Evaluation of Training Strategies for the Management of Third Stage of Labor
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2007

Prevention of Postpartum Hemorrhage Initiative (POPPHI)
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Acknowledgements

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About POPPHI

The Prevention of Postpartum Hemorrhage Initiative (POPPHI) is a USAID-funded, five-year project focusing on the reduction of postpartum hemorrhage, the single most important cause of maternal deaths worldwide. The POPPHI project is led by PATH and includes four partners: RTI International, EngenderHealth, the International Federation of Gynaecology and Obstetrics (FIGO), and the International Confederation of Midwives (ICM).

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  www.pphprevention.org
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMDD</td>
<td>averting maternal death and disability program</td>
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<tr>
<td>AMTSL</td>
<td>active management of the third stage of labor</td>
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<tr>
<td>CCT</td>
<td>controlled cord traction</td>
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<tr>
<td>HBLSS</td>
<td>home-based life-saving skills</td>
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<tr>
<td>IMPAC</td>
<td>integrated management of pregnancy and childbirth</td>
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<tr>
<td>LSS</td>
<td>Life-Saving Skills</td>
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<tr>
<td>MNH</td>
<td>maternal and newborn health program</td>
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<tr>
<td>POPPHI</td>
<td>Prevention of Postpartum Hemorrhage Initiative</td>
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<tr>
<td>PPH</td>
<td>postpartum hemorrhage</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Background

Research has demonstrated the effectiveness of active management of the third stage of labor (AMTSL) as a feasible and low-cost intervention that prevents postpartum hemorrhage. In several major studies, AMTSL was associated with a significant decrease in postpartum hemorrhage (PPH). It is estimated that AMTSL can eliminate at least half of postpartum hemorrhage cases—potentially saving thousands of women’s lives.

PPH, or excessive bleeding after childbirth, is the single most important direct cause of maternal deaths in developing countries, with an estimated 14 million cases of pregnancy-related hemorrhage each year (World Health Organization (WHO) 1998). A woman can die within two hours after the onset of PPH if she does not receive proper treatment. In developing countries, where most births occur in homes or local clinics, the interventions needed to treat postpartum hemorrhage—emergency referrals, obstetric care, blood transfusion, and surgery—are often out of reach. Treatment simply is not available for the majority of women.

The availability of trained personnel is critical to the widespread use of AMTSL. To this end, many programs have incorporated AMTSL into their safe motherhood or related in-service training. However, to reduce mortality from PPH, AMTSL must be available for every woman, regardless of where she gives birth. This requires the training and supervision of maternal health providers at all levels. Periodic updates will also be needed as AMTSL is integrated into pre-service programs.

Before considering recommendations on AMTSL training, POPPHI conducted a small evaluation to review available training strategies. The evaluation comprised the following:

- Review of existing training materials on AMTSL.
- Review of recent literature on relevant training strategies/methodologies.
- Interviews with experienced maternal-newborn trainers.
- Review of alternatives to traditional classroom training.

For the purposes of this report, AMTSL is defined as the use of the following components, used together to prevent postpartum hemorrhage:

- Administering uterotonic drugs (oxytocin is the drug of choice) within one minute of birth.
- Assisting with the delivery of the placenta, known as controlled cord traction (CCT).
- Massaging the uterus, after the placenta has been delivered.

This report summarizes the evaluation, outlines relevant resources, and presents preliminary recommendations based on evaluation findings. An appendix includes a list of technical and training resources including, web links, training documents, and other relevant resources used in the evaluation.
# Existing training materials

Many countries have developed their own training materials; others have adapted generic or other program materials. Several of these safe motherhood/maternal health training materials have AMTSL and/or other components of PPH prevention or management included. The following is not an exhaustive list but those most cited from interviews and literature searches.

