
[1] Define the problem solving method
[2] The steps to problem solving method
[3] Problem solving method practice.

Preparation:

[a] Prepare case studies for group practice.
[b] Collate real problems from the maternity ward or from participant's experience for problem solving practice.

Reference Materials: H.O. 1 and 2.

Time	Objective/ Evaluation indicator	Content	Method/Activity
30 min	A. Identify common or frequent problems facing midwives in practice	1. <u>Possible Responses</u> ▪ The woman who came too late because she lacked information ▪ The distance between the community and the health institution ▪ Transportation difficulties ▪ Cost of care ▪ Lack of equipment and life-saving supplies ▪ Taboos and cultural practices ▪ Too few hands for a crowded clinic 2. <u>Problem identification</u>: Possible responses: The child crying by itself may not be a "problem" because children often cry. But crying may be the sign of a problem. To know whether there is a problem, we can: ▪ ask the child ▪ look for other signs of a problem, such as fever, a bruise or broken bone, a laceration, malnutrition ▪ look for signs of an trauma ▪ look for evidence of abandonment	1. Have participants think over some of the cases they encountered during their ward visits. You may go back to the Newsprint of Day 1 [Session 1 <u>Barriers, Motivators, and Enablers to Care</u>] to refresh their memories of the barriers they identified. Ask them if they wish to identify more of those. Review the list of problems with participants and prioritize it. Encourage them to build scenarios around one of the problems. 2. Ask participants how they know there is a problem. Give them the following example: A child is crying. All children cry. Is this a problem? Is this a sign of a problem? What is the problem? How can we know? In whose eyes does the problem exist? Apply this to one of the situations presented in 1 and have participants establish the problem.
15 mins	B. Explain and apply the steps in a problem solving method (PSM)	3. *<u>STEPS IN PSM</u>* 1. Identify the problem.	3. Now, tell participants to assume they have established that there is a problem. Using the

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Time	Objective/ Evaluation indicator	Content	Method/Activity
		2. Establish causes and potential obstacles. 3. Identify resources and potential enablers. 4. State objectives. 5. Map out a plan of action. 6. List the tasks and assign responsibilities. 7. Implement the plan. 8. Evaluate and modify if necessary.	example chosen in 1 above, ask participants how they would solve this problem. Let them brainstorm, and as they do, write down all their suggestions. Present the model at left under content. Begin to fit their suggestions into the steps of the problem-solving method (PSM) to solve their problem. They may, in trying to apply the PSM, determine that some of their solutions are unfeasible. Go over each step with them to demonstrate how to think through a problem logically. This will help give participants confidence in their own problem solving abilities and will introduce a system for organizing their thinking. Write the steps as you begin to apply them. Involve participants in the discussion by encouraging them to explain whether and how their "solutions" fit into the system.
20 mins	D. Define problem-solving method and explain its relevance to midwifery	1. <u>DEFINITION of PSM</u> PSM is an organised way of dealing with any problem through the identification and examination of	1. Ask participants to come up with a definition of PSM bearing in mind what you have just practically demonstrated.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		all aspects and careful organization of information and resource towards solving it. 2. <u>Possible Responses</u> Midwifery practice in the community will as of necessity require problem-solving skills because the objective is to help people better understand their problems and resolve them. Our clients present not only medical problems that require quick thinking and clinical interventions but also several constraints or problems that may seem removed from the midwives' skill area. Frequently these problems create tragic consequences. The renewed commitment of the midwife to help reduce the high rate of maternal deaths through better standards of practice and life saving skills must include taking a lead in creating partnerships in finding solutions to most problems affecting their clients' well-being. Helping to find solutions will elicit a sense of self-worth, confidence and positive self-concept in the midwife who had been reduced to an apathetic state by	2. Continue by leading a discussion: Why is problem solving an important skill for care providers especially midwives? The more the midwife takes responsibility of the total well-being of her clients, the more the initiative and effort she will bring to maternal health care.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		helplessness and powerlessness. The community will grow in trust for the health provider and feel her sense of concern and commitment to them.	
1 hour	E. Apply the PSM to problems of maternal health		1. Divide participants into small groups. Groups should select a coordinator and rapporteur [secretary]. Provide groups with real problems of real people [preferably from the wards] or from participants' experience. Hand out the PSM model to the groups to use in addressing their respective problems. Explain that participants should feel free to generate other methods to the case if they wished. Tell them they have 30 minutes to carry out this task. 2. Recall participants into larger groups and have them present their solutions for their comments and alternative viewpoints or solution.
15 mins	F. Develop positive personal responses to "hopeless" situations	1. <u>Game: Turning "No-No Phrases" to "Self-Affirming Statements"</u>	1. Have participants reflect on some of the limitations we or the system sets on our ability to take

Time	Objective/ Evaluation indicator	Content	Method/Activity
		Possible responses: No-No: "It can't be done" Yes-Yes: "I remember a nurse who had a similar problem solving it this way" No-No: "There is nothing I can do" Yes-Yes: "I know I can make this situation less painful for my client" No-No: "It is a pity there is no blood and her relatives are not here" Yes-Yes: "There is a staff member who lives not far from her home." No-No: "This poor woman will just die, it's unfortunate." Yes-Yes: "This woman is in my charge and I will do everything in my power to save her." No-No: "There is no doctor around" Yes-Yes: "I've helped the doctor do this procedure done many times before." No-No: "I can't kill myself." Yes-Yes: "If not me, who?"	leadership in problem-solving. Have them come up with some common "truisms" people tell themselves when the going gets tough. You can prompt them with a few of the phrases under contents. Tell them these are "No-No" statements. For each no-no statement put forth by participants or trainers, each participant should come up with at least one "Yes-Yes" assertion.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		2. Possible responses: ▪ Refresher courses ▪ Discussing problems and solutions with other midwives ▪ Joining in with other midwives to subscribe to professional journals ▪ Attending professional meetings ▪ Countering each thought of self-doubt or helplessness with one self-affirming statement.	2. Wrap up the game by challenging participants to henceforth expunge "no-no" phrases from the midwife's vocabulary. Ask clients for ideas on how they might help themselves to keep their "creative juices" flowing.
		3. Midwives in practice owe it to up and coming young midwives to behave as role models in all the skill areas that recognize the human being within the patient. Problem-solving is an urgently needed skill for health providers. There are always several options to every problem. Midwives should explore these options and be creative in responding to problems.	3. Summarize the key points of the session.

PROBLEM SOLVING METHODS [PSM]

Introduction:

Every institution, individual, and organization at one time or another encounters problems. The steps involved in providing solutions may be obvious. However, most often, steps are taken without a conscious awareness of the steps involved. When identification of problems and solutions are not so clear, the problem solving method may be used.

The Problem Solving Method (PSM) is a process of carefully organising information and resources toward solving a problem. Eight steps can be identified in PSM. They include:

(a) Identify problem: State what the problem is. It is important to be specific. In some cases more than one problem may be applicable;

(b) Establish causes/ obstacles: These are individuals, events, institution, attitudes, factors etc, which prevent actual service(s) from being rendered adequately or at all.

(c) Identify resources/ enablers: Identify where help can come from. This may be from within or without, from an individual or an organisation.

(d) State objectives: What specifically would you want done? It must answer question what, when, how, much or how many. It must be comprehensive enough to cover the problem(s) identified.

(e) Map out a Plan of Action: Use the resources you have at you disposal to tackle your problem and attain your objectives

(f) List tasks/responsibilities: What must be done by whom, and when they must be done;

(g) Implement your plan: This is the carrying out of all that has been outlined as plan of action, by those involved and at the appropriate time.

(h) Evaluate: See to what extent the observed problem(s) have been solved. Revise the plan of action as necessary.

Conclusion:

A problem solving method can be applied to problems in varied setting. It may, however, involve some modification to suit the prevailing problem. The benefit of acquiring this skill is the ability to move beyond barriers and limitations to find solutions.

RESPONSIBILITY / ACCOUNTABILITY

TAKING CHARGE

Responsibility is the act of standing up to the course of causing an act to happen or of causing an act from not taking place.

Accountability, as the name implies, calls for the rendering of stewardship of what the responsibility calls for or imposes on an individual. Accountability depends on the responsibility and responsibility has to be matched with authority. The authority fuels the responsibility and has to be accounted for at the end of the day.

Medical care starts from the environment where the midwife lives. The midwife in her neighbourhood has a responsibility to ensure that she makes her presence in the community felt. How does she do this? She has to maintain high quality of good relationship with the people in her environment in general and pregnant women in particular.

This act of friendliness on the part of a midwife, forms a good and adequate starting point in a maternal health care delivery in the community. It helps in encouraging many women who would have otherwise never utilized health care services, especially since a large percentage of our women in the rural areas do not utilize health care facilities. Home visit by midwife plays an important role in encouraging a great number of clients who avail themselves to the hospital services during early pregnancy.

The formal responsibility of a midwife commences when a mother accepts to register in the hospital or at clinic. At this juncture, the midwife may be subject to a formal or legal accountability with respect to her her clients. She enters an informal relationship of accountability to her clients' relations and community and to her employers, professional body/colleagues.

She is expected to use the professional knowledge and skills acquired to perform her professional roles, so as to meet the health care needs of the community. The midwife should provide individualized care bearing in mind the social conditions, beliefs, and other individuals which influence the clients ideas' on child bearing and rearing.

She works with obstetric team and other supportive health workers to ensure responsibility and accountability for each patient entrusted under her care. This includes the following examples:

1. *Antenatal Care:*

- Adequate prenatal assessment
- Early detection of disorders of pregnancy and appropriate action
- Prevention of infection, e.g., immunization against tetanus; maintenance of asepsis
- Maintenance of adequate record-keeping and statistics
- Safe administration of drugs
- Counselling
- Identification of high-risk patients
- Follow-up

2. *Labour:*

- Conducting safe deliveries under aseptic technique
- Monitoring maternal and foetal conditions
- Recording of complications encountered, management, and referral

3. *Puerperium:*

- Prevention of infection
- Promotion and initiation of breastfeeding
- Maintenance of physical and emotional well being
- Observations and records
- Health education on:
  - nutrition, rest and sleep, exercise & ambulation, babycare, orientation to family planning and immunization of baby, post-natal follow-up

In addition to the above, a midwife is also responsible for both the upkeep and the distribution of equipment, drugs and dressings. She has to ensure the payment of necessary hospital dues to the revenue collector. When these are properly handled, equipment and supplies can be maintained over a long time.

SESSION VI

Introduction to Community Assessment and Outreach

Generally, people define a community as a group of people living in a certain area, having a common interest and act in similar way. This limited definition often falls short of the reality.

Since every community is a reflection of the larger society, it is bound to be made up of people with common, as well as conflicts of interests.

Community is where you find the people the midwife is trying to help in their own environment and usually on their own terms. Community beliefs and practices also influence health and decisions about health. If a provider remains in her clinic and does not move about in the community, she robs herself of her great potentials to make a real difference in Maternal Healthcare, and the "enabling leadership" her profession bestows on her.

For this, the midwife must learn the strengths, Problems and Special characteristics of her community through community assessment with the involvement of the people themselves.

Objectives: Participants will be able to:

1. Define Community and Community dynamics
2. Identify approaches to providing partnership in care for women and their families within a community.
3. Plan a community visit for community assessment, in-reach and out-reach.

Time: 2 hrs.

Topics Covered: A. Community Dynamics

B. How to Conduct

C. Community Assessment tools.

Preparation: Nil

Reference Materials: Community Assessment forms?

