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# EXPERT COMMITTEE ON MIDWIFERY TRAINING

## First Report

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WORLD HEALTH ORGANIZATION

PALAIS DES NATIONS

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## EXPERT COMMITTEE ON MIDWIFERY TRAINING

### First Session

*The Hague, 2-7 August 1954*

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## EXPERT COMMITTEE ON MIDWIFERY TRAINING

### First Report \*

The first session of the Committee was held in The Hague from 2 to 7 August 1954.

Dr. Edward Grzegorzewski, acting on behalf of the Director-General, introduced the subject, welcomed the members of the Committee and expressed the thanks of the World Health Organization to the Government of the Netherlands and the Municipality of The Hague for the facilities provided for the session.

Dr. N. J. Eastman was elected Chairman of the Committee and Miss N. Goffard Vice-Chairman ; Miss P. M. Dickens was elected Rapporteur. The agenda submitted by the Director-General was approved and adopted.

### 1. INTRODUCTION

The Committee noted a recommendation made by the Expert Committee on Maternity Care that a joint committee composed of members of the Expert Advisory Panels on Nursing and on Maternal and Child Health be convened to consider the training of midwifery personnel at all levels.<sup>1</sup> It was emphasized that this Committee should consider midwifery training with particular reference to those areas where maternity care services are less well developed and where auxiliary midwifery personnel are required.

Rapid changes are taking place in educational spheres, and a dynamic approach in the planning and execution of training programmes is required. It was recognized that the spirit in which knowledge is applied and a real understanding of people as human beings are important if an educational programme is to be successful.

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\* The Executive Board, at its fifteenth session, adopted the following resolution :  
The Executive Board,

1. NOTES the first report of the Expert Committee on Midwifery Training ;
2. THANKS the members of the Committee for their work ; and
3. AUTHORIZES publication of the report.

(Resolution EB15.R9, *Off. Rec. Wld Hlth Org.* 1955, 60, 3)

<sup>1</sup> See *Wld Hlth Org. techn. Rep. Ser.* 1952, 51, 21.

The Committee discussed the importance of understanding the customs, beliefs and traditional practices of the people for whom midwifery services are to be provided. Technical knowledge is essential, but without this understanding of cultural backgrounds its application is less effective. Dependent on traditional beliefs, there are many variations in the practices relating to pregnancy, child-birth and the newborn. A sympathetic approach when interpreting these factors of custom and culture will give the best opportunities of obtaining progressive changes. Some customs will be found to be definitely valuable, others will have no recognized harmful effects, while a number will be considered as harmful and undesirable. Respect for traditional beliefs that are harmless and the full utilization of those that are valuable will give the best opportunities for gaining the confidence of the mother and her family. This will be a sound basis for success in a programme of continuous health education which will steadily and progressively aim at the disappearance of those practices that are dangerous.

The Committee agreed that, to be effective, the local worker must have a thorough knowledge of local customs and practices ; it also recognized that an appreciation of these factors is very important for those responsible for the planning and administration of maternity care services. The planning of these, however, must essentially be based on a study and analysis of the existing health problems. Furthermore, a programme for maternity care presupposes general health planning for short-term and long-term needs. The Committee recognized that in every country a maternity-care programme (as part of the maternal and child health programme) is dependent on the development of other basic health services such as communicable-disease control, environmental sanitation, maintenance of records for public-health purposes and vital statistics, health education of the public, public-health nursing, and medical care.

The Committee recognized the relationship of the health programme to the social and economic development of the area, and the extent to which changes in these broad programmes will necessitate constant review of administrative patterns and in turn continuing revision of training programmes. For example, the improvement of nutrition is a basic problem for many areas. While health education will help in improving the knowledge of adequate diet and the utilization of existing resources, the raising of the level of nutrition is essentially dependent on the programme for agricultural development and food distribution.