<table>
<thead>
<tr>
<th>Training document</th>
<th>Author(s) or Organization</th>
<th>Technical Content</th>
<th>Intended audience</th>
<th>Training Method</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Managing PPH – Education material for teachers of midwifery | WHO / 2006 | **Midwifery educations modules**  
Education material for teachers of midwifery designed to help equip midwives with essential life-saving skills.  
- Includes PPH? Yes  
- Includes AMTSL? Yes  
- Includes Illustrated Steps? Yes | Midwives Nurse-midwives | Classroom for didactic with clinical practicum  
Uses a competency-based training approach | Developed for in-service education programs preparing but may also be used for pre-service education programs. Manuals contain reference material and learning activities. |
| Life Saving Skills for Midwives (3rd edition) | American College of Nurse-Midwives (ACNM) | Modules include: Antenatal Care, Labor Progress, Episiotomies, Hemorrhage, Resuscitation, Sepsis, Rehydration, Vacuum Extraction and Other Emergencies.  
- Includes PPH? Yes  
- Includes AMTSL? Yes  
- Includes Illustrated Steps? Yes | Midwives Nurse-midwives | Classroom for didactic with clinical practicum  
Uses a competency-based training approach | Developed for in-service education programs but may also be used for pre-service education programs. Manuals contain reference material, skills checklists, and learning activities. |
| Home-Based Life-Saving Skills (HBLSS) | ACNM | The Home Based LSS training manual has a flexible, modular design comprised of 12 preventive and life saving skill topics.  
- Includes PPH? Yes  
- Includes AMTSL? No  
- Includes Illustrated Steps? Yes | Women, family members, communities, community providers | Group learning  
Participants are taught skills but do not practice on clients in a clinical setting | HBLSS is a family focused, community-based program to reduce maternal and neonatal mortality. It was developed to work with women, family members of pregnant women, communities, and community providers. |
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<tr>
<th>Training document</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>Learning Resource Package for Basic Maternal and Newborn Care</td>
<td>JHPIEGO / September 2004 Reference Manual: JHPIEGO (2004). Basic Maternal and Newborn Care: A Guide for Skilled Providers</td>
<td>Focuses primarily on knowledge and skills for providing basic antenatal, childbirth, postpartum, and newborn care. - Includes PPH? Yes - Includes AMTSL? Yes - Includes Illustrated Steps? Yes</td>
<td>Midwife, doctor or nurse with midwifery and life-saving skills</td>
<td>Classroom for didactic with clinical practicum</td>
<td>Developed for in-service education programs preparing but may also be used for pre-service education programs. The learning resource package on CD-ROM contains all of the materials needed to conduct a competency-based in-service training course for skilled providers.</td>
</tr>
<tr>
<td>Learning resource package: Emergency Obstetric Care for Doctors and Midwives</td>
<td>JHPIEGO / MNH Program and Mailman School of Public Health, Columbia University / AMDD Program (May 2003) Reference Manual: WHO/IMPAC (2003). Managing Complications in Pregnancy and Childbirth</td>
<td>Follows a symptom-based approach to the management of life-threatening obstetric emergencies. - Includes PPH? Yes - Includes AMTSL? Yes (included in delivery checklist) - Includes Illustrated Steps? No</td>
<td>Doctors, midwives and/or nurses with midwifery skills</td>
<td>The first two weeks take place in the classroom and weeks three, four and five in designated clinical sites. The first five weeks are followed immediately by a 3-month self-directed practicum at the participant’s worksite, during which the clinical trainers for the course provide at least two follow-up visits for mentoring and further evaluation. Uses a competency-based training approach</td>
<td>Developed for in-service education programs preparing but may also be used for pre-service education programs. Components: - A reference manual - A participant’s handbook containing validated questionnaires, learning guides and skills checklists, case studies, role plays, and clinical simulations - A trainer’s notebook - Well designed learning aids such as videotapes, presentation graphics and anatomic models - Competency-based performance evaluation</td>
</tr>
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</tbody>
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| Learning resource package: Managing complications in pregnancy and childbirth  
http://www.reproline.jhu.edu/english/2mnh/2mcpc/learningpkg_toc.htm | JHPIEGO / last updated August 2006  
- Includes PPH? Yes  
- Includes AMTSL? Yes (included in delivery checklist)  
- Includes Illustrated Steps? Yes | Midwife, doctor or nurse with midwifery and life-saving skills | Classroom for didactic with clinical practicum | Uses a competency-based training approach  
Developed for pre-service education programs but may also be used for in-service education programs.  
Components:  
- Guide for Teachers  
- Reference Manual  
- Technical Modules  
- Anatomic Models  
- Technical Videos |
**Literature review**

