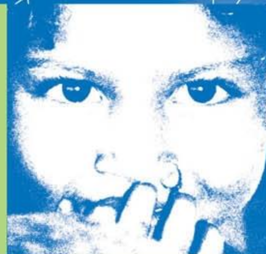
Report



Road Map for Community Midwifery in Southern Sudan

Ministry of Health – Government of Southern Sudan

Gloria 'Ann' Evans, FNP, MSN, DrPH, Policy Fellow

Medoline Etyefyose Lema, RN, RM, MPH

June 2010

LATH
LIVERPOOL ASSOCIATES IN TROPICAL HEALTH

Technical Resource Centre
Liverpool Associates in Tropical Health
Anson House,
25 Anson Street,
Liverpool
L3 5NY
U.K.

Tel: +44 (0) 151 705 3773
Fax: +44 (0) 151 705 3774

trc@lath.com

TABLE OF CONTENTS

Acronyms....4
Executive Summary....4
1. Introduction....8
2. Background or Context....9
3. Methodology or Summary of Activities....11
4. Findings and Conclusions....14
5. Recommendations and next steps....18
6. Acknowledgements....21
Annex 1: Terms of Reference....24
Annex 2: The Consultant Team....31
Annex 3: List of People Interviewed and Facilities Visited....32
Annex 4: Consultants' Calendar....34
Annex 5: References....36
Annex 6: Training Centre Standards....39
Annex 7: Code of Ethics for Nurses....46
Annex 8: Midwifery Standards of Care....51
Annex 9: Code of Ethics for Midwifery....55
Annex 10: Memorandum of Agreement for Training....57
Annex 11: Recommendations Phase I CMW Consultation....58
Annex 12: Register for Nurses and Midwives....62
Annex 13: Southern Sudan Council of Nursing and Midwifery....65

ACRONYMS

AMREF	African Medical and Research Foundation
ANC	Antenatal Care
BPHS	Basic Package of Health Services
BSN	Bachelor of Science in Nursing
CEmOC	Comprehensive Emergency Obstetric Care
CHW	Community Health Worker
CMW	Community Midwife
CPA	Comprehensive Peace Agreement
DGNM	Directorate General of Nursing and Midwifery
EmOC	Emergency Obstetric Care
GOSS	Government of Southern Sudan
HCW	Health Care Worker
HR	Human Resources
ICN	International Conference of Nurses
ICM	International Confederation of Midwives
IMC	International Medical Corps
JTH	Juba Teaching Hospital
LATH	Liverpool Associates in Tropical Health
MCH	Maternal Child Health
MCHW	Maternal Child Health Worker
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOA	Memorandum of Agreement
MOH	Ministry of Health
NGO	Non Governmental Organization
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PPH	Post Partum Haemorrhage
PRDA	Presbyterian Relief and Development Agency
SBA	Skilled Birth Attendant
SMOH	State Ministry of Health
SS	Southern Sudan
SSNMC	Southern Sudan Nursing and Midwifery Council
TBA	Traditional Birth Attendant
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
UNFPF	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

The tragically high maternal mortality ratio of 2054/100,000 in Southern Sudan (SS) demands an evidence-based strategy to address the problem; a problem that some say is no less than a basic human rights issue. Research has clearly shown that access to skilled birth attendance (SBA) can dramatically reduce maternal mortality. Yet 90% of deliveries in Southern Sudan occur in rural areas where health care workers (HCW) are few and where women deliver unattended or attended by persons with little or no training. To address the situation, a new curriculum was developed to train community midwives (CMW) in an 18-month programme with a goal of posting them in rural areas.

Some questioned whether the 18-month CMW programme was long enough to develop competent midwives for working in rural areas. This question was explored in a consultancy in January/February 2010. The consultants reported[1] that graduates with the required delivery experience showed confidence and competence; however, none of these graduates had been posted in rural areas.

Unfortunately, competence and confidence were not uniform, and in some schools students had been allowed to graduate with as few as eight of the curriculum requirement of 25 deliveries, which was half of the original requirement of 50 deliveries. The assessment showed that the CMWs with limited delivery experience lacked the confidence and the knowledge to be posted in rural communities where they probably would have little if any supervision. Given the magnitude of the maternal mortality problem and the urgent need for making SBA widely available, the current consultancy focused on discerning the best options for moving forward.

Objectives of the assignment

Specifically, the current assignment was to "consider options for improving the current state of affairs of the Community Midwifery programme….and propose a road map with both short and longer term actions to improve access of mothers to skilled attendance during labour and delivery." This 'road map' assignment was carried out in May/June 2010 by two consultants, experts in nursing, midwifery, education, public health and policy analysis, in collaboration with the Directorate General of Nursing and Midwifery (DGNM) of the Ministry of Health of the Government of Southern Sudan (MOH-GOSS).

Methodology in Brief

The January/February curriculum assignment resulted in three pages of specific recommendations for advancing community midwifery. The second assignment built on the first, assessing response to the recommendations and the fit of these recommendations with the Basic Package of Health Services (BPHS). In addition, the consultants provided both technical and 'hands on' instrumental assistance in reducing some of the barriers to getting CMWs posted and working in rural areas. To accomplish these goals, it was important to determine what forces internationally, nationally, and even internally in the MOH might facilitate or impede forward motion. Consequently, the consultants made use of multiple meetings regarding reproductive health, hospital planning, and research on maternal and neonatal health. In addition, the consultants initiated meetings to review the findings and recommendations from the curriculum assessment and to facilitate moving forward

[1] Evans GA & Rehnström U. *Assessment of the Community Midwifery Programme in Southern Sudan*. MOH-GOSS/LATH. February 2010.

with the most pressing concerns. Individual meetings with key stakeholders were held and a large body of literature on reducing maternal and neonatal mortality was reviewed as well as literature on posting and retaining health workers in remote areas.

Findings

1. Consensus, Collaboration & Cooperation

Within the MOH there was a lack of consensus, collaboration and cooperation regarding community midwifery. The report from the earlier assignment had not been widely disseminated within the MOH. Specifically, the Director of Training in the Human Resources (HR) Directorate and the Director of Reproductive Health had not received a copy, and none of the nursing and midwifery staff, other than the DGNM had seen the report. Verbal support of community midwifery was uneven and less than enthusiastic. Negative comments lacked an evidence base other than relating an occasional anecdotal experience. These findings were striking, given the five years and much donor funds invested in training community midwives as a primary method of reducing maternal mortality by increasing skilled birth attendance in remote areas. Research clearly indicates that community midwives are key to reducing MMR, even cutting it in half, and that 18-month programmes produce competent midwives.

Somewhat surprisingly, the Human Resources Directorate, responsible for Training and Curriculum, had not followed up on the recommendation to establish a memorandum of agreement to ensure compliance with the curriculum and to halt the practice of graduating students who had accomplished less than one quarter of the currently required 25 deliveries. This seems to this writer a key responsibility of that department and basic to its function. In addition, while HR was developing a tool to assess training institutions, including nursing and midwifery programmes, HR was not working collaboratively with Nursing and Midwifery even though HR lacked staff and expertise in those areas.

Given the short timeframe of the road map consultancy, it was felt important to work strategically and cooperatively. Unfortunately, the DGNM had to be away from the ministry on several occasions and this resulted in delays in identifying and providing key documents and failure to delegate decision making to other staff during these absences, which then prevented group work development of a much-needed regulatory nurse and midwifery practice act document, a central concern of the DGNM. However, a draft of a regulatory document was developed by the consultants and is included in Annex 12.

2. International Trends

International trends that could influence success or failure of policy options in HRH include:

- 'Brain drain'—the exodus of skilled HCWs, particularly nurses and physicians, from developing nations to developed nations, with developing nations bearing the training costs and the developed nations receiving the benefit[2]

[2] Dayrit MM, Dolea C, Braichet JM. One piece of the puzzle to solve the human resources for health crisis. Bulletin WHO, Vol 88, No 5, May 2010.

- Tremendous international shortage of nurses and midwives which could influence availability of importing midwives as well as probability of outward migration of midwives[3]
- Success of shifting tasks from more highly educated and skilled workers to less educated workers with greater time and cost efficiency and greater retention in rural areas[4]
- Growing body of research on policies proving successful in posting and retaining physicians and nurses in rural areas[5, 6]

3. Trends and Factors within Southern Sudan

Trends and factors within Southern Sudan that can have a negative impact on women accessing skilled birth attendance include:

- The deficit of skilled birth attendants, including not enough midwives at the community level and not enough midwives with the required skills and knowledge. Adding to the problem is the recent practice of graduating CMWs before completion of curriculum delivery requirements for achieving competency
- Low standards of training; absence of training centre standards, insufficient number and limited qualification of clinical tutors, failure to fulfil the curriculum requirements for number of deliveries, and lack of regulation of training centres
- Placing CMWs in unclassified status and at low level on civil service pay scale—at the level of cleaners and students
- Placing nurses and midwives in general at low level on civil service pay scale
- Failing to provide jobs to new CMW graduates
- Cultural myth that stalled labour is caused by a woman's infidelity and solution is confessing 'sin' and naming the man, rather than accessing emergency obstetric care (EmOC)
- Cultural belief that a woman is more of a woman if she delivers at home and even alone
- Difficulty posting and retaining professionals in rural areas
- Lacking basic infrastructure, such as roads, means of transportation and communication to connect and transport women to basic or comprehensive EmOC

[3] WHO. Wanted: 2.4 million nurses, and that's just in India. Bulletin WHO, Vol 88, No 5, May 2010.
[4] Pereira C. Task-shifting of major surgery to midlevel providers of health care in Mozambique and Tanzania: A solution to the crisis in human resources to enhance maternal and neonatal survival. Karolinska Insitute, 2010.
[5] Serneels P, et al. Who wants to work in a rural health post? The role of intrinsic motivation, rural background and faith based institutions in Ethiopia and Rwanda. Bulletin WHO, Vol 88, No 5, May 2010.
[6] Blaauw D, et al. Policy interventions that attract nurses to rural areas: A multicountry discrete choice experiment. Bulletin WHO, Vol 88, No 5, May 2010.

- Lacking health care infrastructure—only a few hospitals and other EmOC facilities; limited equipment, supplies and skilled personnel and having facilities that are not acceptable and affordable for delivering women

Recommendations

- Establish training centre regulatory mechanisms, both immediate via HR memorandum of agreement (MOA) and long term via Nurse and Midwifery Practice Act; consider adapting and adopting draft regulatory document provided by consultants (Annex 10)
- Adapt, adopt and implement drafted Training Centre Standards (Annex 6), Midwifery Standards of Care (Annex 8), Midwifery Code of Ethics (Annex 9), and Nursing Code of Conduct (Annex 7)
- Present rationale and scaling option for addressing appropriate CMW pay scale and classification status in civil service system; MOH to advocate for change in policy based on critical need and priority given by President Salva Kiir and MOH
- HR and/or Nursing and Midwifery to create list of CMW graduates and number of deliveries completed and create and coordinate internship opportunities to complete total of 50 deliveries
- MOH to make conditional money available to hire CMWs for rural assignments as a high priority to address serious public health problem
- Leverage 2 to 3 years of CMW rural assignment for access to higher level of training as diploma nurse, diploma midwife, or support in BSN education
- Encourage local surveys of women regarding their preference for building or rehabilitating birthing centres that women will accept and use
- Remove financial barriers and provide incentives for accessing skilled birth attendance in clean, safe, equipped, supplied and supported birthing facilities
- Encourage development of maternal waiting homes in proximity to birthing centres for women with complications and to make access more acceptable to other women
- Recruit or train baccalaureate and graduate level nurses and midwives for leadership roles in management, education, research and regulation of nursing and midwifery professions.

1. INTRODUCTION

Emerging from more than two decades of war the Government of Southern Sudan (GOSS) faces a staggeringly high maternal mortality ratio (MMR) of 2054/100,000, the highest in the world. The 2006 Household Health Survey indicates that fewer than 10% of deliveries occur in the presence of a nurse, midwife or doctor. The majority of women deliver alone or with either an untrained

traditional birth attendant (TBA) or an attendant with limited training. Nearly 90% of deliveries occur in the rural areas where there is limited access to health care and few skilled birth attendants (SBA).

Evidence from multiple studies and years of global research show a dramatic reduction in MMR when deliveries occur with the help of SBAs. Consequently, the Ministry of Health (MOH) of GOSS committed to making skilled maternity care accessible, acceptable, affordable, sustainable and cost effective. In collaboration with African Medical and Research Foundation (AMREF) and United Nations Population Fund (UNFPA), the MOH established a curriculum to train Community Midwives (CMW) to staff the Primary Health Care Centres (PHCC) and bring skilled birth attendance to women living in rural areas.