The Committee endorsed the definition of maternity care accepted by the Expert Committee on Maternity Care :

“ 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 of the care of the pregnant woman, her safe delivery, her postnatal 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.”<sup>1</sup>

It also took note that the Expert Committee on Maternity Care recognized the wide range of medical, midwifery, nursing and auxiliary personnel which is involved in this programme. From the analysis of the existing practices in maternity care programmes it is evident that the pattern of services has developed along different lines in different countries. For example, in some areas over 90% of confinements take place in hospital with either a physician and an obstetrical nurse or a midwife in attendance; in others the majority of normal confinements take place in the home with a doctor, or more frequently a midwife, in attendance. In large areas of the economically under-developed countries, the only attendant on whose presence the mother can rely is a relative or the untrained traditional birth attendant who earns a meagre living by giving delivery service. Nevertheless, starting with even this simple service it is possible to improve the existing practice of midwifery care and to start building the structure of some of the personal health services to the family.

## 2. TYPES AND FUNCTIONS OF MIDWIFERY PERSONNEL

The Committee considered in detail the types of midwifery personnel (apart from physicians) who attend the mother in childbearing. Broadly speaking, it appeared that they could be classified into three groups:

### (1) *Traditional birth attendant*

The traditional birth attendant (e.g., dai, dayah, dukun, matrone, curiosa, hereditary midwife) is a part of the social pattern of the economically less developed areas, as she was earlier everywhere. In many of the economically developed areas the trained midwife is in fact a historical development from the traditional birth attendant. The latter may be a woman of much experience in her chosen occupation. On the other hand, she may be a neighbour or relative who happens to be on the spot at the time of delivery and renders assistance.

### (2) *Auxiliary midwife*

The auxiliary midwife may or may not be literate. She may have been a traditional birth attendant who has been given some training. She is frequently an older woman of character and experience.

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1952, 51, 3

In some areas the education of women is more advanced and the auxiliary midwife is a younger woman who has had sufficient general education of a standard which has made it possible to give her more training in prenatal and postnatal care in addition to perinatal care of mother and baby.

(3) *Fully-trained midwife*

This group includes trained midwife, nurse/midwife, and public-health-nurse/midwife. With few exceptions, the trained midwife is common to all areas of the world.

The nurse/midwife is fully qualified as a nurse and a midwife. In some countries it is necessary to have nursing training before taking midwifery.

The public-health-nurse/midwife has in addition the necessary qualifications in general public-health nursing. In areas where the auxiliary midwifery personnel are used extensively, the public-health-nurse/midwife is used in a supervisory capacity.

Recruits for advanced training for supervisory teaching and administrative positions will be found in this professional group.

Included among the trained midwife group is the worker called "health visitor"<sup>1</sup> in some countries. She is basically a fully-qualified midwife with the addition of public-health training but without full nursing training. Sometimes this public-health training is added to the midwifery training but the present trend is to integrate it throughout.

The border line between the three main groups, and more particularly between those classified as "traditional birth attendant" and the group classified as "auxiliary midwife", differs in different areas. It is dependent on traditions, administrative organization, and level of education.

The Committee agreed that with increased recognition of the need for health services the functions of the midwife extend beyond the provision of service at the time of delivery. Her technical competence must include the knowledge, understanding and skill to give total care to mother and child during pregnancy, labour, and puerperium. She is also required to detect the abnormal and, more important still, the potentially abnormal. An appreciation of the emotional aspects of pregnancy and of the situations which are likely to be encountered is necessary if the midwife is to assist in providing emotional security.

The broader areas of activity where the midwife is called upon to function relate to the prenatal education and supervision of the pregnant

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<sup>1</sup> The health visitor in the United Kingdom is a qualified nurse with maternity and public-health training.

woman and the postnatal care of the mother and child. Her activities may also include a measure of health supervision of the child and the family.

When she works as a member of the health team, an understanding of the broad principles of public health enable her to co-operate more effectively with a group of workers who are conscious of the essentials of a maternity-care programme. Where, on the other hand, she is alone, she may be the one person in the community able to promote general public-health measures, albeit in a simple way.

When planning a training programme for midwives, for one or all of the three groups outlined above, these broad functions should be kept in mind. At the same time the content should be adapted to the local conditions.

In certain areas the programme must be largely concerned with the training of auxiliary midwives since the general level of education does not yet permit the training of an adequate number on a professional level. In areas of the world where the numbers of trained personnel are limited and the service is dependent on the traditional birth attendant, the plans for training should have three aims: to improve the practice of the traditional birth attendant, to prepare fully-trained midwives who are required for the training and supervision of the auxiliary midwives, and to train auxiliary midwives.

