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COLLABORATIVE PARTNERSHIP FOR NURSING AND MIDWIFERY DEVELOPMENT IN THE REGION OF THE AMERICAS

Pan American Health Organization, Human Resources Development Program

Pan American Health Organization, Family Health and Population Program

Pan American Health Organization, Organization and Management of Health Systems and Services Program

University of Pennsylvania, WHO Collaborating Center in Nursing and Midwifery Leadership Systems Program

Division of Nursing, HRSA
Department of Health and Human Services

REPORT OF A WORKSHOP

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CONSULTATIVE GROUP ON MIDWIFERY SKILLS
FOR REPRODUCTIVE HEALTH
30 August to 2 September 1998
Medical Sciences Campus
University of Puerto Rico, San Juan

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CONSULTATIVE GROUP ON MIDWIFERY SKILLS FOR REPRODUCTIVE HEALTH

Introduction

In fall 1997, a collaborative partnership for nursing and midwifery development in the World Health Organization (WHO) region of the Americas was formed. The collaborative partnership included representatives from three Pan American Health Organization (PAHO) programs - Human Resources Development, Family Health and Population, and Organization and Management of Health Systems and Services- the Department of Health and Human Services (HHS), Division of Nursing, HRSA, and the University of Pennsylvania School of Nursing's WHO Collaborating Center in Nursing and Midwifery Leadership.

The goal of the collaborative partnership is long-term and states, *"In keeping with WHA resolutions on Safe Motherhood, nursing and midwifery and the PAHO regional plan of work, the partners will work together to improve the health status of women and families in Latin America and the Caribbean by strengthening nursing and midwifery."*

The objectives of the collaborative partnership include:

1. To facilitate implementation of essential reproductive health competencies for health professionals;
2. To prepare and implement a 3-year action plan with strategies and time line for use of essential competencies in reproductive health within educational institutions, service settings, and major funding agencies; and
3. To provide support and continuity for evolving leadership in nursing and midwifery throughout the region of the Americas.

In March 1998, the partners made a decision to focus the first activity of the partnership on the emerging concept of comprehensive reproductive health services viewed within the context of human development. Through the media of conference calls, electronic mail and fax, the partners designed and implemented a Consultative Group on Midwifery Skills for Reproductive Health. The meeting was held in San Juan, Puerto Rico, from 30 August to 2 September 1998. The working language of the group was Spanish, with translation provided by individuals for the English-only participants.

The Consultative Group consisted of expert midwives, nurses and physicians experienced in reproductive health care at community level They worked together for three days with a wonderful blurring of professional boundaries, and offered advice on the knowledge, skills and attitudes (behaviors) needed by health professionals providing comprehensive reproductive health services in the Americas. This priority for health services had been identified in the PAHO plan of work, an area of great need in Latin America and the Caribbean. Thus, 42 individuals from 18 countries, including the U.S. and Switzerland (WHO-Geneva staff) gathered at the Faculty Club, Medical Sciences campus of the University Puerto Rico in San Juan on 30 August 1998 for a three day workshop (See Appendix A for List of Participants). This group included representatives of the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM). This

report will cover the major activities and outcomes of the workshop titled, *Consultative Group on Midwifery Skills for Reproductive Health.*

Goal of consultative group

The goal of the Consultative Group was: *"In order to improve the health and well being of women and families in Latin America and the Caribbean, the consultative group will define strategies that will strengthen the capacity of health providers (nurses, midwives, physicians) with midwifery skills to provide comprehensive reproductive health care."* This goal was shared with participants in their letters of invitation and affirmed at the beginning of the workshop.

Objectives of the consultative group

The stated objectives of this workshop were set and sent out with the letter of invitation by PAHO staff, along with draft #6 of the *ICM Essential Competencies for Basic Midwifery Practice* (1998) to be used as a basis for beginning the discussion of reproductive health competencies. The objectives were as follows.

At the end of this workshop, the participants will be able to:

1. Reach consensus on essential competencies (knowledge, skills and attitudes) for health professionals responsible for a broad range of reproductive health care services.
2. Identify and discuss issues and strategies for the preparation of health professionals who provide reproductive health services.
3. Identify and discuss issues and strategies for the preparation of the community and the health system for offering reproductive health care services considering essential competencies needed.
4. Discuss issues and strategies for the collaboration among various health professionals and auxiliary health workers providing reproductive health services based on the appropriate division of work in keeping with the essential competencies.
5. Elaborate a plan of action with time line for implementation of the essential competencies in reproductive health throughout the region.

Organization of the workshop

The workshop was organized for maximum participation and minimum presentations. Since all the participants were experts in reproductive clinical services, the agenda was arranged to include directed tasks in small groups following brief, formal presentations by the facilitators. The agenda was continually altered to take advantage of group process and the need to discuss some tasks for a longer time than originally planned. The partners met each day to readjust the schedule as needed and to finalize the next day's work. The final agenda for the workshop can be found in Appendix B.

Day One: August 31, 1998

An official opening ceremony was led by Dr. Jose Hawayek, Acting Dean of Academic Affairs of the Medical Sciences Campus, University of Puerto Rico (UPR). He expressed pleasure on behalf of Chancellor Dr. Adolfo Firpo, that this group had chosen the UPR venue for the

meeting. Acting Dean of the School of Public Health, Dr. Alida de Galletti, also welcomed the Consultative Group to the Medical Sciences campus. Carol Collado brought greetings on behalf of the partners.

The participants introduced themselves to one another, and then Carol Collado helped the group to understand their role as experts in this workshop. It was during this discussion that a theme arose spontaneously from the group: "We are partners for change. We are partners with a common cause: quality reproductive health care in the Americas." Joyce Thompson reviewed the vision, objectives, tasks and proposed agenda for the workshop. Group assignments were given out with the intent of keeping areas of the Americas together when possible (See Appendix C for List of Participants by Group). Maricel Manfredi then discussed the assignment of recorders for each day so that a summary from the participants would be available for the final report. It is from these summaries and partner notes that this report is written.

Global Perspective and Needs in Reproductive Health (Anne Thompson)

Anne Thompson, WHO Geneva Maternal Safe Motherhood Programme, presented "Global needs in reproductive health." (See Appendix D for complete paper) She focused on the continuum of reproductive health care from adolescence through the elder years, highlighting preparation for healthy sexual behavior, family planning and STDs prevention beginning in adolescence. She discussed prenatal, delivery, newborn and postpartum care as key elements of Safe Motherhood, and continuing with cancer screening and care during menopause for the older woman. She noted that the key elements of reproductive health include health promotion, research, social conscience, equity in access to services, legislation, collaboration, preparation of health workers and the inclusion of men in all activities. She briefly reviewed some of the global concerns in reproductive health. They include Safe Motherhood, healthy adolescence, family planning and child spacing services, screening for cancer of the cervix, unsafe abortion, violence and HIV/AIDs as well as other sexually transmitted diseases (STDs).

Anne Thompson continued her discussion of the types of collaboration needed globally for reproductive health. She talked about United Nations agencies, bilateral donor agencies, international initiatives, and non-governmental agencies working together at local, regional, national and international levels. She also stressed the importance of government ministries supporting integrated health services that meet the reproductive health needs of a particular community or person.

One of the important points in Anne Thompson's presentation related to the regional statistics on percent of women receiving prenatal care and those who have a skilled attendant at birth. She also presented a graph demonstrating the unmet need for family planning services in selected countries throughout the world. In response to questions about an emphasis on Safe Motherhood and the actual childbirth experiences of women as a part of reproductive health care, she noted that in countries, such as Bolivia, where maternal mortality rates are extremely high, reproductive health services must begin with Safe Motherhood strategies.

Regional Perspective on Needs in Reproductive Health (Carol Collado)

Carol Collado led a discussion of reproductive health needs in the Region of the Americas. She began the discussion by highlighting the current general situation of people including the changing demographics of the region brought about by a rapid modernization in many countries.

She noted that this epidemiological transition contributes to unresolved social problems, an increase in the use of technologies that, in turn, increase the costs of health and illness care. She noted that an increasing percentage of the population are living in absolute poverty, and that unemployment or insecurity about being employed for any length of time has led to greater inequities in society. The global and regional economic crises also contribute to poor health for many. Some of the symptoms of the unstable societies include an increase in violence and substance abuse and a decrease in knowledge within local communities.

Carol Collado described the current state of health services in the Region. She noted that the services are fragmented, reactive rather than proactive, with great bureaucracies and little strategic planning. She also noted that the population has little input into the services provided and rarely is asked what their health needs are. These services are inefficient in the use of resources, inaccessible to many sectors of the population and receive low ratings for satisfaction from those who do use the services.

Reproductive health services suffer similar maladies in that the emphasis has been on maternal-child health care rather than a comprehensive approach to the health of men and women during their reproductive years. The focus has been on the woman in the design of health services to the exclusion of men, and the orientation is a medical/disease approach rather than health promotion and disease prevention - a health approach. Carol Collado also noted that there has been little societal support for implementing a comprehensive approach to reproductive health within the context of human development.

After a brief review of the maternal mortality ratios by country in Latin America and the Caribbean, Carol Collado discussed the 1994 Cairo International Conference on Population and Development (ICPD) as the basis for a new approach to comprehensive reproductive health. She noted that the ICPD adopted an approach that was oriented to human growth and development and social responsibility. The focus of services should integrate the biological, the psychological and the social aspects across one's life cycle. There should be a gender focus along with sexuality, an ongoing concern for the relation of the population to the environment, involvement of individuals and groups in decisions about services needed, and an intersectoral approach to such services. Above all, ICPD demands that we seek new models of services that reflect this change in paradigm to reproductive health within the context of human development. The settings of such services should include health clinics, schools, places of work, recreation sites, local government and communities. Comprehensive reproductive health services must have political support as well.

The priorities for reproductive health services are to reduce inequities in societies, provide services for those at risk for ill-health who currently cannot enter the health system, improve the quality of services and improve the quality and utilization of information. New approaches require that we adopt a systemic vision of the problems and interventions, base decisions on solid evidence, provide responsive services and learn how to package health messages. The individual strategies include active participation in designing and using reproductive health services, empowerment and self-determination, and creating new ways to act as an agent for needed change in health services and the reproductive health of the entire family as well as the community. Programmatic strategies include a focus integral to health and development, strengthening the information/knowledge base, research, expansion of human resources, defining policies and disseminating information. She summarized the four elements of the change process as values, vision, strategies/policies and realities/actions and asked the groups to consider each of these elements in their discussions. Carol Collado concluded her remarks by challenging each participant

to think of their own country/locale as well as the new vision of reproductive health within the context of human development when carrying out the tasks that followed during the workshop.