An assessment of the new 18-month curriculum indicated that CMWs with ample delivery experience very likely had the competencies to be posted in rural areas. However, many of the students did not complete the requirement of even 25 deliveries, a number reduced from the original curriculum that required 50 deliveries, and none of the ones who had completed that many deliveries were posted in rural areas. The reviewers many recommendations included:

- Training centres must comply with the curriculum
- The curriculum should increase to 50 deliveries either during training or through an internship
- Regulations should be developed to regulate training and practice and prepared for inclusion in the Southern Sudan legislative codes of governance
- The Human Resources (HR) Directorate of MOH-GOSS should develop a Memorandum of Understanding (MOU) with training centres regarding required compliance with the curriculum and not graduating students until the requirements are met

The purpose of the current consultancy was to "consider options for improving the current state of affairs of the CMW programme….and propose a road map with both short and longer term actions to improve access of mothers to skilled attendance during labour and delivery." Specifically, there should also be an action plan for implementation of the chosen option/s with description of needs and basic costing. The team was formulated to include one of the consultants from the first consultancy.

Annex 1 contains the Terms of Reference (TOR) for the consultancy; Annex 2 describes the consultant team.

2. BACKGROUND OR CONTEXT

Background. After more than two decades of war the Ministry of Health in the Government of Southern Sudan found itself with a health system in shambles, basic infrastructure nearly non-existent and a maternal mortality ratio (MMR) of 2054/100,000, the highest in the world and in stark contrast to the <10/100,000 in some of the developed countries. Childbirth, a time that is normally a happy event, is too often a tragic experience for families in Southern Sudan (SS). Some have called MMRs of this magnitude a basic human rights issue that demands a rapid moral response.

With approximately 4.2% of the 8,000,000 Southern Sudanese population delivering each year, this leaves roughly 336,000 women at risk and nearly 7,000 maternal deaths occurring annually. Nearly

90% of these tragic events occur in rural areas, often unattended or attended by untrained individuals or ones with limited training and skills.

However, abundant research indicates that women's access to skilled birth attendance dramatically reduces the MMR. Both President Salva Kiir and the MOH-GOSS have targeted reduction of the unacceptably high MMR as one of their very highest priorities. The MOH, faced with determining the best way forward to reducing the MMR, requested assistance with developing a Road Map to guide both the short and long term journey.

The way forward for midwifery is influenced by many factors, including the current political environments, cultural beliefs, competing demands for resources, international trends, rank in priorities, commitment to action and focused and persistent advocacy for results. At best the path forward is a challenging route, beset with barriers and setbacks. Providing guidance requires an understanding of the various prevailing forces; forces that could either promote or impede progress.

Cultural Beliefs. The population of Southern Sudan is primarily Christian and animist, with many still holding mythical beliefs about causes for the common problems and tragedies of life. Beliefs that directly affect women's access to SBA include a higher social value on women who bear their children at home and unattended, a sign that they are 'more of a woman' than those that seek care. Some also believe that failures of a birth to progress are due to the woman's infidelity and the 'cure' is for the woman to confess her transgressions. Should death occur from the obstructed labour the death is counted as a consequence of the woman's infidelity. By this logic, the woman then 'deserves' to die and is thus responsible for her own death. The birth attendant, if there is one, is then absolved of any responsibility for the maternal death, including the failure to refer the woman for skilled care. This cultural belief is so strong that many women, in the midst of pain, distress and with the demands of those present will 'confess' to an illicit affair. Should the woman survive, this 'confession' may become grounds for further problems with tragic consequences.

Competing demands for resources and priority. In the first consultancy the reviewers found that hospitals and PHCCs were in poor condition, ill-equipped, under-supplied, under-staffed, and staff had limited training and skills, sometimes less than the student there for clinical experience. The monies allocated for health care largely travel via block grants to the states, disallowing any oversight or control from the federal level. The 'trickle down' process too frequently results in few resources making it all the way to the salaries of the hospital and clinic workers. Hospital administrators also complain about their lack of budget to equip and supply their facilities.

International trends. Among the prevailing international trends affecting health care delivery are:

- Worldwide shortage of nurses; example – India needs 2.4 million nurses[7]
- Difficulty placing and retaining doctors and nurses in rural areas; growing body of research on successful interventions to post and retain them
- Rural to urban migration patterns
- 'Brain drain' phenomenon resulting in skilled health care workers (HCW) being trained in and by developing nations and then exiting to work in developed nations for higher salaries

[7] WHO. Wanted: 2.4 million nurses, and that's just in India. Bulletin WHO, Vol 88, No 5, May 2010.

- Task shifting where tasks normally the purview of highly skilled workers are shifted to workers trained in more time and cost efficient educational programs, with greater prospects of rural posting and retention and with lower salary costs to the employing agencies

Status and trends in Southern Sudan. Many factors within Southern Sudan influence the direction and success of training CMWs and posting and retaining them in rural areas. Other factors relate to limited demand for services. Among them are:

- Limited demand for SBA—financial barriers, few and distant facilities, facilities in poor condition and practices not acceptable to women
- Myths about stalled labour being due to woman's infidelity
- Tradition of delivering at home unattended or by a person with little or no training, and lack of referrals for delivery complications
- Poor implementation of the CMW policy: curriculum not enforced leading to many graduating with limited delivery experience and thus insufficient competence for immediate rural posting; few jobs available and those at low pay; poor placement in civil service system – discouraging graduates and hampering recruitment for new classes; lack of health care system infrastructure – facilities, equipment, supplies, staff, support and supervision and no vision for how to post this new cadre into rural areas, meaning the objective of increasing rural women's access to skilled birth attendance goes unfulfilled!
- Generally poor status and poor pay for nurses and midwives
- Pockets of insecurity and rural to urban migration create difficulties in deploying and retaining professionals in rural areas without providing incentives and support strategies
- Lack of consensus, coordination and cooperation on issues that cut across departments within MOH–GOSS places the CMW program at the crossroads of various departments that lack power or strategies to change program directions to make it work
- Language and cultural barriers with some returning and externally trained workers that hamper good patient communication and care

3. METHODOLOGY OR SUMMARY OF ACTIVITIES

Key questions. The team entertained a number of questions, including:

- How does CMW fit within the Basic Package of Health Services (BPHS)?
- What documents provide insight into current planning and international trends?
- What are Directors and other stakeholders saying about CMW? Is there consensus on spreading CMW training and employing CMWs?
- Can the prevailing trends suggest a way forward?
- Are there one or more MOH homes for advocacy and a process for moving CMW forward?

Specific activities. During the five week course of work the consultants met with a wide variety of stakeholders, including UNFPA, UNICEF, UNOCHA, MSH, WHO, MSF-H, GOAL, PRDA, OVCI, Directors General of Primary Health Care, Reproductive Health, Human Resources for Training, Deputy Directors for Curriculum and Training and many others through the workshops and meetings. The

weeks were rich with opportunities to exchange ideas and information from others and to envision ways to move forward. The following are the formal activities in which the team participated:

- Stakeholders meeting. An early key activity was to bring stakeholders together to discuss the findings and recommendations from the Phase I Consultation – Assessment of the Community Midwifery Curriculum. From that stakeholder meeting a plan was made for a Technical Working Group to identify and prioritize concerns to remove the bottlenecks and move forward with Community Midwifery. The minutes of the meeting were circulated via the Southern Sudan Health Forum Google group.

- Document and literature search. Pertinent documents from the MOH, both past and recent, were accumulated and reviewed to determine the history and path of midwifery planning. In addition, the literature was searched for studies and reports that could provide an evidence-based approach to planning for rural posting and for the retention of health care workers.

- Medical directors' and administrators' meeting. The consultants participated in the last day of the three-day LATH led meeting of medical directors and administrators from the three teaching/tertiary care hospitals in Wau, Malakal and Juba. In addition to many other priorities, all three hospitals identified a need for more midwives. The discussions and plans developed by the group also disclosed information about the current limitations on structure, function, equipment, supplies and staffing of the three major hospitals. These limitations highlight the challenges to providing an enabling clinical environment for midwifery and nursing students.

  The three named hospitals are sometimes referred to as the *teaching hospitals* and other times as the *tertiary care hospitals*, distinguished by their specialty staff or by their plans for such in the future. In fact, any hospital affiliated with a teaching institution becomes a de facto *teaching hospital*, an important fact to note as the need to improve all aspects of these institutions is critical to having enabling environments and quality clinical experiences.

- Task-shifting workshop. The consultants also participated in a two-day workshop on task shifting of emergency obstetric care and other surgical procedures to non-physician providers, including midwives. Evidence based lessons learned about task shifting in several African countries included cost and time efficiency, provision of quality care, excellent posting and retention in remote areas, and considerable cost savings in salary. One sobering long-term finding related to retention of physicians versus non-physicians. After seven years, 100% of the physicians trained in their developing, home country had migrated to another country while more than 80% of the non-physicians trained to do surgery had not migrated and were still posted in rural areas. Lessons learned from these decades of experience provide insight into the advantages of training HCWs to meet specific needs and not to initially or substantially offer trainings that foster migration to other countries. With a worldwide shortage of nurses and midwives it is important to provide training that will address the needs of the country and not foster an exodus with its concomitant loss of training investment.

- NGO monthly forum. The NGO monthly forum provided an opportunity to present the results of the Phase I community midwifery assessment, invite discussion from among many NGOs and enquire about possibilities of linking CMWs with internships and jobs.

- CMW Technical Working Group meeting. This meeting was organized to address the issue of needing consensus to move forward with community midwifery and to discuss an appropriate process and plan.

- Reproductive Technical Working Group Meeting**.** During this meeting the findings of the Study on Maternal and Newborn Care in Southern Sudan were presented. This study, focused on three regions: assessed access barriers to skilled birth attendance, including cultural barriers; belief systems; and what women found lacking in the HC facilities. The findings have particular relevance to building new or modifying birthing centres that would be more appealing and more widely used for deliveries.

- Nursing and Midwifery regulation planning meeting. The consultants held a half day meeting with the staff of Nursing and Midwifery of the MOH-GOSS and the Director of the Juba Nursing and Midwifery certificate programme to review documents and discuss a way to move forward with the process of developing a nursing and midwifery regulatory practice act to be included in the legislative code for Southern Sudan. A 10-day WHO consultation in 2008 had resulted in the beginning of an early draft of a document that could *guide* the development of a regulatory document, but not actually *be* the regulation itself. An alternative process was proposed in which existing regulations from other countries might be 'adapted and adopted' in a shorter time frame and with greater likelihood of being reasonably complete.

- Regulatory drafting meeting. The consultants then set up a one-day meeting to review regulations from other countries that had previously been selected by the Directorate General of Nursing and Midwifery (DGNM). The goal was to choose one of these regulatory acts and to work on the process of adapting it for Southern Sudan. However, this process did not occur as the DG/NM believed it would be better to create a new, rather than an adapted, regulation for Southern Sudan. Unfortunately, time did not permit this process. At the end of the meeting the DGNM asked if the consultants could provide a draft regulation as she felt LATH had committed to helping with this process. Although work time for such an option had already been exhausted due to numerous delays, the team did undertake the task and a copy of the draft, adapted particularly from Zambia's nursing and midwifery practice act and including parts from several other countries (Appendix 13). Also included are drafts for Standards for Nursing and Midwifery Training Centres (Annex 6); Nursing Code of Conduct (Annex 7); Midwifery Standards of Care (Annex 8) and Midwifery Code of Conduct (Annex 9).

Constraints to progress. At the start of the mission there was a full one-week's delay in meeting with the MOH counterpart due to the absence of the DGNM as well as her designated substitute. Further absences reduced working time together, and lack of, as well as delayed access to, key documents, was also a problem. The centralization of power and decision-making provided additional obstacles to progress when the DGNM was away. In spite of that there were many opportunities to explore

current activities within the MOH to consider potential directions for action as they relate to reproductive health.

3. FINDINGS AND CONCLUSIONS

3.1. **Fit of CMW within the BPHS.** First, it is clear that the plan for CMWs dates to the earliest MOH planning documents regarding reproductive care in rural areas. A policy and standards document from 2005 clearly states the need for this new cadre of workers for rural posting. The original curriculum requirement of 50 deliveries would have provided excellent experience for rural posting. The document included details for where to place the CMWs in the pay scale, plans for these new workers to replace the Maternal and Child Health Workers (MCHW), plans for more education in the future, job description, competencies, registration and licensing. In all, it is a well thought out plan for community midwifery. The forward to the document closed with urging that it be implemented "with the speed and zeal that it requires." The plan for CMWs continued to appear in subsequent documents including those relating specifically to reproductive health and generally to basic health care.