Time	Objective/ Evaluation indicator	Content	Method/Activity
30 mins	A. Define community and community dynamics	1. Who Am I? Identity game I am "Mary Jones" I am a woman I am one of the Joneses I am a nurse-midwife I am a Yoruba I am a Nigerian I am a civil servant 2. "A community is a group of people living together in a geographical area, who have similar interests." or "A community is a group of people living in the same area with common interests and behave in a similar way?." Different people make up a community - farmers, hunters, traders, moneylenders, landlords, grandmothers, young women, childless couples, single people, widows, royal families, poor, powerless people. These people might be characterized by their profession or trade, religion, social or economic status, language, educational level.	1. Ask someone in the group to identify herself by asking, "Who are you?" Each time she gives a response, ask her, again, "But, who are you?" List her responses on newsprint. 2. Now ask participants to give a definition of community. "What is a community?" Again, write responses and underline wherever the word common, similar or together is used by trainees. 3. Ask participants to think about the way they identified themselves when asked, "Who are you?" Explain that each of their identities represented a different community affiliation. Ask them to consider the different kinds of people who might live in any community. How would they characterize these people?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		Possible Response Not quite: In reality, persons living in the same village community or neighborhood may not even agree on many issues or share the same interests. Some of them may be more affluent than others. Some assume leadership because they are wealthy, educated or forceful. Others beg to eat, and are forced to follow the lead of the powerful. It is important to understand that while elements of harmony and shared interest exist in every community, there will also be undercurrents of conflict.	Is it possible that all of these different people would have one common interest simply because they live in the same geographical area?
		Possible Response A villager who owns a chemist or medicine shop might oppose a free-drug program at the Health Centre. A circumcisor or a TBA might oppose the employment of CHEWS for a community health centre. A riverboat owner might reject proposals to build a bridge across the river.	Ask participants to think of examples of conflicts of interest that might surface in a community and which might affect the people's health and well-being. If participants have difficulty, give a few examples to assist trainees to think of more themselves.
		Definition of community	Summarize the discussion by asking participants to come up with an

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Time	Objective/ Evaluation indicator	Content	Method/Activity
		A community is a group of people living in an area, who may or may not have a common interest or values. A community is not necessarily homogeneous.	expanded and more realistic definition of community.
30 mins	B. Explain the reasons for community outreach.	1. <u>Possible Responses</u> Women (ranging from the very young to middle-aged) who might be characterized as: ▪ Poor women ▪ Low-literate or illiterate ▪ Unemployed ▪ Traders These include women brought in with serious complications of labor and delivery, anaemic, lacking confidence, unfamiliar with health care system, high parity, etc.	1. Ask participants to reflect on their clients. Perhaps they can characterize them. Who are our major clients? What are they like?
		2. <u>Possible Responses</u> ▪ Husbands, ▪ Parents ▪ Mother-in-law ▪ Family ▪ Priest/Mallam ▪ Village Chief ▪ Herbalist/TBA	2. Who are our clients' major influences in the community? Who might influence their health-related behavior, especially reproductive health?
		In most communities in Nigeria, husbands and older relatives have a lot of say in how affairs relating	How do these people influence our clients?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		to women and children are conducted. Husbands especially decide how to spend the family income and what the priorities are: Others are the chief opinion leaders of the community who wield power and influence which might determine the behavior of individuals. They set unwritten codes and patterns for others to copy.	
		3. <u>Reasons for Community Outreach</u>: ▪ The community is where you find the people whom we are trying to help and who come to use in our clinics, in their own natural situation and environment. ▪ It is also where all the people and things that influence their health reside. We must see our client as part of a whole community. To understand her concerns and constraints--and to form a picture of the barriers, motivators, and enablers that play a part in her choiices--we must first understand the community in which she lives. ▪ The distance or barriers that separate women from care are a	3. Ask participants why, if at all, it is necessary for us to go into the community. Refer participants to the first session on barriers, enablers, and motivators. Write their answers on board. Also share the content at left with them.

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Time	Objective/ Evaluation indicator	Content	Method/Activity
		cause of maternal mortality. Midwives need to move into their clients' communities to learn how they might assist people there to find solutions to their immediate needs and concerns. ▪ Because it is time to "bridge the gap" that separates the care-givers in the community, such as TBAs, and their counterparts in the formal health sector (midwives). ▪ Without the community's participation, the midwife's clinic-based safe-motherhood initiatives will not impact on the current mortality ratio.	
20 mins	C. Identify steps necessary for planning and conducting a community outreach	1. <u>Possible Responses</u> ▪ Identify the community (maybe one with the greatest need). ▪ Learn as much as you can about the community: assess, analyze and diagnose everything about the community. ▪ Determine whom in the community you need to approach to gain access. ▪ Plan the visit: inform your hosts about dates, make sure the	1. Have participants brainstorm on how they would go about planning visits to the community to work with the people there. Ask them to suggest steps for community outreach.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		date and time are convenient, and request for the people you wish to meet with to be informed of your visit. ▪ Use interpersonal skills to become introduced to the people. Talk to people and get to know and understand them. Who can best introduce you? The village headman? ▪ Gain their trust and acceptance by letting them define their own needs and priorities. ▪ Use problem-solving skills to assist them in finding solutions. 2. Approaches to visiting a community and getting accepted will depend on the community itself - i.e. its past experiences, present, the culture, and their perception of the visitors. The visitor must use good interpersonal communication skills, show respect, genuine interest and concern in order to penetrate the community. 3. <u>Possible Responses</u> The simplest and most informal way is to talk to them and observe them.	2. Summarize by telling participants that there are no set rules or approaches to going into communities. 3. Ask participants to suggest how they will get information from people.

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Time	Objective/ Evaluation indicator	Content	Method/Activity
		- Survey questionnaires - Group discussions - Private interview - Observation checklists	What are some organized ways to elicit information from people?
		4. <u>Possible Responses</u> The method will depend on what she wishes to find out from the community.	4. Brainstorm with participants on what is involved in each of these and which of these they would use to gather as much useful information as possible to the midwife.
		5. <u>Possible Responses</u> a) <u>Needs</u> ▪ Current local health practices, problems, and their direct causes ▪ Contributing factors that affect people's well-being ▪ What people feel to be their biggest problems and needs (whether health-related or otherwise) ▪ Level of knowledge on the topic b) <u>Social Factors</u> ▪ Traditions, customs, and	5. Ask participants what kinds of things they would want to know about a village they wish to visit or what they might want to find out once they got there?

Time	Objective/ Evaluation indicator	Content	Method/Activity
		practices that affect health ▪ Traditional forms of healing ▪ Community relations and dynamics: how do people there relate to each other? ▪ Traditional forms of education and commu .ication ▪ Leadership structure ▪ Economic status of the majority ▪ Working vocabulary (names of diseases etc) c) <u>Resources</u> • **Human resources:** ***People with special skills***, e.g., leaders, storytellers, artists, performers, teachers, TBAs, healers • Natural resources, e.g., land, water, crops • Infrastructure, e.g., buildings, roads, markets, transportation, communication, tools	

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Time	Objective/ Evaluation indicator	Content	Method/Activity
		• Availability of work, earnings, cost of living • Existing health facilities 6. <u>Possible Responses</u> ► Visit and talk with village leaders, e.g., the chief, headman, school teachers, TBA, religious leaders and others. ► Talk to members of the community. Learn local customs and protocols for visiting or be invited into members' homes. ► Observe the customs and routines of the community, the clothes people wear, the things they talk about, what they eat, number of children, the living condition, the radio programs they listen to. ► Hold a meeting with local women to introduce yourself. ► Ask what they consider their most pressing individual problems and ask them arrange this in order of priority. ► Ask how you might help them.	6. Ask how participants would go about finding this information out.

Time	Objective/ Evaluation indicator	Content	Method/Activity
		7. <u>Possible Responses</u> Community assessment will be used: o To understand community attitudes, beliefs and taboos pertinent to childbearing and to determine whether they are helpful, harmful or irrelevant to health. o Through listening actively to the needs of families and discussing problems, to determine priorities and undertake care which will promote safe motherhood. o To become aware of community perceptions and needs regarding maternal mortality and morbidity. o To understand the community's strengths and weaknesses. o To understand and learn from the traditional care givers and to exchange ideas with them. o To understand the situation of women in the community and grow in appreciation of the difficulties of daily survival and what coping strategies they have adopted. Trainer's own Questions	7. Ask participants, from the midwife's point of view, how will this Community Assessment be used? Have participants brainstorm on the value of conducting an assessment at the start and throughout their outreach activities. Work with participants to compile simple questions for a community

Time	Objective/ Evaluation indicator	Content	Method/Activity
		→ What in this community enables women to achieve safe motherhood? → What in this community prevent women from achieving safe motherhood?	assessment form addressing a specific problem. Another option is to ask them to suggest some pressing questions relating to Maternal Health that they might want have answered during their trip into the community. For example, large numbers of women come in with still births. Why?

Pre/Post Workshop Questionnaires

Interpersonal Communication & Counseling

Workshop for Midwives

1. List any five barriers to maternal health care.

2. How would you desire interpersonal communication

3. List two ways in which people communicate.

4. In what way, do values affect mid wifery practice (List 3 ways)

5. List 5 steps of effective counseling

6. List 3 reasons for community outreach by midwives.

MotherCare/Interpersonal Communication Workshop Evaluation

1. Overall, how would you rate the training methodology

   Exc:..... VG:..... Fair:..... Poor:.....

   Any other comments? .....

   .....

2. Which session(s) did you like best.....

   Why?.....

   .....

3. Which session(s) did you like least of all?.....

b. Make your suggestions for improvement: .....

   .....

4. Was enough time allotted for the various sessions?

	Adequate	Inadequate	Suggestion
Session 1	.....	.....	.....
Session 2	.....	.....	.....
Session 3	.....	.....	.....
Session 4	.....	.....	.....
Session 5	.....	.....	.....
Session 6	.....	.....	.....
Field trip			

5. Please comment on the following:

   - Accommodation .....
   - Workshop environment .....
   - Workshop facilitation .....

- Session contents .....
- Meals .....
- Transportation .....
- Schedules .....
- Trainers .....

6. Any recommendation/suggestions for future workshops.

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PROBLEM SOLVING METHODS [PSM]

Introduction:

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The Problem Solving Method (PSM) is a process of carefully organising information and resources toward solving a problem. Eight steps can be identified in PSM. They include:

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(d) State objectives: What specifically would you want done? It must answer question what, when, how, much or how many. It must be comprehensive enough to cover the problem(s) identified.

(e) Map out a Plan of Action: Use the resources you have at you disposal to tackle your problem and attain your objectives

(f) List tasks/responsibilities: What must be done by whom, and when they must be done;

(g) Implement your plan: This is the carrying out of all that has been outlined as plan of action, by those involved and at the appropriate time.

TYPES OF QUESTIONS

Open-ended Questions	Closed-ended Questions	Probing Questions	Leading Questions
Open-ended questions give opportunity for answers in various ways. This allows for explanation of feeling and concerns. **Examples:-** - How do you feel about getting the baby's layette ready? - What are your concerns during pregnancy? - What do you think of this?	Closed-ended questions are useful for obtaining basic factual information, especially if there is a limited time available, as in an emergency, and in taking a medical history. Require a brief and exact reply; often elicit "Yes" or "No" response. **Examples:** - How old are you? - When was your last period? - How many children do you have?	Probing or clarifying questions encourage the respondent to give further information, and to clarify an earlier point. Require tact in the wording and tone used. Probing questions should be asked gently and nonjudgmentally. **Examples:** - What is it about the care you are receiving that you don't like? (In response to a statement that the care is not good.) - Why do you prefer to deliver at home?	Leading questions encourage the respondent to give an expected response. It is suggestive and puts ideas into the respondents heads. **Avoid using leading questions.** You will not get much useful information when you use this type of question. **Examples:** - Don't you think Midwives are wonderful? - Is this not pretty? - Doesn't this hurt?

HEALTHCARE SERVICES IN NIGERIA

Background Information:

One clear trend in the development of health care facilities in Nigeria is that health care services are more concentrated in the urban areas. But in the past five to six years carefully planned steps have been taken to bring health facilities to the rural settlement in order to promote the health of the rural populace too. These efforts could be seen in the Primary Health Care programme, provision of child survival services e.g. Expanded Programme on Immunization [EPI], and Oral Rehydration Therapy [ORT]. Others include family planning, health education and maternal health services.

Despite these efforts, it has been discovered that very little has been achieved in reducing maternal deaths in rural settings.

According to the World Health Organization [WHO] report (1990) and the Federal Ministry of Health of Nigeria, 800 [WHO] to 1,500 [FMOH] mothers die every year out of 100,000 live births in Nigeria. In some particular areas, 90 - 95% of maternal deaths are cases from the rural areas. This may be attributed to lack of access to prenatal care and delivery with a trained health worker. For instance, less than 50% of rural women attend antenatal clinic while only 30% of them deliver in the health facilities. In view of this it is necessary to identify barriers which affect patients/clients and health care providers; that may stand between the rural women and health care facilities with a view to suggesting solutions to the barriers.

Factors Affecting Health Care Services

Health is defined by the World Health Organization [WHO] as a state of complete physical, social and mental well being, not merely the absence of disease or infirmity. In Nigeria, programs like MAMSER and Better Life for Rural Women contribute to this health goal. In the health sector, services are provided at different levels--Primary, Secondary and Tertiary levels--to achieve this state of health.

Despite the government effort to meet the health needs of the people, it is observed that many people, especially in the rural community, do not have access to health care. The aim of this paper is to identify those barriers to health care and introduce problem solving techniques which could be used to remove identified barriers.

A barrier is defined as something which "holds apart, seperates or hinders." In the context of maternal health, barriers are those customs, preferences, and economic, political, geographical, educational, and technical constraints which seperate women from safe, satisfying, accessible healthcare.

These barriers could be directly related to the clients or the health care providers. Barriers as they affect the clients include:

- *Inaccessibility to clinic:* This may be due to transportation difficulties, location of clinic/hospital and hospital fees/schedules.

- *Cultural/religious beliefs.* For instance some religious groups do not believe in using hospitals or medication, while others would hesitate to come to the hospital if they will be attended to by male staff alone.

- *Socio-economic status.* Low socio-economic status could lead to poverty, ignorance and subsequently malnutrition. These factors to a great extent can hinder clients from benefiting from health care services. For instance in a state of extreme poverty both housing and nutrition which are essential to maintenance of good health may not be affordable.

- *Lack of awareness* of available health services for health care provision often lead to under utilization of health care facilities.

- *Differences in values :* This may result from diversity in cultural and/or religious background. Values are ideas that are shared by members of a community about what is good and desirable (Abdurraham 1991). According to Abdurraham, traditional African values include group supremacy over the individual, discipline, respect for elders, honesty, sharing and helping the less opportuned, and conformity to another in planning and delivering health care services to people. Most of the identified African values are stressed in the Code of Ethics for Nurses. Differences in values, whether they originate from differences between colonial and traditional African culture or differences between ethnic or religious groupings can forge a seperation between caregivers and clients resulting in inability to provide optimal care.