The literature search focused on training programs, strategies and methodologies related to training providers in maternal or reproductive health (not just PPH). The findings revealed information about a wide variety of training programs for different cadres but not necessarily detailed descriptions of the training methodology, content, and/or outcome. A list of the main studies and reports that were reviewed may be found in the appendix. Summary points from the literature review are as follows:

- Training in AMTSL has mainly been documented among skilled providers in facility settings.

- Programs have trained both facility- and community-based providers in some aspect of prevention, recognition, treatment, and/or referral or women with PPH. This sometimes includes AMTSL or at least one of the main components (fundal massage, administration of a uterotonic, CCT or maternal effort to deliver the placenta).

- Training resources are available for skilled birth attendants as well as traditional or community providers.

- Various studies are underway in developing countries to determine behavior change interventions, feasibility, and best practices for implementing AMTSL.

- There was no one method or resource that could be cited as a best practice.

**Review of in-service education programs for the prevention of PPH**

When teaching a clinical skill, such as active management of the third stage of labor, the training course should always be competency-based with a supervised clinical practicum. To teach the theoretical basis for the clinical skill, however, there is no one training methodology or strategy that will be effective for all providers, facilitators, programs and settings. Training in the prevention and treatment of PPH can take many forms but will always require that learners be provided with a chance to practice the new skill in a simulated and clinical setting.

Training clinically active maternal-newborn providers (in-service) to provide a new clinical skill, such as AMTSL, has taken the following forms:

a. *Classroom (group-based) instruction* with clinical practicum – in this case, participants receive both the didactic and clinical training at a central training site

b. *On-the-job instruction* – didactic and clinical training are conducted at the provider’s worksite
   - *One-to-one instruction*: here the training, coaching or mentoring is carried out for a single trainee.
   - *Instruction in small group*: As above but with a number of trainees.

c. *Self-instruction (self-paced) for didactic portion with clinical practicum* – in this case, participants complete the didactic material using a self-paced approach and then go to a central training site for clinical training once they have successfully completed the didactic portion. The self-paced portion of the training program *could be any of the following combinations*:
- **Web-based with on-line support**: here the didactic portion of the training is delivered over an intranet or the Internet, with a facility for remote interaction with a tutor or subject-matter expert. Because bandwidth is normally limited, you have to assume that video and audio would not be available.

- **Stand-alone multimedia PC**: in this case, the training is delivered off the hard disk or, more likely, CD-ROM, with audio and video capabilities.

- **Multimedia PC in small groups**: this is the same as the second example above, but in this case the training is delivered to a small group.

- **Workbook alone**: the training is delivered through a workbook, with support from no other media.

- **Video and workbook**: As above, but with the aid of a video cassette, DVD or TV broadcast.

- **Audio and workbook**: The workbook is supplemented by audio from tape, CD or radio

d. **Classroom (group-based) instruction** with clinical practicum followed by self-directed practicum at the participant’s worksite, during which the clinical trainers for the course provide at least two follow-up visits.

e. A combination of two or more of the above (e.g., centralized classroom instruction with on-the-job clinical training; self-instruction (individually, in pairs, or in a group) for the didactic portion with a clinical practicum in a central site; etc.)