Vision for Reproductive Health

As noted in the introduction to the "competencies" document (Appendix E), the vision for reproductive health has evolved over time. Reproductive health was originally understood as referring to services related to family planning. The definition of reproductive health has moved from the biological to include the affective, the cultural and the implications of population growth for sustainable development. Reproductive health must be viewed as an essential part of human development, based on human rights and responsibilities. On an individual level, reproductive health is a constant during the entire life cycle for both women and men, and extends through the family into the community with a concern for the relationship of population to the environment. Reproductive health is about people and their relationships, their values, their ethics, and their hopes for the future. The definition of reproductive health used in this document is taken from the ICPD 1994 document that reads:

> *Reproductive health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.* These definitions of reproductive health and reproductive health care provided the framework for organizing tasks during the workshop and for establishing competencies needed by professionals who provide reproductive health care.

Task #1: Needs for Reproductive Health in the Americas

Each small group assigned by the partners spent time discussing the realities of reproductive health in their countries using indices of health, reproductive health services availability and use as well as personal experiences and then reported back to the total group in the afternoon for further discussion. The analysis served to identify the needs of individuals, families and communities in order to achieve reproductive health in their lives. They were asked to consider the following question: *What do people need to achieve Reproductive Health as 1) individuals, 2) as families, and as 3) communities?* A unified/consensus statement of needs (realities) for reproductive health that came out of this activity follows and responds to the question above - What do people need to achieve reproductive health? The statements include the realities that need to be in place for every individual and community to achieve reproductive health in its broadest terms

(See Appendix F for the integrated draft of Vision, Values, Strategies and Action suggested by the group).

Individual

Men and women are recognized as persons with rights and responsibilities who participate in the construction of attitudes and behaviors in reproductive health within the context of values and social mores. Education and information are pillars that orient the process of socialization and development of one's concept of reproductive health throughout the life cycle. Sexuality is an integral component of reproductive health, and its consideration is integral throughout the life cycle within formal and informal education.

Family

The family is the fundamental base for the development of the value structure of its members and for the promotion of human development and social responsibility in reproductive health. This facilitates the empowerment for human rights and the development of a culture of health.

Community

Through participation, the needs and priorities of the community are identified. Since communities are constantly changing, this implies the need for understanding and respect for the values and customs of different social groups. This participation is made visible in actions based upon identified needs that have been prioritized by the community.

As individuals, families and communities move toward a societal orientation of reproductive health within the context of human development, vision, values, strategies and actions will be critical. The groups also identified some of the values, strategies and actions as follows.

Values

Specific values inherent in comprehensive reproductive health are protecting and strengthening specific human rights, including the right to privacy and confidentiality, respect for human dignity and the right to participate actively and knowledgeably in decisions affecting one's body and life. Ethical and legal concepts of informed consent, autonomy and self-determination, doing good and avoiding harm and social justice (equity) are essential to the provision of comprehensive reproductive health services. Advocacy and support for the empowerment of women, men and adolescents with rights and their corresponding responsibilities are also key values inherent in a comprehensive approach to reproductive health within the context of human development. These values and ethical concepts also inform the vision stated earlier.

Strategies

The group concurred that individual strategies include active participation, empowerment, and a willingness to become an agent for change. This involves strengthening one's sense of value and self-esteem, and access and use of educational fora and other sources of up-to-date information on reproductive health. Community and program activities require multisectoral support,

social policies that reflect the needs of the population and the collective development of a culture of health rather than a disease approach to health. Other strategies include research to improve the quality of care, alliances and coordination of activities with sectors and social actors, active male involvement and building networks for family and community support. The community needs to be committed to political action needed to make reproductive health a priority and reproductive services available, acceptable and accessible to every adolescent and adult. The community also needs to be the vehicle for the dissemination of accurate, up-to-date, understandable information on reproductive health methods and services.

Action

The group reached consensus on the following actions needed to promote a new vision of comprehensive reproductive health and the services needed to support this vision. Once the expanded competencies are available for testing, all health professional curricula need to be reviewed to make sure the requisite knowledge, skills and attitudes are addressed. Subsequently, standards of practice, manuals, policies and procedures will need to be updated. Interdisciplinary education and clinical experiences would follow the review of curricula. Other suggested actions included preparation of youth leaders as peer counselors in reproductive health, development of support systems for adolescents and adults, including school for fathers. Flexible service schedules and individualized care based on the needs of the population and individuals are other actions needed. In recognition of the expanded definition of reproductive health and its need for attention well before boys and girls are biologically able to procreate, the group suggested that formal and informal training in parent-child relations, safe sexual habits and responsibility to prepare for parenthood begin at early ages.

Each small group reported on the outcomes of their Task #1 and the recorders for the day summarized the work that was used to preface the competency document attached to this report.

Competencies: Development, Content and Consensus

At the end of the first day, Maricel Manfredi led a discussion of competency development for clinical practice and content that is normally included. She provided two articles for reference [McLagan, PA. (May 1997) *Competencies: The Next Generation*. Training and Development, pp.40-47 and Irigoin, M.E. (1996) *El Torno al Concepto de Competencias*. Programa Fortalecimiento de_Servicios de Salud, Ministerio de Salud, Lima, Peru] for the participants and asked that they spend time during the evening hours reviewing the ICM draft of essential competencies for midwifery practice as they begin the definition of essential competencies for reproductive health.

Social Celebration

The participants were transported to the home of the President of the Medical Sciences Campus, University of Puerto Rico, for a reception hosted by Dr. Jose Hawayak. This was a welcome diversion from the day's intense activity, and most appreciated by all who attended.

Day 2: September 1, 1998

Maricel Manfredi was the moderator for the morning session. She welcomed the group and briefly reviewed the previous day's work and evening assignments. Hearing general enthusiasm for the work ahead, she proceeded to introduce the speakers for the early morning.

Professional Association's Roles in Reproductive Health

International Confederation of Midwives (ICM)

Peg Marshall, ICM Regional Representative for the Americas, gave a brief history about ICM. She noted that the ICM was started in 1919, though meetings were suspended during the Second World War. Beginning again in 1954, the ICM holds triennial meetings globally with the next meeting in May 1999 in Manila, Philippines. She noted that ICM is a federation of midwifery associations, and governance is set by the Council that meets prior to each triennial meeting. Midwifery associations whose members meet the ICM/WHO/FIGO international definition of "midwife" are eligible to join ICM. ICM is the only international midwifery organization with non-governmental status (NGO) with the United Nations and its agencies. Peg Marshall noted that the active members in the Region of the Americas include Canada, Chile, Ecuador and the United States. Jamaica, Paraguay and Brazil are members but not active within ICM at this time.

Peg Marshall briefly described the development of competencies for basic midwifery practice that is an ongoing project within ICM, now in its second year and round seven of a Delphi survey of member associations. The seventh draft will be presented to the ICM Council in May 1999 for discussion and action. It is the goal of ICM to provide this essential competency document to all member associations and countries who are interested in reviewing their midwifery education and practice. As noted in the 6th draft being used by participants at this workshop, there are both basic and additional categories for the competencies, taking into consideration what is essential for all midwives and what might vary from country to country and region to region, depending on availability of human resources and particular health needs. At the May 1999 triennial congress, work will begin on developing global standards for midwifery practice based on these competencies.

International Council of Nurses (ICN)

Emerald Leon-Williams was the designated ICN representative to this consultative group. She is the President of the Trinidad and Tobago Nurses' Association. She briefly described efforts within Trinidad and Tobago to develop and expand competencies for nurses and strengthening the nursing curricula to improve standards of education and practice. She noted the nurses' commitment to values and universal ethical principles. The competencies under review will strengthen maternal health care, family planning, prevention and treatment of infectious diseases, and community based care of the sick as well as care of infants and children. In 1997, the revision of midwifery curricula resulted in a module on reproductive health care incorporated within Safe Motherhood, noting the four pillars of family planning, prenatal care, clean and safe delivery, and essential obstetrical care.

Federation of Gynecologists and Obstetricians (FIGO)

Carol Collado presented on some of the current FIGO activities in reproductive health as a representative was not able to attend this consultation. She noted that FIGO headquarters is in

London, England. One of the main objectives of the organization is to promote the highest quality of clinical care for women, and for the past ten years members have been active participants in the global Safe Motherhood programs. The next world conference will be in Washington, D.C. in early 2000.

Carol Collado noted that within the region of the Americas, FIGO received a grant with FNUAP and will be working with professional associations in Canada and the United States to conduct continuing education programs on “Maternity without Risk” and provide technical assistance to Haiti and throughout Central America. She also noted that the FLASOG group in Paraguay has created courses with practical experience in research in the field of reproductive health.

The rest of the morning and early afternoon was spent in small groups with assigned tasks two and three. These were combined the evening before by the partners in order to conserve time and allow for critique and expansion of the competency document for most of the day.

Tasks 2 and 3:

Task 2: Using the health indicators to define priorities in reproductive health within your sub-region, what essential competencies are needed by health professionals providing reproductive health care across the continuum of life?

Task 3: Using the ICM draft #6 competency document as input on defining the essential competencies for reproductive health, consider the following:

Introduction: What concepts and principles are needed for the expanded concept of reproductive health?

What should be the framework for a model of care for reproductive health?

In reviewing the basic and additional lists of knowledges, skills and attitudes, what needs to be added to reflect the expanded concept of reproductive health within the context of human development?

The small groups worked very hard on these combined tasks, and asked for more time in early afternoon to continue their work. They returned to the larger group in mid-afternoon to present the results of their deliberations. The information on Tasks 2 and 3 has been incorporated into the suggested competency document found in Appendix E and will not be discussed here. This revision included a very important group of “broad areas of competency” that permeate all areas of clinical practice in reproductive health, such as learning how to learn, establishing effective interpersonal relationships and communication skills, and knowing how to produce, interpret and disseminate scientific evidence within reproductive health. The group also noted that special emphasis should be placed on the reproductive health of women considering woman’s three main roles: production, reproduction and social. Gender and gender sensitivity was repeatedly discussed by the participants along with the need for evidenced-based interventions and efforts to reduce violence, especially violence against girls and women.