There will be, through a gradual process adjusted to the economic and personnel resources of the country, an upgrading of the traditional birth attendant to the auxiliary group, and an eventual replacement of the auxiliary group by the fully qualified.

### 3. THE FULLY TRAINED MIDWIFE AND THE AUXILIARY MIDWIFE

#### General principles of training

The general principles underlying training programmes are essentially the same for nursing and midwifery personnel and are set out in the first and second reports of the Expert Committee on Nursing.<sup>1</sup>

An educational programme is needed which will not only prepare a competent technical worker but enable the student to develop into a good citizen, capable of managing her own affairs and of making her maximum contribution to society. A main objective of the training is to ensure

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1950, 24, 24; 1952, 49, 9

that the midwife has a preparation for work which enables her to obtain satisfaction and to remain in her profession, even after marriage.

It was agreed that the following attitudes, knowledge, and skills are desired of midwifery personnel (*the degree to which these are acquired and applied will depend on the type of worker and the particular function which she is required to perform*):

- (1) sufficient understanding of the basic physical and biological sciences to be able to follow the course intelligently;
- (2) knowledge of the art and practice of midwifery, including:
  - (a) an understanding of the public-health significance of maternal health, maternal morbidity and mortality, and perinatal mortality, and of the value of records;
  - (b) an understanding of the psychology, physiology and pathology of child-bearing;
  - (c) sound practical skill in:
    - (i) giving prenatal care to the mother, including the nutritional and emotional aspects;
    - (ii) undertaking the normal delivery;
    - (iii) recognizing under what circumstances (prenatal, natal and postnatal) medical aid must be sought, and the value of medical examinations in the prenatal and postnatal periods;
    - (iv) carrying out simple emergency measures in case of difficulty, pending the arrival of medical aid;
    - (v) giving adequate postnatal care to the mother;
    - (vi) giving adequate care to the newborn, and
    - (vii) maintaining proper records;
- (3) sufficient understanding of nursing art and practice to enable her to give adequate nursing care in her own field and in certain circumstances to guide the mother on home nursing procedures until more skilled aid is available;
- (4) knowledge of the rules and regulations governing the practice of midwives and a high standard of professional ethics;
- (5) sufficient understanding of the public-health organization and of the administrative measures for safeguarding personal and community health to enable her to function effectively as a member of the public-health service;
- (6) sufficient understanding of the social structure in which she will work and of the social, cultural and economic factors influencing health to enable her to function effectively in the community;<sup>1</sup>

<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, 69, 10-11 (sections 3.1.2 to 3.1.4)

(7) sufficient understanding of human motivation and behaviour to give her an insight into her own attitudes, so that she may establish good personal relationships with the families under her care ;<sup>1</sup>

(8) sufficient understanding of the principles of learning and methods of teaching to enable her to give health education to individuals and groups, and to enable her to train and supervise other workers.

Although the objective is to prepare midwifery personnel who will have the skills and understandings described above, it is recognized that this may not be possible to the degree desired except for the fully-trained group.

The first report of the Expert Committee on Nursing stated that " the programme of every basic school of nursing should include the integration of the principles of mental health, public health, and prevention of disease, to prepare the nurse for her functions in teaching patients and families about positive health ".<sup>2</sup> The same principle is applicable to midwifery training and should be introduced in the preliminary training period.

The Committee noted that in some countries midwifery training is a speciality based on nursing and that the trend in this direction is increasing. As it is evident that the midwife requires some nursing skills the Committee was in agreement with the statement expressed by the Expert Committee on Nursing at its first session that where possible, this training be given jointly with nurses.<sup>3</sup> This might be a common programme for both groups for the first months of the basic course. It would, in addition, permit the possibility of the midwife qualifying as a nurse without having to take the complete basic training. This applies also for the nurse who wishes to become a midwife. It was noted, however, that in some countries the training of midwives may be linked more closely with medical training (e.g., feldscher-midwife).

The Committee considers that there is a need for all nurses caring for mothers and infants to have knowledge and some skill in carrying out the functions involved in the total care of maternity patients throughout the prenatal, delivery, and postnatal periods. Training and experience in maternity nursing is essential for all good nursing practice and should be included in the basic training of all nurses.

