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# THE MIDWIFE IN MATERNITY CARE

## Report of a WHO Expert Committee



WORLD HEALTH ORGANIZATION
GENEVA
1966

## WHO EXPERT COMMITTEE ON THE MIDWIFE IN MATERNITY CARE

*Geneva, 19-25 October 1965*

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# THE MIDWIFE IN MATERNITY CARE

## Report of a WHO Expert Committee

A WHO Expert Committee on the Midwife in Maternity Care met in Geneva from 19 to 25 October 1965. The meeting was opened by Dr P. Dorolle, Deputy Director-General, who welcomed the members and outlined the purpose of the Committee. He said that the development of midwifery services in many countries and changes in modern health services had made advisable a reassessment of the contribution made by the midwife in maternity care. Each country had its own problems, and he hoped the Committee would be able to make some recommendations that might help to solve them.

Dr Allan C. Barnes was unanimously elected Chairman, Mrs M. Šlajmer-Japelj Vice-Chairman, and Dr D. Morley and Mrs K. A. Pratt Rapporteurs.

### 1. INTRODUCTION

It is now over ten years since the report of the WHO Expert Committee on Midwifery Training [1] was published, and thirteen years have elapsed since the publication of the report of the WHO Expert Committee on Maternity Care.[2] In the meantine, other WHO Expert Committee have referred to maternity care as a part of the public health services or in connexion with the training of auxiliary workers, including auxiliary midwives.[3]

The WHO Expert Committee on the Midwife in Maternity Care was convened to review the work of the midwife and to define her contribution to maternity care in the light of developments and changes that have occurred during the last decade. In its discussions it covered as many geographical areas as possible and considered the work of traditional birth attendants as well as that of midwives and auxiliary midwives.

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1955, **93**.

[2] *Wld Hlth Org. techn. Rep. Ser.*, 1952, **51**.

[3] *Wld Hlth Org. techn. Rep. Ser.*, 1958, **156**.

## 2. MATERNITY CARE

### 2.1 Definition

The Committee considered the definition of maternity care recommended by the WHO Expert Committee on Maternity Care in 1952.[1] This was thought to be comprehensive and was re-affirmed with one minor alteration reflecting more recent trends. The definition as adopted by the Committee reads as follows:

> The object of maternity care is to ensure that every expectant and nursing mother maintains good health, learns the art of child care, has a normal delivery, and bears healthy children. Maternity care in the narrower sense consists in the care of the pregnant woman, her safe delivery, her postnatal care and examination, the care of her newly born infant, and the maintenance of lactation. In the wider sense it begins much earlier in measures aimed to promote the health and well-being of the young people who are potential parents, and to help them to develop the right approach to family life and to the place of the family in the community. It should also include guidance in parent-craft and in problems associated with infertility and family planning.

The only change was the insertion of the words " care and " after the word " postnatal " in the second sentence.

### 2.2 Developments

Many developments and changes in the pattern and concepts of maternity care have been accelerated in the last decade.

An outstanding development is the increase in the number of deliveries taking place in hospitals or maternity centres. In certain countries almost 100% of the mothers have their babies in hospital. In others, the percentage is smaller, but nearly everywhere there has been an increase in the provision of hospital facilities, especially in urban areas, which has resulted in improved safety for mother and child at the time of delivery.

Linked with the increase in hospital confinements has been the trend towards a shorter stay in hospital. This has resulted from the continuing shortage of maternity beds and from a change in attitude towards postnatal care. Mothers are now encouraged to get up earlier and to do as much as possible for themselves and their babies, and consequently they go home earlier than in the past. Where this change in the pattern of maternity care has occurred, it has led to a division of responsibilities: the domiciliary midwife is mainly concerned with prenatal and postnatal care, while the hospital midwife deals with the delivery. In some countries, continuity of care by any one midwife or even by a group of midwives is becoming increasingly difficult.

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1952, **51**, 3.

Another development occurring in some countries is the increasing interest taken by the medical profession in normal midwifery. This has affected the work of the midwife in that she now works much more closely with the doctor. Furthermore, a number of other people are participating in certain aspects of maternity care. The midwife has thus become a member of a team which, in addition to the obstetrician, paediatrician and family doctor, may include the public health nurse or health visitor, maternity nurse, and physiotherapist. Where there is a shortage of midwives in the hospital service, auxiliary staff who are not trained in midwifery are employed to undertake duties that do not require the technical skill of the midwife, who often must provide supervision for these workers.