3.2. **Lack of consensus.** However, from discussions with various directors within the MOH and with other stakeholders there emerged a lack of consensus on the value and future of community midwifery. Some felt the training should be extended and the curriculum revamped. Others were more concerned with identifying the 'bottlenecks' to employing the CMWs and posting them in rural areas. This lack of consensus was a critical finding since over five years of effort from multiple organizations and many donors have led to a curriculum and programme with promise for addressing the critical shortage of skilled birth attendants in the rural areas.

Research on 100 years of MMR reduction revealed that "no country has managed to reduce their maternal mortality figures without investing in the capacities of midwives working at the community level undertaking home births."[8] The International Confederation of Midwives (ICM) estimates that up to 90% of maternal deaths could be averted by midwives supported in functioning health systems[9]. One author[10] notes that all midwifery programmes ranging from 18 months to five years produced competent midwives. Finally, during a 10-year post war period, Zimbabwe experimented with 6-month, and 12-month programmes, then settled on an 18-month midwifery programme to provide community

[8] Louden I. *Maternal mortality in the past and its relevance to the developing world today.* ACJN 2000; 72 (1S): 241S-46S.

[9] ICM. News Release: 350,000 more midwives needed to reduce unnecessary deaths and injuries in childbirth. 30 April 2010.

[10] Sherratt DR. *Rapid scale up of midwives is vital for saving the lives of mothers and newborns.* Background paper for UNFPA workshop 21-23 March 2006, NY. Scaling up the Capacities of Midwives to Reduce Maternal Mortality and Morbidity. NY, 2006.

based SBAs where workers offered life-saving procedures, managed some complications and referred others in timely and appropriate manners[11].

Thus, the evidence strongly supports a policy in Southern Sudan to rapidly scale up SBA access by fully implementing the 18-month CMW programme. The horrendous MMR coupled with the limited numbers of comprehensive emergency obstetric care (CEmOC) centres in Southern Sudan provide compelling arguments for making SBA available at the village level as quickly and as efficiently as possible.

Through the course of the consultation there seemed to be movement toward finding solutions to the pay and civil service classification issues that threaten the survival and potential of the CMW programme. In addition, the DGNM agreed that developing future blocks of education in nursing or midwifery would be an acceptable alternative to adding an additional year to the initial training of CMWs.

3.3. **Lack of coordinated efforts and departmental collaboration.** Clearly there is a need for reaching consensus on the best ways for moving forward and for coordinating those activities. The functions and goals of nursing and midwifery cut across directorate lines of authority and responsibility. Departments of Reproductive Health, Primary Health Care and Nursing and Midwifery all share a focus on the care of women in the reproductive period.

Also, HR currently has the authority and responsibility for assuring quality of health training, adequacy of training centres and protection of the curricula. Yet HR lacks staff with disciplinary training in areas such as nursing and midwifery that would help to inform decision-making processes. To date, HR admits to difficulty in identifying times when the Department of Nursing and Midwifery could and should collaborate. An example of this occurred during the multiple meetings for developing a tool to assess training facilities, including nursing and midwifery programmes. Nursing and Midwifery staff were not invited to participate until the consultants proposed that the process could benefit by such collaboration. A suggestion by HR that perhaps the LATH nursing and midwifery consultants should accompany HR on site visits suggested recognition that disciplinary perspective would be valuable. HR could gain some of the same consultative benefit by working more closely with Nursing and Midwifery. However, this requires active involvement and participation of the DGNM in activities related to HR planning and management, something that is currently not taking place.

3.4. **Addressing the pay and classification issues.** Revisiting the pay and classification issues of the heath care workers appears as a priority for inclusion of the new categories of workers at the level their education and responsibility deserve. The current salary level and category of the CMW are impediments for the progress of training and posting the CMWs in the rural areas and deserve a thorough review with the goal of finding a creative solution. One option is to scale the pay based on educational level before entering CMW training, status as a CMW, and allow credit for additional training.

[11] UNFPA/ICM *Investing in midwives and others with midwifery skills to save the lives of mothers and newborns and improve their health. 2008.*

3.5. Lack of broad dissemination of information. Although the final report from Phase I of the Community Midwifery assessment included findings and three pages of detailed recommendations, the report had not been widely shared and, in fact, the Director of Human Resources for Curriculum and the Director for Reproductive Health had not received a copy. Even within the office of Nursing and Midwifery, the staff, other than the Director herself, claimed not to have seen the document. Furthermore, those organizations that are currently training Community Midwives had not received the report and thus lacked the benefit of the recommendations that would help improve their programs.

3.6. Policy analysis of CMW Vs Registered Midwife/Nurse Midwife options. Given that all parties were not in agreement about whether to sustain the effort of developing the new cadre of Community Midwives or to revert to the option of producing registered midwives or nurse midwives, a policy analysis was developed using critical criteria for having accessible, acceptable, affordable and sustainable skilled birth attendance in rural areas. Although the midwives with an additional year of education would likely have some additional knowledge and skills, all other criteria favour the CMWs. These criteria include cost and time to train, probability of accepting a rural posting, retention and salary cost to the health system. In the consultants' view, the excruciatingly urgent need to provide women greater access to skilled birth attendance in light of Southern Sudan's heart breaking MMR argues loudly for producing and rurally posting a large number of CMWs in the immediate years and perhaps even for the coming decades. Many developing countries have found that short-term solutions often continue to be the best solutions for the long-term. Below is the policy analysis comparing the two options.

Conclusions are drawn from 1). longer programmes are inherently more expensive and require more time to complete; 2). additional months or years of training would necessarily provide the opportunity for additional acquisition of knowledge and skills; 3). generally, salaries increase with years of education; 4). recent results of research in task shifting from physician to non-physician providers shows greater posting and retention in rural areas – over 80% of non-physicians with 0% of the physicians remaining after 7 years;[12] and 5). research on midwifery education indicates 18-month programs are adequate to produce midwives with the necessary basic competencies recommended by the International Confederation of Midwives.[13]

3.7. Defining more options or initiating actions? After the review of pertinent documents and research literature; meeting with a large number of stake holders in and out of government; attending workshops addressing reproductive approaches to improving care and reducing the MMR, the review team offers but a few *new* recommendations in addition to the three pages of recommendations in the February 2010 report for the Phase I Community

[12] Pereira C. Task-shifting of major surgery to midlevel providers of health care in Mozambique and Tanzania: a solution to the crisis in human resources to enhance maternal and neonatal survival. Karolinska Institute. 2010.

[13] UNFPA *Investing in midwives and others with midwifery skills to save the lives of mothers and newborns and improve their health. 2008*

Midwifery consultation. The recommendations are specific, detailed, substantial, and, though not exhaustive, are quite comprehensive; a copy is included in Annex 10.

The February recommendations span legal matters, curriculum and training centre issues, internships, updating skills and expanding delivery experiences of recent graduates, increasing the number and quality of midwives in the clinical teaching setting, improving the enabling environment, and providing in-service training. The consultants also made recommendations for developing educational options for nurses and midwives to pursue Bachelor and Masters level courses in nursing leadership and management to create the workforce needed to plan, manage and lead the future advances in nursing and midwifery.

What is critically needed now is not a wealth of new recommendations, but *action* in *moving forward* with many of the earlier ones, some of which can help assure quality of training, competency and confidence of the graduates and may be accomplished with little or no additional cost. It is surprising, in fact that an MOU between HR and the training centres has yet to be implemented to assure that CMW students are not graduated until they meet the requirements of the curriculum. To help with that process, the team drafted a Training Centre Standards document that can be used or adapted; a copy appears in Annex 6.

3.7. Unemployed CMW graduates. Given the high MMR and the development of a programme to specifically address the problem, it is a tragic waste of resources to have capable students not doing the work for which they were trained. To date, there are 96 graduates of the various CMW trainings. What is not known is how many were discouraged by lack of jobs and are now doing other kinds of work, and how many of these, if located, might be encouraged and interested in accepting rural postings. This is a possibility that needs to be explored. If, for instance, 50 could be located and placed in rural areas, the cost would likely be less than USD 200,000 (based on one NGO's report of paying USD $300 per month for rural posting of 4 CMWs) and could provide a large number of women with access to skilled birth attendance. The currently on-going Training Institution mapping can provide this information, but actions need to be taken to ensure than even before graduation these skilled birth attendants have been allocated positions in the rural areas. A mapping of HRH gaps and possible posts for midwifery could be done with the State MOH HR and MOH-GOSS Departments and these posts should be published before each graduation so that new CMWs could apply for these posts. Another possibility is for HR to regularly publish vacancies of potential employers.

There is a need for a formal process to link willing applicants with interested employers, some of whom can provide support, supervision and continuing development for the new CMW. A process of doing this was begun during this consultancy by placing a notice on the South Sudan Health Forum Google group. There were two replies from potential employers wanting to support and hire CMWs. The consultant provided a link between the potential employers and the programmes that are training students; but a more sustaining process is needed. Ideally, programmes that are training community midwives would have ongoing contact with NGOs, FBOs and other employing agencies and would be able to link students with potential employers even before graduation.

4. RECOMMENDATIONS AND NEXT STEPS

Recommendations focus on 1). improving **quality of CMWs** by regulating training and practice, by providing internships, by linking recent CMW graduates with NGO jobs with acceptable facilities, adequate equipment and supplies, supervision and dependable salaries, 2). improving **availability of CMWs** by addressing pay and classification issues, assuring employment of graduates and posting in rural areas, 3). increasing **demand for CMW services** by educating communities, increasing availability/access, making rural posting an appealing option, and removing barriers – financial and acceptability deterrents; creating temporary lodging near birthing centres, and 4). **preparing highly educated and skilled nursing and midwifery human resources** for the increasingly complex future of health care in Southern Sudan.

4.1. Immediate actions: up to 6 weeks; little or no cost.

- HR create an MOA with training centres, re. compliance with the curriculum; enforce it; an example MOA is presented in Annex 9
- HR and NM collaborate on creating a registry of CMW graduates and request reports from training centres on actual numbers of deliveries accomplished by graduates during the training period. An example of a possible register is presented in Annex 11. The current health institutes mapping exercise is updating the list of training institutions and will include contact details
- NM & HR work with secondary health facilities, particularly teaching hospitals to establish internship opportunities for CMWs needing more delivery experience before posting them in rural areas. An alternative could be to deploy the CMWs in rural health care centres, provided they are supported by experienced midwives – perhaps linked to a lead agency or NGO program
- NM should convene another CMW Technical Working Group (TWG) meeting to review the drafted training centre standards and codes of conduct for nurses and midwives; adapt if needed; adopt and implement in training centres and workplaces as appropriate. The ongoing TWG should include, at a minimum, NM, HR, Primary Health Care/Reproductive Health, UNFPA, WHO, UNICEF and AMREF
- NM and HR facilitate linking CMWs with potential NGO employers in rural areas; consider creating a website where both job seekers and employers can post their availability; another option is for HR directorate of MOH-GOSS and SMOH to create a quarterly job opportunities bulletin
- NM with other stakeholders begin review of draft of Nurse and Midwifery Practice Act; adapt if needed; adopt and forward for legislative action.

4.2. Immediate actions: up to 6 weeks; cost undetermined.

- NM & HR develop and present a concept paper to UNFPA for funding of CMW internships to reach minimum of 50 deliveries
- NM & HR appeal the classification of CMWs, present the rationale (catastrophic MMR) of need for CMWs and advocate for adjusting salaries in a scaled manner depending on education before entry to CMW training, CMW status, plus any further education; cost depends on number of employees and levels of pay increase
- NM & HR request review of classification of all nurses and midwives for evidence of gender bias and address upward adjustment of salaries to encourage unemployed workers to seek employment; cost depends on number of employees and levels of pay increase
- NM & HR establish a registry of both employed and unemployed nurses and midwives in Southern Sudan

4.3. Short-term actions: up to 12 months

- MOH Departments advocate for posting CMWs in Primary Health Care Units (PHCC) in rural areas that have reasonably close linkage with a CEmOC centre; work with states to make this sustainable as a basic public health measure; consider conditional or external funding for salary, equipment, supplies, housing and other incentives to attract and retain CMWs; initiate in three sites with ready access for supervision, monitoring and evaluation
- Determine what incentives are needed to assure posting and retention in rural areas; draw from published research, current practices with NGOs in Southern Sudan, and/or initiate studies about this in Southern Sudan
- Develop formal processes, rewards and incentives for TBAs to work with the CMWs as assistants; engage TBAs in helping plan this transition[14]
- Firmly establish free access for maternal and neonatal care in Southern Sudan and provide incentives for pre- and postnatal care and skilled birth attendance[15]
- Health planning for building or rehabilitating rural facilities to include local surveys or focus groups to gain input from women on creating acceptable facilities and services that would appeal to women and encourage their use; try to link these activities with women's groups and female leaders within States to promote women's advocacy, ownership, leadership and modelling of political action
- Establish appealing and acceptable maternity waiting homes in areas with basic and comprehensive EmOC; educate communities on the benefits of these and encourage community ownership and cooperation through small construction grants

[14] WHO, SEARO. Hermijanti S. *Partnership between midwives and traditional birth attendants in improving utilization of MNH services in Indonesia.* August 2009.