### **Selection of students**

Careful selection of students is important. The Committee considered the general education required for entry into courses for the preparation of both the fully-trained midwife and the auxiliary midwife. It noted

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1951, **31**, 7, 44

<sup>2</sup> *Wld Hlth Org. techn. Rep. Ser.* 1950, **24**, 12

<sup>3</sup> *Wld Hlth Org. techn. Rep. Ser.* 1950, **24**, 16 (section 3.2.1)

great variations depending on such factors as the general educational facilities of the country, the interest of the better-educated women in the profession, and the number of candidates available. For the trained midwife it was considered desirable to have the same entrance standard as for nurses. The Committee agreed that no standard could be set for the auxiliary group but that gradual raising of the admission requirements should take place. Any candidate having the education required should be encouraged to take the training for the fully qualified midwife rather than for the auxiliary.

The question of age of admission was discussed. Here also considerable variation in practice was noted. For the fully-trained midwife the range is from 17 to 40 years. The Committee considered it undesirable to suggest a chronological age limit, either minimum or maximum. Emotional maturity, intelligence, and other aptitudes are of greater importance, and adequate methods of assessing these, adapted to the conditions of the area concerned, should be employed in selection. The auxiliary midwifery personnel may have a somewhat higher age of admission to training, since some may have been traditional birth attendants and many are married women.

It was recognized that there is a danger of losing candidates when the minimum entrance age is high. In one country this has been overcome by offering the girls opportunities to work as assistants to the trained staff in health or maternity clinics. This experience serves as a good basis for later midwifery training and is valuable as mothercraft training and preparation for marriage. It also offers an opportunity for selection of students. If this practice is followed it is advisable to arrange for general education to continue.

#### **Facilities for training**

Without underestimating the importance of adequate physical facilities, it must be stressed that the most important consideration for midwifery training is good human relationships at all levels. The team approach to all aspects of care should be demonstrated in every training programme, both in and between the hospital and the domiciliary field.

The Committee considered the facilities required for training.

##### **1. *Clinical***

It was agreed that this training should take place in a maternity hospital or unit, which should include :

- (a) a prenatal unit, including ward facilities and a prenatal clinic ;

- (b) an admission and first-stage unit ;
- (c) a labour room ;
- (d) a post-natal unit, with provision for "rooming-in", nursery facilities for special purposes, and a post-natal clinic ;
- (e) facilities for preparation of formulas as required ;
- (f) an operating-theatre unit ;
- (g) an isolation unit ;
- (h) a laboratory, and other technical facilities.

A large maternity hospital or department is obviously more economical to run than a smaller unit ; furthermore, the larger the number of beds the wider will be the student's experience. The unit should provide for normal and abnormal cases.

If the student can be given some experience in a gynaecological ward or clinic it is likely to prove valuable.

The number of students accepted for training will need to be related to the estimated number of confinements taking place in the hospital and in the domiciliary field.

The Committee agreed that a maternity unit of 50 beds is the minimum which could provide adequate training for midwives ; one of 30 beds might be suitable for the training of auxiliary midwives. If the turnover is insufficient, or if a larger number of students is accepted, it may be necessary, for training purposes, to arrange affiliation with smaller units which accept only minor departures from normal. However, this should be done only if these smaller units are closely linked with a larger unit providing adequate consultant service.

Too great a demand for beds in relation to the supply, with consequent rapid turnover of cases, is a handicap to the training of the student, who may come to the conclusion that delivery care is the be-all and end-all of her work.

The Committee considered that the midwife student should have experience, under supervision, in complete maternity care (prenatal, delivery, and postnatal) of a minimum of twenty cases.

The Committee considered the question of desirable ratios of trained midwifery staff to maternity beds, and of trained staff to students. It found that many factors, such as the educational background of the student, age, working hours, work capacity, quality of teaching, all of which are peculiar to the local situation, must be taken into consideration when suggesting such ratios. However, it considered 1:5 the minimum ratio of fully-trained staff members to maternity beds and 1:4 the corresponding

ratio of such staff members to students. These figures do not include administrative or full-time teaching staff.

The Committee stressed the importance of domiciliary experience, including practice in home delivery, during the training period. It is in domiciliary care that the student most easily learns her role in the maternity services of the area and their relationship to the other health services. She comes into close contact with family and community life and in this setting she will learn to adapt her technique whilst maintaining an essential standard of care. The varying conditions she will meet should develop resourcefulness and self-confidence.