Increasing emphasis is now being laid on the prevention of perinatal deaths. The frequency of perinatal mortality surveys in various countries, in which midwives have participated, emphasises the need to discover the cause of these deaths and to highlight ways in which they can be prevented. During the last ten years, more attention has also been paid to the importance of the prenatal period, and emphasis has been placed on early and continued care. Better standards of prenatal care, among other factors, have contributed to improvements in maternal and perinatal mortality rates. A larger proportion of the midwife's time is presently spent on this aspect of her work than was formerly the case.

There has in some countries been a growing demand for teaching in preparation for childbirth, including instruction in the various methods used to relieve pain. This instruction is usually given to groups of expectant mothers, and midwives are participating in it to an increasing extent. At the same time, the importance of the psychological aspects of childbearing and the need to help expectant mothers and fathers to adjust themselves to their roles as parents is receiving more attention.

Legislation concerned with the protection of women workers during the maternity period has contributed towards the improvements of maternal care. The International Labour Conference has played an important role since its first session in 1919, when it laid down a set of standards for maternity protection, a concept that has been recognized and incorporated into the legislation of many countries and also embodied in general terms in the Universal Declaration of Human Rights.[1] These standards are not only concerned with employment rights for women workers during their maternity period, but also specify measures to safeguard the health of mothers both before and after confinement.[2]

In certain parts of the world, a change of attitude towards population

[1] United Nations (1963) *The universal declaration of human rights : a standard of achievement*, New York.

[2] International Labour Organisation (1965) *A world survey of national law and practice*, Geneva.

problems is taking place that has led governments to adopt a population policy encouraging family planning. This was reflected in the discussions that took place at the Eighteenth World Health Assembly, where the following Resolution [1] was passed:

The Eighteenth World Health Assembly,

Having considered the report of the Director-General on Programme Activities in the Health Aspects of World Population which might be developed by WHO,[2]

Bearing in mind Article 2 (*l*) of the Constitution which reads : " to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment ";

Noting resolution 1048 (XXXVII) adopted by the Economic and Social Council at its thirty-seventh session, August 1964;

Believing that demographic problems require the consideration of economic, social, cultural, psychological and health factors in their proper perspective;

Noting that the United Nations Population Commission at its thirteenth session, April 1965, attached high priority to the research and other activities in the field of fertility;

Considering that the changes in the size and structure of the population have repercussions on health conditions;

Recognizing that problems of human reproduction involve the family unit as well as society as a whole, and that the size of the family should be the free choice of each individual family;

Bearing in mind that it is a matter for national administrations to decide whether and to what extent they should support the provision of information and services to their people on the health aspects of human reproduction;

Accepting that it is not the responsibility of WHO to endorse or promote any particular population policy; and

Noting that the scientific knowledge with regard to the biology of human reproduction and the medical aspects of fertility control is insufficient.

1. APPROVES the report of the Director-General on Programme Activities in the Health Aspects of World Population which might be developed by WHO;[2]

2. REQUESTS the Director-General to develop further the programme proposed :

(*a*) in the fields of reference services, studies on medical aspects of sterility and fertility control methods and health aspects of population dynamics; and