One group noted the importance of viewing any competency document as changing with changing needs and demographics of countries/regions. Therefore those who would use the

document need to have the flexibility to analyze the current needs and priorities in their country and then change the competencies to fit those priorities and needs. It was agreed by all that this is an important caveat to use with any such competency document - its use needs to be tailored to the country/community. The group also discussed the need to address changes required in the provision of services and the administration of systems of care in reproductive health. This includes having appropriate and sufficient supplies, equipment and qualified personnel available to guarantee the safety and integrity of all persons (adolescents, adults) who come for reproductive health care. One group also suggested the need for a family record including psychosocial history and common questions that professionals might use to obtain a history of violence, etc. Quality assessment and continuous quality improvement of health services is a requirement as individuals and systems seek to implement an integrated reproductive health approach to health services.

It should be noted here that the experts were generous with time, spirit, and knowledge, and the resulting competency document is truly a reflection of their expertise and wisdom. It is anticipated that this document will be sent to the participants, Ministers of Health, agencies responsible for regulation of health workers, international associations and professional associations of midwives, nurses and physicians. The next phase of competency development will include testing for validity in a variety of countries.

Carol Collado and Sandra Land provided a summary of work to date and clarified the ongoing vision and reality of reproductive health within the context of human development.

Brainstorming Objectives 2,3 4

The final hours of the afternoon were spent in small groups with the task of brainstorming over Objectives 2,3,4 - issues and strategies for the preparation of health workers with integrated reproductive health competencies. A summary of ideas regarding Objective 2 included the need for interdisciplinary preparation of health workers with an emphasis on humanized caring and care, the preparation of individual cadres of health worker in accord with the scope of practice they are expected to realize, use of new reproductive technologies on indication, and involving the community in all aspects of planning and implementation of reproductive services. It was also noted that new teaching methods are needed to prepare health workers with gender, cultural and ethnic sensitivity in order to create a culture of health. Preparation of faculty to teach comprehensive reproductive health must be a priority, with several participants noting that many faculty also need preparation in how to teach, especially how to teach critical thinking. Discussion of the need to keep teaching in touch with the reality of clinical practice followed along with an emphasis on quality assurance and legal aspects of practice. Planned updates in the form of continuing education are also needed for all cadres of health workers.

Objective 3 discussion included issues related to strategic planning within agencies, operational research (both quantitative and qualitative), and clarification of roles and expectations of all levels of health workers. Several experts also discussed the need for emphasis on professional ethics and what it means to be a professional health worker. A suggestion was made to use a variety of media to promote understanding of the concept of reproductive health and what communities and individuals can do to promote it. Other discussion focused on current inadequate referral systems and lack of trust among health workers that can jeopardize the health of individuals seeking reproductive care.

Objective 4 resulted in awareness that health professionals need to understand and respect the values and traditions within the community, especially those community leaders/workers who have garnered the trust and admiration of the community for their service in times of need. Traditional health workers must be valued and understood, including expertise and limitations in providing reproductive services. Collaboration is based on mutual trust and respect, and this is learned by working with as well as in the community. Above all, emphasis in all reproductive health care must be on high quality, safety and appropriateness with a high regard for team work. Programs to upgrade the knowledge and skills of traditional health personnel are essential for their self-esteem and integration within the health care team in reproductive health. Local projects involving different disciplines is one method of learning about each other's roles and competencies.

The end of the day included review of Task #4 - the development of an action plan during the evening. Several participants then took advantage of viewing two videos from WHO. They were "Why did Mrs. X die?" and "Opening the gates to life" - the introduction to the Mother-Baby Package.

Day 3: September 2, 1998

The final day of the consultation began with enthusiasm. Sandra Land was the facilitator and each person presented their Action Plan to the total group. Task #4 asked each person to respond to the following statement from his/her own perspective: "What I will do to improve the quality of reproductive health." The group was asked to speak to local, national and international actions. A summary of such actions and major themes are offered to the reader. The individual plans are to be carried out when the participants return to their countries.

Local Actions

For those in educational institutions, work with curriculum committees on the review of existing content in relation to the evolving competencies for reproductive health, introduce/enhance the use of research in the field, and plan for programs in schools of public health including advanced degrees for nurses and midwives.

Work in schools, churches and colleges to bring knowledge of the importance of reproductive health and each person's responsibility for their own health throughout life.

Use information gained in this workshop to compile a bibliography for use by colleagues and prepare/provide a variety of seminars and workshops for the community.

Support quality models of reproductive services and work to replicate.

National Actions

- Increase participation/partnerships with WHO/AMRO country representatives to spread knowledge of reproductive health within the context of human development.
- Support country level commissions on reproductive health within Ministries of Health.
- Campaign for use of folic acid and childhood vaccinations.
- Strengthen legislation in support of comprehensive reproductive services and well prepared health professionals to provide such services within local communities.
- Participate in the elaboration of standards of reproductive care for adolescents, women and men.
- Participate in national professional organizations and offer information on the vision for reproductive health for the new millennium.
- Offer courses to nurses, midwives and physicians in content related to reproductive health and organize national conferences on this topic.
- Publish information on comprehensive reproductive health and services needed.

International Actions

- Participate and present papers on reproductive health at international meetings.
- Plan and implement regional meetings with a reproductive health focus.
- Work more closely with WHO/AMRO and participate in their meetings on reproductive health.
- Request WHO materials on reproductive health to distribute to all health professional schools for use by faculty and students.
- Seek grant funds for conferences, curriculum revision, community education in reproductive health.
- As can be seen from this brief summary, each participant left the meeting with a full plan of action and new partners for collaboration within countries and among countries in the various regions of the Americas. Follow-up by mail is planned to support and encourage action throughout the Americas and beyond.

Evaluation of workshop

The final activity of the workshop was a written evaluation. Participants were asked to also write suggestions as to how this consultative group might work in the future. Overall evaluation of the three days was very positive with each objective being met. Details of the evaluation can be found in Appendix G.

Summary of outcomes of the workshop

It was anticipated that there would be three distinct outcomes from this first workshop: 1) consensus on essential competencies for health professionals in reproductive health; 2) consensus on competencies for teachers/clinicians in reproductive health; and 3) an action plan to implement essential competencies throughout the region of the Americas. The major outcome was #1 - a draft of Essential *Competencies Suggested for Health Workers Providing Comprehensive Reproductive Health Services* (See Appendix E). These competencies were based on the *Vision for Reproductive Health in the Americas* presented in the introduction to this document. The second planned outcome was not realized and will be the focus of a future workshop addressing preparation of teachers in reproductive health. Individual and regional action plans were developed during the workshop and shared with all participants at the end of the third day.

Overall, the partners are pleased with the results of this consultative group and continue with enthusiasm to seek ways to continue the work started during these three days.

Future Plans

The draft competency document has been edited for use as a stand-alone document. It is planned to send this document to participants, Ministries of Health, professional groups, and those responsible for regulation of health professionals and community workers with a cover letter from WHO/PAHO partners asking for feedback, additions/deletions, and encouraging use/testing of the

competencies. The partners are also seeking other sources of funding to continue the work begun at this workshop, and informally continue to work together to promote the new vision of reproductive health for the Americas.

APPENDIX A

Consultative Group on Midwifery Skills for Reproductive Health
30 August to 2 September 1998

Faculty Club, Medical Sciences Center
University of Puerto Rico, San Juan

FINAL AGENDA FOR CONSULTATIVE GROUP

Sunday, August 30, 1998

9:00 am Meeting of Partners Planning Group

Arrival of Participants at Hotel del Centro, Medical Sciences Campus (room assignments given upon arrival)

Monday, August 31, 1998

7:00 am Breakfast on own

7:30 am Registration - Faculty Club (5th floor)
Sonia Senariz - Director Continuing Education, UPR

9:00 am Opening Ceremony
Dr. Jose Hawayek, Acting Rector, Medical Sciences Campus, UPR
Dr. Alida de Galletti, Acting Dean, School of Public Health, Medical Sciences Campus, UPR
Dr. Carol Collado, Coordinator, Family Health & Population Program, PAHO/WHO

9:45 am Introduction of participants and observers: moderator Dr. Joyce Thompson

10:00 am Overview, vision, objectives
- Joyce Thompson, Maricel Manfredi
Theme "Partners with a common cause: Quality Reproductive Health Care in the Americas"
Review of workplan for Consultative Group
Group assignments and tasks

10:30 am Coffee and Tea

11:00 am Global Perspective and Needs in Reproductive Health
- Anne Thompson, WHO Geneva, Division of Family and Reproductive Health, Maternal Safe Motherhood
Questions and Discussion

11:45 am	Regional Perspective on Needs in Reproductive Health - Carol Collado, Coordinator, Family Health & Population Program, PAHO/WHO Questions and Discussion
12:15 pm	Lunch on own
2:00 pm	Small group discussion of Reproductive Health needs Task #1: Vision for Reproductive Health
3:00 pm	Report of small groups on Task #1
3:45 pm	Coffee and tea
4:15 pm	Competencies: Development, content, consensus - Maricel Manfredi - Joyce Thompson
5:00 pm	End of Day 1: Evening Assignments: Review contents of folder Review essential competencies document
6:00 pm	Bus transport to President's Home
7:00 pm	Social Celebration: President's Home, Medical Sciences campus, UPR

Tuesday September 1, 1998

7:00 am	Breakfast on own
8:00 am	Welcome and review of Assignments: Moderator - Maricel Manfredi
8:15 am	Role of Health Professional Groups in Competency Development and Implementation - International Confederation of Midwives - Peg Marshall - International Council of Nurses - Emerald Leon-Williams
8:45 am	Small group work: Tasks #2 & #3 2. Using health indicators from sub-region, define essential competencies needed by health professionals 3. Critique ICM document for omissions/additions
10:00 am	Coffee and tea
11:00 am	Continued work on competencies in small groups
12:00 noon	Lunch on own
1:30 pm	Small group reports: Consensus on Midwifery Skills for Reproductive Health