It is not enough to see the distance between the rural women and health care services only from the

socio-economic status and environment of the woman. A further look into the quality of services and health personnel offering these services may afford us a comprehensive or a broad outlook. This approach can guarantee positive effects for intervention strategies. Factors such as knowledge deficit, lack of drugs and equipment, poor aseptic technique, poor interpersonal relationships and managerial problems such as lack of monitoring and evaluation, poor motivation, poor record management, and low levels of responsibility are enough to increase the barrier already observed.

KNOWLEDGE DEFICIT:

Good performance and productivity depend largely on the knowledge, skills, and attitudes possessed by the health care personnel. A sound background knowledge is essential for effective health care delivery. The basic training health care providers received is therefore not enough to cope with the increasing health care demand of the society. As the societal demand changes, the health care providers have to expand their knowledge and skills, through training and retraining, and by reading current books and journals to keep abreast of the developments in health care services. Failure to do this will lead to gross knowledge deficit and poor quality healthcare. Gradually, the personnel will become incompetent and lack confidence. This also affects the relationship with their clients as the client bound to loose confidence in the health care provider.

It is therefore pertinent for every health worker to develop a positive attitude to learning and become research minded. Research is defined as an attempt to increase available knowledge by discovering new facts through systematic, scientific enquiry (Clerk and Hockey 1981).

Research involves careful observation and documentation of facts from which inferences could be drawn. For health care practice to be improved, providers must try to carry out studies which will provide them with feedback on their strengths and weaknesses, effectiveness of working tools, and management. Providers must also involve themselves in assessing the community problems to determine the community barriers to effective health care/needs.

It is not enough to collect and analyse this information (data), but efforts must be made to solve the identified problems through any means possible.

Health care providers must become acquainted with knowledge and skills of Problem Solving, Communication and Interpersonal relations and research. Research is very beneficial as it widens the scope of knowledge, and keeps provider abreast of current changes. For instance, it is through research that knowledge on benefits of exclusive breastfeeding, AIDS awareness and precautions, increased maternal mortality rate; and the need to go into the community to provide care at grassroots level became apparent. Inadequate exposure to research information often leads to incompetence and shying away from responsibilities.

In any provision of healthcare we must evaluate:

- *Lack of Drugs and Equipment:* Inadequate equipment and drugs in the health centres and hospitals may lead to sub-standard care or no care at all. Some equipment can be improvised while others cannot. Drugs cannot be improvised. Lack of needed supplies make clients lose confidence.

- *Unethical Conduct:* Failure to observe professional ethics in discharging professional responsibilities could be strong barrier to health care provision. Where clients needs for confidentiality, respect, and consideration are not recognized by the health care provider. They may not attend such clinics.

- *Managerial Problems:* Managerial problems may include factors such as lack of monitoring and evaluation of health care services, inadequate managerial skills of health workers, poor staff motivation, and poor record management.

Monitoring is needed to ensure the *MAINTENANCE* (continuous functioning) or correction of strategies adopted for an identified goal on one hand. Monitoring means keeping track of how the process is going towards achieving the goals. *EVALUATION* on the other hand is the process or collection of processes used to determine the extent to which the goals have been achieved; that is, whether the program has had the desired impact. The importance of monitoring and evaluation is actually to give feedback on how the efforts into health care services are yielding results and what may be needed to correct them. It may help to answer questions like "how many pregnant women attended our clinic last month?" "Where are they from?" "How many have been attending our clinic in the past six months?" "What was the nature of their problems?" "How many mothers died in our clinic yearly?" "Why did they die?" "How many mothers lost their babies at delivery?" "Why did the babies die?" "How well are we caring for our patients?" "Do we have enough drugs?" "Why are they not enough, if they are not?" "Do we treat our patients with respect?" "Why is there a drop in our client flow?" "How effective are our solutions to their problems?" "Can we easily obtain past information on our clients?" and so on.

Very often our inability to answer these questions is due to the fact that health workers are not adequately trained in how to obtain information from clients or that they are not adequately motivated [moved] to obtain them. Equally important is the evaluation of duties due to poor supervision of services and responsibilities by the superior officers [Matron in charge of a Unit or Unit Heads]. In other words, nobody cares where and how documents/equipments are kept, whether they are kept or not, and who is expected to keep and give out information when needed. It is necessary to assign responsibilities and to check daily, weekly, monthly, randomly as the case may be as to whether they are being carried out the way they are expected. The systematic recording of

information will enable the clinic to retrieve information when needed.

SUPPORT VISIT FORM
NIGERIA LIFE SAVING SKILLS TRAINING PROGRAMME

GENERAL INFORMATION

1. NAME OF MIDWIFE VISITED:

2. NAME OF SUPPORT VISITOR(S):

3. DATE:

CLINICAL FACILITIES AT ANTENATAL CLINIC	*SATIS. FACTORY*	*NEEDS IMPRO-MENT*
1. HAS WINDOWS FOR LIGHT AND AIR		
2. HAS PRIVACY FOR CLIENT EXAM AND HISTORY TAKING		
3. HAS NECESSARY FORMS		
▸ ANTENATAL RISK ASSESSMENT		
▸ ANTENATAL CARD		
▸ REFERRAL FORM		
4. HAS NECESSARY EQUIPMENT FOR EXAMINATION		
A. PLACE FOR HISTORY TAKING		
B. PLACE FOR CLINICAL EXAMINATION		
» BLOOD PRESSURE APPARATUS		
» WEIGHING SCALES		
» URINE TESTING EQUIPMENT		
» HAEMOGLOBIN TESTING/TALLQUIST		
» HEIGHT		
C. PLACE FOR PHYSICAL EXAMINATION		
→ EXAMINATION BED/TABLE		
→ FOETAL STETHOSCOPE		
→ MEASURING TAPE		
→ PATELLAR HAMMER.		
→ GESTATION WHEEL		

5. ARRANGES FURNITURE WELL TO ENCOURAGE INFORMAL CONVERSATION

CLIENT MANAGEMENT	SATIS. FACTORY	NEEDS IMP-ROVEMENT
1. PROVIDES PRIVACY FOR EXAMINATION		
2. ASKS AND LISTENS		
A. ASK RELEVANT QUESTIONS ABOUT CLIENT PROBLEMS		
B. ASK COMPLETE SET OF QUESTIONS RELATED TO PROBLEMS		
C. USES GOOD COMMUNICATION SKILLS		
3. LOOKS AND FEELS		
A. DOES CLINICAL EXAM CORRECTLY		
B. DOES PHYSICAL EXAM CORRECTLY		
C. USES NECESSARY EQUIPMENT FOR EXAM NATIONS E.G.TAPE MEASURE, PATELLAR HAMMER.		
4. IDENTIFIES CHIEF PROBLEMS/NEEDS		
5. TAKES NECESSARY ACTION		
A. ON EACH PROBLEM OR NEED		
B. REFERS WHEN NECESSARY		
C. GIVES CORRECT EDUCATION/COUNSEL-LINING (DIET, REST, ETC.)		
D. HAS A WAY OF FOLLOW-UP OF DEFAULTERS.		
6. HAS A WAY TO EVALUATE THE CARE		
7. HAS ENOUGH ANTENATAL RISK ASSESSMENT FORMS		
8. LABOUR WARD CARE SET UP		
HAS LABOUR BED:		
▸ TROLLEY AND PELVIC EXAMINATION, TRAY, SUTURING TRAY		
▸ KEEPS EQUIPMENT CLEAN/STERILE/ PROP RLY COVERED		
▸ OBSERVES ASEPTIC TECHNIQUE AND PRINCIPLES		
▸ USES STERILIZATION METHOD CORRECTLY FOR: » INSTRUMENTS		

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» GLOVES
» SWABS

► HAS BASIN FOR HAND WASHING
► HAS COT FOR BABY
► HAS INFANT RESUSCITATION EQUIPMENT

9. COMMODITIES

♦ HAS VACUUM TUBING AND CUPS
♦ HAS SWABS
♦ IS VACUUM PUMP WORKING?
♦ IS VACUUM EXTRACTOR KEPT CLEAN
♦ IS VACUUM EXTRACTOR STORED PROPERLY
♦ STORES EQUIPMENT CORRECTLY
♦ HAS SUFFICIENT PARTOGRAPH FORMS.

10. KEEPING OF RECORDS

KEEPS CLIENT RECORD, COMPLETE AND WELL FILLED

▲ PRENATAL
▲ LABOUR
▲ REFERRALS
▲ INCIDENT REPORTING FORMS

SENDS INCIDENT FORMS TO TRAINING CENTRE REGULARLY AND ON TIME

KEEPS RECORD ON:

▼ NORMAL DELIVERIES
▼ VACUUM EXTRACTIONS
▼ EPISIOTOMY OR LACERATION SUTURING
▼ CARDIO PLUMONARY RESPIRATION

FOLLOW UP ACTIVITIES

FOLLOW-UP CLIENTS AFTER:
✲ VACUUM EXTRACTION
✲ EPISIOTOMY OR SUTURING
✲ TREATMENT FOR SEPSIS
✲ TREATMENT FOR HAEMORRHAGE
✲ TREATMENT FOR OTHER COMPLICATIONS

RELATIONSHIP WITH CLIENTS AND ASSISTANTS

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- TEACHES ASSISTANTS TO BE MORE USEFUL
- SHOWS PATIENCE WITH CLIENTS
- HAS GOOD RELATIONSHIP WITH:
  - » TBAs
  - » OTHER MIDWIVES
  - » REFERRAL HOSPITAL STAFF.

GENERAL IMPRESSION:

REMARKS AND CONCLUSIONS:

SIGNATURE VISITING TRAINER

SUPPORT VISIT FORM
CLIENT MANAGEMENT - COUNSELLING

The following section relates to how midwives interact with clients. Please observe at least one counselling session in the clinic and indicate how the midwife did in each of the following areas. **Classify her performance as: "Good", "Average" or "Poor" by circling the appropriate number.**

If you are unable to observe a counselling session, note so by writing "No sessions observed" across the table.

Type of Visit: _____ antenatal _____ labor and delivery _____ post partum

Activity	Good	Average	Poor	NA
In general, how well would you say the midwife did the following:				
1. Greeted the client with respect	1	2	3	4
2. Listened attentively to the client	1	2	3	4
3. Asked the client questions about the pregnancy and any symptoms of complications	1	2	3	4
4. Used language and terms the client understood when explaining about her pregnancy and/or complications	1	2	3	4
5. Asked the client if she had any more questions	1	2	3	4
6. Directed the client to return for a future visit or referred the client elsewhere for a future visit.	1	2	3	4

Please write comments or observations here: _____

_____

_____

_____

_____

_____

_____

Interview of Post-Natal Women

Objective: To obtain information regarding what women are told at the time of discharge from hospital.

Age_____
Parity_____
Complications_____
Type of delivery_____
Delivery Date_____
Travel time to hospital_____

1. How are you feeling? (Probe for fever, bleeding, etc.)

2. What were you told about your delivery?

3. What were you told about how to care for yourself when you og home?

4. What were you told about how to care for your baby? (Breastfeeding, cord care, problems)

5. Were you given any information about family planning?

6. If yes, .were you told where and when to go?

7. Has anyone taken your blood pressure?

8. If yes, were you told if it is normal?

9. Were you given any medications or prescriptions.

10. If yes, were you told what they are for?

11. Were you told where to go for your check up in six weeks?.

12. Do you plan to go?

13. Do you have any advice on how we can improve our services here?

Maternity Care Protocols

This set of protocols covers maternity care at the Life Saving Skills training centers at Adeoyo Maternity Hospital and Bauchi Specialist Hospital. They have been written by the midwife trainers and physician backups. These protocols may be added to or modified from time to time as needed.

Premature Rupture of Membranes

For women with a term pregnancy who are **in labor** with membranes ruptured:

-rural midwifery practices will start to give antibiotic prophylaxis after eight or more hours of ruptured membranes. Prophylaxis could be ampicillin-cloxacillin (Ampiclox) 500 mg. po q 6h. If unavailable give procaine penicillin 1.2 million (mega) units IM stat.

-urban hospital midwifery practices will start to give antibiotic prophylaxis after twelve or more hours of ruptured membranes.

For women with a term pregnancy who are **not in labor** with membranes ruptured:

-rural midwifery practices will give a first dose of prophylactic antibiotics after eight hours of ruptured membranes and transfer her to a referral center.

-urban midwifery practices will start to give antibiotic prophylaxis after twelve or more hours of ruptured membranes.

For women with a pre-term pregnancy who are **in labor.**

-urban and rural midwives will give antibiotic prophylaxis after twelve hours of ruptured membranes, deliver the infant, stabilize the infant, and refer the mother and infant to a center with specialized care if available and indicated.

For women with a pre-term pregnancy who are **not in labor.**

- urban and rural midwives, give an prophylactic dose of antibiotics after twelve hours of ruptured membranes and transfer the mother to a hospital capable of caring for high risk neonates.

Antibiotic Prophylaxis for Episiotomies

-prophylaxis is not indicated for routine episiotomy repair. However, it should be given for women with massive contamination of the wound, for a very traumatic delivery, or if the repair is over eight hours after the incision is made. Episiotomy repairs should be made as soon as possible to prevent sepsis.

If needed, give crystalline penicillin 4 million (mega) units as a loading dose followed by Ampicillin 250-500 mg by mouth every six hours for five days.

Pitocin (Syntocinon) Augmentation of Labor

It is not appropriate to use pitocin induction or augmentation of labor in a rural midwifery practice. Complications developing from such a practice (ruptured uterus, fetal distress, etc.) could not be managed. Pitocin induction and augmentation in an urban setting should be done with the knowledge and consent of a physician.