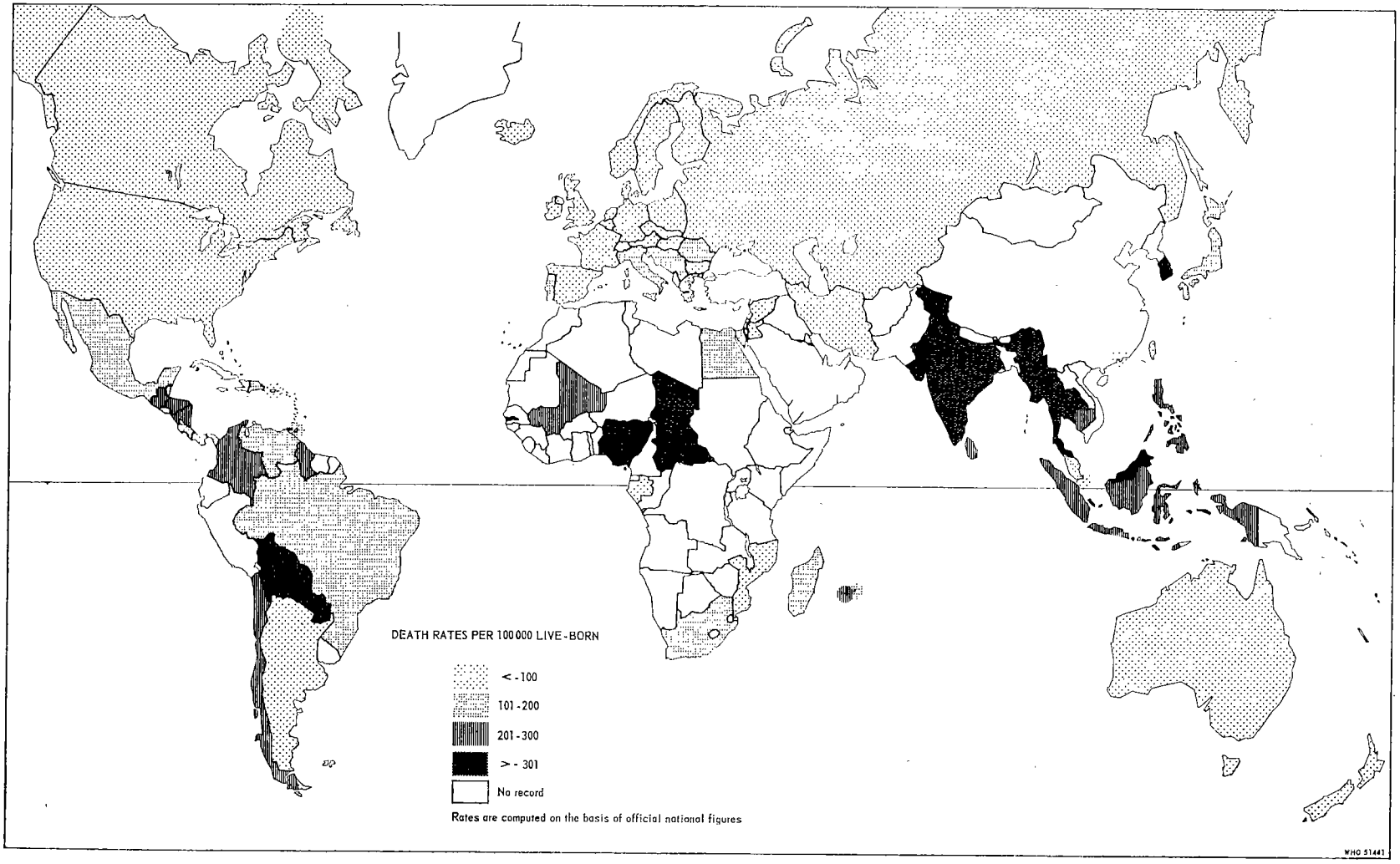
(*b*) in the field of advisory services as outlined in Part III, paragraph 3, of his report,[2] on the understanding that such services are related, within the responsibilities of WHO, to technical advice on the health aspects of human reproduction and should not involve operational activities; and

3. REQUESTS the Director-General to report to the Nineteenth World Health Assembly on the programme of WHO in the field of human reproduction.

Experience in countries where family planning has been introduced has indicated that its inclusion in the maternity and child-health services

[1] Resolution WHA 18.49 (*Off. Rec. Wld Hlth Org.*, 1965, **143**, 35).

[2] *Off. Rec. Wld Hlth Org.*, 1965, **143**, 158.


DEATH RATES PER 100 000 LIVE-BORN
< - 100
101 - 200
201 - 300
> - 301
No record
Rates are computed on the basis of official national figures
WHO 51441

has a favourable influence on maternity care. The midwife's close contact with the family places her in a particularly suitable position to participate in family planning programmes.

The increased use, during pregnancy and the puerperium, of cytological studies in the detection of cancer, has in many areas given the midwife new duties and responsibilities.

The participation of midwives in important surveys connected with maternity care has indicated that they are able to make an appreciable contribution in the field of research. This is a promising trend, and it is to be expected that more attention will be given to the preparation of midwives for research work.

### 2.3 Present situation

The global position in regard to maternal health, although showing considerable improvement, gives no cause for complacency. In the last decade, the wide differences in the standard of maternity care provided in different areas of the world have remained. These differences are illustrated by the map on p. 7. The maternal mortality remains unknown over large areas and is in excess of 3 per 1000 births in many others. Figures collected from over 100 countries suggest that two-thirds of the births in the world are delivered without a trained attendant.[1] The facts that figures may be lacking for certain parts of the world and that the quality, completeness and coverage are not the same for all countries may affect the comparability of the data.