Services used for domiciliary midwifery training may be those organized and administered by the maternity hospital or as part of the health service of the community, or a combination of the two, or in collaboration with midwife practitioners. Administrative arrangements vary widely. Occasionally a health unit maintained by a university or medical college, by an institute of hygiene, or by a voluntary agency may be available as a practice field.

Competition for cases may arise when medical, midwifery and auxiliary midwifery students have experience in the same institution and/or training area. It has been found advantageous in some areas to separate the different groups, but when this is done some opportunity should be given for the various groups to work together. This will strengthen understanding and appreciation of the functions of other members of the team.

The essence of preparation for a profession such as midwifery is co-ordination between the theoretical and practical aspects of training. With full co-operation this can be achieved by those responsible in the health services, the obstetrical teaching department, and the training schools for midwives and nurses.

## *2. The school*

Much of the practical experience in a midwifery training programme will be acquired in a maternity hospital. However, the school of midwifery should be an entity directed by a person with administrative ability and suitable technical qualifications. This person might be a nurse/midwife, a midwife, an obstetrician or a public-health-nurse/midwife. In any case there should be an advisory committee, the members of which are representative of midwifery, public-health nursing and obstetrical practice. In the development of nursing schools it has been found an advantage to separate the school budget from the hospital budget; the Committee agreed that the same principle is applicable to midwifery schools. There should be enough financial support for the school to ensure the provision of a real educational programme.

### 3. *The teaching unit*

The facilities may include :

- (a) classrooms ;
- (b) demonstration room ;
- (c) library ;
- (d) offices for teachers ;
- (e) suitable equipment for obstetrical teaching. The minimum required would seem to be :

Obstetrical models (adult and foetus) ;

Bony pelvis and foetal skull ;

Urine and haemoglobin testing apparatus ;

Scales for weighing ;

Sphygmomanometer and stethoscope ;

Visual aids ;

Blackboard ;

Bags for use in the home for delivery and postnatal care.

Where there is no preliminary training school common to nursing and midwifery students, extra equipment will be required.

### 4. *Residential accommodation*

In many areas of the world provision must be made for residential accommodation if the training programme is to be implemented. Accommodation for the student when obtaining domiciliary experience is no less important than when she is training in hospital, and provision for this should be made.

### 5. *Transport*

In planning domiciliary experience, provision should be made for adequate transport facilities for the students and supervisory staff.

The Committee agreed that the training of auxiliary midwives may be carried out in the same premises, and with the same personnel, as that of fully qualified midwives. For auxiliaries there will be more emphasis on the practical aspects and less on theory. In areas where different types of midwifery personnel are trained, it may be necessary to have at least part of the programme in separate places, with the midwife group in one and the auxiliary group in the other. This would avoid difficulties which may arise when cases which the auxiliary student deems to be her prerogative are required for the midwife student. As the midwife student

gains confidence and experience she may pass on to another area where her work will include establishing harmonious relationships with the auxiliary and participating in her training and supervision.

### Methods of teaching

The future work of the student will bring her into close contact with individuals having varying attitudes, behaviour and emotional stability and representing different social, economic and cultural backgrounds. She will observe childbearing as a normal physiological process and will observe degrees of failure of this normal function during the prenatal, natal and postnatal periods.

“What people learn depends on many factors, ... which they, as individuals, bring to the situation. Since learning is a change in an individual's ideas and practices, this change can be brought about only through the individual's own efforts. So long as he is passive towards a situation no learning takes place.”<sup>1</sup> In considering methods that may be used in teaching midwives, emphasis is therefore laid on those which stimulate individual activity. These include :

- (1) *The case study.* The student notes in a case study book the relevant facts about a particular mother to whom she is giving full care. She records the family history, home visits, details of the prenatal, natal and postnatal periods, and specific information about the baby. By so doing, the student gains an appreciation of the factors involved in complete maternity care. She also learns the value of keeping records.
- (2) *The case assignment.* By this method a student has a certain number of mothers and babies assigned to her for care. Provided that supervision is adequate, this develops her sense of responsibility and brings a feeling of satisfaction. It is desirable to have case assignment in both hospital and domiciliary practice. This method affords the student a good opportunity for appreciating the close relationship between the child, the mother and the father.
- (3) *Clinical teaching.* This teaching with the midwife-teacher, obstetrician, paediatrician or other member of the team, relates theory to practice in an actual situation in the home, in the clinic, at the bedside, or in the operating theatre. It affords an opportunity for study and discussion of the factors involved in the care of the particular individual.
- (4) *Group discussion.* This “may consist of a variable number of people ... who have come together to study a question ... or to