Pregnancy Induced Hypertension

In the case of severe PIH and/or eclampsia (BP 160/110 and /or hyperreflexia) rural midwives should sedate, stabilize, and refer the patient for physician management. A foley catheter should be placed. Sedation may be achieved by Sodium Amytal 200 mg IM q 6-8 hours or Paraldehyde 8-10 ml. q 6 hours, or Valium 10-20 mg. q 6 hours IM or IV.

Urban midwives should treat as above plus give Apresoline 20 mg stat by slow IV push while awaiting arrival of the physician. Apresoline should be given for any diastolic of 100 mmHg or higher with or without seizures.

Mild to moderate pregnancy induced hypertension. Both urban and rural midwives should put the patient on bed rest and sedate her. If hyperreflexia should occur she should be sedated and referred.

Adopted by Bauchi and Adeoyo Training Centres
November 5, 1992

Name:_____ Date Trained:_____

Centre where trained:_____

Nigeria LSS Skills Use Record

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Month			
1. Antenatal Risk Assess. Form			
2. Partograph Labour Forms			
3. Active Management of 3rd State			
4. Manual Removal of Placenta			
5. External Bimanual Compression			
6. Internal Bimanual Compression			
7. Digital Removal Products Conception			
8. Vacuum Extraction			
9. Infant Resuscitation			
10. Adult Resuscitation			
11. Heimlich Maneuver			
12. Give Local Anesthesia			
13. Repair Mediolateral Episiotomy			
14. Repair Median Episiotomy			
15. Repair Cervical Laceration			
16. Repair Vaginal Laceration			
17. Start Intravenous drip			
18. Give rectal hydration fluids			
19. Give Intraperitoneal Fluids			
20. Give ORS/ORT			
21. Treat PROM			
22. Treat Sepsis			
23. Other (specify)			

APPENDIX H

ANTENATAL RISK ASSESSMENT REVIEW

PLACE: NAME OF FACILITY

TYPE OF FACILITY:
1. STATE HOSPITAL
2. DISTRICT HOSPITAL
3. LGA MATERNITY
4. PRIVATE MIDWIFE

Please check whether the information is recorded on the ARA Form and compare management with the Protocol set out in the LSS Manual

Plotting:
1 = yes
0 = no
9 = Not applicable

Management Appropriate:
1 = yes
0 = no
9 = NA

Management Appropriate includes referral to physician if: (a) Hgb < 8 gms when registering over 28 wks gestation (b) Hgb < 8 gms on visit and not improved to 8 mgs in 2-3 wks treatment (c) Reflexes hyperactive any visit (d) Blood Pressure over 140/90 or 15 or more points increase in diastolic

Record Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	total	avg
1. Plots gestational age based on LNMP																						
2. Plots up & down single week's line																						
3. Plots blood pressure, weight, & uterine growth every visit																						
4. If elevated BP 140/90, checks and records reflexes																						
5. Plots growth on proper week gestation																						
6. Checks Hemoglobin first visit																						
7. Checks Hgb every visit until up to 8 gms or 55 %																						
8. Fills history portion of graph completely																						
9. Records drugs ordered/given																						
10. Refers to physician when abnormality noted																						

PARTOGRAPH REVIEW

PLACE
TYPE OF FACILITY:

NAME OF FACILITY
1. STATE HOSPITAL
2. DISTRICT HOSPITAL
3. LGA MATERNITY
4. PRIVATE MIDWIFE

STATE

Please check whether the information is recorded on the partograph and compare management with the Protocol and/or case record:

Plotting: 1=yes
0=no
9=Not applicable (NA)

Management Appropriate: 1=yes
0=no
9=NA

Latent phase: Before & at Action line
Active phase: On or left Alert line
Between Alert line & Ac L.
At/beyond Action L.

Record Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Total	Average
1. Start of Partograph correct																						
2. Plot cerv. dilat. 4 hrly in active phase																						
3. Plot descent of head 2 hourly																						
4. Plot fetal heart at least 2 hourly																						
5. Plot contractions at least 2 hourly																						
6. Complete partograph at delivery																						
7. Latent phase mgt before 8 hrs																						
8. Latent phase Mgt at 8 hrs Action Line																						
9. Active phase on or left Alert L.																						
10. Active Phase between AL and Act. L.																						
11. Active phase at/beyond Act L.																						

Dear Trainee:

The Life Saving Skills Training Program for Midwives in Nigeria is a brand new program. You are among the first midwives to participate in this type of specialized learning. The aim of the program is to decrease maternal mortality and morbidity.

In order to determine whether or not the program has achieved its aims, it is important that we evaluate how well you have been trained. Because it is impossible for us to be with you during the emergencies you have been trained to handle, we are asking that you help us evaluate the program in the following way:

Each time you experience an emergency, please fill in an attached incident form. Forms should be filled in if you have a patient with:

antenatal or post-partum haemorrhage
obstructed labour/cephalo-pelvic disproportion
pre-eclampsia/eclampsia
sepsis from abortion, prolonged rupture of membranes, puerperal fever, other post-partum infection.

Please collect your forms together and send them to the LSS Training

Centre by _____ 19 ____ and again by _____ 19 ____

Mail them to:

_____

_____

_____

_____

If you will be travelling to your training centre, you may deliver them to the centre in person and let us know how you feel about the training you have had. Please note, we want to collect at least ten sets of forms from each midwife trained.

Thank you very much for your help in improving the training for the midwives who will come after you.

Sincerely,

Your LSS Training Team

Incident Reporting Form

Your Name: _____ Today's Date: _____

Which Training did you attend? Month: _____ Year: _____

Centre: _____

Your Mailing address: _____

_____

What was the emergency/problem that you treated? _____

_____

Please describe your case below:

Patient Name: _____

Age: _____ Parity: _____

LMP: _____ EDD: _____

Weeks gestation when seen: _____

What was the condition of the patient when she presented at your clinic?

BP: _____ Pulse: _____

Estimated blood loss: _____

Reflexes: _____

Edema: _____

Other important facts: _____

_____

What did you do for this patient and in what order did you do them?

_____

_____

_____

What was the response of the patient (got better, stayed the same, died)?

What follow-up care did she receive at your maternity or health post, at the hospital or other place?

How confident and competent did you feel to handle this emergency/ problem?

If you did not feel confident, what specifically would have helped you to feel more confident and competent?

Please add as many pages of paper as necessary to describe the care of this patient fully.

APPENDIX K

Telegram:: HEALTH BOARD

Telephone.....

Telex.....

(All Correspondence to the Secretary)

Ref. No. HMB/ADM/S/915/T.1/3...
Hospital Services Management Board,
Administration.....*Division*
Bauchi State
P. M. B. 0033,
Bauchi, Nigeria

Date..24th....February,.....*19*..93.

The Sole Administrator,
Specialist Hospital,
Bauchi.

The Medical Supt i/c,
General Hospital,
Gombe,
Azare,
Toro,
Darazo,
Misau.

INVITATION FOR WORKSHOP ON LIFE SAVING SKILLS UNDER MOTHER-CARE PROJECT FROM 3RD - 5TH MARCH, 1993:

In the continuing effort to reduce maternal mortality and morbidity, and also reduce peri-natal mortality the above named workshop is slated to start at School of Midwifery Conference Hall on 3rd March, 1993 to 5th March, 1993.

2. The following Doctors are expected to attend:-

(i) Gombe General Hospital - Dr. Dauda Barau
Dr. Nuhu Kumangh

(ii) Darazo General Hospital- Dr. Dumah

(iii) Toro General Hospital - Dr. Gagayare

(iv) Misau General Hospital- Dr. Yakubu Mordi

(v) Azare General Hospital - Dr. S. Sulaiman
Dr. Isa Umar.

(vi) And from Specialist Hospital Bauchi three Doctors each ~~two~~ three Gynae Department, Surgery Department and two each from medicine and Paediatrics.

3. Accommodation is being arranged with effect from 2nd March, 1993 at Auwalah Hotel, Bauchi for those coming from out stations.

(DR. DANJUMA SULAI)
EXECUTIVE SECRETARY
HOSPITALS MANAGEMENT BOARD,
BAUCHI.

Ref.NO.HMB/ADM/S/T/915/4

Hospitals Management Board,
Administration Division,
P. M. B. 0033,
B A U C H I.
Bauchi State.

24th February, 1993.

Copy to:

Magreet Marshall CNM,EID,MPN,
Project Co-ordinator,
Mother-Care Project, Family Health Services,
1601 Adeola Hopewell Street,
Victoria Island, Lagos, Nigeria.

Above and overleaf for your information, please.

(DR. DANJUMA SULAI)
MB, BS, MSc, FRCP (LON)
EXECUTIVE SECRETARY,
HOSPITALS MANAGEMENT BOARD,
BAUCHI.

Mothercare Family Health
Services
1601 Adeole Hopewell St.
Lagos, Nigeria
February 23, 1993

The Honorable Commissioner
Ministry of Health
Bauchi

To the attention of Caleb Maina

Dear sir

This letter is putting into writing our several conversations regarding the Continuing Education Workshop for Doctors.

The meeting is for doctors who render Maternity care in Toro, Misau, Darazo, Gombe, Azare, and Bauchi. We have planned for fifteen doctors and hoped to have one or two from each of the outlying centers.

Those from out of town should report to the Awalah Hotel Tuesday evening March 2nd. The workshop will begin at 8Am Wednesday March 3rd at the School of Midwifery classroom and March 5th afternoon.

If due to the strike or any other reason the letter of invitation are not sent by Friday the 26th, please let me know so I can cancel the travel plans of our two international guests and guests from Ibadan and Lagos.

Thank you very much for your assistance.

Sincerely,
Peg Marshall
Project Training Officer

ANTENATAL RISK ASSESSMENT REVIEW

APPENDIX L

PLACE: NAME OF FACILITY

TYPE OF FACILITY:
1. STATE HOSPITAL
2. DISTRICT HOSPITAL
3. LGA MATERNITY
4. PRIVATE MIDWIFE

Please check whether the information is recorded on the ARA Form and compare management with the Protocol set out in the LSS Manual

Plotting:
1 = yes
0 = no
9 = Not applicable

Management Appropriate:
1 = yes
0 = no
9 = NA

Management Appropriate includes referral to physician if: (a) Hgb < 8 gms when registering over 28 wks gestation (b) Hgb < 8 gms on visit and not improved to 8 mgs in 2-3 wks treatment (c) Reflexes hyperactive any visit (d) Blood Pressure over 140/90 or 15 or more points increase in diastolic

Record Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	total	avg
1. Plots gestational age based on LNMP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
2. Plots up & down single week's line	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
3. Plots blood pressure, weight, & uterine growth every visit	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
4. If elevated BP 140/90, checks and records reflexes	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
5. Plots growth on proper week gestation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
6. Checks Hemoglobin first visit	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
7. Checks Hgb every visit until up to 8 gms or 55 %	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
8. Fills history portion of graph completely	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
9. Records drugs ordered/given	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
10. Refers to physician when abnormality noted	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

Life Saving Skills Training Programme
Continuing Education Workshop for Doctors
Bauchi Specialist Hospital
March 3-5, 1993

Wednesday, March 3rd

8 AM Welcome, Introductions- Dr. Danjuma Sulai
Registration
Film: Why Did Mrs. X Die?
Overview of Maternal Mortality in the World- Peg Marshall
Overview of Maternal Mortality in Nigeria- Dr. Shola Franklin

Tea Break

10:30 Registration and Overview of the MotherCare Project- Mrs. 'Lola Payne

Progress to date with the Bauchi LSS Training Programme- Mrs. Salome Sambo

Some solutions to the high Maternal Mortality Problem in Nigeria- Dr. Shola Franklin

Lunch

2:00 What solutions to high Maternal Mortality have been tried in other places?

Film: Vital Allies

Life Saving Skills Programme in Ghana: How expanded roles for midwives and management protocols (e.g. partograph) can improve maternity care- Dr. Joseph Taylor

Thursday, March 4th

8 AM Update on Vacuum Extraction: Use of the CMI soft cup system- Dr. Joseph Taylor

Film: The CMI Vacuum Extraction Setup

Tea Break

10:30 Update on the Management of Anaemias- Dr. Shola Franklin

Introduction to the Antenatal Risk Assessment Form and how we can track our high risk populations- Peg Marshall

Lunch

2:00 Update on Pregnancy Induced Hypertension- Dr. Shola Franklin

Update on the Management of Prevention of Obstructed Labour
Introduction to the Partograph- Emily Medina
Management of Obstructed Labour and its Sequelae- Dr. Joseph Taylor

Friday, March 5th

8 AM Implementation of the WHO partograph protocols- Dr. Shola Franklin and Peg Marshall

Tea Break

10:30 AM Update on the Management of Haemorrhage- Dr. Waziri Saleh

Update on the Management of Sepsis- Dr. Joseph Taylor

Lunch

2 PM What are the short, intermediate, and long term steps we must take to reduce maternal and infant mortality?

Panel Discussion:

Dr. Magaji
Mrs. Mahmood
Dr. Jorge
Mr. Tula
Mrs. Sambo
Dr. Taylor

To: Dr. Magaji, Ministry of Health
Mrs. Mahmood, School of Midwifery
Dr. Jorge, Bauchi Specialist Hospital
Mr. Tula, Bauchi Specialist Hospital
Mrs. Sambo, Bauchi Specialist Hospital
Dr. Taylor, Ghana Life Saving Skills Programme

From: Peg Marshall, ACNM
MotherCare Project

Date: February 24, 1993

Re: Panel Discussion

You are invited to join a panel at the Life Saving Skills Continuing Education Programme for Doctors. This session will take place at 2 PM on Friday March 5th. The workshop will be held in the conference room of the School of Midwifery, Bauchi Specialist Hospital.