[15] Yates R. *Women and children first: an appropriate first step toward universal coverage.* Bull World Health Organ 2010; 88: 472-473.

- Improve clinical tutoring – an effort currently being initiated by UNFPA recruiting 50 midwives – to place 5 in each of 10 states at county hospitals or other large PHCCs
- Recruit unemployed nurses and midwives within Southern Sudan by determining the current barriers to them seeking and accepting employment; provide appropriate incentives
- Develop training/continuing education modules based on assessed needs of workers and workplace
- Control initiation and continuation of training programmes based on plans and capacities to meet curriculum needs, including clinical experiences; relocate programmes where the needs cannot be met
- Recruit graduate level educated nurses or midwives with strong administrative and regulatory experience to lead regulatory council for nurses and midwives
- Recruit at least one Masters level nurse or midwife with leadership and management experience for the Directorate of Nursing and Midwifery
- Recruit at least one Bachelors level or higher nurse or midwife to work with new diploma nursing and midwifery programme

4.4. Long-term actions: through next decade

- Develop basic training modules to raise educational level of CMWs to level of diploma midwives and nurse midwives; offer after CMW completes at least 3 years of rural service
- Develop basic and advanced training strategies based on Southern Sudan Health Policy for developing and staffing its health facilities
- Recruit from within country or from outside, six diploma level or higher midwives for each of the three tertiary care hospitals to raise standards of care and improve clinical tutoring
- Recruit or send out for Bachelors and Masters nursing and midwifery education to develop leaders to take nursing and midwifery forward in management, research, education and regulation
- Monitor and evaluate training, rural posting, and retention of nurses and midwives at different levels of education; include training issues, job placement and patient acceptance of male midwives
- Assess educational needs of current nursing and midwifery workforce and develop continuing education programmes to address them
- Expand CMW training programmes deeper into all states as clinical capacities and quality allow

- Provide health career counselling in last six years of basic education to inform students about range of possibilities in nursing and midwifery as well as other areas of health care

5. ACKNOWLEDGEMENTS

The review team would like to express their gratitude to all of the people who participated and contributed to this review, especially to Director General Janet Michael and her staff – Mrs. Anite, Victoria, and Mary Rose from the Directorate of Nursing and Midwifery; Drs. Baba, Olivia, Angok, Makur, Sarah Petrie, and Koang from MOH; Drs. Alex and Buwa from UNFPA; Drs. Grace and Carmen from LATH/MOH; Dr. Mwesigwa from AMREF; Joyce from UNICEF; Dr. Omar from IMC; Dr. Micah from PRDA; Lise Grande from UNOCHA; and Roya Sadrizadeh and Robert Lobor from WHO.

Many others contributed their time, experience and wisdom to the project, including members of GOAL, OVCI, Save the Children, MSF Spain, MSF Holland, staff at Juba Teaching Hospital, and others whose identification we unfortunately missed in large group meetings. The commitment of so many people was supportive, inspiring and deeply appreciated.

This consultancy was undertaken as part of the LATH Technical Assistance to Health Priorities Programme in support of the MOH-GOSS.

ANNEX 1: TERMS OF REFERENCE

Terms of Reference for a Consultancy to Develop a Road Map for the Implementation of a Programme of Community Midwifery in Southern Sudan with a view to Improving Access of Women to Skilled Attendance during Labour and Delivery

Background and Context

The signing of the Comprehensive Peace Agreement (CPA) between the SPLM and The Government of Sudan on January 9th, 2005, after 22 years of civil strife in Southern Sudan provided a historic opportunity to overcome the devastation of war and the neglect of human development. Such strife has caused Southern Sudan to suffer from some of the worst indicators in health and social development. Accessibility to health services remains gravely poor and health care outcomes dismal. The results of the South Sudan Household Health Survey of 2006 estimated the maternal mortality ratio to be 2,300/100,000 and the child mortality rate to be 250/1000 live births, the highest levels in the world. The infant mortality rate is 102/1000 live births and the under-five mortality rate is 135/1000 live births, mainly caused by preventable infectious diseases coupled with child malnutrition. Over one third of children are underweight; 13.5% of them severely; 22.0% have moderate and 7.3% severe wasting or acute malnutrition. Only 17% of under-fives are fully immunized. The standard of women's health is also very low. Only 23.1% of expectant mothers receive antenatal care from a skilled birth attendant and only 13.6% deliver in a recognised health institution.

Health care coverage is estimated to be only 30% of the population in stable areas. NGOs and faith-based organisations, funded from international sources, are providing most of the health services. This has resulted in a patchwork of short-term, mostly uncoordinated health interventions that reach a small proportion of the population. While government services are available in the major towns, particularly Juba, Malakal, Rumbek and Wau, they are under-resourced, inefficient and of poor quality. Substantial regional inequalities in access to healthcare are also found within the low overall coverage; PHC coverage in the Equatoria States is broadly in line with the sub-Saharan Africa averages, while it is considerably lower in the Upper Nile and Bahr-el-Ghazal regions.

The material resources and managerial expertise for administering the health sector of Southern Sudan are insufficient and largely dependent on external financial and technical assistance. Overall, existing infrastructure and equipment are extremely poor, with a large proportion of hospitals and health centres in either a state of disrepair or having the capacity and characteristics of lower-level facilities. In addition, the facilities are unequally distributed among the regions. On average, in rural areas there are about 14,000 people per health unit, 75,000 per health centre and about 400,000 people per hospital, where a recent inventory of hospitals describes a heavy, largely derelict infrastructure. Finally, the situation in regard to human resources for health is inadequate both in terms of numbers and professional categories, and is complicated by sensitive post conflict issues. Poor staffing standards and a lack of qualified personnel have resulted in a high number of low-level staff and a shortage of mid- and higher-level cadres such as midwives and pharmacists, making it even more difficult to implement the recently prepared HRH policy and strategy.

Following the CPA, the Southern Sudanese led by the SPLM, were joined by the international community in a Joint Assessment Mission (JAM) followed by the development of the interim health policy, both of which provided a roadmap for the recovery and reconstruction of healthcare in the country. Given the structural weaknesses of the system, true progress can be registered only through long-term, sustained interventions. At the same time, there is an obvious requirement to address the urgent health needs of the population through rational short-term initiatives in order to

save lives and reduce suffering. The Ministry of Health (MOH) has therefore been pursuing a two-track strategy, establishing a balance between the development of core capacities of the health system (Track 1) and the immediate delivery of essential services to a significant proportion of the population (Track 2). Current opportunities for strengthening management and restoring services include the official launching of the "Health Policy for the Government of Southern Sudan 2007-2011" in December 2007, the continuing development of cumulative policies and strategies since 1997, and a more effective partnership among the health authorities and international partners. All of these provide a strong foundation upon which a modern sector-wide healthcare delivery system can be developed.

In the new health policy, primary health care remains the cornerstone of the health system. It emphasises that the Government of Southern Sudan (GOSS) and MOH-GOSS have the political will and commitment to successfully implement and achieve this policy. However, pre-requisites to success are continuing peace, security, and adequate availability of resources. The new policy is the first to propagate the spirit of the CPA**,** thus envisioning the MOH's leadership, governance, and responsibility on the development and implementation of pro-poor policies for Southern Sudan.

Based on this the MOH-GOSS embarked on an internal reorganisation and development in which it organized itself into 11 Directorates, namely:

a) Human Resources, Research, Planning & Health Systems Development
b) Primary Health Care
c) Administration & Finance
d) Preventive Medicine
e) Curative Medicine
f) External Assistance and Coordination
g) Nursing & Midwifery
h) Pharmaceutical Services & Supplies
i) HIV/AIDS
j) Nutrition
k) Medical Commission

Each of these directorates is in the process of internal reorganization and capacity strengthening to enable competent and effective stewardship for health care in Southern Sudan. A similar service management reorganization is going on in the States MOH, in order for them to provide effective leadership in the implementation of the GOSS Health Policy at state and county levels. A strategic and results-based measure of implementation was highlighted in the Health Policy, with clear goals and objectives based on the MOH-GOSS redefined priorities and values. In 2007 and successive years a participatory and public health budget has been developed in line with the overall national development planning strategy. The budgets are based on a medium term plan geared to specific results out of concrete actions by the different directorates of the MOH. The strategy is explicit on the link and ideal balance between priority health programmes and well performing health systems, and emphasises effective partnerships with other stakeholders to ensure increased coverage of quality health services.

Purpose

In February 2010, two LATH experts in Nursing and Midwifery together with the Nursing and Midwifery Directorate of MOH-Government of Southern Sudan, undertook a joint situation analysis on the state of the Community Midwifery (CMW) Programme in the country. The purpose of the assignment was: *to assess the current clinical skills of midwives trained following the fast track approach in relation to the needs and possibilities for offering obstetric services mainly at community and county levels, and provide recommendations for upgrading their clinical competence, including a revision and possible expansion of the current curriculum, as required*.

The mission findings were:

a) The curriculum for CMW was adequate provided it is fully implemented and the students receive ample practice in the number of deliveries. However, there is a critical shortage of faculty midwives and therefore reduced possibilities for mentoring students. In addition, the number of deliveries students need to be granted graduation (50) was regularly not met and had actually been reduced in some training institutions. This has diminished the practical skills of students and increased the need for tutoring during at least the first years of practice as well as subsequent in-service training and supervision.

b) Generally, the standards of care are low and not systematically assessed or monitored. There are large deficiencies in basic equipment and essential supplies, which further contribute to low standards of care.

c) The competences of CMW graduates vary from good in Juba Teaching Hospital to low in the County Hospitals visited during the assessment.

In conclusion, the report stated: "*It is difficult to say whether the CMW could function at the fullness of the expected role in the intended rural setting. The only students who met the required number of deliveries were working in the Juba Teaching Hospital with nurse midwives and obstetricians, where their skills and knowledge were expanded by a <u>full year of practice in an enriched clinical environment</u>, compared to the county hospitals. <u>None of the graduates evaluated were working in the remote rural areas due to legal barriers and lack of jobs</u>. Therefore, there was no opportunity to assess their performance in the intended setting. It is <u>unlikely</u> that a three year diploma programme conducted in these same clinical settings would have provided more than a small incremental increase in skills and knowledge, since the clinical practice aspect was so weak.*

The purpose of the current mission is to produce a road map with short term and longer term interventions to try and improve the current state of affairs and support the establishment of a quality, cost effective programme of community midwifery, to improve the access of women in rural areas to skilled attention during labour and delivery. Attention to delivery by skilled personnel in health care centres (basic) and reference centres (comprehensive obstetric units) has proved its success in reducing maternal mortality world-wide. In addition, skilled attention during pregnancy can improve maternal health and increase acceptance of modern family planning methods, another cornerstone strategy in the reduction of maternal mortality.

A preliminary assessment of the problems with possible options includes the following:

PROBLEM	POSSIBLE AMELIORATING STRATEGIES	RISKS/CONDITIONS FOR SUCCESS
How to increase access to quality maternal care for rural women through the deployment of CMWs to rural areas	Offer special contract with incentives. Linking them to a State hospital or County Hospital as a mentoring initiative. Mobile CMW vs. CMW in a fixed post in the field.	Cost Need a mentoring strategy for less experienced midwives to be attracted to this possibility. Need mentoring as well as means of transportation.
Possibility for action: combination of all three ameliorating strategies combined with information disseminated to the community, and creation of demand.		
Improving Standards of Care in County and State hospitals	Setting Standards of care and measuring against targets. Setting Standards of care and measuring against targets as a condition for registration as CMW. Setting Standards of care and measuring against targets for incentive/performance payment	To be supported by in-service supportive supervision. Needs professional regulation and registration. Measurement of performance requires a systematic and consistent monitoring system. Linking performance and payment is a complicated task.
Improving practical training	Practical training: Minimum of 50 deliveries before qualifications are attained. Extend practical training by providing mentoring for six to twelve months in State Hospitals. State Hospitals provide attention to delivery for free and link to communities to increase demand.	Requires accreditation process for hospitals that will benefit from the work of junior staff, but that need to have senior staff for training. Community links need to be established and demand created.
Improving basic training	Improving training at the nursing school: • Training of academic staff. • Performance of academic staff.	Could be a possibility linked to above strategy: visiting professors, stages in universities abroad?

Specific Tasks

In collaboration with the Nursing and Midwifery Directorate General of MOH-GOSS consider options for improving the current state of affairs of the CMW programme (outlined but not limited to the those quoted above), and propose a road map with both short and longer term actions to improve access of mothers to skilled attendance during labour and delivery.