- The vision
- The competencies

3:00 pm	Discussion of vision and reality: Carol Collado, Sandra Land
3:30 pm	Tea Break
4:00 pm	Small group work: Brainstorming session on Objectives 2,3,4: Issues and strategies for the preparation of health workers with integrated reproductive health competencies
5:00 pm	Review of Workplan for Next Day Assignments for Evening: Begin Action Plan
6:00 pm	Preview of videos from WHO: "Why did Mrs. X die?" and "Opening the Gates to Life"
6:30 pm	Dinner on Own
8:00 pm	Task #4 - Action Plan development by country groups

Wednesday, September 2, 1998

7:00 am	Breakfast on own Checkout from Hotel for those leaving today
8:15 am	Review of work to date: Moderator - Dr. Sandra Land
8:30 am	Presentation of Action Plans
10:45 am	Tea Break - working session
11:00 am	Summary and Plans for Future
12:00 noon	Evaluation
12:30 pm	Departure

26 September 1998

APPENDIX B

CONSULTATIVE GROUP ON MIDWIFERY SKILLS FOR REPRODUCTIVE HEALTH
30 August to 2 September 1998

Faculty Club, Medical Sciences Center
University of Puerto Rico, San Juan

Small Work Groups

Caribbean Group (English)
Barbados
Pauline Sergeant
Margaret Williams
Maria Barker

Jamaica
Sandra Reid
Dorothy Rooms

Trinidad
Emerald Leon-Williams (ICN)

Anne Thompson (WHO-Geneva)
Pablo Lavin (Chile)
Sandra Land (PAHO)

Mixed Group
Chile
Ivelise Segovia
Berta L. Martinez

Puerto Rico
Rosa Melendez
Jose Gorrin
Myriam Castro de Castaneda

Magda Barini Garcia (HHS)

Central America Group
Costa Rica
Maria Griselda Ugalde Salazar

Panama
Cleopatra Allen
Luz America Cedeno

Honduras
Chrystabel Parchment

Nicaragua
Leyla Solis Piuza
Marlene Oporta Urbina

Dominican Republic
Jenny Garcia

Guatemala
Raul Najarro

Carlos Vargas (Mexico)
Peg Marshall (ICM)
Guillermo Otero-Herman (Puerto Rico)

Andean Group
Peru
Juana Echeandia
Zaida Zagaceta Guevara

Mexico
Severino Rubio Dominguez
Maria Teresa Ayala

Brazil
Marli Villela Mamede
Maria Antonieta Rubio Tyrnell

Joyce Thompson (Penn)
Carol Collado (PAHO)
Victor Huapaya (Peru)

Ecuador
Mercedes Ayala
Patricia Narvaez de Espinoza

Colombia
Iraides Soto

Maricel Manfredi (PAHO)
Ernest Pate (PAHO)
Gisela Pimentel (PAHO)
Irene Sandvold (HHS)

APPENDIX C

GLOBAL NEEDS IN REPRODUCTIVE HEALTH

Anne Thompson, MSM/RHT
Puerto Rico
September, 1998

Reproductive health touches the core of our humanity, of its past, its present and its future. It accounts for much that is rewarding and joyous in life - its absence can be the source of misery and even of humiliation. And yet it remains largely misunderstood, misinterpreted and little discussed. Slowly, sometimes very slowly, that is changing, and that change is the main reason why we are here today.

This year has seen countries and regions worldwide concentrated on the development of plans and strategies for the implementation of a coherent service of reproductive health. Now, here in San Juan, midwives and nurses from many different countries of Latin America are taking up the challenge. Nearly five years after the Cairo Conference, the fourth International Conference on Population and Development (ICPD), the time seems ripe for this exercise. Each of us, in our different positions, with our different responsibilities and faced with the different realities of the countries in which we work, has had both time and opportunity to reflect on the principles agreed at Cairo.

Five years ago the concept of reproductive health was fairly new. Even its translation was a problem in many languages. Although in many respects the content - the different elements of RH such as family planning and sexually transmitted infections - was well known, the underlying philosophy of the concept, which supposes an integrated approach to the lifetime experience of individuals in terms of their reproductive health, was unfamiliar. All of a sudden, the focal point for consideration was the individual and her or his needs, and hopes and concerns, rather than the simple question of service provision. As a result of many meetings, discussions and debates, particularly multisectoral efforts to draw a new profile of reproductive health and to develop strategies to make it accessible to all, we have deepened our understanding of the concept and become familiar with the language. Where, previously, midwives and nurses might have been tempted to say "but we've been doing that for years" - family planning, maternal and child health services etc - they are now looking harder at the real needs of the populations they serve and trying to identify the gaps.

This paper will attempt, very briefly, to give you a taste of the sort of discussions which have been going on worldwide and which are now bearing fruit as countries start to reorganize their health services to correspond better with the needs and aspirations of their people. Since my work takes me more frequently to Africa than anywhere else, you will understand that many of the examples that I quote will come from there. However, every comer of the globe is engaged in this exercise of trying to put into practice the principles spelled out at Cairo (App. 1). The task is enormous, and many parts of the world are experiencing considerable economic and political difficulty which make prioritizing reproductive health very difficult - after all, it is not the only health problem to demand attention. However, it is an issue which affects everyone, and an issue which touches the very heart of human experience, human relations and human fulfillment, even if, too frequently, it is insufficiently discussed. Health workers are well positioned to understand this, if they will only stop for a moment to reflect on the meaning of the

services they offer and the reality of peoples lives. Sadly, all too often, they do not, or cannot take this step, so services become mechanized, routinised, compartmentalized and, in the end often heartless or unfeeling.

Starting the Process

First let's look at what needs to be done. Reproductive health is the result of the interplay of many factors, in society, in the individual and in the health system. Countries which have recognized this have ensured that their strategies reflect this complexity and have resisted the temptation to reduce reproductive health to the simple provision of certain services. Rather than draw up a "shopping list" of the components of reproductive health, many countries have developed a matrix which enables them to acknowledge and incorporate the many different elements from many different sectors which have a part to play in determining RH outcomes. Such matrixes use a *lifetime approach* (OHP 1) to identifying the issues while describing the *enabling environment* (OHP 2) needed in society if appropriate change is to be made, before they go on to define the *essential components* (OHP 3) of the RH programme needed for their country, both within and outwith the health system. No country or region starts from zero, for even the most disadvantaged have some basic provisions, even if they are poorly distributed or not of good quality, so one of the first places to start from is a thorough inventory of what already exists. No country's strategy looks exactly like another, for regional, cultural, economic and developmental differences will shape the particular form that any given country profile will take.

Nonetheless, countries have an enormous amount to learn from each other, a great deal of experience to share. For this reason VMO headquarters and regional offices has been engaged with facilitating inter-country or sub-regional meetings in different parts of the world as RH strategies are developed. During this last year African countries from the Mediterranean to the Cape of Good Hope have taken part in the development of country plans based on a Strategy for the African Region 1998-2007[1] (App.2). This has involved four sub-regional meetings of about a dozen countries each in different parts of the continent - and with different language groups, since so much of Africa is Francophone. To make what I am talking about more concrete I shall describe something of the process that has been going on for the past couple of years. The Strategy for Africa was developed over a period of time and endorsed by the Ministers of Health from the Region. Its central feature is a matrix like the one I have just described above.

The components of the matrix were agreed after a long period of discussion among the various partners (OHP 4), but it is important to note that the matrix is simply an indicative framework on which countries can build.

A good example of such adaptation comes from Namibia, in the extreme south west of the African continent. There is an excellent public health infrastructure in the country and a well-trained cadre of midwives, with a relatively low maternal mortality rate However, the situation analysis which provided the basis for developing their own RH matrix made it clear that there were two major problems which were insufficiently addressed. The very high proportion of young people in the country, together with its recent history and its religious and cultural background meant that RH needs of adolescents and approaches to deal with the high rate of sexual and domestic violence had to be priorities. While many sub-Saharan African countries to

the north of Namibia still had to retain maternal mortality reduction and the elimination of Female Genital Mutilation among priority targets for their RH programmes, Namibia found that it needed to develop a strategy with a different profile.

A recent Round Table on Adolescent Sexual and Reproductive Health reviewed progress made in the five years since Cairo.[2] It noted that some 85% of the world's adolescents live in developing countries. Although early marriage and some harmful traditional practices are diminishing, young people are increasingly exposed to unwanted pregnancy, STDs and HIV infection. Every year some 60 000 adolescent women die from pregnancy related problems, one of the major causes of death among female adolescents, while up to 4.4million undergo unsafe abortions[3]. Sexual abuse and exploitation, including using very young people for commercial sex trade, are real concerns. Many such youngsters find themselves heavily disadvantaged and have their chances of maturing (culturally, spiritually, intellectually and emotionally, as well as physically) greatly limited by the constraints of their environment, as they find themselves homeless, on the street, refugees, displaced or caught up in civil unrest.

Services to meet the reproductive health needs of young people must reach out well beyond the walls of the health system. They need information, a safe place to talk, people who can listen without sitting in judgement and, sometimes, health services which will be sympathetic as well as discreet and efficient. Imagination and creativity are needed to break the adult barriers surrounding adolescent sexuality and reach young people through community-based, school-based and media-based activities, as well as through the health system. One such example is the "Scenarios from the Sahel" competition which mobilized 12000 young people from three countries to develop 4000 scenarios designed to sensitize young people to the problem of HIV 30 were selected to be turned into short films and videos. The project had such an enormous impact on creating awareness about HIV and AIDs that it is likely to be replicated elsewhere in Africa.

Violence, sexual and domestic, violence which has become an everyday experience for many women and girls, to the point where in some parts of the world mothers take their daughters to the clinic at the onset of puberty to make sure that they are protected against pregnancy if rape should occur, violence for which there is little or no redress, whatever the law says, is another aspect of women's reproductive lives which calls for action. At one clinic I visited, run jointly by the social services and the police, the age range for the victims of rape in the previous year ran from three years old to eighty-four. Some countries have decided to take a public stand against the escalation of such violence and to build violence-reduction programmes into their strategy for Reproductive Health.[4]

Such developments cannot be hurried too much, particularly at a time when most countries are simultaneously implementing major reforms in their health systems. Precisely because reproductive health both influences and is influenced by many other sectors other than the health system the development of national priorities can only be done at all accurately by engaging in consensus building, at national, regional and local levels.(OHP 4) This takes time and resources. This meeting, here in Puerto Rico, is a vital part of such consensus building, only at a different level. It gives the opportunity to a significant group of health workers with very considerable experience from a number of countries in the same region to reflect on the realities which they hold in common and on the differences which they recognize in their own countries. The exercise should highlight the specific contribution which you can make to the development of a national RH strategy which corresponds with people's real needs.