The title of this panel discussion is :

What are the short, intermediate, and long term steps we must take to reduce maternal and infant mortality?

We invite you to add your views and experience to this discussion. The audience will include doctors providing maternity care from Bauchi, Azare, Darazo, Misau, Toro, and Gombe and the Life Saving Skills trainers from the Bauchi programme.

You are invited to attend the entire three day workshop. A time table is attached for your use.

Training Report Format

Dear LSS Trainers:

At the end of each training please compile a training report. It should be sent to Mrs. 'Lola Payne, MotherCare Project Coordinator. She will send copies to Peg Marshall and Colleen Conroy, MotherCare, Washington.

Please include in each report:

1. Dates of the training
2. Names, title, and worksite of each trainee
3. pre and post test scores for each trainee
4. copy of the clinical experience form for each trainee (how many times each skill was practiced during the training itself)
5. Problems/challenges encountered in planning or conducting the training and how they were overcome.
6. Did you try any innovations during this training? If so, what and how did it work out?
7. Overall impression of how the training went.

The registration/application forms and final evaluation forms should be saved and sent to Mrs. Payne. Pre/post tests should be torn into small pieces and discarded after the scores have been recorded. Please send the report to Mrs. Payne within two week of the completion of training. Although the reports do not need to be very long, they should be "meaty"- helpful in planning even better trainings as time goes on.

More grease to your elbows!!

Sincerely,

Peg Marshall
Training Coordinator

February 25, 1993

Mr. Yakubu Iliya
Director of Nursing Services
Bauchi State Ministry of Health

Dear Mr. Iliya:

We are very happy that the Life Saving Skills training programme has been able to go on in modified form despite the current job action. Thank you for all of your assistance and freeing up of staff to permit the programme to go on.

The next three trainings are scheduled for:

March 29-April 16 Eleven trainees for each session
April 26-May 14
May 24-June 11

It would be very helpful in sending your letters of invitation to participants that they be grouped three from a place. It would be very difficult for one trainee to return to her worksite and start up use of the partograph or antenatal risk assessment tool by herself. If several of them can return home together, a critical mass for change is more likely. Trainees should bring with them uniforms, scrub dresses if they have them, and bed sheets.

We had saved four spaces for midwives from Bauchi Specialist Hospital. Due to the current work stoppage, we have five from Bauchi Specialist in our current training (including one midwifery tutor). Therefore, the remaining spaces are for midwives from the outlying areas. However, it would be helpful if your would give one or two names of Bauchi midwives to Mrs. Sambo, Chief Trainer. She would then be free to add a Bauchi person at the last minute if one of the scheduled outlying midwives fails to arrive as scheduled. We have 33 training slots remaining for 5 LGA maternities, 5 state maternities, plus Bauchi Urban Maternity. We have had one midwife from Bauchi Urban Maternity in the current training. If the slots can not be filled by the designated maternity please keep in mind the possibility of adding private sector midwives. We are anxious to have midwifery education (already done) and private sector

midwives represented in the training.
Thank you very much for your assistance.

Sincerely,

Margaret Marshall CNM, EdD, MPH
MotherCare Training Coordinator

cc. Mrs. 'Lola Payne
MotherCare Project Coordinator

Mrs. Salome Sambo
Chief Trainer, Bauchi LSS Training Programme

February 25, 1993

Mr. Caleb Maina
Director of Primary Health Care Services
Bauchi State Ministry of Health

Dear Mr. Maina:

We are very happy that the Life Saving Skills training programme has been able to go on in modified form despite the current job action. Thank you for all of your assistance and freeing up of staff to permit the programme to go on.

The next three trainings are scheduled for:

March 29-April 16 Eleven trainees for each session
April 26-May 14
May 24-June 11

It would be very helpful in sending your letters of invitation to participants that they be grouped three from a place. It would be very difficult for one trainee to return to her worksite and start up use of the partograph or antenatal risk assessment tool by herself. If several of them can return home together, a critical mass for change is more likely. Trainees should bring with them uniforms, scrub dresses if they have them, and bed sheets.

We had saved four spaces for midwives from Bauchi Specialist Hospital. Due to the current work stoppage, we have five from Bauchi Specialist in our current training (including one midwifery tutor). Therefore, the remaining spaces are for midwives from the outlying areas. However, it would be helpful if your would give one or two names of Bauchi midwives to Mrs. Sambo, Chief Trainer. She would then be free to add a Bauchi person at the last minute if one of the scheduled outlying midwives fails to arrive as scheduled. We have 33 training slots remaining for 5 LGA maternities, 5 state maternities, plus Bauchi Urban Maternity. We have had one midwife from Bauchi Urban Maternity in the current training. If the slots can not be filled by the designated maternity please keep in mind the possibility of adding private sector midwives. We are anxious to have midwifery education (already done) and private sector

midwives represented in the training.
Thank you very much for your assistance.

Sincerely,

Margaret Marshall CNM, EdD, MPH
MotherCare Training Coordinator

cc. Mr. Yakubu Iliya
Director of Nursing Services

Mrs. 'Lola Payne
MotherCare Project Coordinator

Mrs. Salome Sambo
Chief Trainer, Bauchi LSS Training Programme

February 25, 1993

Dr. Danjuma Sulai, Executive Secretary
State Health Management Board
Bauchi, State

Dear Dr. Sulai:

I am sorry to keep missing you. I tried visiting you at the ministry without success. This job action has kept everyone incredibly busy.

With the great assistance of Ministry of Health staff and Bauchi Specialist Hospital staff we have been able to carry on the Life Saving Skills training programme in a modified version. The trainers are doing a tremendous job. You can be very proud of the talent on your staff.

The doctor's continuing education workshop is still scheduled to go on March 3-5. Thank you very much for getting the letters of invitation out in a timely fashion. I certainly hope the job action will be happily solved prior to the workshop.

We would like to invite you to open the workshop at 8 AM on Wednesday March 3rd. The workshop will be held at the conference room at the School of Midwifery. A programme is attached for your use. Please stay for all of it that your time schedule permits.

I am looking forward to seeing you again.

Sincerely,

Margaret Marshall CNM, EdD, MPH
MotherCare Training Coordinator

WELCOME ADDRESS BY DR. DANJUMA SULAI
MB. BS. MRCP. FRCP. EXECUTIVE SECRETARY
HOSPITALS MANAGEMENT BOARD BAUCHI STATE:

When a woman dies just before, during, or after labour (delivery) the event is most sad: The husband is thrown into deep grief especially if the woman was on her first delivery (Prainip) and therefore early in his marriage where the woman had delivered before (multip) the sight of the other Children evokes more pity, sadness and despair as these Children are now motherless:

2: Death of women associated with pregnancies are so common that they rank high among causes of death. Death rates so high as to be described ABOMINABLE AND UNACCEPTABLE have been reported in Nigeria. These deaths have bad social, psychologic and economic consequences.

3: In biologic term maternal death, and indeed serious injuries to mothers during delivery are preventable: Some measures that will reduce these unnecessary deaths and injuries includes:-

(i) A positive change in our cultural habits of early marriages of girls, multiparity of our women, and the insistance of the grannies to take the deliveries.

(ii) We, health workers should motivate women to attend Ante-Natal care, and demonstrate to them a loving-care such that, we will attract them to come back to our maternities to deliver: Poor attitude of-staff in labour rooms have scared many women-many!.

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(iii) Health Workers, especially those in gynaecobstetrics should acquire enough skills (Life Saving Skills) to foresee, detect, and handle efficiently pregnant mothers with possible dangers. A system of effective care must be laid out for such high-risk mothers, all the time.

4. Ladies and gentlemen we are gathered to day under the auspices of the Mother-Care Project of Family Health Programme to exchange ideas and learn more skills in ways and means to reduce maternal deaths and morbidity. It is a wonderful opportunity to have midwives and doctors who work in gynae-obstetrics Department, general surgeons, and even us Physicians and Paediatricians all under one roof to dispationately thrush out these multi-disciplinary problems. We are going to be assisted by experts with international and local experience.

5. I have the honour and privillege to welcome all of our guests, and to assure them of our commitment to work relentlessly to improve the lot of child-bearing, women and the children they deliver.

6. I challenge us to make our deliberations very s scientific and yet within the frame-work of our existing socio-cultural and economic development. Our solutions have to be relevant to our needs and to the level of understanding of our patients and their relations who have immense influence in them.

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Thank you,

God Bless us all!

To: Dr. Waziri Saleh
Rima Maternity Clinic

From: Peg Marshall
MotherCare Project

Date: February 25, 1993

Re: The Life Saving Skills workshop for Doctors

Dear Dr. Saleh:

It was a pleasure to meet you. We are delighted you will be able to join us and make a presentation. You have been scheduled for Friday March 5th.

10:30 AM Update on the Management of Haemorrhage- Dr. Waziri Saleh

The venue is the conference room at the School of Midwifery at Bauchi Specialist Hospital. Attached is a copy of the programme. Please do join us for whatever portions of the programme you can work into your schedule.

We look forward to seeing you.

Sincerely,

Margaret Marshall
MotherCare Training Coordinator

Participants at Bauchi Physicians' Conference

Dr. Hassan B. Gagare, MO,General Hospital Toro

Dr. D.D. Barau, MO,General Hospital Gombe
Dr. Kumangh Umru, SMO, General Hospital Gome

Dr. Suleman Sa'an, MO, General Hospital Azare
Dr. Mohammed Isa Umar, MO I/C, General Hospital Azare

Dr. C.F. Buma, MO,General Hospital Darazo

Dr. Yakuba Modi ALiyu, MO II, General Hospital Misau

Dr. Jorge Jorge, Consultant Obstetrician, Bauchi Specialist Hosp.
Dr. D.O. Chima, SMO, (Obstetrics)Bauchi Specialist Hospital
Dr. Arabs Rukujei, MO II (Obstetrics) Bauchi Specialist Hosp.
Dr. Mohammed Alkali, MO,(Obstetrics) Bauchi Specialist Hospital

Dr. Sola Avong, MO, (Pediatriacs) Bauchi Specialist Hospital
Dr. M. Areng, SMO,(Pediatrics) Bauchi Specialist Hospital
Dr. Robbium Yusuf, MO, (Pediatrics) Bauchi Specialsit Hosp.

Dr. Faruk Buba, MO (Internal Medicine) Bauchi Specialist Hospital
Dr. I.B. Peter-Kio SMO (Internal Medicine) Bauchi Specialist Hosp.
Dr. Iris Ojeda, Consulting Physician, Bauchi Specialist Hosp.
Dr. Violeta Castillo Abros, Consulting Physician, Bauchi Specialist

Dr. Reynaldo Hernandez, Consultant Surgeon, Bauchi Specialist Hosp.

Life Saving Skills Training Program
Continuing Education Workshop for Doctors
Oyo and Osun States at Adeoyo Maternity Hospital Ibadan
March 16 - 18, 1993

Tuesday, March 16

8 AM Welcome, Introductions-
Registration
Film: Why did Mrs. X Die?
Overview of Maternal Mortality in the World - Peg Marshall or Dr. Franklin
Overview of Maternal Mortality in Nigeria - Dr. Sola Franklin

Tea Break

10:30 Registration and overview of the MotherCare Project - Mrs. 'Lola Payne

Progress to date with the Oyo State LSS Training Program

Some solutions to high Maternal Mortality problem in Nigeria - Dr. Sola Franklin

Lunch

2:00 What solutions to high Maternal Mortality have been tried in other places?