### Innovative training approaches

Learning can also take place through other modes, either in the absence of or complementary to the training approaches listed above. There are numerous examples of these approaches, but the following are those most commonly cited by those interviewed.

a. **Peer learning approaches**:¹ this refers to the use of teaching and learning strategies in which students learn with and from each other without the immediate intervention of a trainer or tutor. Also known as “cooperative learning,” such approaches may be established and/or monitored by trainers (and may even occur in their presence), but trainers are not involved in directly teaching or controlling the learning activities. Examples of peer learning include study groups, student-led skill practice sessions, team projects, and peer feedback sessions in class.

b. **Learning through observation**: a very basic form of learning, often applied to infants and children, in which something is learned through repetitious observation. In the clinical area, this could apply to a skill or practice being learned by watching it being performed, often by a more experienced provider. This type of learning is not always intentional as clinical practice techniques and habits (not always good ones) are often picked up in this manner, especially by pre-service students and new clinicians without realizing it.

c. **E-learning**: refers to computer-generated or computer-enhanced learning. This usually is a form of self-study and is often free of charge. E-learning is useful for acquiring new knowledge but lacks the “hands-on” practice necessary to gain skill

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competency. It also requires a computer and internet access. Many technologies can be used in e-learning such as multimedia CD-ROMs, web-based learning/teaching courses or materials, websites, simulations, and discussion boards. Examples include:

- The Preventing Postpartum Hemorrhage course from the USAID Global Health E-learning Center (www.globalhealthlearning.org).
- Emergency Obstetric Care for Doctors and Midwives, developed by JHPIEGO and the Averting Maternal Death and Disability program. The course, which includes information on PPH management, was developed for training providers but can also be used for self-learning. It can be downloaded from http://www.reproline.jhu.edu.
- Tutorials: though this review did not identify one specific to PPH prevention or management, these types of programs can be very useful for learning new knowledge and in some instances, skill observation. Examples include the interactive tutorial on basic newborn care by Save the Children/Bolivia and the tutorial on Malaria in Pregnancy by JHPIEGO.
- E-mail discussion forums: usually an informal process with a group of several people who “discuss” ideas, share resources/technical updates, and ask and respond to questions about a particular topic. One advantage is that it can be started, expanded, or stopped anytime and participants are free to join in as desired or available. The POPPHI director, along with some colleagues, participated in such a discussion on community-based management of PPH.

Developing a curriculum and schedule for training

When developing a curriculum and schedule for training, the facilitators will need to consider the following factors that affect the length and type of training:

1. The level of provider and his/her scope of practice – The training program will have to take into account the national scope of practice for the provider being trained. For example:
   - Mali: policy was changed in 2003 to permit midwives to give oxytocin.
   - Malawi: midwives are not permitted to do manual removal of placenta.
   - Tanzania: midwives are not permitted to do bimanual compression.

2. Specifics of training:
   a. Is this for a pre-service or in-service education program?
   b. Are these new skills or updates of skills previously learned?
   c. Are these new skills or attempts to improve / remediate the practice of AMTSL?
   d. Is training in AMTSL / prevention of PPH being integrated into an existing training curriculum or being presented as a single topic training?
   e. Training method: classroom (group-based), on-the-job, self-paced, or mixed (any two or more training methods used together)?
3. Technical content:
   a. AMTSL only.
   b. ATMSL + PPH prevention (any of the following components: prevention and
treatment of anemia during pregnancy, giving birth with a skilled attendant,
partograph, care during first and second stages of birth, birth preparedness and
complication readiness, immediate postpartum care).
   c. AMTSL + Management of PPH (immediate management, specific management -
therapeutic uterotonic drugs, manual removal of placenta, bimanual
compression, etc.).
   d. AMTSL + Infection Prevention (IP)

4. Available resources (e.g., human, financial, logistic).

5. Learning and training styles of potential learners and facilitators.

Wherever possible, knowledge and skills for preventing and/or managing PPH should be
integrated into technical content on antenatal, childbirth and postpartum care in pre-
service education programs preparing skilled providers. While it is acknowledged that
pre-service integration is the key to sustainability, in-service training in PPH prevention
and management is still necessary to ensure that currently practicing clinicians are
providing quality, evidence-based care.