How do we find out what is needed?

All this activity has set the scene for the global implementation of the principles of Cairo. How are to we find out what people's needs are, either at a global or at a local level? In fact, I suspect that the process of finding out is far more interesting and probably more effective at a local level than globally, where it all too often means establishing careful estimates based on the country data provided by governments and from other sources. At local level, even in very small ways, you have all sorts of possibilities, such as focus groups and exit interview, or even simply a systematic visit to the women you have looked after during birth before they leave the facility, open to you to find out what women's needs really are as they perceive them. A few years back the ACNM produced a button with an important slogan "Listen to women........ if we don't do that we shall never learn what they REALLY need.

A straightforward example of the sort of information received from women which helps planners design reproductive health services is seen in the next two figures. (OHP 5 & 6). The first shows the percentage of married women of reproductive age who currently use contraception. The dark colour is for 1994. You can see that your own region stands at about 60%, level with Asia. The next table is far more informative, for it shows not simply the current family planning use, but also the unmet need to space births (in blue) and to limit family size (in pale pink). These last two figures tell health planners much more clearly than the first one what the real, present need is, and even what the type of need is, whether just to space births more effectively or to determine the size of the family. These two needs require different responses and planners, for example, in Peru, Ecuador and Bolivia as well as Egypt, Kenya and Burundi will realize that a high proportion of the contraceptive demand in their countries is to enable couples to limit the size of their families rather than simply to ensure a longer interval between births - most of these couples just do not want to increase the size of their families, and need advice and services to help them achieve their goal, as Cairo stated "the right to decide the number and timing of pregnancies".

What can we do globally?

At a global level we have to remember the maxim "think globally, act locally", for, as even the UN's own document on the "World's Women"' says, it is almost impossible to generalize in this area. Reproductive health is so very individual, so sensitive and so situation-specific that great global generalizations just do not work.

We have therefore to work with partners such as UNICEF and UNFPA, as well as with international NGOs and others with immense field experience, to *develop tools* which can be adapted to local use, such as the recently published series on indicators for Reproductive Health, the MotherCare community diagnosis material, the sisterhood method for maternal mortality investigation and the safe motherhood needs assessment. In partnership with others we can continue the process of *setting standards* **-** work which is set out for a wide range of reproductive health issues in the Mother-Baby Package and more specifically in the document on Care in Normal Birth. *Improving clinical and management skills* is part of our job, by developing materials such as the Midwifery Teaching Modules, the Reproductive Health Electronic Library and management materials for national planners of reproductive health programmes as well as a workshop for district managers for safe motherhood. Our *advocacy role* involves sensitizing decision makers and politicians worldwide to what needs to be done-

this year's major effort around Safe Motherhood is a good example - and supplying them with the *information* on which to base their decisions, as well as to provide a foundation from which to *monitor progress***.**

An example of the sort of information which is used to persuade planners and politicians to invest in women's health is seen in the following slide. (OHP8) This shows the maternal and perinatal mortality in UN sub-regions compared with the presence of a skilled attendant at birth or for antenatal care. As you can see, there is a direct correlation between the presence of the skilled attendant at birth (dark blue) and a decrease in maternal mortality - this has been one of the clearest lessons learned over the ten years of the Safe Motherhood Initiative, but it still has to be demonstrated to people who do not necessarily understand the special nature of childbirth, a perfectly normal event which occasionally and very suddenly can go dramatically wrong, threatening the lives of both the mother and her baby and demanding the immediate availability of high levels of skill if they are to be saved. A number of developing countries, such as Sri Lanka, Myamnar, Indonesia and Cuba, have recognized this lesson of history and have deliberately planned to professionalise care in childbirth, making trained midwives available at community level so that women can access services as near their homes as possible and that there is minimum delay in recognizing problems and taking action when they arise.

Reproductive health is, of course, much more than care in childbirth, but very often, and particularly in countries where women's status and consequently her care are not well catered for, where she has little access to education, little control over the decisions which determine her own life and no economic independence, childbirth care is an obvious place to start to improve reproductive health generally[6]. For one thing, the months of pregnancy offer the potential, if they are well used, for teaching the woman and her family about many other aspects of their lives as a family, as a couple. They also are one of the very few points in most women's lives where there is contact with the health system, and that precious opportunity has to be used to the utmost to promote the woman's health and that of her family.

Three words govern much of what we are attempting to do in partnership with governments worldwide to improve reproductive health; we are trying to make sure that every woman has access to the care she needs, we are trying to increase the COVERAGE of services. Next we are working to make sure that that service is of a consistently high standard and is based on the best evidence for good practice - we are trying to ensure QUALITY services. Finally, we are trying to make sure that people's needs are met in such a way that they do not have to go to a whole range of different outlets - we are trying to ensure that the reproductive health service is INTEGRATED. In some parts of the world integrated RH services are a fast increasing reality, with health centres changing their work-schedules to meet the local people's needs: midwives in Namibia were making sure they were around when school closed so that the young adolescents had someone to discuss their questions with. In Zambia clinics were making sure that women who were experiencing violence or difficulty at home were able to talk to someone when they came to the clinic to have the baby weighed. At the same time they could also be checked for STDs if they were worried.

One of the major concerns of health planners is the under-use of services. This is a complex issue with many causes. It is well known, for instance, that adolescents will avoid using health facilities if it is at all possible. Why, though, do so many women who attend faithfully for antenatal visits during pregnancy finally stay at home to deliver alone, in difficult conditions, or helped simply by a relative or TBA? Sometimes the reasons are financial - they simply cannot

afford the fees. More often they are related to deep seated, undisclosed cultural preferences, when they are not a response to poor quality services or staff attitudes which leave them feeling stripped of their dignity. In South and Central Asia women are overwhelmingly reluctant to be attended by a male health worker - their shyness, their modesty as well as their low status and economic situation bar them from seeking care within the formal health system[7]. Although Reproductive Health is, in the first instance clearly an issue which is determined outside the health system, the way that system functions, the way it is perceived, can have an enormous impact on the eventual health outcomes of a particular community or group. This has to be a major focus for operational research in the future as governments seek to design the RH services best adapted to the needs and challenges of their populations.[8]

Conclusion

Ten years of research has taught us many things, positive and negative regarding reproductive health[9]. People's lives are changing and more women are being educated. They are marrying later, having their first child later and their families are getting smaller. More of them have access to medical care during pregnancy and more of their children are surviving. However, there are still many parts of the world where more than half the women of reproductive age still have no education, marry before the age of eighteen or do not know how to get a modem contraceptive. Up to a quarter of them in some places have experienced the death of a young child and still nearly 600 000 of them die as a result of pregnancy or childbirth each year - millions will remain scarred for life by the lack of care during delivery, while millions more will experience genital tract infection and sexual violence and exploitation. Despite all the gains in recent years much remains to be done, many needs remain unmet.

Providing an integrated reproductive health service starts with understanding people's needs and continues with the willingness to change the way we do things. It means listening to women, to young people, to older people, to men. It also means listening to the evidence, and making sure that our practice is constantly readjusted in the light of the best available data. Often we don't like our routines disturbed, we don't like our view of what is the best thing to do challenged, we particularly don't like to relinquish the power of deciding what we shall do when and how. In spite of all this, I deeply believe that midwives and nurses are among the people best placed to bring about a real change in achieving reproductive health for all. They - you - are there at critical moments in people's lives. They - you - if only you will use your best skills, can offer a listening ear, non-judgmental care and objective, informed advice to those of all ages who seek reassurance but are often afraid or too embarrassed to ask. Reproductive health is about partnerships - of course - but the partnership is often more about empowering the individual to take charge of her or his own health rather than simply providing services in the traditional pattern. Because you are women (most of you!), because you live the same hopes and fears, anxieties and pains in your own lives, your own bodies, because you are professionals responsible, aware, informed and accountable as well as trained to empathy and skilled for caring you are the frontline reproductive workers par excellence of tomorrow's world.

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1. WHO Regional Office for Africa 1998 *Reproductive Health – Strategy for the African Region 1998-2007.* AFR/RC47/8. World Health Organization Regional Office for Africa, Harare.

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3. WHO 1998 *The Second Decade: Improving Adolescent Health and Development,* WHO/FRH/ADFU98.18, World Health Organization, Geneva.

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5. United Nations 1995 *The World's Women 1995 - trends and statistics.* Social Statistics and Indicators Series K No 12. United Nations. New York.

6. DHS 1996 *The Status of Women: Indicators for Twenty-Five Countries*. DHS Comparative Studies no.21. Macro International Inc.

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8. CERPOD 1997 *Youth in Danger - Reproductive Health in the Sahel. Results of a regional survey in five West African countries.* CERPOD, Bamako.

9. DHS 1994 *Women's lives and experiences - a decade of research findings from the Demographic and Health Surveys Program.* Macro International Inc. Maryland

APPENDIX D

draft....**#3 – March 1999**

CONSULTATIVE GROUP ON MIDWIFERY SKILLS FOR REPRODUCTIVE HEALTH

ESSENTIAL COMPETENCIES SUGGESTED FOR HEALTH WORKERS PROVIDING COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

Introduction

The situation of reproductive health in the Region of the Americas demands a concerted response from health professionals that requires significant changes in the way in which they are educated and practice their professional roles. As one response, a partnership was formed in Fall 1997 that included the Pan American Health Organization's (PAHO) Human Resources Development, Family Health and Population and Organization and Management of Health Systems programs; the University of Pennsylvania School of Nursing; and the Department of Health and Human Services Division of Nursing. The goal of this partnership is to improve the health status of women and families in Latin America and the Caribbean. The first activity was to bring together a group of expert nurses, midwives, and physicians from the Region of the Americas to offer consultation on the skills needed to implement a comprehensive approach to reproductive health, in keeping with the recommendations of the Plan of Action from the Cairo International Conference on Population and Development (ICPD).

The Consultative Group met at the University of Puerto Rico, Medical Sciences Campus from 30 August to 2 September 1998. During the consultative workshop on reproductive health for the Americas, participants (midwives, nurses and physicians) were asked to reach consensus on the knowledge, skills and attitudes needed by health professionals expected to provide comprehensive reproductive health services to individuals. This document reflects a synthesis of the group discussions and recommendations.