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1954, 89, 8, 9 (sections 4.1 and 4.2)

enjoy the exchange of ideas. . . . Successful group discussion can be the most complete of those methods which rely principally on communication through the spoken word.”<sup>1</sup> It enables each member of the group to contribute ideas, to ask questions and to express himself about the subject.

(5) *The demonstration.* This has value in teaching a technique or procedure to a group and should be followed by student practice under supervision.

Methods that do not call for active participation on the part of the student will be less successful. The lecture is one of those, but it is useful for presenting material not readily available in clinical form.

Visual and auditory aids such as models, films, film strips and flannel-graphs are valuable in teaching. They should preferably, be made locally and where possible by the students themselves. This will increase their effectiveness as a teaching aid.

The Committee noted the great need for midwifery manuals or books suitable for the teaching of auxiliary midwifery personnel. Although it doubted that it would be possible to prepare a manual suitable for the world at large, it suggested that WHO consider ways of helping to meet this need. It suggested that governments and public-health agencies be encouraged to provide and distribute suitable professional literature for all midwifery personnel.

Emphasis was placed on the need for continuous review, and revision when indicated, of the curriculum content for all groups of students. As an essential part of any training programme the Committee stressed the need to make provision for periodic refresher courses for midwifery personnel at all levels. In many instances these courses would most appropriately take the form of in-service training and continued supervision, particularly for the auxiliary group and for the traditional birth attendant. Refresher courses and in-service training are indeed a necessary part of a good supervisory programme.

The Committee emphasized the need for qualified technical supervision, especially for auxiliary midwives. In addition every practising midwife should have medical advice readily accessible.

#### **Preparation of the midwife teacher**

In the training of midwives, as in any other educational programme, the need exists for teachers who have “the ability to transmit knowledge, create a situation wherein the student may learn more readily, stimulate

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1954, 89, 35

students to learn, and inspire high ideals in the practice of the profession".<sup>1</sup>

The general principle, expressed by the Expert Committee on Nursing, holds good throughout, that "the competence of midwives also depends considerably on the quality of the teaching and supervision they receive. This should be carried out by experienced midwives who, in most countries, would also be nurses and who should have a knowledge of public health."<sup>2</sup>

In carrying out the training programme the midwife teacher will have the assistance and collaboration of other members of the teaching team, e.g., the obstetrician, the paediatrician, and the public-health nurse.

It has been recognized that "nurses who serve as teachers ... must have additional preparation beyond that of the basic educational programme".<sup>3</sup> This is equally true of midwives.

In selecting students for training as teachers, consideration should be given to the personality characteristics which are required and which may be of even more importance than purely technical competence.

### 1. *The clinical teacher*

The Committee emphasized the importance of the clinical teacher. In midwifery training this is the qualified midwife who is responsible for the care of the patient and for the clinical teaching and supervision of the student assigned to her. In such a situation teaching and supervision are indivisible, though emphasis may vary under different conditions. The work of the clinical teacher should be so planned that there is time for both teaching and supervisory functions.

The clinical teacher may be practising in hospital or in a domiciliary area. She may be a public-health nurse attached to a maternal and child health centre.

The clinical teacher rarely has any special post-certificate training in preparation for her teaching functions. She gains understanding of her teaching responsibilities chiefly through experience and promotion. In some cases she may be appointed directly after her own training to a position entailing the supervision of students.

The Committee were of the opinion that all hospital and domiciliary midwives who have a responsibility for practical teaching should have a short course in teaching methods and that where possible this should be a prerequisite to their appointment. This course should include some

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, **69**, 18

<sup>2</sup> *Wld Hlth Org. techn. Rep. Ser.* 1952, **49**, 15

<sup>3</sup> *Wld Hlth Org. techn. Rep. Ser.* 1950, **24**, 14

aspects of administration, human relationships, health education and the principles of public health.