Expected Deliverables

a) Identification of options for action.
b) Development of an action plan for implementation of chosen option with description of needs and basic costing.
c) Assessment of the findings will be presented to the Executive Board.

Programme Management and Administration

As currently organised, the Ministry of Health is responsible for stewardship and oversight of the health system (including policy setting, coordination and planning, regulation, and monitoring and evaluation), which allows the government to assert ownership and control over the system and to effectively oversee governmental and non-governmental service delivery. The consultant will liaise with a central-level Executive Board, comprising the Minister, the Under Secretary, the Director General, and the Directors of the Departments responsible for taking ultimate decisions of sector wide significance.

Under this contract, the consultant(s) will report to Mrs Janet Michael, Director General of Nursing & Midwifery. LATH Consultants will work on a team with MOH-GOSS officers of the Nursing and Midwifery Directorate designated as counterparts for this assignment. The LATH Programme Manager in-country, Dr Simon Gould, and Dr Carmen Maroto Camino, LATH Public Health Technical Advisor, will monitor the assignment and provide guidance and support to the team.

6) Qualifications and Experience

The assignment requires two experts in midwifery or nursing and midwifery with expertise and capacity in strategic planning:

- Nurse/Midwife with over 10 years experience;
- Working experience in low income countries essential, post-conflict a bonus;
- Experience in strategic planning with capacity for evidence-based planning. Able to think “outside the box” and to consider and weigh options, as was well as advise on possible short and long term interventions.
- Proven ability to work as part of a team and with a variety of players in a fast paced environment;
- Good communication skills and able to meet deadlines;
- Commitment to capacity building, ensuring ownership and participation of stakeholders in the process and results of the mission.

Timeline and Level of Effort for Mission (Phase II)

TASKS and TIMELINE	LOCATION	Timeline/ 6 weeks = 36 days each expert
Preparation	Home based	1 day both experts
Field work	Southern Sudan	30 days both experts
Presentation and discussion of findings Report finalization Contingency	Juba Juba	1 day 3 days 1 day

ANNEX 2: THE CONSULTANT TEAM

The consultant team was made up of Dr. Gloria 'Ann' Evans, RN, MSN, FNP, DrPH, Policy Analyst from the United States of America, and Mrs. Medoline Etyefyose Lema, RN, MW, MPH from Kenya and Tanzania. Together they have many years of experience in health consultations, teaching from certificate to graduate level programs, program design and directing, public health, policy analysis, and clinical work as nurse practitioner and midwife.

ANNEX 3: LIST OF PEOPLE INTERVIEWED

Persons met	Title	Organisation
Dr. Samson Baba	Director General, External Assistance & Coordination	MOH- GOSS
Anite Peter	Director Clinical Practice	MOH- GOSS, Nsg & Midwifery
Victoria Abua	Deputy Director training	MOH- GOSS, Nsg & Midwifery
Dr. Angok Kuol	Director Reproductive Health	MOH- GOSS
Dr. Grace Murindwa	Long Term Technical Assistant	LATH
Dr. Omar	Medical Coordinator	IMC
Elin Jones	Medical Coordinator	MSF- Holland
Dr. Robert P. Napolean	Director Research &Planning	MOH- GOSS
Dr. Samuel Koang	Director Training and Continuous Education Professional Development	MOH- GOSS
Kuol Arap Alor	Deputy Director Curriculum Development	MOH- GOSS
Suzan Poni Dila	Matron	Juba Teaching Hospital
Sake Jemelia Beda	Head of Maternity Ward	Juba Teaching Hospital
Mary Rose Juwa	Director Midwifery Health	MOH- GOSS
Roya Sadrizadeh	Technical Officer, Nursing & Allied Health	WHO
Janet Michael	Director General, Nursing and Midwifery	MOH-GOSS
Dr. Dragudi Buwa	Head of the Office	UNFPA
Lise Grande	Deputy Resident and Humanitarian Coordinator	UNOCHA
Dr. Sarah Petrie	Health Sector Co-Lead Health NGO	MOH- GOSS
Bilha Achieng	Midwifery Programme Assistant	UNFPA
Joyce C. Mphaya	Health Specialist (Safemotherhood & PMTCT	UNICEF
Dr. Romanos Mkerenga	Chief Health	UNICEF
Stakeholders meeting	16 Participants	MOH-GOSS, NGO's and UN agencies
Justin Geno	M&E Officer	GOAL
John Mwesigwa	Country Director	AMREF
Moses Rama	Juba County Supervisor	OVCI
Julien Bucyabahiga	Communication Officer	UNFPA
Dr. Fikru Zeleke	RH Program Advisor	UNFPA

Abdi Aden	IMC- Principle, Maridi County	AMREF
Robert Lobor	NPO/NPS	WHO
Kedrick Kiawon	PHC Specialist	UNICEF
Dr. Busieka Micah	Director	PRDA
HR- Task shifting for maternal survival	40 participants from overseas &all States in South Sudan	MOH-GOSS in collaboration with Karolinska Institute
NGO Forum	Representative from NGO's in South	Representative from NGOs in Southern Sudan
Petronella	Principal	Nursing &Midwifery College
Dr. Makur	Director, Reproductive Health	MOH-GOSS
Reproductive health Working Group	WHO,UNICEF, UNFPA, MSH,LATH, MOH-GOSS	Unicef, UNFPA, MOH-GOSS, MSH, Save the Children, MSF-Spain, GOAL
Repent Khamis	Nurse Tutor	Certificate Nursing School
Isidoro Thomas	Nurse Tutor	Certificate Nursing School
Dr. Alexander Dimiti	Programme Officer- UNFPA	UNFPA
Antony Lasuba	Health Officer	UNICEF
Sunday Imunu	RH Inspector	MOH-GOSS
Lorna Jackson	Deputy Matron	Juba Teaching Hospital
Dr. John Alwar	PHC Advisor	MOH-GOSS
Mark Beesley	Consultant	LATH

ANNEX 4: CONSULTANTS CALENDAR

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SAT
3rd May Travel Nairobi-Juba LATH Office LATH project Manager	4th DG Communication & External Assistance	5th DG Primary Health Care Director Community Nursing & Midwifery	6th IMC, MSF- H Director Planning Research, Matron - JTH	7th Directorate Nursing & Midwifery Director Training TA's Network HR meeting	8th
10th WHO, Technical Officer, Nursing& Allied Health Officer DG Nursing & Midwifery	11th Initiate Planning process with DG Nursing Midwifery	12th DG Nursing & Midwifery	13th	14th Head of Office- UNFPA UNOCHA Deputy Resident & Humanitarian Coordinator Sector CoLead Health (NGO)	15th LATH Office
17th UNICEF, Head Health & Nutrition& Health Specialist (Safemotherhood & PMTCT)	18th DG Nursing and Midwifery	19th Preparation- stakeholders meeting	20th Stakeholders - Nursing, Community Midwifery, Training Institution Meeting	21st LATH office	22nd Observe Conclusions and Recommendations to improve management of Teaching Hospitals
24th Human resource for maternal Survival – Task Shifting to Non clinical (Networking)	25th Human resource for maternal Survival – Task Shifting to Non clinical Networking	26th Nursing & Midwifery Directorate	27th NGO Forum Meeting on regulations and Codes of Conduct	28th - Nursing Directorate	29th
31st – Director Reproductive Health & Community Nursing and Midwifery	1st June Nursing & Midwifery Directorate	2nd -Nursing & Midwifery Directorate	3rd – Reproductive Health technical Working group	4th - Training task force meeting & Nursing Regulations	5th Draft Nurses Midwives regulation. BoD presentation preparation

7th Draft Nurses& Midwives regulation BoD presentation preparation	8th Finalising training institution standards, and Nurses and Midwives codes on ethics	9th Presentation “Community Midwifery strategies” Report writing	10th Report writing	11th Report writing& departure	

ANNEX 5: REFERENCES

1. Blaauw D, et al. Policy interventions that attract nurses to rural areas: A multi-country discrete choice experiment. Bulletin WHO, Vol 88, No 5, May 2010.

2. Chen, Lincoln. Striking the right balance: health workforce retention in remote and rural areas, Bulletin WHO, Vol. 88, No 5, May 2010, 321-400.

3. Dayrit MM, Dolea C, Braichet JM. One piece of the puzzle to solve the human resources for health crisis. Bulletin WHO, Vol 88, No 5, May 2010.

4. DFID. Achieving skilled attendance for all; a synthesis of current knowledge and recommended actions for scaling up. DFID August 2005.

5. DFID. Reducing maternal deaths: Evidence and action, a strategy for DFID. September 2004.

6. Evans GA & Rehnström U. Assessment of the community midwifery programme in Southern Sudan. MOH-GOSS/LATH. February 2010.

7. Fauveau V, Sheratt D, de Bernis L, Human resources for maternal health; multi-purpose or specialists? September 2008. In Human Resources for Health www.human-resources-health.com/content/6/1/21

8. Government of Southern Sudan Ministry of Health & Southern Sudan Commission of Census, Statistics and Evaluation, Sudan Household Health Survey (Southern Sudan Report) 2006

9. Government of Southern Sudan Ministry of Health, Curriculum for Training Community Midwives, Reviewed Draft 2007-2008

10. Government of Southern Sudan Ministry of Health, Health Policy: Government of Southern Sudan 2007-2011

11. Government of Southern Sudan Ministry of Health, Southern Sudan Maternal, Neonatal and Reproductive Health Strategy Action Plan 2008 - 2011

12. Government of Southern Sudan Ministry of Health, Trainers' Manual for Training Community Midwives May 2006

13. Hansen J. Evaluation of the Ministry of Health's 2005 recruitment process and related factors affecting the number of midwives employed in Cambodia, July 2005.

14. ICM, News Release: 350,000 more midwives needed to reduce unnecessary deaths and injury in childbirth. 30 April 2010.

15. ICM. Standards of Practice

15. ICM/WHO, Strengthening Midwifery Toolkit 1, Guidelines for policymaker and planners to strengthen the regulation, accreditation and education of midwives, 2006.

16. ICM/WHO, Strengthening Midwifery Toolkit 2, Legislation and regulation of midwifery-making pregnancy safer, 2006.

17. ICM/WHO, Strengthening Midwifery Toolkit 3, competence for midwifery practice, 2006.

18. ICM/WHO, Strengthening Midwifery Toolkit 4, developing standards to improve midwifery practice and ensure safer pregnancy and childbirth, 2006.

19. ICM/WHO, Strengthening Midwifery Toolkit 5, developing a midwifery curriculum for Safe Motherhood, 2006.

20. ICM/WHO, Strengthening Midwifery Toolkit 6, Developing effective programme for preparing midwifery teachers, 2006.

21. ICN. Code of ethics for nurses, 2006.

22. IMPAC Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors 2003 WHO http://www.who.int/reproductive-health/impac/index.html

23. IMPAC Managing newborn problems: a guide for doctors, nurses, and midwives 2003. http://www.who.int/reproductive-health/publications/mnp/index.html

24. IMPAC Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice.2006http://www.who.int/making_pregnancy_safer/documents/ 924159084x/en/

25. IMPAC WHO Recommended Interventions for Improving Maternal and Newborn Health 2005 http://www.who.int/making_pregnancy_safer/documents/who_mps_0705/en/

26. Klein, Miller and Thompson; A Book for Midwives: Care for Pregnancy, Birth, and Women's Health, Hesperian Foundation, 2009

27. Liljestrand Jerker/SIDA, Supporting midwifery, 1997.

28. Louden I. Maternal mortality in the past and its relevance to the developing world today. ACJN 2000; 72 (1S): 241S-246S.

29. Pereira C. Task-shifting of major surgery to midlevel providers of health care in Mozambique and Tanzania: A solution to the crisis in human resources to enhance maternal and neonatal survival. Karolinska Insitute, 2010.

30. Policy and Standards of Community Midwifery Training in South Sudan, 2005.

31. Sherratt DR. Rapid scale up of midwives is vital for saving the lives of mothers and newborns. Background paper for UNFPA workshop 21-23 March 2006, NY. Scaling up the capacities of midwives to reduce maternal mortality and morbidity. NY, 2006.

32. UNFPA, Towards MGD5: scaling up the capacity of midwives to reduce maternal mortality and morbidity. Workshop report, New York, 21-23 March 2006.

33. UNFPA/ Sheratt D, White P, Chhuong C, Report of the comprehensive midwifery review in Cambodia, September 2006.

34. UNFPA/ICM, Investing in midwives and others with midwifery skills to save the lives of mothers and newborns and improve their health, 2006.

35. UNICEF, Midwife training programme aims to reduce maternal mortality in Afghanistan, January 2009.

36. WHO, Consensus on essential competencies of skilled birth attendants in the African region, Report of regional consultation, Brazzaville, 27 Feb-1 Mar, 2006.