## 3. THE MIDWIFE

### 3.1 Definition

In considering the midwife and her functions in maternity care, the Committee adopted the following definition as a basis for its discussions:

> A midwife is a person who is qualified to practise midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the postnatal period, to conduct normal deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognize the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor, and to carry out emergency measures in the absence of medical help. She may practise in hospitals, health units or domiciliary services. In any one of these situations she has an important task in health education within the family and the community. In some countries, her work extends into the fields of gynaecology, family planning and child care.

[1] Data from a survey for 1961 carried out by a Joint Study Group of the International Federation of Gynecology and Obstetrics and the International Confederation of Midwives, in collaboration with WHO.

### 3.2 Functions

Within the context of this definition, the Committee discussed in detail the functions of the midwife in relation to: (1) the mother, (2) the infant, (3) the family and the community.

The following paragraphs are intended to give a picture of the work that could normally be within the competence of a midwife. The Committee recognized, however, that the extent to which the midwife undertakes these responsibilities herself depends on the structure of the health services in different countries, on regulations laid down by governments, and on the availability of medical and other personnel.

(1) *The mother*

(*a*) *Prenatal period.* The midwife's responsibility is to establish an understanding relationship with the expectant mother and to gain her confidence. She should encourage her to attend the clinic regularly for prenatal care throughout pregnancy, advising and, where possible, ensuring, that the expectant mother receives medical examinations.

In giving prenatal care, the midwife should take a detailed medical and obstetrical history and either carry out the following examinations or see that they are carried out at the appropriate time : general evaluation of the woman's health, measurement of height and weight, blood pressure estimation, recognition of signs of oedema, urinalysis, blood tests, abdominal palpation, auscultation of foetal heart sounds, clinical pelvimetry and pelvic examination.

During the pregnancy, the midwife observes the physical and emotional progress of the expectant mother, records evidences of foetal growth and recognizes signs of abnormality or potential abnormality for which medical aid should be sought. She carries out any preventive health measures appropriate to the area in which she works.

In addition to clinical care, the midwife should provide health education for the mother suitable to her cultural, social and economic circumstances and, in particular, advise her on her own nutritional and other health needs in pregnancy and those of the child she expects. She should prepare her for successful lactation and help her to welcome a baby of either sex. She may also give her psychological preparation for childbirth.

The midwife should be aware of the other health and social services available in the community and contact them when required.

(*b*) *Labour and delivery.* The responsibilities and duties of the midwife in conducting labour and delivery include at least the following : [1]

[1] This is not intended to be a restrictive list of the midwife's functions during labour.

An initial review of the mother's prenatal record; history of the labour and physical examination; estimation of the progress of labour; detection of warning signs of complications in mother or foetus; nursing care, including emotional support and the relief of pain; the delivery and immediate care of the newborn, including tying and cutting the cord and prophylaxis of the eyes; the management of the third stage of labour; the delivery and examination of the placenta; and examination of the mother for lacerations. The midwife must observe aseptic techniques at all times. When complications occur, she must summon medical aid as soon as possible and, in the meantime, do her best for the mother and infant.

In some countries, the midwife may be competent in such techniques as episiotomy, perineal repair, vacuum extraction and forceps delivery. She may give oxytocic drugs to control haemorrhage, and other medications.

(*c*) *The postnatal period.* The midwife's responsibilities are to supervise the mother's recovery from pregnancy and labour, giving all necessary nursing care, and to detect deviations from the normal. She should give advice and assistance in the hygiene of the puerperium, including the need for rest and postnatal exercise, and supervise the establishment of lactation and the care of the breasts. She should help and advise the mother with regard to the care of the baby, and assist where necessary in her adjustment to the situation created by the arrival of the new baby (e.g., she should draw attention to the needs of the next-youngest sibling, who may often be under one year of age). The midwife must explain the importance of postnatal examination and care and advise the mother to take advantage of existing services. She should also encourage her to attend child health clinics where she can obtain guidance in the care and feeding of the baby. The need for immunization of the child should be explained, and information about the services available given. Where a public health nurse takes over the responsibility for the health of the child, the midwife should introduce her to the mother and brief her on the case history of the mother and child.

(2) *The infant*

The midwife's responsibilities are to give attention to the establishment of respiration at birth and to see that it is adequately maintained. She must recognize the dangers of anoxia and, while awaiting medical help, apply skilfully the measures available to her for its relief. She must make a thorough examination of the newborn for any abnormality and know how to obtain assistance if required.