## 2. *The midwife tutor*

In large schools most of the midwife tutor's time may be spent in teaching and in correlating the practical and theoretical instruction. In other schools it may be necessary, though not desirable, for her to combine teaching and administration or teaching and supervision in a domiciliary service.

In addition, the tutor should be responsible for arranging the students' educational timetable. She may also act as liaison between teachers and students and give tutorial and demonstration classes. She will maintain records of students' attendances and progress and make contact with local organizations and authorities in regard to observation visits. She may be responsible in whole or in part for the practical instruction in domiciliary midwifery. A further important duty is to arrange staff conferences for the discussion of new methods and techniques and the better integration of theory and practice. The programme will require frequent revision and it is upon the tutor, in collaboration with those in administrative control, that this responsibility rests.

This is a highly responsible position, demanding ability to work co-operatively and a thorough knowledge of the methods and techniques adopted in each department involved in the maternity-care programme. The tutor should possess the personality and emotional maturity which will give her a keen sense of her responsibilities.

An educational body offering a course intended to prepare the midwife tutor for her functions may require her to have, in addition to nursing training, a number of years' practical midwifery experience in hospital and domiciliary health service. A certificate or diploma should be granted on satisfactory completion of the course.

The Committee stressed that there is need for more facilities for the preparation of midwifery teaching personnel. It also noted the statement of the Expert Committee on Maternity Care relative to the training of midwifery personnel: "When facilities are inadequate for this purpose, the strengthening of teaching facilities should take precedence over the increase of service facilities."<sup>1</sup> The Committee emphasized the opinion expressed by the Expert Committee on Maternity Care that students going outside their own area should first have basic training, post-basic training if available, and experience, in their own country or area. It

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1952, 51, 22 (section 8.6)

recommended the establishment of regional training centres for the training of midwifery teaching personnel.

It was agreed that, in drawing up programmes for the training of teaching and administration personnel, emphasis should be placed on common basic courses for teachers and administrators of midwifery, nursing, and public-health nursing. In some countries these have been established separately. A combined programme is less costly and makes better use of highly qualified teaching personnel. In addition, the value of learning and working as a team is emphasized.

#### 4. THE TRADITIONAL BIRTH ATTENDANT

Of the numerous traditional birth attendants at present engaged in midwifery practice, some will successfully be recruited for training as auxiliary midwives. The number within a given area who can be recruited will depend on local circumstances, but the majority will not be eligible for training as auxiliary midwives. However, it is essential that in a programme of maternity care all resources be utilized to the full. The training of the traditional birth attendant will require a special approach if the best use is to be made of her potential leadership position in village life and her co-operation is to be obtained in developing maternal and child health programmes. The Committee fully recognised that the traditional birth attendant has, in general, a thorough knowledge of the community in which she functions. Her authority within the village in many instances gives her opportunities to exercise influence. While these qualities derived from natural ability are extremely useful, it is necessary to bear in mind that in the absence of any form of schooling her comprehension and perception for technical matters will often be slow. Her training should therefore be related to what is already sound in her practice. The main emphasis will be on the principles of cleanliness, the recognition of symptoms of abnormality during pregnancy, and refraining from interference during labour.

Since many of the traditional birth attendants will be no longer young, their capacity for learning new skills will generally be limited. Therefore, in teaching, procedures may have to be broken down into simple units, allowing time for each one to be mastered before introducing another. In so doing, the teacher needs to ensure that there are no gaps in the new methods, otherwise the student will fill these from her previous undesirable practice.

Day-to-day working with the teacher will be the means of securing full participation in the learning process. The pace will be matched to

the individual's capacity and will allow for periods of consolidation until, by constant repetition, the practical methods learnt become fully automatic so as to be followed even in difficult situations and emergencies. On the whole the teaching will be in the form of well-supervised in-service training. The training will essentially be given either by a qualified midwife or by an auxiliary midwife. Most of the training will be given in the domiciliary service, but it is essential that some orientation be given to the existing health and medical-care services.

Some of the methods of teaching outlined for the fully-trained and the auxiliary midwife will also be used in training the traditional birth attendant. It will be necessary, however, to consider her as a member of the team so that she understands her own functions and knows when and where she should transfer her responsibilities to the more highly trained midwife.