Background

With new expectations, changes are demanded in the way in which we stimulate the normal development processes, design services, promote healthy lifestyles, and respond to demands to further the reproductive health of the people of the Region. In spite of significant advances on the conceptual level in the past several years, in part stimulated by public debates around the international conferences, the operational expression of reproductive health as evidenced in the health sector and in other environments such as schools or workplaces is still a beginning process. Policies, services, and community activities will need to be developed to assure reproductive health for all.

Reproductive health must become a political and societal priority, with adequate resources and support allocated from national government to local communities. Comprehensive reproductive health services requires societal participation, legal support for providers and

services, and a mandate for quality care. Reproductive health professionals must be committed to this quality mandate and use exquisite and effective interpersonal skills and communication with all members of society.

Process for change

A framework for the process of change was presented to the Consultative Group as background for discussions and decisions that followed. This included four essential elements: values, vision, strategies/policies and realities/action. The consultative group was asked to consider these elements and to put them in the framework of comprehensive reproductive health. The vision for reproductive health used in this document is taken from work done within the Family Health and Population Program, Pan American Health Organization, and ratified by the Ministers of Health in the 25th Pan American Sanitary Conference in September 1998. Other materials such as draft #6 of the *ICM Essential Competencies for Basic Midwifery Practice* (1998) were used as background information. In the group discussions, some approached the development of reproductive health competencies from the strategy/policy perspective initially and others began with values. All groups then tested the vision, values, strategies and actions against the health realities in their own country. The composite summary of the deliberations are included in the information that follows.

Values

Specific values inherent in comprehensive reproductive health are protecting and strengthening specific human rights including the right to privacy and confidentiality, respect for human dignity and the right to participate actively and knowledgeably in decisions affecting one's body and life. Ethical and legal concepts of informed consent, autonomy and self-determination, doing good and avoiding harm, and social justice (equity) are essential to the provision of comprehensive reproductive health services. Advocacy and support for the empowerment of women, men and adolescents with rights and responsibilities are also key values inherent in a comprehensive approach to reproductive health within the context of human development. These values also inform the vision that follows.

Key Reproductive Health Concepts

The key concepts that define the unique role of professionals in reproductive health in promoting the health of women, men and childbearing families include: working with women to promote self-care and the health of women, men, infants and families; respect for human dignity and treating women as persons accorded full human rights; advocacy for those whose voices have been silenced; empowerment of those whose voices must be raised for better health care; cultural sensitivity, and working with women, men, policy makers and health care providers to overcome those cultural practices that harm women; and a focus on health promotion and disease prevention viewing pregnancy as a normal life event. Professionals in reproductive health recognize that the greatest impact on global maternal-child and reproductive health begins with the status of women and young girls that ensures equity and that they have better conditions of living such as adequate nutrition, clean water and sanitation. Reproductive health professionals are committed to the improvement of basic living conditions as well providing competent health services.

Vision for reproductive health[1]

The concept of reproductive health is one that has been developing for some time. It was originally understood as referring to those services which were provided for family planning; however, this definition has been transformed several times. It has moved from the biological to consider the affective, the cultural, and the implications of population growth for sustainable development. The present amplified concept positions reproductive health as an essential part of human development. It is based on human rights and responsibilities, both individual and societal. It encompasses the principles of equity, respect for self-determination, and consideration of human beings as embodying biopsychosocial integrity, and it incorporates a gender perspective.

On an individual level, reproductive health is a constant during the entire life cycle. It extends through family and community groups and is concerned with the relation of population to the environment. Reproductive health is about people and their relationships, their values, their ethics, and their hopes for the future. There is perhaps no other area in health that touches individuals and societies so profoundly and, because of this, it is often subject to strong debate and different interpretations. However, without underestimating such differences, it is clear that many concerns in regards to reproductive health are common to all belief and value systems. These common concerns have important implications for the field of public health. Many urgently need concerted action in order to continue progress and to consolidate the gains made during this century.

Needs for Reproductive Health (Realities)

In keeping with the new vision of reproductive health, the consultative group discussed the realities of reproductive health within their countries using indices of health, reproductive health services availability and use, and personal experiences. This analysis served to identify needs of individuals, families and communities to achieve reproductive health in their lives.

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> . . . a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (ICPD 1994).

Individual

Men and women are recognized as persons with rights and responsibilities who participate in the construction of attitudes and behaviors in reproductive health within the context of values and social mores. Education and information are pillars that orient the process of socialization and development of one's concept of reproductive health throughout the life cycle. Sexuality is an integral component of reproductive health, and its consideration is integral throughout the life cycle within formal and informal education.

Family

The family is the fundamental base for the development of the value structure of its members and the promotion of human development and social responsibility in reproductive health. This facilitates the empowerment of human rights and the development of a culture of health.

Community

Through participation, the needs and priorities of the community are identified. Since communities are constantly changing, this implies the need for understanding and respect for the values and customs of different social groups.

As individuals, families and communities move toward a societal orientation of reproductive health within the context of human development, vision, values, strategies and actions will be critical.

The Reproductive Health Model of Care

In keeping with the vision of comprehensive reproductive health viewed within the context of human development, the model of care needed is based on health promotion and disease prevention. This health orientation views reproduction and childbearing as a normal life event, and is based on helping individuals, families and communities understand their responsibility for health, including reproductive health. The Reproductive Health Model of Care includes: monitoring the physical, psychological, spiritual and social well-being of individuals throughout the life cycle beginning prior to conception and continuing into the elder years. This includes special attention to sexual education; prevention of sexually transmitted diseases including HIV/AIDS and cancer of the cervix; preconception care and counseling for men and women; attention to Safe Motherhood including prenatal, labor/delivery and postnatal care of the woman/newborn/family; providing individualized education, providing appropriate information to individuals that allow those persons to be involved in the decision making process, and offering counseling related to family planning/child spacing; minimizing inappropriate technological interventions; and identifying and referring individuals who require specialist attention. This model of care is based on human development and social responsibility and therein lies its accountability.

Scope of reproductive health practice

Reproductive health practice focuses on the development of individual, family and community capacities to promote their reproductive health and to avoid harm. In addition to the traditional aspects in the provision of services, the life cycle focus involves a life-long learning process in relationship to the different age-related manifestations of sexuality and reproductive health, including consideration of pregnancy as a normal life event.

Reproductive health services begin prior to conception and include special attention to the needs of newborns, the girl-child, adolescents, pregnant women/families. The professional in reproductive health provides necessary supervision, care, support and counseling. Reproductive health care includes primary health care supervision within the community; health counseling and education for adolescents, men, women, the family and the community including self-care strategies and preparation for parenthood; the provision of family planning/child spacing services; skilled attendance at birth; the detection of abnormal conditions in the individual; the procurement of specialized assistance as necessary (consultation or referral); and the implementation of primary and secondary emergency measures. Reproductive health care practice is conducted within a community-based health care system that may include non-professional, indigenous workers such as Traditional Birth Attendants (TBAs), traditional healers, auxiliary nurses/midwives, and other community-based health workers.

Health professionals assume responsibility and accountability for their practice, facilitated by critical thinking and use of a decision-making framework. They recognize all individuals as persons worthy of respect. They apply up-to-date knowledge and skills in caring for each adolescent, woman and family. The safety and overall well-being of the individuals being served is of foremost concern to the health professional. The health professional strives to support the adolescent's and woman's sense of well-being and their informed reproductive choices in the context of a safe experience that is also culturally relevant. The health professional's decision making process utilizes a variety of sources of knowledge, intuitive precepts, and the ability to think critically and make sound clinical judgments. The decision process is dynamic, responds to the changing health status of each individual seeking reproductive health services, and anticipates potential problems before they occur. Health professionals in reproductive health involve the individuals they care for and their families in all parts of the decision-making process and in developing a plan of care for a healthy reproductive cycle of life, including the pregnancy and birth experience. The following framework for decision making is offered as a model for use in reproductive health care by health professionals.

Framework for Decision Making

Step 1: Collect information from the individual, their health records, physical examination, and any laboratory tests in a systematic way for a complete assessment.

Step 2: Identify actual or potential problems based on the correct interpretation of the information gathered in Step 1.

Step 3: Develop a comprehensive plan of care with the individual and relevant others based on the individual's needs and supported by the data collected.

Step 4: Carry out and continually update the plan of care within an appropriate time frame.

Step 5: Evaluate the effectiveness of care given with the individual and family, consider alternatives if unsuccessful, returning to STEP 1 to collect more data and/or develop a new plan.

Broad areas of competencies

Throughout this document, the term "competency" is used to refer to a series of performance statements of competency in a given clinical area followed by the specific knowledge, skills and behaviors under each broad statement required of the health professional (midwife, nurse, physician) for safe practice in any setting with a primary health care focus. They answer the questions, "What does a professional in reproductive health need to know and what do they do in the course of providing health services across the life span with a primary health care focus?" The competencies developed recognize that in addition to their own clinical areas of responsibility, some midwives, nurses and physicians have a responsibility to supervise, delegate and evaluate reproductive health services carried out by non-professional and indigenous health workers with limited or no formal preparation for a role in reproductive health service delivery.

Having analyzed the actual context in the region of the Americas for professional practice which takes into account both different levels of attention (care) and the processes of health care reform active in the majority of the countries, the consultative group defined several broad areas of competency that are included in each area of reproductive care during the life cycle. It should be noted that these areas go beyond the strict clinical interpretation of midwifery skills needed for comprehensive reproductive health, and include other relevant areas.

The broad areas of competencies include:

- learning how to learn and how to think critically
- establishing supportive interpersonal relationships
- establishing effective communication patterns
- producing, interpreting and using appropriate information for decision-making; eg. health indices, discrimination of the quality of care based on patterns of use of services, data bases, etc.
- providing quality services
- managing and organizing health service delivery
- stimulating active community participation
- organizing and implementing appropriate educational fora for students, health workers and population groups
- advocating and promoting comprehensive reproductive health
- participating in the development of health policies for reproductive health
- ensuring that the practitioner remains up to date in their knowledge and clinical practice

Summary

The statement of essential competencies that follows incorporates the values, vision, strategies and actions needed by a professional in reproductive health to implement comprehensive reproductive health care within the context of development.