The midwife should record the birth weight of the baby, and she is responsible for its feeding and nursing care. She should observe its

general progress and seek medical aid if there is any deviation from the normal.

(3) *The family and the community*

The report of the WHO Expert Committee on Training of Health Personnel in Health Education of the Public, in discussing the educational role of all categories of midwifery personnel says that: " In general, the essence of the village midwife's educational influence is her rapport with the villagers among whom she is a respected member ".[1]

Because the midwife assists at a time when her help is greatly appreciated, she is welcomed into the homes of the people of every kind of community. This affords her excellent opportunities for health education within the family. She can help the family to prepare for and adjust themselves to the arrival of the new baby, and she can assist the husband to understand his wife's physical and emotional needs. She finds opportunities to advise on nutrition, on hygiene and on other health matters and observes the health of the children and other members of the family. If required, she gives advice and guidance about their care.

From the family, the midwife's role in health education may spread out into the community. She may participate in the education of young potential parents to prepare them for marriage and family life. She should make efforts to get into touch with expectant mothers as early as possible, explaining to them and their families the importance of prenatal care.

In some countries, midwives work in gynaecological clinics and take part in cancer detection programmes. They also participate in family planning services where these have been established.

In addition to these activities, the midwife may also help in the promotion of health measures in the community, such as the active immunization of expectant mothers to protect their babies against tetanus neonatorum.

*Other responsibilities*

In certain areas of developing countries and in isolated areas of some developed countries, because she is frequently the only health worker in the community and enjoys the confidence of the mothers, the midwife may also have, in addition to her primary function of maternity care, responsibility for the health of young children. Her activities will be primarily preventive, consisting of such measures as immunizations and health education, with special emphasis on nutrition. In countries where she is carrying out these activities, the midwife can help in the prevention of certain diseases, such as malaria.

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1958, **156**, 23.

If she is the only health worker in the community, the midwife may also be responsible for the provision of simple treatment of diseases common in childhood and for screening out such children as require more skilled care.

Records are an integral part of any successful maternity service, and the maintenance of the majority of them is the responsibility of the midwife; her records form the basis from which regional and national statistics are assembled. Periodic analysis of these records is often followed by a change in procedure and/or policy, which may bring about an improvement in the standard of service.

The notification of births is often the legal responsibility of the midwife, and in some circumstances she is also required to register them.

### 3.3 Education and training

Although the primary purpose of this Committee was to review the functions of the midwife, it was agreed that some consideration should be given to her education and training.

In 1955, the WHO Expert Committee on Midwifery Training made detailed recommendations [1] regarding content of training and selection of students, all of which this Committee reaffirmed. There are, however, certain points that should be emphasized.

(1) *Educational standard for acceptance for training*

The Committee agreed that, in view of the high level of competence and responsibility required of the midwife, she should have completed secondary education, and that in any case the standard for acceptance for training should not be less than that required for nurses and teachers. At the same time, the Committee recognized that in some countries it is possible for young women who have not had the opportunity to complete a secondary education to do so while they are pursuing midwifery training. On completion of their studies, they obtain a certificate or diploma in both general education and midwifery.

(2) *Nursing experience*

The Committee noted that there is a trend in many countries towards a closer integration of the two professions of nursing and midwifery. In some countries it is necessary to complete general nursing training before proceeding to midwifery training, and in others experience in mater-

[1] *Wld Hlth Org. techn. Rep. Ser.*, 1955, 93.

nity care is being introduced into nursing training. In still other countries, a common basic training is given to nurses and midwives, after which they specialize in one or other of these professions.

The need to prepare the midwife to fulfil a broader function, particularly in rural areas, has been recognized in some countries by the provision of training programmes that include public health nursing, with emphasis on child care, as well as midwifery.

In countries where training of midwives is quite separate from that of nurses, nursing experience is included in it.

While the Committee agreed that nursing experience is an essential part of the training of a midwife, it did not consider it necessary for all midwives to be fully-trained nurses.

It was noted that in some countries no reduction in the length of training is made for fully-trained nurses who wish to train as midwives, and vice-versa; thus, nurses have to undertake the full midwifery training, and midwives must take the full nursing course. This seems wasteful of time and training facilities and, in order to avoid duplication or overlapping of curricula, the Committee recommended that the planning of nursing and midwifery training be co-ordinated at the national level.