37. WHO, Education material for teachers of midwifery-Second edition, Modules 1-6, 2008.

38. WHO, Global standards for the initial education of professional nurses and midwives, 2009.

39. WHO, Making a difference in countries: Strategic approach to improving maternal and newborn survival and health, WHO 2006.

40. WHO. Wanted: 2.4 million nurses, and that's just in India. Bulletin WHO, Vol 88, No 5, May 2010.

41. WHO, ICM, FIGO, Making Pregnancy Safer; the critical role of the skilled attendant. Department of Reproductive Health and Research, 2004.

42. WHO/ICM, Education material for teachers of midwifery-Second edition. Foundation module, 2008.

43. WHO/ICM, Education material for teachers of midwifery-Second edition, Managing postpartum haemorrhage, 2008.

44. WHO/ICM, Education material for teachers of midwifery-Second edition, Managing eclampsia, 2008.

45. WHO/ICM, Education material for teachers of midwifery-Second edition, Managing puerperal sepsis, 2008.

46. WHO/ICM, Education material for teachers of midwifery-Second edition, Managing prolonged labour and obstructed labour, 2008.

47. WHO/ICM, Education material for teachers of midwifery-Second edition, Managing incomplete abortion, 2008.

48. WHO/SEARO, Hermijanti S. Partnership between midwives and traditional birth attendants in improving utilization of MNH services in Indonesia. August 2009.

49. Yates R. Women and children first: an appropriate first step toward universal coverage. Bulletin WHO 2010; 88: 472-473.

ANNEX 6: TRAINING CENTRE STANDARDS

TRAINING CENTRE STANDARDS[16]

CONTENTS

Introduction: 37
Outcomes:....................39
Accreditation....................40
Infrastructure....................40
Partnerships....................40
Curriculum....................41
Core curriculum....................41
Assessment of students....................41
Faculty requirements....................42
Admission policy and selection....................43
Entrance criteria....................43

INTRODUCTION:

The need for training centre standards is required urgently in Southern Sudan for several reasons - the nursing and midwifery training institutions are not yet accredited, most of the training institutions were established during the civil conflict and trainings were tailored to the capacities of the supporting agency and the identified immediate needs.

Though one could claim an existence of certain numbers of health-care staff in Southern Sudan, the quality and level of their competencies in some cases is questionable. The great variation in the levels of *initial education* upon entry for nurses and midwives in Southern Sudan is difficult to define in comparison to other sub-Saharan contexts. Entry levels to the various school programmes broadly vary, ranging from primary schools to secondary schools. Most countries in sub-Saharan Africa still consider initial nursing education programmes at diploma level to be sufficient while some countries specify it at university-level as a point of entry to the health professions for nurses and midwives (in practice, university-level education is more frequently specified for nursing than for midwifery).

Despite slow beginnings, the move to raise the qualification requirements of initial education programmes for professional nurses and midwives as well as community level health workers is gaining momentum in Africa. It is important for Southern Sudan to incorporate this ambition and to create a mechanism that can allow continuous professional development for the existing cadre of nurses and midwives and other health care professionals. In the longer term this will not only improve the overall quality of health services but will also equip nurses and midwives to participate and contribute to policy development and the decision making process.

[16] Adapted from *Global standards for the initial education of professional nurses and midwives*, WHO, 2009

It is crucial that the MOH-GOSS introduce temporary training standards immediately in order to ensure the training institutions are aware of and adhere to the requirements for the current and future students to achieve the required competency. The MOH-GOSS should determine the timeframes for the implementation of the training standards and provide the information to the relevant training institutions. This document describes the key elements of the training standards and their respective goals.

The goal of the training standards is to establish educational criteria and ensure outcomes that:

- meet the health system needs and related competencies;
- promote the progressive nature of education and lifelong learning; and
- ensure the employment of practitioners who are competent and who, by providing quality care, promote positive health outcomes in the populations of Southern Sudan.

There are, however, potential problems that may limit immediate implementation of the training standards. It is critical that the implementation of the training standards consider the various existing health care worker cadres that do not meet the set entry criteria but have been trained and are providing health services.

The MOH-GOSS should take into account the existing health care workers and the specific factors related to Southern Sudan such as different entry points for education, cultural beliefs and norms, prior learning, experience, low access to skilled attendants, coupled by the difficult and vast geographical terrain.

The training standards are to provide an opportunity for Southern Sudan to invest in building the capacity required to raise the standard of education of existing nursing and midwifery programmes and to enable them to provide competent care (Maternal Child Health Workers, Community Midwives, Certified Nurses, Certified Midwives).

The training standards for the initial education of professional nurses and midwives should serve as a benchmark for moving education and learning systems forward to produce a common competency-based outcome in an age of increasing standardization. It is anticipated that the training standards will be used in the nursing, midwifery and other health-related professions, and by policy-makers and decision-makers in ministries of health and education, the public services, and other organizations.

These standards represent the views of nursing and midwifery constituencies throughout the world. Regular revisions, in partnership with other international professional organizations, are anticipated. The training standards should be applicable in:

- establishing an approach to the provision of competency-based education programmes;
- adhering to the established guidelines and developed training curriculum;
- stimulating the creation and performance of nursing or midwifery schools and programmes that meet the regional and societal needs and expectations relevant to Southern Sudan;
- establishing benchmarks for continuous quality improvement and the progression of education in nursing and midwifery.

The training standards may furthermore:

- act as a catalyst in advocating for education change, reform and quality improvement;
- serve as leverage in building capacity for adequate numbers of nurses and midwives and a competent nursing and midwifery workforce for strengthening health systems;
- serve as a basis for the development of Southern Sudan standards for continued education for nurses and midwives.

While several factors are of paramount importance in the design, implementation and outcome of the training standards, the following three principles underpin all the standards:

- Established competencies provide a sound basis on which to build curricula for initial education to meet Southern Sudan health population needs
- The interaction between the nursing or midwifery student and the client is the primary focus of quality education and care
- An inter-professional approach to education and practice is critical.

OUTCOMES:

- Graduates demonstrate established competencies in nursing and midwifery practice
- Graduates demonstrate sound understanding of the management of pregnancy and related complications
- Graduates of an initial programme in nursing or midwifery meet requirement prescribed in the training curriculum and are able to work independently and within a team
- Graduates are awarded a certificate after satisfactory completion of theoretical and practical training
- Graduates are eligible for entry into further education programmes
- Nursing or midwifery schools employ methods to track the professional success and progression of education of each graduate

Nursing or midwifery schools prepare graduates who will demonstrate:

- use of evidence in practice
- cultural competence
- the ability to practice in the health-care systems and meet the needs of the rural population within Southern Sudan
- ability to identify complications that require referral before the patient's life is in danger
- the ability to manage resources and practice safely and effectively
- the ability to be effective client advocates and professional partners with other disciplines in health-care delivery
- community service orientation

Existing training institutions should provide to the MOH-GOSS:

- Their mission, vision and objectives
- Nursing or midwifery schools should demonstrate that their programmes meet the current and medium health-care needs of Southern Sudan

- Nursing or midwifery schools clearly define the educational and clinical outcomes of the programme
- Nursing or midwifery schools employ nurses or midwives with the relevant expertise in the subject matter and the ability to develop and revise their programmes
- Nursing or midwifery schools have in place and use a system of formative and summative assessment of the programme's educational and clinical objectives and outcomes
- Nursing or midwifery schools define role descriptions for theoretical and clinical educators including, but not limited to, faculty, clinical supervisors, mentors, preceptors and teachers
- Internships should be tailored to the training programme to ensure that graduates gain the required competency and confidence

ACCREDITATION

- Nursing or midwifery schools are an integral part of higher education institutions that meet standards, must adhere to the developed curriculums, regularly update and seek approval from the MOH-GOSS on major changes to the training programme
- Nursing or midwifery schools have criteria in place that meet accreditation standards for clinical practice components of their programmes, academic content and the demonstration of professional outcomes
- Nursing or midwifery schools and their programmes are recognized by MOH-GOSS and are operating according to the set rules until the regulatory body is in place and officiated

INFRASTRUCTURE

- Nursing or midwifery schools have accessible, current and relevant physical facilities including, but not limited to, classrooms, clinical practice sites, information and communications technology, clinical simulation laboratories and libraries
- Nursing or midwifery schools have a system and policy in place that ensures the safety and welfare of students and faculty
- Nursing or midwifery schools have professional support personnel and human resources to meet programme and student demand
- Nursing or midwifery schools have a budget allocation and budget control that meets programme, faculty and student needs
- Nursing or midwifery schools have a system in place for student-support services

PARTNERSHIPS

- Nursing or midwifery schools demonstrate successful partnerships with MOH-GOSS, with other disciplines, with clinical practice sites, community leaders, with clinical and professional organizations and with international partners

CURRICULUM

Nursing or midwifery schools should:

- Deliver programmes that take into account workforce planning and health-care policies of Southern Sudan
- Ensure that plans adhere to the MOH-GOSS approved curriculum
- Provide classroom and clinical learning that delivers the knowledge and skills required to meet the needs of the Southern Sudan population
- Establish and demonstrate balance between the theory and practice components of the curriculum
- Demonstrate use of recognized approaches to teaching and learning in their programmes, including, but not limited to, adult education, self-directed learning, e-learning and clinical simulation
- Provide classroom and clinical learning based on established competencies and grounded in the most current, reliable evidence
- Enable the development of clinical reasoning, problem solving and critical thinking in their programmes
- Conduct regular evaluations of curricula and clinical learning, and include student, client, stake-holder and partner feedback
- Ensure that programmes offer opportunities for multi-disciplinary content and learning experiences

CORE CURRICULUM

- Nursing or midwifery curricula provide core content that will enable their graduates to meet the established competencies
- Nursing programmes provide core content in nursing theory, practice, interventions and scope of practice
- Midwifery programmes provide core content in midwifery theory, practice, interventions and scope of practice for strengthening health systems through the primary health-care approach
- Nursing or midwifery programmes provide supervised clinical learning experiences that support nursing or midwifery theory in diverse settings

ASSESSMENT OF STUDENTS

- Nursing or midwifery schools assess student learning, knowledge and skill development throughout their programmes, using reliable evaluation methodologies
- Nursing or midwifery schools use a variety of methods to assess the subject matter being studied including, but not limited to, student performance-based assessment and client/stakeholder feedback
- Nursing or midwifery schools have student retention systems in place
- The head of a nursing or midwifery programme is a nurse and midwife who holds as a minimum a diploma in nursing and midwifery, has undergone a 1 year nursing tutor training programme, is educated and experienced in leadership and administration, and demonstrates knowledge as an educator. The longer term goal should set the bar for the minimum education level at a bachelor’s degree - preferably a graduate

degree - with advanced preparation and clinical competence in their specialty area as well as advanced qualifications in administration

- The core academic faculty are nurses and midwives who demonstrate knowledge as educators and have as a minimum a diploma in Nursing and Midwifery with the goal of undergoing further training to acquire higher qualification when feasible (subject to funding and other requirements). The longer term goal should set the bar for the minimum education level at a bachelor's degree - preferably a graduate degree - with advanced preparation and clinical competence in their specialty area
- Other health professionals who are guest lecturers in nursing or midwifery programmes hold the required qualifications and possess clinical and educational expertise in their specialty

FACULTY REQUIREMENTS

Academic	Clinical	Professional development
The head of a nursing or midwifery programme is a nurse and midwife who holds as a minimum a diploma in nursing and midwifery, has undergone a 1 year nursing tutor training programme, is educated and experienced in leadership and administration, and demonstrates knowledge as an educator. The longer term goal should set the bar for the minimum education level at a Bachelor's degree - preferably a graduate degree - with advanced preparation and clinical competence in their specialty area as well as advanced qualifications in administration. The core academic faculty are nurses and midwives who demonstrate knowledge as educators and have as a minimum a diploma in Nursing and Midwifery with the goal of undergoing further training to acquire higher qualification when feasible (subject to funding and other requirements). The longer term goal	Clinical faculty comprises nurses, midwives and other health professionals who hold a minimum of a diploma and possess clinical and educational expertise in their specialty area. Nurses and midwives with clinical expertise in the content area being taught are designated to supervise and teach students in that clinical practice area. Nursing or midwifery schools form partnerships to secure a variety of qualified people to be clinical supervisors and teachers.	Nursing or midwifery schools have a policy and system in place that validates the updated clinical and educational expertise and competency of faculty. Nursing or midwifery schools have a system in place that provides faculty with opportunities for development in teaching, scholarship, practice and external professional activity. Nursing or midwifery schools have a system and policy in place and provide time and resources for competency development for staff. Nursing or midwifery schools have a policy and system in place for reward and recognition of staff in

should set the bar for the minimum education level at a bachelor's and preferably a graduate degree - with advanced preparation and clinical competence in their specialty area. Other health professionals who are guest lecturers in nursing or midwifery programmes hold the required qualification and possess clinical and educational expertise in their specialty.		accordance) with the set criteria.