Film: Vital Allies

Life Saving Skills Program in Ghana: How expanded roles for midwives and management protocols (e.g. partograph) can improve maternity care - Dr. Joseph Taylor

Wednesday, March 17th

8 AM Update on Vacuum Extraction: Use of the CMI soft cup system - Dr. Joseph Taylor

Film: The CMI Vacuum Extraction Setup

Tea Break

10:30 Update on the Management of Anaemia - Dr. A. Obisesan
Introduction to the Antenatal Risk Assessment Form and how we can track our high risk populations - Peg Marshall

Lunch

2:00 Update on Pregnancy Induced Hypertension - Dr. Shola Franklin

Update on the Management of prevention of obstructed Labour
Introduction to the Partograph - Jumoke Adekogba
Management of obstructed Labour and its Sequelae - Dr. Joseph Taylor

Thursday, March 18th

8 AM Implementation of the WHO partograph protocols - Dr Sola Franklin and Peg Marshall

Tea Break

10:30 AM Update on the Management of Hemorrhage - Dr. O. Williams, Consultant Alafia Hospital, Ibadan

Update on the Management of Sepsis - Dr. A. Awomolo - Iwo Specialist Hospital, Osun State

Lunch

2 PM What are the short, intermediate, and long term steps we must take to reduce maternal and infant mortality?

Panel Discussion:

Dr. Ojengbede
Dr. O. Williams
Dr. N.A.O. Williams
Dr. Sola Framsibi
Dr. O. Obisesan
Dr. A. Awomolo

Friday March 19
8.am Interpersonal Communication - Mrs. Mako

Participants at Ibadan's Physician Conference

Dr. N.O.A. Williams, Chief Medical Consultant, Adeoyo Maternity, Ibadan, Oyo State

Dr. K.O. Iyun, Chief Consultant, Adeoyo Maternity, Ibadan, Oyo State

Dr. Victor Biodun Bello, Senior Consultant Ob-Gyn, Adeoyo Maternity, Ibadan, Oyo State

Dr. T.A. Fulami, House Officer, Adeoyo Maternity, Ibadan, Oyo State

Dr. K.O. Otukoya, House Officer, Adeoyo Maternity, Ibadan, Oyo State

Dr. E. O. Sanya, House Officer, Adeoyo Maternity, Ibadan, Oyo State

Dr. (Mrs.) R.O. Adeyemi, St. Peter's Maternity Hospital, Aremo, Ibadan, Oyo State

Dr. B.T. Kasika, Medical Officer, Adeoyo Maternity, Ibadan, Oyo State

Dr. S.A. Adediran, Senior Medical Officer, Adeoyo Maternity, Ibadan, Oyo State

Dr. S. B. Adeoye, Senior Medical Officer, Adeoyo Maternity, Ibadan, Oyo State

Dr. J.K. Fahm, Medical Officer, Jericho Nursing Home, Ibadan, Oyo State

Dr. Olaymola Apena, House Officer, Iwo, Osun State

Dr. L.O. Odesanmi, Medical Officer I, Iwo, Osun State

Dr. Ayodeji Awomolo, Principal Medical Officer, Iwo State Hospital, Osun State

Dr. Francis Anibasa, Medical Officer, Eruwa District Hospital, Oyo State

Dr. Gbenga Adepoju, Medical Officer, Osogbo, Osun State

Dr. Olusegun Aforabi, Senior Medical Officer, Osogbo, Osun State

Dr. S.N.H. Ibeh, Senior Medical Officer II, State Hospital Ilesa, Osun State

Dr. O.A. Ogundiran, Medical Officer I, Ife, Osun State

PARTOGRAPH REVIEW

PLACE
TYPE OF FACILITY:

NAME OF FACILITY
(1.) STATE HOSPITAL
2. DISTRICT HOSPITAL
3. LGA MATERNITY
4. PRIVATE MIDWIFE

STATE

Please check whether the information is recorded on the partograph and compare management with the Protocol and/or case record:

Plotting: 1 = yes
0 = no
9 = Not applicable (NA)

Management Appropriate: 1 = yes
0 = no
9 = NA

Latent phase: Before & at Action line
Active phase: On or left Alert line
Between Alert line & Ac L.
At/beyond Action L.

Record Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Total	Average
1. Start of Partograph correct	0	1	0	0	1	0	0	1	0													
2. Plot cerv. dilat. 4 hrly in active phase	NA	1	1	0	1	NA	1	NA	1													
3. Plot descent of head 2 hourly	NA	0	0	0	0	0	0	NA	0													
4. Plot fetal heart at least 2 hourly	NA	1	1	0	1	0	1	1	0													
5. Plot contractions at least 2 hourly	NA	1	1	0	1	1	1	NA	1													
6. Complete partograph at delivery	0	0	0	0	0	0	0	0	1													
7. Latent phase mgt before 8 hrs	NA	NA	NA	NA	NA	NA	NA	NA	NA													
8. Latent phase Mgt at 8 hrs Action Line	NA 0	NA 1	NA	NA	NA	NA	NA	NA	NA													
9. Active phase on or left Alert L.	1	NA 1	1	0	1	1	1	1	1													
10. Active Phase between AL and Act. L.	NA	-	1	1	1	0	1	-	1													
11 Active phase at/beyond Act L.	NA	1	...	...	1	...	1	...	...													

ANTENATAL RISK ASSESSMENT REVIEW

APPENDIX U

PLACE:

NAME OF FACILITY [illegible]

TYPE OF FACILITY:
(1) STATE HOSPITAL
2. DISTRICT HOSPITAL
3. LGA MATERNITY
4. PRIVATE MIDWIFE

Please check whether the information is recorded on the ARA Form and compare management with the Protocol set out in the LSS Manual

Plotting:
1 = yes
0 = no
9 = Not applicable

Management Appropriate:
1 = yes
0 = no
9 = NA

Management Appropriate includes referral to physician if: (a) Hgb < 8 gms when registering over 28 wks gestation (b) Hgb < 8 gms on visit and not improved to 8 mgs in 2-3 wks treatment (c) Reflexes hyperactive any visit (d) Blood Pressure over 140/90 or 15 or more points increase in diastolic

Record Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	total	avg
1. Plots gestational age based on LNMP	0	[illegible]	1	1	0	1	1	1	1	1	0	1	0	1	0	1	1	1	0	1		
2. Plots up & down single week's line	0	[illegible]	1	1	0	1	1	1	1	1	0	1	0	1	0	1	1	1	0	1		
3. Plots blood pressure, weight, & uterine growth every visit	0	[illegible]	1	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	0	1		
4. If elevated BP 140/90, checks and records reflexes	0	NA	NA	NA	0	0	NA	0	NA	0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
5. Plots growth on proper week gestation	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1		
6. Checks Hemoglobin first visit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
7. Checks Hgb every visit until up to 8 gms or 55 %	0	NA	NA	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
8. Fills history portion of graph completely	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	0	1	0	1	1		
9. Records drugs ordered/given	0	1	1	1	0	1	0	0	0	1	0	1	0	0	0	0	0	1	0	0		
10. Refers to physician when abnormality noted	NA 0	NA 0	NA 0	NA	1	0	NA	0	NA	1	NA	0	NA	NA	NA	[illegible]	NA	NA	NA	NA		

PARTOGRAPH REVIEW

APPENDIX V

PLACE

TYPE OF FACILITY:

NAME OF FACILITY

(1) STATE HOSPITAL
2. DISTRICT HOSPITAL
3. LGA MATERNITY
4. PRIVATE MIDWIFE

STATE

Please check whether the information is recorded on the partograph and compare management with the Protocol and/or case record:

Plotting: 1 = yes
0 = no
9 = Not applicable (NA)

Management Appropriate: 1 = yes
0 = no
9 = NA

Latent phase: Before & at Action line
Active phase: On or left Alert line
Between Alert line & Ac L.
At/beyond Action L.

Record Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Total	Average
1. Start of Partograph correct	1	1 2h 0	1 2h 0	1 2h 0	1 2h 0	1	1	0	1 2h 0	1	1	0	0	0	1	1	1	1 2h 0	1 2h 0	1	16 9	
2. Plot cerv. dilat. 4 hrly in active phase	1	1	1	1	1	1	1	0	1	1	0	0	0	0	0	0 5hr	1	1	1	1	13	
3. Plot descent of head 2 hourly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
4. Plot fetal heart at least 2 hourly	0	0	0	0	0	1	1	0	1	1	0	0	0	0	0	0	0	1	1	0	6	
5. Plot contractions at least 2 hourly	0	0	0	0	0	1	1	0	1	1	1	0	0	0	0	0	0	1	1	0	7	
6. Complete partograph at delivery	0	1	1 1-2h 0-1hr	1 1-2h 0-1hr	1 1-2h 0-1hr	0	1	0	1	0	0	1	0	0	0	0	1 1-2h 0-1hr	1 1-2h 0-1hr	1	0	10	
7. Latent phase mgt before 8 hrs	NA	NA	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	0	
8. Latent phase Mgt at 8 hrs Action Line	NA	NA	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	0	
9. Active phase on or left Alert L.	NA	1	1	1	1	NA	NA	0	NA	NA	0	NA	0	0	NA	NA	1	1	NA	NA	6	
10. Active Phase between AL and Act. L.	1	NA	NA	NA	NA	1	1	0	1	1	NA	NA	NA	0	NA	0	NA	NA	1	NA	6	
11. Active phase at/beyond Act L.	0 NA	NA	NA	NA	NA	NA	NA	0	NA	NA	NA	1	NA	0	0	NA	NA	NA	NA	0	1	

OVERVIEW OF THE LIFE - SAVING SKILLS TRAINING FOR MIDWIVES

Maternal mortality is one of the great neglected problems of health care in developing countries. Most of the tragedies that occur are preventable through the provision of adequate maternity care.

According to the UNICEF annual report State of the World's Children 1990, maternal mortality for Ghana during the period 1980-1987 was 1000 per 100,000 live births. This has naturally been a matter of great concern to health workers, policy makers and the general public in Ghana for quite some time. A number of strategies have been set in motion in an attempt to arrest or remedy this grave situation.

In Ghana, as in many other developing nations, health resources, and particularly the pool of ~~physicians~~ doctors, are grossly inadequate and unevenly distributed, particularly in the rural areas where about 70% of the populace resides. It is also worth mentioning that in most rural areas the midwife is not only the main health provider but also a referral point for traditional birth attendants (TBAs). It is against this background that it has become increasingly necessary to review the roles and functions of midwives in the health care delivery system as a whole and for maternity care in particular in our country. The Life-Saving Skills Training Program is geared towards continuing education and the up-dating of knowledge and skills for midwives to avert unnecessary maternal and neonatal deaths, especially in areas where ~~physicians~~ doctors are not available.

The training course provides midwives with an expanded number of skills for preventing and dealing with obstetrical emergencies and complications. The training includes theory and clinical practice. The duration is two (2) weeks and it is competency based. The course content is divided into nine (9) modules:-

The Modules used for the training are:-

1. INTRODUCTION TO MATERNAL MORTALITY:-

Major causes of maternal deaths in Ghana:

Haemorrhage
Sepsis
Pregnancy Induced Hypertension
Obstructed Labour
Abortion

Factors Contributing to Maternal Deaths (Non-Medical)

Use of the problem solving method for physical assessment.

2. ANTENATAL RISK ASSESSMENT AND TREATMENT:-

Haemoglobin Testing

Reflex Testing

Updating for early recognition and treatment of pregnancy induced hypertension

Prevention and treatment of anaemia

Assessment of gestational age including fungal height measurement.

3. MONITORING LABOUR PROGRESS:-

Use of the Partograph for early recognition and treatment/referral for obstructed labour.

4. PREVENTION AND TREATMENT OF HAEMORRHAGE:-

Active management of third stage
Manual removal of the placenta
Bimanual compression of the uterus
Digital evacuation of the uterus.

5. MANAGEMENT OF DIFFICULT DELIVERIES:-

Vacuum Extraction

6. RESUSCITATION:-

Infant Resuscitation
Adult Resuscitation (CPR)
Heimlich Maneuver

7. EPISIOTOMIES AND LACERATION REPAIR:-

Cutting and suturing episiotomies
Cervical and vaginal inspection
Repair of cervical and other lacerations
Local infiltration (anesthesia)

8. HYDRATION AND REHYDRATION:-

Intravenous fluid therapy
Rectal fluid therapy
Intraperitoneal fluid therapy
Oral rehydration therapy.

9. PREVENTION AND MANAGEMENT OF SEPSIS/INFECTION:-

Choricamnionitis
Postpartum infections/endometritis
Dehydration
Malaria

Mastitis/Breast abscess
Thrombophlebitis
Upper respiratory infection
Urinary tract infection
Ophthalmia neonatorum
Septicemia
Postpartum tetanus.

At the end of every module there is a check list which has two purposes:-

1. The midwife should use it as a guide for checking her own skills

2. The Supervisors (trainers) should use it when they evaluate how well the Midwife performs.

There are ratings to show levels of absorption or deficiency.

Our practice has been to see to it that both trainee and trainer are equally satisfied with the learning process.

The pilot project was ran by the Ghana Registered Midwives Association, in collaboration with the American College of Nurse Midwives and the Ministry of Health. During the training period, we made support visits to participants work site, and conducted a project evaluation.

The purpose of the support visits and evaluation was to:-

(1) Assess trainee performance of newly acquired life saving skills at the trainee work site.

(2) Determine how the Life Saving Skills training programme could be strengthened and used current strengths in a follow-on project.

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(3) Develop plans for a follow-on project so that these Life Saving Skills can be shared with as many people as possible.

During support visits the trained midwives repeatedly pointed out that by using the suture-sparing method of episiotomy repair, they were noticing improved healing, fewer gaping episiotomies, less pain and greater ease in walking. They had also noticed a decrease in the rate of post-partum haemorrhages through routine use of active management of the third stage. Trainers also noted that their work environments were cleaner and increased attention was paid to using good aseptic technique. With regards the use of the partograph, it was clear that their tracking of progress of labour and timely referrals have improved. Many of those using the antenatal risk assessment forms noted that it was easier to tell when clients are falling into difficulty by graphing such parameters as blood pressure, uterine growth and weight gain. It was also clear that use of the form had resulted in much greater attention to tracking haemoglobin throughout pregnancy.

RESUSCITATION:

There were many stories of successful resuscitation of infants. This has been one of the major strengths of the program. Previously, it was common that the midwife would inappropriately resuscitate the baby by blowing on its face or fanning the air over the baby's head. Infants were also often placed in cold water or struck. This only does not help, but can increase asphyxia by lowering the infants body temperature. Midwives related with pride that they are now able to save babies, they previously would have classified as dead.