(3) *Content of training*

(*a*) *Domiciliary experience.* The Committee considered that domiciliary experience is a very important part of midwifery training. Domiciliary training does not consist only of experience in home deliveries; home visits during the prenatal and postnatal periods provide a valuable insight into the home conditions of the mothers and help to broaden the student's understanding and skill in giving maternity care, either in the hospital or the domiciliary services.

(*b*) *Special subjects.* The Committee considered that the following subjects, which are already recommended for inclusion in midwifery training programmes, should receive greater attention, in view of the changing pattern of maternity care: (i) methods of health education, (ii) nutrition, (iii) psychological preparation for childbirth, (iv) the emotional needs of mother and baby, (v) local customs and beliefs relative to childbearing, and (vi) preparation for supervision and administration.

(*c*) *Family planning, infertility and demography.* In countries where the midwife is to play her part in the provision of family planning services, this subject must be taught, either during her midwifery training or in special courses. These courses might include: instruction in population problems, reproductive physiology, psychological approach, contraceptive methods, and field work, including attendance at clinics.

(*d*) *Child care.* Recognizing that the midwife working alone in rural areas often has to assume responsibility for the health of young children, the Committee recommends that, where the midwife has this responsibility, she should receive special preparation in this field.

(4) *Continuing education of the midwife*

The Committee agreed that, if midwives are to be encouraged to keep up to date in their specialty, they need the stimulation of postgraduate education and refresher courses. This may be provided in the form of lectures, study-days, discussions and demonstrations arranged by individual hospitals or health administrations and professional organizations. It was noted that, in some countries, refresher courses at regular intervals are obligatory for all practising midwives, and the Committee expressed the opinion that legislation to this effect should be introduced as far as possible in all countries.

### 3.4 Summary of recommendations on education and training

(1) The standard for entry to midwifery training should not be less than that required for nurses and teachers.

(2) In countries where the training of midwives is separate from that of nurses, there should be co-ordination of the curricula at national level. This would enable some reduction in length of training to be given to nurses who wish to train as midwives and vice-versa.

(3) Where the midwife is to participate in family planning services she should be given special preparation for this work.

(4) Where the midwife is required to undertake the care of young children, she should receive special preparation in this field.

## 4. THE AUXILIARY MIDWIFE

The word " auxiliary " is used in the sense defined by the WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel : [1]

*An auxiliary worker* is a technical worker in a particular field with less than full professional qualifications. The auxiliary worker is one who may also be trained to a level of function comparable to that acceptable for professional workers in a particular country or region.

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1961, **212**, 4.

The Committee agreed that auxiliary midwives are valuable members of the maternity and child health services and often occupy posts of considerable responsibility.

### 4.1 Functions

These will depend on the staffing pattern of the services in which the auxiliary midwife works. Where she works under the continuous supervision of a midwife, she assists in carrying out most of the functions pertaining to maternity care and may take full responsibility for some of them.

In areas where such immediate and continuous supervision is not available, she independently carries out the functions of a midwife and has to take greater responsibility. In addition to this, she may herself supervise less qualified workers (e.g, traditional birth attendants). To help her maintain a safe level of performance and to improve her technical skill in such situations, she needs regular and thoughtful guidance and opportunities to attend refresher courses.

### 4.2 Training

Depending on the auxiliary midwife's level of general education, courses extend from one to two years, although shorter periods of training still exist.

There are considerable advantages in giving the training in the area in which she will work, since this will contribute to her knowledge of local health conditions and encourage her to remain in the area.

Local training centres need to be provided, with field training areas and qualified midwifery tutors. Close co-operation with the staff of the maternity services, where practical experience will be gained, is essential.

Often, the auxiliary midwife comes from a part of the country that lacks opportunities for completing general education. Such young women are recruited into midwifery because of their interest in the profession, and they should have the opportunity to complete their general education. Educational courses may be given on a part-time basis so that the auxiliary midwife may continue to work while she studies. Successful completion of these studies would then make it possible for her to proceed to full midwifery training.

Experience in many areas of the world has shown that the functions of the auxiliary midwife may be broadened, and that she is frequently capable of assimilating and applying practical teaching in new subjects. With adequate preparation, she can function effectively in such fields as child care, nutrition programmes and other local health services.

## 5. THE TRADITIONAL BIRTH ATTENDANT

For many women, in many parts of the world, assistance at childbirth is provided only by traditional birth attendants. These persons may be illiterate and mostly have no training at all in midwifery, but they are usually well versed in folklore relating to maternal and infant care and are likely to be among the most highly respected members of their communities.