ESSENTIAL COMPETENCIES SUGGESTED FOR HEALTH WORKERS PROVIDING COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

GENERIC KNOWLEDGE, SKILLS AND BEHAVIORS FROM THE SOCIAL SCIENCES, PUBLIC HEALTH, AND THE HEALTH PROFESSIONS

Competency #1: Professionals in reproductive health have the requisite knowledge, skills and attitudes from the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for individuals from childhood through the later years.

Basic Knowledge and Skills:

1. Understanding and respect for local culture [customs].
2. Beneficial and harmful traditional and modern routine health practices.
3. Resources for alarm and transport [emergency care] of sick community members who need additional care.
4. Direct and indirect causes of maternal and neonatal mortality and morbidity in the community.
5. Advocacy and empowerment strategies for adolescents and women promoting human rights and equity.
6. Lobbying, negotiation and networking strategies.
7. Intersectoral approaches to reproductive health.
8. Benefits and risks of available birth settings.
9. Organization and management of delivery systems for health services, including access issues.
10. Advocacy for safe and comprehensive reproductive health care and services.
11. Effects of gender on reproductive health and choices.
12. Roles of women in society; eg. social, reproductive, worker.
13. Knowledge of the community - its state of health including water supply, housing, environmental hazards, food, common threats to health, and level of education.
14. Indicators of use of reproductive services.
15. Reproductive rights for men, women, adolescents.
16. Ethical issues in sexuality and reproduction.
17. Regulation/laws governing professional practice.
18. Evidence-based practice: analysis of production of information and interpretation of results.
19. Outcome evaluation processes for reproductive health.
20. Delegation and supervision strategies of lesser trained health workers.

Additional Knowledge and Skills

21. Epidemiology, sanitation, community diagnosis and vital statistics.
22. National and local health infrastructures and how to access needed resources for reproductive health care.
23. Community-based primary care using health promotion and disease prevention strategies.
24. Knowledge of national immunization programs and provision of/or access to immunization services for community members.

Professional Behaviors - The health professional:

1. Is responsible and accountable for clinical decisions.
2. Participates in periodic updates of knowledge and skills to remain current in practice.
3. Uses universal precautions, infection control strategies and clean technique.
4. Uses appropriate consultation and referral during care.
5. Remains non-judgmental, culturally respectful [non-authoritarian] during care.
6. Uses a partnership model of working with women/men/adolescents so they can make informed choices about all aspects of their care and take responsibility for their own health.
7. Knows and uses listening and facilitation skills.
8. Knows the indications for and applies techniques of adult and infant cardiopulmonary resuscitation.
9. Knows how to assemble, use and maintain equipment and supplies appropriate to setting of practice.
10. Works collaboratively with other health workers to improve the delivery of services to women and families.
11. Advocates for women's choices within institutional settings.
12. Understands and practices in an ethical manner.

PRE-PREGNANCY CARE AND FAMILY PLANNING

Competency #2: Professionals in reproductive health provide accurate, culturally sensitive health education and health promotion support to all in the community in order to achieve healthy family life, planned pregnancies and positive parenthood.

Basic Knowledge of:

1. Growth and development related to sexuality, sexual development and sexual activity, including alternative sexual orientations.
2. Female and male anatomy and physiology related to conception and reproduction.
3. Cultural norms and practices surrounding sexuality, sexual practices and childbearing.
4. Components of a health history, family history and relevant genetic history.
5. Physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy.
6. Health education content targeted to reproductive health, sexually transmitted diseases (STD's), HIV/AIDS, and child survival.
7. Natural methods for child spacing and other locally available and culturally acceptable methods of family planning.
8. Barrier, steroidal, mechanical, chemical and surgical methods of contraception control and indications for use.
9. Counseling methods for women and men needing to make decisions about methods of family planning.
10. Signs and symptoms of urinary tract infection and common sexually transmitted diseases in area.
11. Screening for breast and prostate cancers.
12. Content for teaching self-examination of breasts and prostate gland.
13. Factors involved in decisions relating to unplanned or unwanted pregnancies.
14. Assessment of and counseling for infertility.
15. Indicators of common acute and chronic disease conditions defined by geographic area of the world, and referral process for further testing/ treatment.

16. Indicators of and methods of counseling/referral for dysfunctional interpersonal relationships including sexual problems, domestic violence, emotional abuse and physical neglect.
17. Gender focus.

Basic Skills:

1. Take a comprehensive history.
2. Perform a physical examination focused on the presenting condition of the woman.
3. Order and/or perform and interpret common laboratory studies such as hematocrit, urinalysis or microscopy.
4. Use health education and basic counseling skills appropriately.
5. Provide locally available, culturally and religiously acceptable methods of family planning.
6. Teach breast and prostate self-examination techniques.
7. Record findings and interventions [actions, what was done].

Additional Skills:

8. Use the microscope, and other diagnostic tools available.
9. Provide all available methods of barrier, steroidal, mechanical, and chemical methods of family planning.
10. Take or order cervical cytology smear (Pap test).

CARE AND COUNSELING DURING PREGNANCY

Competency #3: Professionals in reproductive health provide quality antenatal care that maximizes the potential for a healthy pregnancy, and that includes early detection and treatment/referral of selected complications.

Basic Knowledge of:

1. Basic anatomy and physiology of the human body.
2. Menstrual cycle and process of conception.
3. Signs and symptoms of pregnancy.
4. How to confirm a pregnancy.
5. How to diagnose an ectopic pregnancy, multiple fetuses, and other risk factors.
6. Dating pregnancy by menstrual history, size of uterus and/or fundal growth patterns.
7. Components of a health history, including emotional status, social and family support.
8. Components of a focused physical examination for antenatal visits.
9. Normal findings [results] of basic screening laboratory studies defined by need of area of the world; eg. iron levels, urine test for sugar, protein, acetone, bacteria.
10. Normal progression of pregnancy: body changes, common discomforts, expected fundal growth patterns.
11. Normal psychological changes in pregnancy, impact of pregnancy on the family, and emotional risk factors.
12. Safe, locally available herbal/non-pharmacological preparations for the relief of common discomforts of pregnancy.
13. How to determine fetal well-being during pregnancy including fetal heart rate and activity patterns.
14. Nutritional requirements of the pregnant woman and fetus.

15. Basic fetal growth and development.
16. Education needs regarding normal body changes during pregnancy, relief of common discomforts, hygiene, sexuality, nutrition, work inside and outside the home, and techniques to handle stress and anxiety.
17. Preparation for labor, birth and parenting.
18. Preparation of the home/family for the newborn.
19. Indicators of the onset of labor.
20. How to explain and support breastfeeding.
21. Techniques for increasing relaxation and pain relief measures available for labor.
22. Effects of prescribed medications, street drugs, traditional medicines, over the counter drugs on pregnancy and the fetus.
23. Effects of smoking, alcohol use and illicit drug use on the pregnant woman and fetus.
24. Signs and symptoms of conditions that are life threatening to the pregnant woman; eg. pre-eclampsia, vaginal bleeding, premature labor, severe anemia, and methods for teaching these to women and men.

Additional Knowledge of:

25. Signs, symptoms and indications for referral of selected complications and conditions of pregnancy: eg. asthma, HIV infection, diabetes, cardiac conditions, post-dates pregnancy, Rh sensitization.
26. Effects of above named chronic and acute conditions on pregnancy and the fetus.

Basic Skills:

1. Take an initial and ongoing history each antenatal visit.
2. Perform a physical examination and explain findings to woman.
3. Take and assess maternal vital signs including temperature, blood pressure, and pulse.
4. Assess maternal nutrition and its relationship to fetal growth.
5. Perform a complete abdominal assessment including measuring fundal height, position, lie and descent of fetus.
6. Assess fetal growth.
7. Listen to the fetal heart rate and palpate uterus for fetal activity pattern.
8. Perform a pelvic examination, including sizing the uterus and determining the adequacy of the bony structures.
9. Calculate the estimated date of delivery.
10. Educate women and families about danger signs and when/how to contact a midwife.
11. Teach and/or demonstrate measures to decrease common discomforts of pregnancy.
12. Provide guidance and basic preparation for labor, birth and parenting.
13. Identify variations from normal during the course of the pregnancy and institute appropriate interventions for:
    a. low and/or inadequate maternal nutrition;
    b. inadequate fetal growth;
    c. elevated blood pressure, proteinuria, presence of significant edema, severe headaches, visual changes, epigastric pain associated with elevated blood pressure;
    d. vaginal bleeding;
    e. multiple gestation, abnormal lie at term;
    f. intrauterine fetal death;
    g. rupture of membranes prior to term.

14. Perform basic Life Savings Skills competently.
15. Record findings and interventions.
16. Counsel women about health habits; eg. nutrition, exercise, safety, stop smoking.
17. Perform clinical pelvimetry [evaluation of bony pelvis].
18. Perform breech births in emergency situations.
19. Identify and refer variations from normal during the course of the pregnancy, such as:
    a. small for dates [light]/large for dates [heavy] fetus.
    b. suspected polyhydramnios, diabetes, fetal anomaly (eg. oliguria).
    c. abnormal laboratory results.
    d. infections such as sexually transmitted diseases (STD's), vaginitis, urinary tract, upper respiratory.
    e. fetal assessment in the post-term pregnancy.
20. Treat and/or collaboratively manage above variations from normal based upon local standards and available resources.
21. Perform external version of breech presentation, explain and analyze potential complications.

Additional Skills:

22. Monitor fetal heart rate with doppler.

CARE DURING LABOR AND BIRTH

Competency #4: Professionals in reproductive health provide appropriate and culturally sensitive care during labor, conduct a clean and safe birth, and handle selected emergency situations to maintain the health of women.