It is believed that training and supervision of traditional birth attendants on these lines should result in a measure of improvement in the attention given to women of childbearing age in those areas where there is a great shortage of better-qualified midwifery personnel. With improvement of the general level of education of the community, more traditional birth attendants may be encouraged to become trained as auxiliary midwives.

## 5. LEGISLATION

The Committee considered that in many areas of the world the success of a maternity-care programme depends largely on the midwife and the quality of her practice.

The Committee emphasized that in preparing legislation for the regulation of midwifery training and practice there is a need for flexibility to permit easy revision as changes are indicated. It also emphasized that education of the public in the use of the trained midwife must accompany and should preferably precede legislation.

Recognizing that the purpose of legislation in this field is the protection of the patient (mother and newborn) and of the attendant, it follows that legislation should provide for :

- (1) maintenance of adequate standards of training and examination ;
- (2) regulation and supervision of practice ;
- (3) protection of the title and status of the midwife.

Countries which are in the process of developing a midwifery service should provide some form of control of those practising midwifery without recognized qualifications. It is suggested that a register be kept at local level of all those in regular midwifery practice.

Where there may be reluctance to turn from the traditional attendant to the trained midwife, difficulties may arise if legislation is introduced which cannot be enforced.

The Committee noted that in some countries, joint councils, having representation from the midwifery, nursing, and public-health nursing groups, are set up. One of the functions of the council relates to control of the training of nursing and midwifery personnel. The Committee considered this a desirable practice.

The Committee noted the survey of midwifery legislation which had been prepared by WHO<sup>1</sup> and commented on its value.

## 6. CONCLUSIONS

In its deliberations the Committee considered the position of the midwife and her training. This was discussed in relation to the maternity care programme as part of the general public-health programme and within the broad framework of the social and economic situation of the various countries.

The difficulty of drawing conclusions which would apply to specific areas or to specific groups was recognized. Only broad principles could be stated, and each country planning a training programme would necessarily have to work out the details to fit its particular needs.

The Committee also recognized that for large areas of the world the maternity-care programme is relatively undeveloped, and that for the majority of births skilled attendance and complete care is lacking. This regrettable deficiency is essentially due to the great shortage of medical, trained midwifery, and public-health personnel. The traditional birth attendant and the auxiliary are being used to help make up this deficiency.

To meet the personnel requirements, the Committee believes that the extensive use of auxiliary midwives as part of the maternity-care team is necessary until enough fully-trained midwives become available. In addition, the improvement of the skills of the untrained attendant should receive full consideration. This will result in a gradual evolution from the use of the traditional birth attendant to that of the auxiliary midwife and the fully qualified midwife. The increase in personnel, however, will not provide better protection of the women of childbearing age unless the training of the midwife is broadened to include sufficient knowledge and understanding to enable her to give prenatal, perinatal and postnatal care. This necessitates some knowledge of public health and certain

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<sup>1</sup> *Int. Dig. Hlth Legis.* 1954, 5, 433

nursing skills. At present these aspects need strengthening in the training of midwifery personnel, both for the fully-trained and for the auxiliary groups. Where training is given on an in-service basis to the traditional birth attendant, simple facts relating to these aspects should also be included.

In all programmes the content must be planned according to local needs, conditions, and type of personnel to be trained. The teaching of the traditional birth attendant and the auxiliary midwife will require much emphasis on the practical aspects and presentation of the material in a clear and simple manner. This teaching requires special ability. Emphasis must also be placed on the need for continuous supervision and the availability of a more qualified person for assistance when required.

At all levels of development a team approach between the personnel who are practising and those being trained should be emphasized continuously.

In order to implement maternity-care programmes as rapidly as possible, extension of facilities for the training of service and teaching personnel becomes essential.

In view of the great attention which many countries in the economically less developed areas are giving to the protection of women of childbearing age, the Committee recommends that at appropriate times WHO should promote the holding of regional conferences which will evaluate the expanded training and use of midwives in relation to the maternity-care programmes. These conferences should be based on exchange of information on the experience that is now being gained throughout the world.

Since programmes for midwifery training are so closely related to the health problems of pregnancy and childbirth, including the influence of custom and culture, the Committee recommends that WHO arrange research and studies to promote better understanding of the problems and help make the training programmes more realistic.

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