In spite of the fact that the traditional birth attendant makes a contribution to maternal and infant care, legislation aimed to prohibit her from practice exists in many countries of the world. However, repressive legislation has repeatedly failed, and it is gradually being recognized that the traditional birth attendant fulfils a useful role in areas where health services are not sufficiently developed, but that some instruction must be given to her so that she can play her part in the health service structure.

Programmes are therefore being developed for bringing the traditional birth attendant into the cadre of health personnel. In many areas, with co-operation from WHO and UNICEF, training programmes have been established for improving the knowledge and performance of the traditional birth attendant. At the completion of a programme of instruction, she is supplied with a kit containing supplies and equipment, soap, cord dressings and medication for eye prophylaxis. She is encouraged to bring her client to the health centre and, in some instances, receives a small remuneration for this service. Such programmes are already going on successfully in a number of countries, and other countries are contemplating similar ones.

The traditional birth attendant's work is usually limited to the confinement and early postnatal period. However, because of her influence on families and the community, she can, with additional preparation, participate in preventive health measures particularly related to the infant and young child. Despite wide variations in the level of literacy, she can be taught to keep simple records and thus contribute to the collection of vital statistics.

It is recognized that, without a system for regular supervision, the traditional birth attendant cannot maintain a level of acceptable performance. For this reason, it is essential that provision for supervision and guidance be an integral part of any programme designed to train and utilize the traditional birth attendant.

The maintenance of a register of these women is imperative and should be the responsibility of the health authorities of the area.

## 6. COLLABORATION WITH OTHER HEALTH WORKERS

In diagnosis, prevention and treatment, medicine increasingly requires the team approach. This is true of maternity care, calling, as it often does, on the midwife and auxiliary midwife, the nurse and public health nurse, the family doctor, paediatrician, obstetrician and social worker.

The Committee discussed the various factors that contribute to successful teamwork, as well as the role of the midwife in that team.

One of the threats to team care is lack of co-ordination, which may be confusing and produce a feeling of insecurity. It is essential that the policies of maternity care be known and agreed upon by all team members, and that the team should not only be a " paper " unit but should meet regularly for discussion of common problems. Such free intercommunication is particularly important in connexion with patient referral. Interchange of relevant information not only keeps all members of the team briefed but also serves a valuable educational purpose.

Mutual understanding and respect of the team members is essential in developing that sense of security and satisfaction which enables them to carry out their work to the best of their ability. Differences in seniority or training should not interfere with this, and the obstetrician and other leaders have a particular responsibility in developing good relationships within the team.

The midwife carries a special responsibility with regard to the successful functioning of the maternity-care team in its relationships with the community. Her close contact with the mother and her family enables her to be the link between the family and other members of the team and to ensure that the maximum use is made of their services. Where misunderstandings arise, as they are likely to do during the emotional period of childbirth, the midwife can do much to resolve them.

If the importance of team maternity care is recognized in more advanced countries, it is even more important in developing areas. In these places, the slender resources of trained personnel necessitate a team approach for the maximum return from their efforts.

## 7. THE MIDWIFE IN POSTS OF SENIOR RESPONSIBILITY

### 7.1 Administration and supervision

In order for the midwifery services to function efficiently, it is necessary to have qualified midwives responsible for their administration and supervision. The provision of a post for a midwife in the health services at the national level is of the greatest importance. This midwife participates in the planning of maternity services and has particular responsibility for their midwifery aspects. She also serves in an advisory capacity on national committees dealing with maternity and child-health services.

There should be similar posts at intermediate and local levels where the midwife is responsible for the administration of the services and supervision of midwifery staff. Her functions in the supervision and guidance of her staff provide one of the most effective measures for developing higher standards of maternity care.

In the hospital maternity service, the responsibilities of a midwife administrator include the organization of the work of the midwives and auxiliary personnel, participation in the appointment, orientation and in-service training of the staff, and evaluation of staff performance.

She should be a member of the hospital committee or similar body dealing with policy and administration of the maternity service, and should be in a position to present estimates of requirements regarding personnel, equipment and supplies.

Where the hospital serves as an educational centre for midwifery training, the midwife administrator collaborates with the midwife tutor in charge of the school in planning the curriculum and selecting practice areas.

There are other administrative posts held by midwives in professional, voluntary and international organizations.