Basic Knowledge of:

1. Physiology of labor.
2. Anatomy of fetal skull, critical diameters and landmarks.
3. Psychological and cultural aspects of labor and birth.
4. Indicators that labor is beginning.
5. Normal progression of labor and how to use the partograph or similar tool to identify uterine dystocia.
6. Measures to assess fetal well-being in labor.
7. Measures to assess maternal well-being in labor.
8. Process of fetal passage [descent] through the pelvis during labor and birth.
9. Comfort measures in labor: eg. family presence/assistance, positioning, hydration, emotional support, non-pharmacological methods of pain relief.
10. Transition of newborn to extrauterine life.
11. Physical care of the newborn - breathing, warmth, feeding.
12. Promotion of skin-to-skin contact of the newborn with mother when appropriate.
13. Ways to support and promote uninterrupted [exclusive] breastfeeding.
14. Physiological management of the 3rd stage of labor.
15. Indications for emergency measures: eg. retained placenta, shoulder dystocia, atonic uterine bleeding, neonatal asphyxia.
16. Indications for operative delivery: eg. fetal distress, cephalo-pelvic disproportion, placenta previa, uterine rupture, placental abruption.

17. Indicators of complications in labor: bleeding, labor arrest, malpresentation, eclampsia, maternal distress, fetal distress, infection, prolapsed cord.
18. Principles of active management (Brandt-Andrews, controlled cord traction) of 3rd stage of labor.

Basic Skills:

1. Take a specific history and maternal vital signs in labor.
2. Perform a screening physical examination.
3. Do a complete abdominal assessment for fetal position and descent.
4. Time and assess the effectiveness of uterine contractions.
5. Perform a complete and accurate pelvic examination for dilation, descent, presenting part, position, status of membranes, and adequacy of pelvis for baby.
6. Provide psychological support for woman and family.
7. Provide adequate hydration, nutrition and comfort measures during labor.
8. Provide for bladder care.
9. Promptly identify abnormal labor patterns with appropriate and timely intervention and/or referral.
10. Perform appropriate hand maneuvers for a vertex delivery.
11. Manage a cord around the baby's neck at delivery.
12. Cut and repair an episiotomy if needed.
13. Support physiological management of the 3rd stage of labor.
14. Guard the uterus from inversion during 3rd stage of labor.
15. Inspect the placenta and membranes for completeness.
16. Estimate maternal blood loss.
17. Inspect the vagina and cervix for lacerations.
18. Repair vaginal/perineal lacerations and episiotomy.
19. Manage postpartum hemorrhage.
20. Provide a safe environment for mother and infant to promote attachment.
21. Initiate breastfeeding as soon as possible after birth and support exclusive breastfeeding.
22. Perform a screening physical examination of the newborn.
23. Record findings and interventions.

Additional Skills:

24. Perform appropriate hand maneuvers for face and breech deliveries.
25. Inject local anesthesia when needed.
26. Apply forceps and/or vacuum extraction when needed.
27. Manage malpresentation, shoulder dystocia, fetal distress appropriately.
28. Identify and manage a prolapsed cord.
29. Perform manual removal of placenta.
30. Identify and repair cervical lacerations.
31. Perform internal bimanual compression of the uterus to control bleeding.
32. Insert intravenous line, draw bloods, perform hematocrit and hemoglobin testing.
33. Prescribe and/or administer pharmacological methods of pain relief when needed.
34. Administer oxytoxics appropriately for labor induction or augmentation and treatment of postpartum bleeding.
35. Transfer woman for additional/emergency care in a timely manner when indicated.

POSTNATAL CARE OF WOMEN

Competency #5: Professionals in reproductive health provide comprehensive, high quality postnatal care for women and their families.

Basic Knowledge of:

1. Normal process of involution and healing following delivery [abortion].
2. Process of lactation and common variations including engorgement, lack of milk supply, etc.
3. Maternal nutrition, rest, activity and physiological needs (eg. bladder).
4. Infant nutritional needs emphasizing exclusive breast-feeding.
5. Parent-infant bonding and attachment; eg. how to promote positive relationships.
6. Indicators of subinvolution eg. persistent uterine bleeding, infection.
7. Indications of breastfeeding problems and possible solutions offered.
8. Signs and symptoms of life threatening conditions; eg. persistent vaginal bleeding, urinary retention, incontinence of feces, postpartum pre-eclampsia.
9. Care and counseling needs during and after abortion.
10. Signs and symptoms of abortion complications.

Additional Knowledge of:

11. Indicators of selected complications in the postnatal period: eg. persistent anemia, hematoma, embolism, mastitis, depression, thrombophlebitis.

Basic Skills:

1. Take a selective history, including details of pregnancy, labor and birth.
2. Perform a focused physical examination of the mother.
3. Assess for uterine involution and healing of lacerations/repairs.
4. Initiate and support uninterrupted [exclusive] breastfeeding.
5. Educate mother, father and other family members on care of woman and infant after delivery including rest and nutrition.
6. Identify hematoma and intervene as appropriate.
7. Identify maternal infection, treat or refer for treatment as appropriate.
8. Record findings and interventions.

Additional Skills:

9. Counsel woman/family on sexuality and family planning post delivery.
10. Counsel and support woman who is post-abortion.
11. Evacuate a hematoma.
12. Provide appropriate antibiotic or other medicines for treatment for infection.
13. Refer for selected complications.

NEWBORN CARE (up to 2 months of age)

Competency #6: Professionals in reproductive health provide care for the essentially healthy infant from birth to two months of age.

Basic Knowledge of:

1. Newborn adaptation to extrauterine life.
2. Basic needs of newborn: airway, warmth, nutrition, bonding.
3. Elements of assessment of the immediate condition of newborn; eg. APGAR scoring system for breathing, heart rate, reflexes, tone and color.
4. Basic newborn appearance and behaviors.
5. Newborn assessment including clinical history, weight, length, head circumference and glucose levels; evaluate urinary and fecal output during first 24 hours.
6. Normal newborn and infant growth and development.
7. Selected variations in the normal newborn; eg. caput, molding, mongolian spots, hemangiomas, hypoglycemia, hypothermia, dehydration, infection.
8. Elements of health promotion and prevention of disease in newborns and infants.
9. Immunization needs, risks and benefits for the infant up to 2 months of age.

Additional Knowledge of:

10. Selected newborn complications, eg. jaundice, hematoma, adverse molding of the fetal skull, cerebral irritation, non-accidental injuries, causes of sudden infant death.
11. Normal growth and development of the preterm infant up to 2 months of age.

Basic Skills:

1. Clear airway to maintain respirations.
2. Maintain warmth but avoid overheating.
3. Assess the immediate condition of the newborn; eg. APGAR scoring or other assessment method.
4. Perform a screening physical examination of the newborn for conditions incompatible with life.
5. Position the infant for breastfeeding.
6. Educate parents about danger signs and when to bring infant for care.
7. Begin emergency measures for respiratory distress (newborn resuscitation), hypothermia, hypoglycemia, cardiac arrest.
8. Transfer newborn to emergency care facility when available.
9. Record findings and interventions.

Additional Skills:

10. Perform a gestational age assessment.
11. Educate parents about normal growth and development, child care.
12. Assist parents to access community resources available to the family.
13. Support parents during grieving process for congenital birth defects, loss of pregnancy, or neonatal death.
14. Support parents during transport/transfer of newborn.
15. Support parents with multiple births.
16. Offer genetic counseling when necessary.

PERIMENOPAUSAL CARE (this needs work - new category)

Competency #7: Professionals in reproductive health provide comprehensive, appropriate care for women during the perimenopausal period of their lives.

Basic knowledge of:

1. Signs and symptoms of menopause, including physiologic changes in woman's organs of reproduction.
2. Risk factors for cardiovascular accidents and bone density.
3. Emotional and psychological responses to cessation of reproductive activity.
4. Indications and use of hormonal replacement therapy.
5. Change in screening times, methods for breast, cervical and uterine cancer.

Basic Skills:

1. Health history
2. Complete physical examination.
3. Counseling for changes in sexuality, body image.
4. Suggest strategies/interventions used to diminish unwanted symptoms (eg. hot flushes).
5. Perform cancer screening tests.

GLOSSARY OF SELECTED TERMS

APGAR score = a rating scale (0,1 or 2) for breathing, heart rate, reflexes, muscle tone and color of newborn generally counted at 1 and five minutes after birth. Developed by Dr. Virginia Apgar.

Autonomous care = self-directed and responsible for decisions in the provision of health care.

Bonding/attachment = the concept of mother/father and baby getting to know one another

Clinical Pelvimetry = vaginal measurement of bony pelvis; eg. pubic arch, sidewalls, curve of sacrum.

Counseling = active suggestions for dealing with specific life situations.

Education = providing knowledge and promoting understanding through teaching.

Ethics and human rights = knowledge of what is good, bad, right, wrong in treating one another.

Focused physical examination = examination of selected areas of body related to reason for care.

Illicit drugs (street drugs) = generally refers to opiates, illegal substances; eg. Cocaine.

Primary emergency care = activities that treat an existing emergency; eg. bimanual compression of uterus for postpartum hemorrhage.

Secondary emergency care = community activities needed for alarm and transport of women needing specialist care.

Selective health history = obtaining history related to presenting condition.

APPENDIX E

VISION FOR REPRODUCTIVE HEALTH

Individual

Men and women are recognized as persons with rights and responsibilities in the development of their reproductive health throughout the life cycle, even before birth. The education and information are pillars that orient the process of socialization and development.

Family

The family is the fundamental base for the development of active social responsibility in reproductive health care. This development facilitates the empowerment for human rights and the development of a culture of health.

Community

An orientation to respect for the values and customs of different social groups and to support a change process in the exercise of active social responsibility. Visualizing this participation in actions based upon identified needs prioritized by the community. Sexuality is a component inherent in reproductive health; the consideration is integral throughout the life cycle, in formal and informal education.

Values

Strengthening of the ethic in regards to rights of

- privacy
- confidentiality
- informed consent
- humanization
- autonomy
- exercise of self-determination
- empowerment for reproductive rights

Strategies

- multisectoral support
- Strengthening values and self-esteem
- participative education
- Social policies that integrate aspects such as
    - needs of the population
    - abortion
    - fertility management
- Research to improve quality of care
- Collective development of a culture of health

- Social participation with equity and universality
- Alliances and coordinations with sectors and social actors
- Health services which are accessible and readily available
- Active male participation in reproductive health
- Ecologically sustainable development
- Networks for family and community support

Action

- Review of curricula
- Interdisciplinary work experiences
- Preparation of youth leaders for peer reproductive health
- Formal and informal training starting at early ages and including aspects such
- As parent child relations, single parent families and free choice in family planning alternatives
- Development of support systems
- School for fathers
- Flexibility in service schedules and care based upon the needs of the population.

APPENDIX F

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