ADMISSION POLICY AND SELECTION

- Nursing or midwifery schools have a transparent admission policy that specifies the process of student selection and the minimum acceptance criteria
- Nursing or midwifery schools have a transparent non-discriminatory admission and selection process
- Nursing or midwifery schools have a system and policy in place that takes into account different entry points of students, recognition of their prior learning, experience and progression options toward higher education goals (maternal child health care workers, community midwives)
- Nursing or midwifery schools have entry requirements that meet the criteria for institutions in Southern Sudan including, but not limited to, completion of secondary education

ENTRANCE CRITERIA

Nursing and midwifery schools admit students:

- With backgrounds in basic science and mathematics who demonstrate skills in the language of instruction and in dealing with the clients
- Who have the ability to meet the requirements of the programme
- Who meet the institution's health and any other requirements, as well as any requirements for selection
- Who have completed other training programmes e.g. maternal child health care workers, community midwives, community health workers) and can demonstrate that they are taking steps to complete their secondary education
- Who demonstrate the will to serve in health and the ability to be independent learners

ANNEX 7: SOUTHERN SUDAN NURSING CODE OF ETHICS-DRAFT

THE SOUTHERN SUDAN NURSING CODE OF ETHICS[17]

TABLE OF CONTENTS:

ELEMENTS OF THE CODE....45
1. NURSES AND PEOPLE 45
2. NURSES AND PRACTICE.... 45
3. NURSES AND THE PROFESSION 45
4. NURSES AND CO-WORKERS 45
Tables: 46
Element of the Code #1: NURSES AND PEOPLE 46
Element of the Code #2: NURSES AND PRACTICE.... 47
Element of the Code #3: NURSES AND THE PROFESSION 47
Element of the Code #4: NURSES AND CO-WORKERS.... 47
PROPAGATION OF THE SOUTHERN SUDAN CODE OF ETHICS FOR NURSES....48
DEFINITION OF TERMS USED IN THE SOUTHERN SUDAN CODE OF ETHICS FOR NURSES 48

[17] Adapted from ICN CODE of Ethics for Nurses

The Code of Ethics for Nurses has four principal elements that outline the standards of ethical conduct.

ELEMENTS OF THE CODE

1. NURSES AND PEOPLE

The nurse's primary professional responsibility is to people requiring nursing care.

In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.

The nurse holds in confidence personal information and uses judgement in sharing this information.

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.

The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

2. NURSES AND PRACTICE

The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning.

The nurse maintains a standard of personal health such that the ability to provide care is not compromised.

The nurse uses judgement regarding individual competence when accepting and delegating responsibility.

The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence.

The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people.

3. NURSES AND THE PROFESSION

The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.

The nurse is active in developing a core of research-based professional knowledge.

The nurse, acting through the professional organisation, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

4. NURSES AND CO-WORKERS

The nurse sustains a co-operative relationship with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

The *South Sudan Code of Ethics for Nurses* should be a guide for action based on social values and needs. It will have meaning only as a living document if applied to the realities of nursing and health care in a changing society.

To achieve its purpose the Code must be understood, internalised and used by nurses in all aspects of their work. It must be available to students and nurses throughout their study and work lives.

HOW TO APPLY SOUTHERN SUDAN *CODE OF ETHICS FOR NURSES*

The four elements of the *Code of Ethics for Nurses*, give a framework for the standards of conduct. The following chart will assist nurses to translate the standards into action. Nurses and nursing students can therefore:

- Discuss, disseminate the Code with co-workers and others.
- Use a specific example from experience to identify ethical dilemmas and standards of conduct as outlined in the Code. Identify how you would resolve the dilemmas.
- Work with different groups, people to clarify ethical decision making and reach a consensus on standards of ethical conduct.
- Collaborate with your national nurses' association, co-workers, and others in the continuous application of ethical standards in nursing practice, education, management and research.

Tables:

Element of the Code # 1 : NURSES AND PEOPLE		
Practitioners and Managers	**Educator's and Researchers**	**Nursing Council**
Provide care that respects human rights and is sensitive to the values, customs and beliefs of all people.	In curriculum include references to human rights, equity, justice, solidarity as the basis for access to care.	Develop position statements and guidelines that support human rights and ethical standards.
Provide continuing education in ethical issues.	Provide teaching and learning opportunities for ethical issues and decision making.	Lobby for involvement of nurses in ethics review committees.
Provide sufficient information to permit informed consent and the right to choose or refuse treatment.	Provide teaching/learning opportunities related to informed consent.	Provide guidelines, position statements and continuing education related to informed consent.
Use recording and information management systems that ensure confidentiality.	Introduce into curriculum concepts of privacy and confidentiality.	Incorporate issues of confidentiality and privacy into a national code of ethics for nurses.
Develop and monitor environ-mental safety in the workplace.	Sensitise students to the importance of social action in current concerns.	Advocate for safe and healthy environment.

Element of the Code #2: NURSES AND PRACTICE		
Practitioners and Managers	**Educators and Researchers**	**Nursing Council**
Establish standards of care and a work setting that promotes safety and quality care.	Provide teaching/learning opportunities that foster lifelong learning and competence for practice.	Provide access to continuing education, through journals, conferences, distance education, etc.
Establish systems for professional appraisal, continuing education and systematic renewal of licensure to practice.	Conduct and disseminate research that shows links between continual learning and competence to practice.	Lobby to ensure continuing education opportunities and quality care standards.
Monitor and promote the personal health of nursing staff in relation to their competence for practice.	Promote the importance of personal health and illustrate its relation to other values.	Promote healthy lifestyles for nursing professionals. Lobby for healthy work places and services for nurses.

Element of the Code #3: NURSES AND THE PROFESSION		
Practitioners and Managers	**Educators and Researchers**	**Nursing Council**
Set standards for nursing practice, research, education and management.	Provide teaching/learning opportunities in setting standards for nursing practice, research, education and management.	Collaborate with others to set standards for nursing education, practice, research and management.
Foster workplace support of the conduct, dissemination and utilisation of research related to nursing and health.	Conduct, disseminate and utilise research to advance the nursing profession.	Develop position statements, guidelines and standards related to nursing research.
Promote participation in national nurses' associations so as to create favourable socio-economic conditions for nurses	Sensitise learners to the importance of professional nursing associations.	Lobby for fair social and economic working conditions in nursing. Develop position statements and guidelines in workplace issues.

Element of the Code #4: NURSES AND CO-WORKERS		
Practitioners and Managers	**Educators and Researchers**	**Nursing Council**
Create awareness of specific and overlapping functions and the potential for interdisciplinary tensions.	Develop understanding of the roles of other workers.	Stimulate co-operation with other related disciplines.

Develop workplace systems that support common professional ethical values and behaviour.	Communicate nursing ethics to other professions.	Develop awareness of ethical issues of other professions.
Develop mechanisms to safeguard the individual, family or community when their care is endangered by health care personnel.	Instil in learners the need to safeguard the individual, family or community when care is endangered by health care personnel.	Provide guidelines, position statements and discussion forums related to safeguarding people when their care is endangered by health care personnel.

PROPAGATION OF THE *SOUTHERN SUDAN CODE OF ETHICS FOR NURSES*

To be effective the *Southern Sudan Code of Ethics for Nurses* must be familiar to nurses. The Nursing& Midwifery Directorate should strive to disseminate the CODE to schools of nursing, practising nurses, the nursing press and other mass media. The Code should also be disseminated to other health professions, the general public, consumer and policy-making groups, human rights organisations and employers of nurses.

DEFINITION OF TERMS USED IN THE SOUTHERN SUDAN CODE OF ETHICS FOR NURSES

Co-worker: Other nurses and other health and non-health related workers and professionals.

Co-operative relationship: A professional relationship based on collegial and reciprocal actions, and behaviour that aim to achieve certain goals.

Family: A social unit composed of members connected through blood, kinship, emotional or legal relationships.

Nurse shares with society: A nurse, as a health professional and a citizen, initiates and supports appropriate action to meet the health and social needs of the public.

Personal health: Mental, physical, social and spiritual well-being of the nurse.

Personal information: Information obtained during professional contact that is private to an individual or family, and which, when disclosed, may violate the right to privacy, cause inconvenience, embarrassment, or harm to the individual or family.

Related groups: Other nurses, health care workers or other professionals providing service to an individual, family or community and working toward desired goals.

ANNEX 8: STANDARDS OF PRACTICE - MIDWIFERY

Southern Sudan Standards for the Practice of Midwifery[18]

TABLE OF CONTENTS:

STANDARD I 50
MIDWIFERY CARE IS PROVIDED BY QUALIFIED PRACTITIONERS 50
STANDARD II 50
MIDWIFERY CARE OCCURS IN A SAFE ENVIRONMENT WITHIN THE CONTEXT OF THE FAMILY, COMMUNITY, AND A SYSTEM OF HEALTH CARE 50
STANDARD III 50
MIDWIFERY CARE SUPPORTS INDIVIDUAL RIGHTS AND SELF-DETERMINATION WITHIN BOUNDARIES OF SAFETY 50
STANDARD IV 51
MIDWIFERY CARE IS COMPRISED OF KNOWLEDGE, SKILLS, AND JUDGMENTS THAT FOSTER THE DELIVERY OF SAFE, SATISFYING, AND CULTURALLY COMPETENT CARE 51
STANDARD V 51
MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN PRACTICE GUIDELINES 51
STANDARD VI 51
MIDWIFERY CARE IS DOCUMENTED IN A FORMAT THAT IS ACCESSIBLE AND COMPLETE 51
STANDARD VII 51
MIDWIFERY CARE IS EVALUATED ACCORDING TO AN ESTABLISHED PROGRAM FOR QUALITY MANAGEMENT THAT INCLUDES A PLAN TO IDENTIFY AND RESOLVE PROBLEMS 52
STANDARD VIII 52
MIDWIFERY PRACTICE MAY BE EXPANDED BEYOND THE SSNMC CORE COMPETENCIES TO INCORPORATE NEW PROCEDURES THAT IMPROVE CARE FOR WOMEN AND THEIR FAMILIES 52

[18] ICM.

Midwifery practice as conducted by certified nurse-midwives (CNMs), certified midwives (CMs) and Community Midwives (CMWs) is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the post partum period, care of the newborn, and the family planning and gynaecological needs of women. The CNM and CM practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client. CNMs, CMs, CMW practice in accord with the Standards for the Practice of Midwifery, as defined by the Southern Sudan Nursing and Midwifery Council (SSNMC). In the absence of such council, transitional measures should be applied to ensure licensing is implemented.

STANDARD I

MIDWIFERY CARE IS PROVIDED BY QUALIFIED PRACTITIONERS
The midwife:

- Is certified by the SSNMC designated certifying agent.
- Shows evidence of continuing competency as required by the SSNMC designated certifying agent.
- Is in compliance with the legal requirements of the jurisdiction where the midwifery practice occurs.

STANDARD II

MIDWIFERY CARE OCCURS IN A SAFE ENVIRONMENT WITHIN THE CONTEXT OF THE FAMILY, COMMUNITY, AND A SYSTEM OF HEALTH CARE
The midwife:

1. Demonstrates knowledge of and utilizes country regulations that apply to the practice environment and infection control.
2. Demonstrates a safe mechanism for obtaining medical consultation, collaboration, and referral.
3. Uses community services as needed.
4. Demonstrates knowledge of the medical, psychosocial, economic, cultural, and family factors that affect care.
5. Demonstrates appropriate techniques for emergency management including arrangements for emergency transportation.
6. Promotes involvement of support persons in the practice setting.

STANDARD III

MIDWIFERY CARE SUPPORTS INDIVIDUAL RIGHTS AND SELF-DETERMINATION WITHIN BOUNDARIES OF SAFETY
The midwife:

1. Practices in accord with the Philosophy and the Code of Ethics set by the SSNMC
2. Provides clients with a description of the scope of midwifery services and information regarding the client's rights and responsibilities.
3. Provides clients with information regarding, and/or referral to, other providers and services when requested or when care required is not within the midwife's scope of practice.

4. Provides clients with information regarding health care decisions and the state of the science regarding these choices to allow for informed decision-making.

STANDARD IV

MIDWIFERY CARE IS COMPRISED OF KNOWLEDGE, SKILLS, AND JUDGMENTS THAT FOSTER THE DELIVERY OF SAFE, SATISFYING, AND CULTURALLY COMPETENT CARE
The midwife:

1. Collects and assesses client care data, develops and implements an individualized plan of management, and evaluates outcome of care.
2. Demonstrates the clinical skills and judgments described in the Midwifery training curriculum Core Competencies for Basic Midwifery Practice.
3. Practices in accord with the SSNMC Standards for the Practice of Midwifery.
4. Practices in accord with service/practice guidelines that meet the requirements of the particular institution or practice setting.