These administrative and supervisory posts should be held by midwives who have had post-basic training and considerable experience in midwifery. As the functions of the midwife administrator do not differ from those of administrators in other fields, part of this course could profitably be taken with students from the nursing and allied professions. Countries should be encouraged to develop their own post-basic courses.

### 7.2 Teaching

Schools of midwifery should have a Principal Midwifery Tutor who is responsible for organizing and directing the theoretical and practical teaching of the students and should be assisted by other qualified midwife tutors and clinical teachers.

Midwife tutors should have had considerable experience in midwifery and should have successfully completed a post-basic course in preparation for teaching.

The status, functions and training of the midwife-tutor have already been defined by the WHO Expert Committee on Midwifery Training [1] and are reaffirmed by this Committee.

*The clinical teacher.* The Committee recognized the importance of a close correlation between theoretical and practical teaching in the training of midwives. It considered that this can best be achieved where the midwife tutor has the opportunity to carry out some clinical teaching

[1] *Wld Hlth Org. techn. Rep. Ser.*, 1955, **93.**

herself. It was also realized that clinical teaching is an important part of the work of the midwives responsible for the services in the ward. These midwives should receive preparation for their teaching duties.

In some countries, special posts for clinical instructors have been created to supplement the clinical teaching given by the service staff. These instructors should be responsible to the head of the school and should receive special preparation.

## 8. RESEARCH AND EVALUATION

The Committee welcomed the increasing part played by the midwife in research in the field of maternity care. It was considered that the midwife could usefully participate in research in such problems as:

(1) utilization studies aimed at the most efficient use of her working time,

(2) evaluation of training programmes in order to discover how well they prepare the student midwife for her future work,

(3) studies of local beliefs pertaining to sex life, conception, pregnancy, abortion, confinement, the postnatal period and the care of the newborn, and how they affect the behaviour of the mother and the family,

(4) studies of factors concerned with the identification of high-risk groups during pregnancy and childbirth, and

(5) research into the action of drugs, particularly analgesics.

The Committee recommended that courses in research methodology might be included in post-basic training for midwives participating in this work.

## 9. SUMMARY AND CONCLUSIONS

In this section there will be no attempt to recapitulate each of the individual recommendations contained in the body of the report, since they have been clearly indicated and need no repetition here. Many of them endorse suggestions that other committees have made and that the present committee felt should be reiterated and stressed. Some of the recommendations deal with the education and training of the midwife; these are pertinent because changing functions demand a change in training content.

Having reviewed the changes in the pattern of maternity care, examined the present situation and evaluated future trends, the Committee was firmly convinced that the work of the midwife is a permanent and essential part of maternity care throughout the world. This is as true for those

countries where the maternity services are of the highest standards as it is everywhere else. Indeed, it is evident that the responsibilities of the midwife have expanded and are likely to continue to do so in the foreseeable future. While this expansion is in itself a recognition of the value of her work, the Committee was concerned that her primary function in maternal and child care should not be jeopardized. Many of the recommendations stem from a desire to protect this function.

The Committee recommended that health authorities should take their full share of responsibility in supporting the efficient function of the midwife. Such support should include among other things:

Provision of training facilities and establishment of posts for employment;

Provision of adequate medical support and consultation;

Provision of equipment both for practice and for educational institutions including, where possible, text-books suitable to the locality;

Financial support for the midwife to attend refresher courses and post-basic training courses;

Utilization studies of the work of the midwife to indicate the present use of her time, and also to assess the value of the various activities (many of them traditional and inherited) to the welfare of the patients;

Registration of traditional birth attendants, where they exist, to guarantee their supervision and improve their skill;

Maintenance of accurate vital statistics, so that the effectiveness of maternity care may be regularly assessed at both national and local levels.

It was recommended that the medical profession participate actively in supporting and making more effective the functions of the midwife. Changing patterns of maternity practice and hospitalization have rendered continuity of patient care difficult for the midwife and have often created frustrations in daily practice. The physician therefore must render prompt consultation support, maintain clear lines of communication on the maternity care team, assist in training activities and give full recognition to the professional stature of his midwife colleagues. Under certain circumstances, the wise and efficient utilization of midwives may help meet problems arising from shortages of medical manpower.

The Committee reaffirmed the recommendations on legislation made by the WHO Expert Committee on Midwifery Training.[1]

It also noted the survey of midwifery legislation prepared by WHO in 1954 [2] and hoped it might be brought up to date.

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1955, **93**.

[2] *Int. Dig. Hlth Legis.*, 1954, **5**, 433.