Non-training approaches

While training in a clinical skill is important, non-training approaches may serve to
generate interest in a specific intervention, ensure sustainability of the practice, and
promote wide use of the intervention.

a. Promotion of clinical interventions by “champions” or charismatic
leaders/advocates. This involves learning about a practice, procedure or topic
through a person or persons who are strong advocates of the topic or practice. This
“champion” is an expert in the topic/practice, is intensely dedicated to its defense
and promotion. Examples include the following:

   • Suellen Miller: a midwife researcher who has been involved in the research for
   and testing of the anti-shock garment for the management of PPH. Dr. Miller
   travels and writes extensively, advocating the importance of this innovative
technology to save mothers lives, especially in low-resource settings.

   • Abhay Bang: a physician dedicated to the reduction of newborn mortality
   through community or home-based strategies. Dr. Bang has dedicated his life to
   community work and has successfully designed programs to reduce newborn
   morbidity and mortality. Providers and program managers worldwide continue to
   learn from his advocacy, research, and hands-on involvement in this cause. The
   Government of India, having also learned from his work, is now replicating his
   strategies in other Indian states.

b. Promotion of clinical interventions using behavior change communication
(BCC). BCC aims to foster positive behavior; promote and sustain behavior change
in the individual and in the work environment; and maintain appropriate behavior.

   • Uganda: The percentage of women who had a vaginal birth and had AMSTSL
   performed is quite low in spite of the fact that AMTSL is taught in pre-service and
   in-service education programs. A BCC strategy is being tested in Uganda which is
part of an integrated, multilevel, interactive process with providers aimed at
developing tailored messages and approaches using a variety of communication
channels. The goal of the BCC strategy will be to find ways to ensure sustained
performance of AMTSL in the workplace.

c. **Promotion of clinical interventions using regional or national launches.**
Sponsoring a national or regional launch about prevention of PPH and promotion of
AMTSL can serve to foster champions, inform policy makers and providers, generate
a movement that leads to higher coverage of AMTSL, and regenerate enthusiasm
about programs promoting AMTSL.

- **Mali:** AMTSL was introduced into in-service programs in Mali in 2003. Since then,
  the Ministry of Health and some local NGOs have provided training for providers
  in AMTSL in certain districts or zones in Mali, but the percentage of providers
  trained in and practicing AMTSL is still low. Having a Ministry of Health-sponsored
  launch has helped to generate renewed interest and efforts to increase the
  percent of women who benefit from AMTSL. These efforts include:
  institutionalizing AMTSL by introducing its instruction into pre-service education
  programs; a unified effort by the MOH and international / national NGOs and GOs
to ensure that all districts and all regions get assistance to train all skilled birth
  attendants in AMTSL; and working with health committees at all levels to ensure
  that providers have the necessary supplies and medications to provide AMTSL
  safely.

- **Benin:** AMTSL was introduced to Benin in 2003 and since then a majority of
  skilled birth attendants have been trained in it. The national survey showed
  coverage for AMTSL of only 17%, in spite of these vigorous efforts. This finding
  has led the MOH to work with international and national partners to develop
  innovative strategies to improve practice in providers that have already been
  trained and improve future training efforts.

d. **Promotion of clinical interventions using national surveys.**
Sponsoring a
national survey on the coverage of AMTSL can serve to inform policy makers and
motivate providers to improve practice.

- **Benin:** AMTSL was introduced to Benin in 2003 and since then a majority of
  skilled birth attendants have been trained in it. The national survey showed
  coverage for AMTSL of only 17%, in spite of these vigorous efforts. This finding
  has led the MOH to work with international and national partners to develop
  innovative strategies to improve practice in providers that have already been
  trained and improve future training efforts.

e. **Ensuring sustainability and quality of clinical interventions using quality
   assurance techniques and supportive supervision.** It is well known that regular
   supervision is important for ensuring sustained change of a clinical skill or behavior.
   Supportive supervision can ensure sustainability of a practice through several
   mechanisms: Providers can receive timely feedback on their performance which can
   serve to motivate them; deficiencies in performance can be identified early and a
   clear plan made with the provider to improve practice; supervisors can work with
   providers to address conditions in the workplace that may be hindering the provider
   from practicing the new skill, etc. In most countries, however, logistical problems
   hinder regular supervision, and supervisors are looking for innovative ways to ensure
   quality.