HAEMORRHAGE:-

The treatment of haemorrhage has always been within the scope of practice of the midwife. However, the scope of treatments allowed the midwife has changed markedly over the time. Manual removal of the placenta is a controversial procedure to some obstetricians based in urban areas.

They fear the midwife could contribute to sepsis and stimulate intractable bleeding in the case of placenta accreta. It was of interest to note that of ninety-five (95) incident forms filled, thirty-four (34) of them dealt with the need to handle haemorrhage. All but two of the retained placentas were successfully removed by the midwives. The two unsuccessful removals were transferred to hospital and both patients did well. Bimanual uterine compression was a new skill to many of the midwives. They found it easy to implement in practice.

PREGNANCY INDUCED HYPERTENSION:-

In general, the midwives had updated their knowledge and skills regarding PIH. They were no longer managing severe preeclampsis at home on Valium and Lasix. Testing client's reflexes was a new skill for all the midwives. They found it simple to learn and Valuable in separating those women with edema from stasis and anaemia from those beginning to show signs of cerebral irritation. Their criteria for referrals had also improved.

VACUUM EXTRACTION:-

Of the 95 incident forms filled 37 had used the vacuum extractor. All 37 extractions were successful.

It was evident from the evaluation of the pilot project and follow-on support visits. that the objectives of the project were fully met. It was clear that there was increased awareness amongst midwives as to the causes of maternal death and how to

prevent them. Furthermore, antenatal and perinatal services had improved thus facilitating better Maternal Health and Care. The midwives relate that they feel more confident and competent in their practice.

The training programme was shared with the International Health Community through presentations at the National Council for International Health (NCIN) in Washington D.C. and at the F.I.G.O. precongress workshop sponsored WHO and World Bank in Singapore. Additionally, an article entitled Life-Saving Skills Training for Midwives: Report on the Ghanaian experience has been published in the International Journal of Gynaecology and Obstetrics. The training manual has been adopted by the WHO and the W.A.G.S. as a reading manual. At the moment L.S.S is underway in ~~Indonesia and~~ Uganda.

At the recent National consultative meeting on Safe Motherhood held in Accra in January 1993, Life-Saving Skills programme was adopted by the Ministry of Health as one of its strategies for Safe Motherhood. In addition L.S.S. has been incorporated into the Midwifery Training curriculum.

CONCLUSION:-

The Life-Saving Skills Training Program is another attempt at reducing maternal mortality and morbidity in Ghana by 50% by the turn of the century. We believe that it will increase and enhance awareness among midwives as to the causes of maternal deaths and how to prevent them. Furthermore, it ought to improve antenatal and perinatal services, thus facilitating better maternal health care. The goal is to (more better expeditiously) identify, treat, and transfer women with emergencies or potential emergencies in time to save these precious lives. The idea of midwives performing manual removal of placenta is not new. What is new is the mutual respect which develops between doctors and midwives as the newly developed skills are performed with competence and confidence. Our experience so far shows that if given the proper encouragement and support, the midwives are

undoubtedly capable of teaching and performing many interventions hitherto carried out by ~~physicians~~ doctors or obstetricians. These women constitute an army of health professionals whose potential has not been fully exploited and utilized, a fact that we cannot afford to disregard.

If we are to make any significant impact on safe motherhood, then there is the need for concerted effort and firm commitment from service providers, policy makers and the general public. There is the need to make maternity services as assessable as possibly to women through the delegation of responsibility and team work; excluding any one group or under utilizing their potential could spell disaster for Family and Community Health.

Finally, we wish to acknowledge:-

(1) Carnegie Corporation of New York and UNICEF for funding the programme.

(2) The Ministry of Health for providing the facilities for training, trainers and a vehicle for support Visits.

(3) The American College of Nurse-Midwives for their Technical assistance.

(4) The Ghana Registered Midwives Association for Co-ordinating the programme.

(DR. J. E. TAYLOR)
OBSTETRICIAN AND GYNAECOLOGIST

COMMUNIQUE ISSUED AT THE END OF LIFE SAVING SKILLS TRAINING PROGRAMME CONTINUING EDUCATION PROGRAMME FOR DOCTORS HELD 3 - 5 MARCH, 1993 AT BAUCHI SPECIALIST HOSPITAL, BAUCHI

It is agreed by participants that:

1. Maternal Mortality rate has reached an unacceptable level;

2. Most causes of maternal mortality are preventable;

3. The MotherCare Initiative is a timely and bold attempt at reducing maternal mortality.

The workshop further resolved that:

[a] Government being the main provider of Health Services in our area, should view more seriously provision of maternal and child health especially in the area of effective antenatal care in cooperating the use of the Antenatal Risk Assessment form.

[b] Health Personnel involved in maternal health services should rededicate ourselves to ensure safe motherhood even in the presence of inadequate facilities;

[c] Bureaucracies involved in procurement of drugs, surgical and other materials needed in obstetric care should be minimized;

[d] In view of the increased responsibility of the Midwife in the provision of maternal health services, Midwifery training standard should be improved;

[e] Government should get politically committed to the life saving skill programme;

[f] Continuing education programme should be organized for all those involved in maternal health services;

[g] Communities, individuals and non-governmental organizations should assist in the provision of maternal health services;

[h] The government should declare an annual remembrance day [similar to that of soldiers who died at war] for all women who died of preventable causes associated with pregnancy, childbirth and puerperium;

[i] All women, whether individually or as groups should embrace the life saving skills programme;

[j] The partograph is accepted as part of the labour room practice and it's [partograph] use must be encouraged anywhere child delivery is taken; and

[k] Maternal and Perinatal Mortality audit should be an integral part of routine departmental programmes.

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NIGERIA - LIFE-SAVING SKILLS

APPENDIX Y

Evening of arrival receive book of modules.
Homework: Study module on Maternal Mortality

	DAY 1 - MONDAY	DAY 2 - TUESDAY	DAY 3 - WEDNESDAY
8:00 AM	Welcome Introductions Overview of Course Overview of Maternal Mortality Video: Vital Allies Registration Pre-Test	Review Maternal Mortality & Communications Visit to the Wards VC and IPC Introduction to Barriers to MCH Care	Review Communications & Barriers to Care Using the Problem Solving Approach on Barriers to Care
10:30 AM	BREAK	BREAK	BREAK
11:00 AM	Introduction to the Clinical Problem Solving Method		
2:00 PM	LUNCH	LUNCH	LUNCH
3:00 PM	Values Clarification and Interpersonal Communications	Barriers to Quality Maternal Child Health Care Video: Why Did Mrs. X Die	Review of the Clinical Problem Solving Method Vacuum Extraction Seminar Video on Vacuum Extraction
	CLINICAL ASSIGNMENT:	CLINICAL ASSIGNMENT:	CLINICAL ASSIGNMENT
		8:00 AM TO 8:00 PM - MIDWIVES 1,2,3 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 4,5 ON CALL	8:00 AM TO 8:00 PM - MIDWIVES 6,7,8 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 9,10 ON CALL
		Homework: Study Module on Vacuum Extraction-Review handouts	Homework: Study Module on Episiotomy and Laceration Repair-Handouts on AIDS

NIGERIA - LIFE-SAVING SKILLS

	DAY 4 THURSDAY	DAY 5 - FRIDAY	DAY 6 - SATURDAY
8:00 AM	Review material on Vacuum Extraction Episiotomy and Laceration Repair Seminar	Review Episiotomy and Laceration Repair Prevention and Treatment of Haemorrhage Active Management of the Third Stage Manual Removal of the Placenta Bimanual Compression of Uterus	CLINICAL ASSIGNMENT: 8:00 AM TO 8:00 PM - MIDWIVES 1,2,3 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 4,5 ON CALL
0:30 AM	BREAK	BREAK	
11:00 AM	Suturing Practice	Introduction to Use of the Partograph	
:00 PM	LUNCH	LUNCH	DAY 7 - SUNDAY
:00 PM	AIDS and the Practice of Midwifery		CLINICAL ASSIGNMENT: 8:00 AM TO 8:00 PM - MIDWIVES 6,7,8 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 9,10 ON CALL
	CLINICAL ASSIGNMENT	CLINICAL ASSIGNMENT	
	8:00 AM TO 8:00 PM - MIDWIVES 4,5 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 1,2,3 ON CALL	8:00 AM TO 8:00 PM - MIDWIVES 9,10 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 6,7,8 ON CALL	
	Homework: Study Module on Prevention and Treatment of Haemorrhage	Homework: Study on Monitoring Labour Progress	

NIGERIA - LIFE-SAVING SKILLS

	DAY 8 - MONDAY	DAY 9 - TUESDAY	DAY 10 - WEDNESDAY
8:00 AM	Review Prevention and Treatment of Haemorrhage Use of Partograph for Labour Management	Review use of the Partograph More on the Partograph	Review Antenatal Risk Assessment Use of the Antenatal Risk Assessment Tool in Prevention and Treatment of Anemias and Pregnancy Induced Hypertension
10:30 AM	BREAK	BREAK	BREAK
11:00 AM	Continue	Introduction to use of Antenatal Assessment Tool	Practice use of Tool at Antenatal Clinic
:00 PM	LUNCH	LUNCH	LUNCH
:00 PM	Aseptic Technique		
	CLINICAL ASSIGNMENT:	CLINICAL ASSIGNMENT:	CLINICAL ASSIGMENT:
	8:00 AM TO 8:00 PM - MIDWIVES 1,2 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 3,4,5 ON CALL	8:00 AM TO 8:00 PM - MIDWIVES 6,7 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 8,9,10 ON CALL	8:00 AM TO 8:00 PM - MIDWIVES 3,4,5 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 1,2 ON CALL
	Homework: Study Module on Partograph	Homework: Study Module on Antenatal Risk Assessment	Homework: Study Modules on Hydration and Management of Sepis

NIGERIA - LIFE-SAVING SKILLS

	DAY 11 - THURSDAY	DAY 12 - FRIDAY	DAY 13 SATURDAY
8:00 AM	Review Antenatal Risk Assessment IV Fluid Management Recognition and Treatment of Sepsis: PROM Puerperal Fevers Incomplete and Septic Abortions	Review Hydration, Rehydration and Sepsis Cardio Pulmonary Resuscitation and Heimlich Maneuver	CLINICAL ASSIGNMENT 8:00 AM TO 8:00 PM - MIDWIVES 6,7,8 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 9,10 ON CALL
10:30 AM	BREAK	BREAK	
11:00 AM	Continue	Community Assessment: Preparttion for Field Visits	
2:00 PM	LUNCH	LUNCH	DAY 14 - SUNDAY
	CLINICAL ASSIGNMENT:	CLINICAL ASSIGNMENT:	CLINICAL ASSIGMENT:
	8:00 AM TO 8:00 PM - MIDWIVES 8,9,10 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 6,7 ON CALL	8:00 AM TO 8:00 PM - MIDWIVES 1,2,3 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 4,5 ON CALL	8:00 AM TO 8:00 PM - MIDWIVES 1,2,3 ON CALL 8:00 PM TO 8:00 AM - MIDWIVES 4,5 ON CALL
	Homework: Study Modules on Cardio-Pulmonary Resuscitation and Heimlich Maneuver	Homework: Review all Modules	

NIGERIA - LIFE-SAVING SKILLS

	DAY 15 - MONDAY	DAY 16 - TUESDAY	DAY 17 WEDNESDAY
8:00 AM	1/2 Group on all day Field Field Visit: Community Assessment Midwives: 1,2,3,9,10 1/2 Group in AP or L&D	1/2 Group on all day Field Visit: Community Assessment Midwives: 4,5,6,7,8 1/2 Group in AP or L&D	Debriefing on Field Visits
10:30 AM	BREAK	BREAK	BREAK
11:00 AM	1/2 Group Practice CPR	1/2 Group Practice CPR	Review any/all content areas
2:00 PM	LUNCH	LUNCH	LUNCH
	CLINICAL ASSIGNMENT:	CLINICAL ASSIGNMENT:	CLINICAL ASSIGMENT:
	8:00 AM TO 8:00 PM MIDWIVES 6,7,8 ON CALL 8:00 PM TO 8:00 AM MIDWIVES 9,10 ON CALL	8:00 AM TO 8:00 PM MIDWIVES 4,5 ON CALL 8:00 PM TO 8:00 AM MIDWIVES 1,2,3 ON CALL	8:00 AM TO 8:00 PM MIDWIVES 9,10 ON CALL 8:00 PM TO 8:00 AM MIDWIVES 6,7,8 ON CALL
	Homework: Review all Modules	Homework: Review all Modules	Homework: Review all modules and handouts

NIGERIA - LIFE-SAVING SKILLS

	DAY 18 - THURSDAY	DAY 19 - FRIDAY	
8:00 AM	1/2 Midwives work Antenatal Clinic 1/2 Midwives work Intrapartum	Review post-test Review any area needing discussion	
10:30 AM	BREAK	BREAK	
11:00 AM	Post-test given	CLOSING CERMONY CERTIFICATES DISTRIBUTED	
2:00 PM	LUNCH	LUNCH	
3:00 PM		HOME BOUND!!!	
	CLINICAL ASSIGNMENT:		
	Those most in need of Clinical Opportunities		

S:MOTHER\MOTHER\MATERIAL\LIFESCH

APPENDIX Z

Federal Republic of Nigeria

THE MOTHERCARE PROJECT FOR SAFE MOTHERHOOD IN NIGERIA

WITH THIS CERTIFICATE CONFIRMS ATTENDANCE OF

_____

AT A THREE-WEEK WORKSHOP ON LIFE SAVING SKILLS FOR MIDWIVES

AT_____

FROM_____TO_____1993

Mrs. Lola Payne
MotherCare Project Coordinator

Chief Trainer

Hon. Commissioner for Health
State Ministry of Health (SMOH)

Life Saving Skills Doctors conference

Name----------

Mailing Address----------

Work site----------

Rank----------

Do you care for pregnant women? No-------, Yes--------

Please describe in what capacity----------

Do you perform caesarian sections? Yes------,No-------

Do you perform hysterectomies? Yes-------, No--------

Do you perform vesico- vaginal fistulae repair? Yes---No-----

Are their skills you wish to learn to render better care to women and newborns? No-------, Yes------- Please specify-----

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Please estimate how many maternal deaths occur at your institution per month--------, Newborn deaths per month------

What inputs do you need to render better care to pregnant women and newborns?----------

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What continuing education needs do you have ?----------

Final Evaluation Form

Name----------

Today's Date----------

What was the most valuable part of this conference for you?