- **Niger:** The Quality Assurance Project has applied the Improvement Collaborative
  model to rapidly improve quality of maternal and newborn care via adoption and
  implementation of Essential Obstetric and Newborn care (EONC) standards at
  national policy and local facility levels. In an Improvement Collaborative, teams
  from different sites work together intensively to share and apply strategies for
  rapidly implementing identified best practices.
Recommendations

1. When possible, use existing training materials and adapt them for country-specific use.
2. Decentralize training activities to the district level.
3. Use a mixed learning approach that combines a self-paced component for the theoretical portion and a clinical practicum.
4. Develop short technical updates that can be adapted for various types of in-service training.
5. Update/revise the CD-ROM on AMTSL and make it available in different media (e.g., transparencies, PowerPoint, hard copy, video). Include audio/visuals in modules. Consider an interactive CD-ROM for self-study.
6. Field test new training strategies.
7. Field test BCC strategies to increase practice of AMTSL.
8. Field test innovative strategies to ensure continued quality practice of AMTSL.
9. Support operations research of community-based AMTSL.
10. Support integration of PPH prevention and management into pre-service curricula (midwifery, medical and nursing as well as other relevant providers like clinical officers)
11. Support the training and follow up of clinical and classroom faculty including examiners and staff at all student clinical sites. These often include physicians who are not otherwise involved in technical updates.
13. Use the QA approach for scaling up AMTSL at the national level; this approach will lead to a higher coverage of AMTSL and will bring with it huge improvements in overall care for women and babies (see http://www.urchs.com/ and http://www.urchs.com/projects/quality/gap_project.html).
Appendix

Literature review
The following is a list of the main articles, reports, and websites reviewed.

1. **Title:** A cluster randomized controlled trial of a behavioral intervention to facilitate the development and implementation of clinical practice guidelines in Latin American maternity hospitals
   
   **Author:** Althabe F, Buekens P, Bergel E, Belizán JM, Kropp N
   
   
   **Website:** [http://www.biomedcentral.com/content/pdf/1472-6874-5-4.pdf](http://www.biomedcentral.com/content/pdf/1472-6874-5-4.pdf)
   
   **Summary:** A significant proportion of the health care administered to women in Latin American maternity hospitals during labor and delivery has been demonstrated to be ineffective or harmful, whereas effective interventions remain underutilized. The routine use of episiotomies and the failure to use AMTSL are good examples. The aim of this trial is to evaluate the effect of a multifaceted behavioral intervention on the use of two evidence-based birth practices, the selective use of episiotomies and AMTSL (injection of 10 International Units of oxytocin). The intervention is based on behavioral and organizational change theories and was based on formative research. 24 hospitals in 3 urban districts of Argentina and Uruguay will be randomized. The main outcomes to be assessed are the rates of episiotomy and oxytocin use during the third stage of labor. Secondary outcomes will be perineal sutures, postpartum hemorrhages, and birth attendants’ opinions.

2. **Title:** Curriculum analysis for the midwife curriculum development group
   
   **Author:** Herem A (GTZ).
   
   
   **Summary:** This report provides an analysis of 5 current midwifery training programs (Cambodia), and recommendations to a working group for supporting its decision-making, including how to upgrade skills of current midwives, what midwifery training might be provided to nurses and how to provide such training, and provision for training of new midwives. Only one curriculum specifically mentions AMTSL (“controlled management of the third stage”), but no other useful information is given.

3. **Title:** A midwifery model for training traditional midwives in Guatemala: a report from the field
   
   **Authors:** Foster J, Anderson A, Houston J, Doe-Simkins M
   
   **Website:** [http://www.midwivesformidwives.org/pdf/article02.pdf](http://www.midwivesformidwives.org/pdf/article02.pdf)
   
   **Summary:** This report describes the characteristics of a model of training of traditional birth attendants. Information was gathered through interviews of the traditional birth attendants themselves, trainers, allied health professionals, and volunteers. Does not give much on content of training.