What was the least valuable part of this conference for you?

Please evaluate/rate the following:

venue----------

food----------

technical guest speakers----------

panel discussion speakers----------

choice of topics----------

handouts----------

audiovisual aids used----------

What are your suggestions for topics for future cohtinuing education workshops? ----------

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How could this conference have been improved? ----------

What can you do in your own worksite and community to reduce maternal mortality? ----------

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APPENDIX CC

Name: [illegible] Date Trained: _____

Centre where trained: [illegible]

Nigeria LSS Skills Use Record

199__

Month	[illegible]		
1. Antenatal Risk Assess. Form	N		
2. Partograph Labour Forms	2		
3. Active Management of 3rd State	25		
4. Manual Removal of Placenta	4		
5. External Bimanual Compression	NIL		
6. Internal Bimanual Compression	NIL		
7. Digital Removal Products Conception	1		
8. Vacuum Extraction	NIL		
9. Infant Resuscitation	6		
10. Adult Resuscitation	NIL		
11. Heimlich Maneuver	NIL		
12. Give Local Anesthesia	4		
13. Repair Mediolateral Episiotomy	18		
14. Repair Median Episiotomy	NIL 6		
15. Repair Cervical Laceration	NIL		
16. Repair Vaginal Laceration	6		
17. Start Intravenous drip	29		
18. Give rectal hydration fluids	NIL		
19. Give Intraperitoneal Fluids	NIL		
20. Give ORS/ORT	3		
21. Treat PROM	4		
22. Treat Sepsis	6		
23. Other (specify) BREECH / CONTROLLED PRES	2 / 1		

Name: [illegible] Date Trained: 26/10/92 – 17/11/92

Centre where trained: BAUCHI STATE

Nigeria LSS Skills Use Record

199__ NOV. 18, '92

Month	TO FEB. 17, '93		
1. Antenatal Risk Assess. Form	80		
2. Partograph Labour Forms	100		
3. Active Management of 3rd State	20		
4. Manual Removal of Placenta	13		
5. External Bimanual Compression	15		
6. Internal Bimanual Compression	11		
7. Digital Removal Products Conception	23		
8. Vacuum Extraction	—		
9. Infant Resuscitation	45		
10. Adult Resuscitation	6		
11. Heimlich Maneuver	—		
12. Give Local Anesthesia	15		
13. Repair Mediolateral Episiotomy	22		
14. Repair Median Episiotomy	--		
15. Repair Cervical Laceration	—		
16. Repair Vaginal Laceration	14		
17. Start Intravenous drip	57		
18. Give rectal hydration fluids	—		
19. Give Intraperitoneal Fluids	—		
20. Give ORS/ORT	30		
21. Treat PROM	5		
22. Treat Sepsis	15		
23. Other (specify)	—		

Name: Mrs H.S Mahmood Date Trained: OCT 1992.

Centre where trained: Bauchi

Nigeria LSS Skills Use Record

1992

Month	NOV	DEC	JAN
1. Antenatal Risk Assess. Form	5	2	—
2. Partograph Labour Forms	5	2	2
3. Active Management of 3rd State	5	2	2
4. Manual Removal of Placenta	NIL	NIL	NIL
5. External Bimanual Compression	NIL	NIL	NIL
6. Internal Bimanual Compression	NIL	NIL	NIL
7. Digital Removal Products Conception	NIL	NIL	NIL
8. Vacuum Extraction	NIL	NIL	NIL
9. Infant Resuscitation	-	1	—
10. Adult Resuscitation	NIL	NIL	—
11. Heimlich Maneuver	NIL	NIL	—
12. Give Local Anesthesia	1	NIL	
13. Repair Mediolateral Episiotomy	1	NIL	NIL
14. Repair Median Episiotomy	NIL	NIL	NIL
15. Repair Cervical Laceration	NIL	NIL	NIL
16. Repair Vaginal Laceration	NIL	NIL	NIL
17. Start Intravenous drip	3	2	3
18. Give rectal hydration fluids	NIL	NIL	NIL
19. Give Intraperitoneal Fluids	NIL	NIL	NIL
20. Give ORS/ORT	4	1	2
21. Treat PROM	—	—	—
22. Treat Sepsis	1	—	—
23. Other (specify)			

Name: [illegible] Date Trained: _____

Centre where trained: [illegible]

Nigeria LSS Skills Use Record

199__

Month	[illegible]		
1. Antenatal Risk Assess. Form	[illegible]		
2. Partograph Labour Forms	5		
3. Active Management of 3rd State	[illegible]		
4. Manual Removal of Placenta	[illegible]		
5. External Bimanual Compression	[illegible]		
6. Internal Bimanual Compression	1		
7. Digital Removal Products Conception	[illegible]		
8. Vacuum Extraction	[illegible]		
9. Infant Resuscitation	[illegible]		
10. Adult Resuscitation	[illegible]		
11. Heimlich Maneuver	—		
12. Give Local Anesthesia	[illegible]		
13. Repair Mediolateral Episiotomy	[illegible]		
14. Repair Median Episiotomy	5		
15. Repair Cervical Laceration	—		
16. Repair Vaginal Laceration	5		
17. Start Intravenous drip	[illegible]		
18. Give rectal hydration fluids	—		
19. Give Intraperitoneal Fluids	—		
20. Give ORS/ORT	[illegible]		
21. Treat PROM	3		
22. Treat Sepsis	[illegible]		
23. Other (specify) [illegible]	[illegible]		

Name: [illegible] Date Trained: [illegible]

Centre where trained: BAUCHI SPECIALIST HOSPITAL

Nigeria LSS Skills Use Record

199__

Month	[illegible]		
1. Antenatal Risk Assess. Form	[illegible]		
2. Partograph Labour Forms	[illegible]		
3. Active Management of 3rd State	12		
4. Manual Removal of Placenta	[illegible]		
5. External Bimanual Compression	[illegible]		
6. Internal Bimanual Compression	NIL		
7. Digital Removal Products Conception	NIL		
8. Vacuum Extraction	NIL		
9. Infant Resuscitation	9		
10. Adult Resuscitation	[illegible]		
11. Heimlich Maneuver	NIL		
12. Give Local Anesthesia	[illegible]		
13. Repair Mediolateral Episiotomy	[illegible]		
14. Repair Median Episiotomy	[illegible]		
15. Repair Cervical Laceration	[illegible]		
16. Repair Vaginal Laceration	[illegible]		
17. Start Intravenous drip	[illegible]		
18. Give rectal hydration fluids	NIL		
19. Give Intraperitoneal Fluids	NIL		
20. Give ORS/ORT [illegible]	[illegible]		
21. Treat PROM	[illegible]		
22. Treat Sepsis	[illegible]		
23. Other (specify) [illegible]	1		

Pulse check, positioning

Name: Mrs I D Adekeyiga Date Trained: October 28th – Nov 17th

Centre where trained: Benin Specialist Hospital

Nigeria LSS Skills Use Record

1993

Month	Nov 17th – Mar 17th 1993		
1. Antenatal Risk Assess. Form			
2. Partograph Labour Forms	200		
3. Active Management of 3rd State	120		
4. Manual Removal of Placenta	2		
5. External Bimanual Compression	4		
6. Internal Bimanual Compression			
7. Digital Removal Products Conception			
8. Vacuum Extraction			
9. Infant Resuscitation	10		
10. Adult Resuscitation	4		
11. Heimlich Maneuver			
12. Give Local Anesthesia	20		
13. Repair Mediolateral Episiotomy	20		
14. Repair Median Episiotomy			
15. Repair Cervical Laceration			
16. Repair Vaginal Laceration	2		
17. Start Intravenous drip	12		
18. Give rectal hydration fluids	1		
19. Give Intraperitoneal Fluids	1		
20. Give ORS/ORT	48		
21. Treat PROM	2		
22. Treat Sepsis			
23. Other (specify)			

Name: Mrs. Clara Sanda Date Trained: 26th Oct — 17th Nov 19

Centre where trained: Bauchi Specialist Hosp. Bauchi

Nigeria LSS Skills Use Record

199__

Month	15th Nov — 15th Mch.		
1. Antenatal Risk Assess. Form	25		
2. Partograph Labour Forms	240		
3. Active Management of 3rd State	150		
4. Manual Removal of Placenta	3		
5. External Bimanual Compression	1		
6. Internal Bimanual Compression	2		
7. Digital Removal Products Conception	—		
8. Vacuum Extraction	—		
9. Infant Resuscitation	45		
10. Adult Resuscitation	—		
11. Heimlich Maneuver	—		
12. Give Local Anesthesia	25		
13. Repair Mediolateral Episiotomy	30		
14. Repair Median Episiotomy	—		
15. Repair Cervical Laceration	—		
16. Repair Vaginal Laceration	3		
17. Start Intravenous drip	50		
18. Give rectal hydration fluids	—		
19. Give Intraperitoneal Fluids	—		
20. Give ORS/ORT	200		
21. Treat PROM	15		
22. Treat Sepsis	—		
23. Other (specify)			

Name: Mrs. M. A. Olejede Date Trained: October 26th – Nov. 17

Centre where trained: Bauchi Specialist Hospital.

Nigeria LSS Skills Use Record

1993

Month	Nov 18 – Mar 18, 1993		
1. Antenatal Risk Assess. Form	200		
2. Partograph Labour Forms	10		
3. Active Management of 3rd State	10		
4. Manual Removal of Placenta	1		
5. External Bimanual Compression	Nil		
6. Internal Bimanual Compression	Nil		
7. Digital Removal Products Conception	Nil		
8. Vacuum Extraction	Nil		
9. Infant Resuscitation	2		
10. Adult Resuscitation	Nil		
11. Heimlich Maneuver	Nil		
12. Give Local Anesthesia	5		
13. Repair Mediolateral Episiotomy	5		
14. Repair Median Episiotomy	Nil		
15. Repair Cervical Laceration	Nil		
16. Repair Vaginal Laceration	Nil		
17. Start Intravenous drip	2		
18. Give rectal hydration fluids	Nil		
19. Give Intraperitoneal Fluids	Nil		
20. Give ORS/ORT	10		
21. Treat PROM	Nil		
22. Treat Sepsis	Nil		
23. Other (specify)	Nil		

Name: [illegible] Date Trained: [illegible]

Centre where trained: [illegible] Hospital.

Nigeria LSS Skills Use Record

199__

Month	[illegible]		
1. Antenatal Risk Assess. Form	—		
2. Partograph Labour Forms	62		
3. Active Management of 3rd State	35		
4. Manual Removal of Placenta	3		
5. External Bimanual Compression	5		
6. Internal Bimanual Compression	—		
7. Digital Removal Products Conception	—		
8. Vacuum Extraction	—		
9. Infant Resuscitation	15		
10. Adult Resuscitation	1		
11. Heimlich Maneuver	—		
12. Give Local Anesthesia	6		
13. Repair Mediolateral Episiotomy	6		
14. Repair Median Episiotomy	—		
15. Repair Cervical Laceration	—		
16. Repair Vaginal Laceration	—		
17. Start Intravenous drip	5		
18. Give rectal hydration fluids	—		
19. Give Intraperitoneal Fluids	—		
20. Give ORS/ORT	—		
21. Treat PROM	—		
22. Treat Sepsis	—		
23. Other (specify)	-		

Name: MRS E. F. OYEDIJI Date Trained: 26th October – 17th November

Centre where trained: BAUCHI

199__

Nigeria LSS Skills Use Record

Month	Nov 1992 – March 93		
1. Antenatal Risk Assess. Form	20		
2. Partograph Labour Forms	30		
3. Active Management of 3rd State	10		
4. Manual Removal of Placenta	2		
5. External Bimanual Compression	—		
6. Internal Bimanual Compression	—		
7. Digital Removal Products Conception	—		
8. Vacuum Extraction	—		
9. Infant Resuscitation	20		
10. Adult Resuscitation	—		
11. Heimlich Maneuver	—		
12. Give Local Anesthesia	3		
13. Repair Mediolateral Episiotomy	3		
14. Repair Median Episiotomy	—		
15. Repair Cervical Laceration	—		
16. Repair Vaginal Laceration	—		
17. Start Intravenous drip	—		
18. Give rectal hydration fluids	—		
19. Give Intraperitoneal Fluids	—		
20. Give ORS/ORT	50		
21. Treat PROM	—		
22. Treat Sepsis	—		
23. Other (specify)			