4. **Title:** Report on the evaluation of advanced midwifery training in South Africa
**Author:** Mativandlela TM  

**Summary:** This reports on the Decentralised Program for Advanced Midwifery (post-graduate course) and the distance learning/self-study Perinatal Educational Program programs. The results indicated that the skills of the advanced midwives are not being utilized effectively, and the Perinatal Educational Program not widely implemented nor the distributed manuals being utilized.

5. **Title:** Health service quality improvement after normal delivery: competency-based training  
**Author:** PRIME II  
**Website:** [http://www.gfmer.ch/Endo/PGC_network/Health_service_quality_improvement.htm](http://www.gfmer.ch/Endo/PGC_network/Health_service_quality_improvement.htm)

**Summary:** PRIME II trained skilled birth attendants in AMTSL for vaginal deliveries at eight pilot sites in Mali as part of the United States Agency for International Development’s (USAID’s) special initiative to prevent PPH in four African countries (Mali, Benin, Ethiopia, and Zambia). PRIME II also helped to begin work at the national level to incorporate AMTSL into service standards and protocols, start the process of revising pre-service training curricula to include AMTSL, and emphasize the importance of endorsing skilled attendants to administer oxytocics. Key Results: Provider scores for overall performance of AMTSL (record-keeping, infection prevention, administration of oxytocin, controlled cord traction, and uterine massage) increased from 29% at baseline to 94% at final evaluation. Vaginal births with AMTSL at the intervention sites increased considerably, from 0% to 55% (6,151/11,191 births). No complications were reported at any of the sites. The Ministry of Health has indicated their interest in country-wide scale-up of AMTSL, and USAID/Mali has included prevention of PPH as a high-impact service in its two bilateral projects.

6. **Title:** Skilled birth attendance: what does it mean and how can it be measured?  
**Author:** Carlough M, McCall M  
**Website:** [http://www.figo.org/content/PDF/AMDDPages0505-04.pdf](http://www.figo.org/content/PDF/AMDDPages0505-04.pdf)

**Summary:** This is a clinical skills assessment of maternal child health workers in Nepal. These workers have a 15-week basic course and then a 6-week refresher in midwifery skills. This study compares the results of clinical skills assessments from 104 randomly selected maternal and child health workers and concluded that refresher trained providers performed better than those who were not. Also, maternal and child health workers on average have an acceptable level of knowledge and skill to function as community skilled birth attendants. Not all the skills of this cadre were mentioned, but “PPH management” appeared to include administration of uterotonics and uterine massage.

7. **Title:** Improved responses to neonatal emergencies (Nicaragua)  
**Author:** PRIME II  

**Summary:** This is a brief on the pilot project in rural Nicaragua to improve emergency obstetric and neonatal care. Focus was on danger signs, delays, and response to postpartum bleeding. Final evaluation demonstrated significant
improvement in provider performance. Management of PPH by physicians, nurses, and auxiliary nurses also improved.

8. **Title:** Making it happen: using distance learning to improve reproductive health provider performance  
   **Author:** PRIME II  
   **Summary:** This document examines distance learning as an effective training approach for reproductive health providers in developing countries and provides illustrative examples for training. It helps the reader plan and implement effective distance learning.

9. **Title:** No magic bullets: a systematic review of 102 trials of interventions to improve professional practice  
   **Source:** *Journal of the Canadian Medical Association*  
   **Author:** Oxman AD, Thomson MA, Davis DA, Hayes B  
   **Summary:** This reports on a study to determine the effectiveness of different types of improving health professional performance and health outcomes. It concludes that there are no “magic bullets” for improving the quality of health care, but a wide range of interventions that if used appropriately could lead to important improvements in professional practice and patient outcomes.

10. **Title:** What is whole-site training?  
    **Author:** EngenderHealth  
    **Summary:** Whole-site training is an approach for meeting the learning needs of all staff at a health care service-delivery site. This paper describes whole-service training, the advantages it offers, the challenges it faces, and examples of where it is being used. The approach has been developed in response to the training needs of health care providers working in reproductive health in developing countries.
Training materials