STANDARD V

MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN PRACTICE GUIDELINES
The midwife:

1. Describes the parameters of service for independent and collaborative midwifery management and transfer of care when needed.
2. Establishes practice guidelines for each specialty area, which may include, but is not limited to, primary health care of women, care of the childbearing family, and newborn care.
3. Includes the following information in each specialty area:
   a) Parameters and methods for assessing health status
   b) Parameters for risk assessment
   c) Parameters for consultation, collaboration, and referral
   d) Appropriate interventions including treatment, medication, and/or devices.

STANDARD VI

MIDWIFERY CARE IS DOCUMENTED IN A FORMAT THAT IS ACCESSIBLE AND COMPLETE

The midwife:

1. Uses records that facilitate communication of information to clients, consultants, and institutions.
2. Provides prompt and complete documentation of evaluation, course of management, and outcome of care.
3. Promotes a documentation system that provides for confidentiality and transmissibility of health records.
4. Maintains confidentiality in verbal and written communications.

STANDARD VII

MIDWIFERY CARE IS EVALUATED ACCORDING TO AN ESTABLISHED PROGRAM FOR QUALITY MANAGEMENT THAT INCLUDES A PLAN TO IDENTIFY AND RESOLVE PROBLEMS

The midwife:

1. Participates in a program of quality management for the evaluation of practice within the setting in which it occurs.
2. Provides for a systematic collection of practice data as part of a program of quality management.
3. Seeks consultation to review problems, including peer review of care.
4. Acts to resolve problems identified.

STANDARD VIII

MIDWIFERY PRACTICE MAY BE EXPANDED BEYOND THE SSNMC CORE COMPETENCIES TO INCORPORATE NEW PROCEDURES THAT IMPROVE CARE FOR WOMEN AND THEIR FAMILIES

The midwife:

1. Identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice.
3. Demonstrates knowledge and competency, including:
   a) Knowledge of risks, benefits, and client selection criteria.
   b) Process for acquisition of required skills.
   c) Identification and management of complications.
   d) Process to evaluate outcomes and maintain competency.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.

ANNEX 9: CODE OF ETHICS FOR MIDWIVES

CODE OF ETHICS FOR MIDWIVES[19]

Introduction

The aim of the *code on ethics for midwives* is to provide a benchmark for the standard of care as related to the training of midwives in Southern Sudan. The code intends to highlight the standard of care that should be provided to women, babies and families through the development, education, and appropriate utilization of the professional midwife. In keeping with its aim of promoting women's health and placing the focus on the midwife, the following code is to guide the education, practice and research of the midwife. This code acknowledges women as persons with human rights, seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect, trust, and the dignity of all members of the community and society at large.

THE CODE

1. Midwifery Relationships:

a. Midwives should provide information to expectant women to support the process of making a choice and promote the woman's acceptance of appropriate decisions to achieve safe delivery.
b. Midwives should work with women and should encourage them to participate actively in decisions about their care, and empowering women to speak for themselves on issues affecting the health of women and their families in their culture/society.
c. Midwives, together with community members, are to define and emphasize women's needs for health services and to ensure that resources required are highlighted as a priority.
d. Midwives support and sustain each other in their professional roles, and actively nurture their own and others' sense of self-worth.
e. Midwives work with other health professionals, consulting and referring as necessary, when the woman's need for care exceeds the competencies of the midwife.
f. Midwives recognise the human interdependence within their field of practice and actively seek to resolve inherent conflicts.
g. The midwife has responsibilities to her or himself as a person of moral worth, including duties of moral self-respect and the preservation of integrity.

2. Practice of Midwifery:

a. Midwives provide care for women and childbearing families with respect for Southern Sudan's cultural diversity while educating and discouraging the practices that are harmful e.g. female genital cutting (FGC).
b. Midwives encourage realistic expectations of childbirth by women within their own society, with the minimum expectation that no women should be harmed by conception or childbearing.
c. Midwives use their professional knowledge to ensure safe birthing practices in all environments and cultures.

[19] ICM. Code of Ethics. International Confederation of Midwives. 2003

d. Midwives respond to the psychological, physical, emotional and spiritual needs of women seeking health care, whatever their circumstances.
e. Midwives act as effective role models in health promotion for women throughout their life cycle, for families and for other health professionals.
f. Midwives actively seek personal, intellectual and professional growth throughout their midwifery career, integrating this growth into their practice.

3. The Professional Responsibilities of Midwives:

a. Midwives hold in confidence client information in order to protect the right to privacy, and use judgement in sharing this information.
b. Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.
c. Midwives may refuse to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.
d. Midwives understand the adverse consequences that ethical and human rights violations have on the health of women and infants, and will work to eliminate these violations.
e. Midwives participate in the development and implementation of health policies that promote the health of all women and childbearing families.

4. Advancement of Midwifery Knowledge and Practice:

a. Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.
b. Midwives develop and share midwifery knowledge through a variety of processes, such as peer review and research.
c. Midwives participate in the formal education of midwifery students and midwives.

ANNEX 10: MEMORANDUM OF AGREEMENT FOR TRAINING- DRAFT

Memorandum of Agreement (MOA)

Between

Ministry of Health of the Government of Southern Sudan (MOH-GOSS) and ___________________

Date

What: This is a regulatory document to establish the terms by which the Ministry of Health of the Government of Southern Sudan grants permission for an agency to conduct training of certain health care providers.

Why: The purpose of the MOA is to assure the quality of the training, the processes involved, and the quality of the product, i.e., the graduate of the programme, with the ultimate goal of assuring the quality of care received by the people of Southern Sudan.

Terms of the Agreement: The training centre agrees to:

- Submit a proposal for training that defines the location for classes and clinical sites; minimum education and age of students at entry; language requirements; minimum education of course principal, course instructors and clinical instructors; ratio of clinical instructors to students; physical description of training centre facility and student accommodations; internet and technology capacity; data and supporting documents (MOAs) from clinical site agencies attesting to expected adequacy of clinical sites to accomplish training competencies and agreement that training centres can make use of clinical facilities; provides information about other training centres competing for access to the same clinical experiences, e.g. deliveries, and assurance that the new programme will either not exceed the clinical capacity in that area or assurance that other sites will be used to meet the course requirements
- Comply with the MOH-GOSS Standards for Training Centres
- Use the curriculum provided by the MOH-GOSS
- Limit class sizes to the Centre's capacity to meet both classroom and clinical requirements
- Fulfil the curriculum requirements before graduating students. Specifically, the training centre will assure that the student:
  1. Completes the full requirement of hours
  2. Successfully passes all course content
  3. Fulfils clinical experience requirements
  4. Successfully demonstrates required competencies

ANNEX 11: RECOMMENDATIONS, PHASE I CMW CONSULTATION

Assessment of the Community Midwifery Programme in Southern Sudan – February 2010

Recommendations and Next Steps

Part 1. Create the legal processes for practice of Community Midwives in Southern Sudan

1. Establish within the Department of Human Resources with collaboration with the Department of Nursing and Midwifery the requirements and process for registering Community Midwives, to include the minimum educational standards of graduation from the Community Midwifery programme and documentation of a minimum of 25 supervised deliveries and a preference for 50.

2. Correct and upgrade pay scale/s for CMWs to be compatible with other professional salaries of equivalent status; provide incentives and higher salaries for "hardship" status to encourage graduates to work in the most distant rural communities served by PHCCs and PHCUs; require 50 documented supervised deliveries for rural deployment where support and supervision would be low.

Part 2. Locate and update skills of graduated CMWs who are currently working even though they did not complete the 25 minimum delivery requirement or were unable to find CMW employment

1. Using data from the training centres and community contacts locate graduates of CMW programmes and identify the number of completed deliveries for each. Contact the graduates and encourage them to enter an internship in the teaching hospitals to complete a minimum of 25 and preferably a total of 50 deliveries.

2. Set up paid internships in each of the three teaching hospitals, placing these CMWs close to their home, when possible.

3. Identify potential midwifery tutors for these CMWs within the teaching hospitals and provide tutoring short courses for these staff.

Part 3. Identify graduated CMWs currently working who desire further education

1. Create opportunities for the CMWs to enter higher education programmes such as: Diploma in Nursing, programmes offered in neighbouring countries, e.g. Diploma in Midwifery and/or BSc in Nursing

Part 4. CMW Curriculum and Training Centres

1. Control the Midwifery Curriculum and training by restricting accreditation for training to those training programs that follow the curriculum, and meet at least minimum standards set for training centres. Develop Memorandum of Understandings (MOUs) for these agreements.

2. Establish a curriculum review process involving training centres, DG Nursing and

Midwifery, and other stakeholders at least every three years.

3. Create a sufficient number of well-prepared midwife teachers, who are also competent in midwifery practice, essential for the effective education and training of midwives

4. Generate adequate number of clinical tutors for the CMW students at the clinical sites.

5. Work with consultants and stakeholders on establishing minimum standards for Community Midwifery training centres.

6. Create an annual written self-review process for training centres based on the developed standards.

7. Create an on-site review of training centres on a recurring basis, at least every 5 years.

8. Applicants for training need to be tested on English proficiency prior to acceptance into the programme, with a minimum secondary school 1 level of reading.

9. The 2009 Hesperian *“A Book for Midwives: Care for Pregnancy, Birth, and Women’s Health”* by Klein, Miller, and Thompson should become the primary text for training in Community Midwifery. Each student should be provided a copy for use at the beginning of the programme and retained for reference after graduation.

10. Increase numbers of CMWs produced each year to be able to increase coverage of births (short and medium-term action,) as well as increase quality.

11. For future classes require 50 deliveries for graduation as specified in 2006 CMW Curriculum.

12. A national, independent and externally certifiable examination process must be established. The process must have clear and confirmable criteria, rules, procedures and trained expert midwifery specialists as evaluators. All students must have their competency assessed and be able to successfully demonstrate that they have achieved the basic competencies required of a CMW in Southern Sudan before graduation. The purpose for this national assessment is to certify that each new graduate has gained the requisite professional competencies and therefore earned the legal right to practice midwifery in Southern Sudan.

Part 5. Clinical setting

a) Increase coverage of health facilities staffed by adequate numbers of competent midwives

1. Increase the overall production and outside hiring of midwives and CMWs to meet the numbers needed. Currently Southern Sudan is unable to meet the targets for increasing the coverage of births by skilled attendants in line with the MDGs, and goals of reducing MMR will not be met in the near future.

2. CMWs practicing within hospitals equipped for handling premature births need additional training through short courses or in-services on neonatal issues and equipment.

b) Adequate working environment

1. Develop and implement a functioning procurement system.

2. Ensure that all hospitals and health facilities are provided with sufficient drugs, supplies and equipment.

3. Develop and implement job descriptions, roles and responsibilities.

4. Ensure appropriate salaries for the Nurses, Midwives and CMWs.

5. Ensure timely disbursement of salaries to all health personnel.

6. Develop and implement appropriate medical records.

7. Introduce the utilization of the partograph and monitoring charts.

8. Develop and implement a practical monitoring system for maternal morbidity and mortality.

9. Establish continuous data collection on rates, timing and direct causes of intrapartum-stillbirths and perinatal deaths.

10. Develop and implement evidence based clinical guidelines, standards and protocols.

11. Develop and implement regular staff meetings for case studies.

12. Introduce clinical audits to monitor health-system performance and compliance with clinical guidelines.

Part 6. In-service Training

1. Develop and implement technical supervision of midwifery practice. Competent midwives and CMWs working in the teaching hospitals should be allocated to conduct this supervision of practice.

2. Train midwives and CMWs in mentoring and supervision.

3. Implement continuous competency based in-service training and capacity building for midwives and CMWs. The following subjects are recommended to be covered:

a. cord prolapse
b. shoulder dystocia
c. vaginal breech birth
d. antepartum and postpartum haemorrhage
e. basic adult resuscitation
f. basic neonatal resuscitation
g. perineal suturing
h. eclampsia

ANNEX 12: REGISTER FOR NURSES AND MIDWIVES - DRAFT

==DRAFT==

REGISTRATION FORM

Personal Details:

Surname:	
Maiden name:	
First name:	
Other names:	
Sex:	
Date of birth:	
Place of birth:	
Nationality:	

Contact Details:

State of Assignment:	
State of Origin (if different):	
E-mail:	

Phone number:	
Employment status	

Area of main training:

1. General Nurses			
2. Certified Midwives			
3. Community Midwife			
4 . Certified Midwife			
5. Health Visitor			
6. Nurse Tutor			
7. Others (*specify*):			

Relevant Training Institution:

Name of Training Institution:	
State/County of Training Institution:	
Physical address of Training Institution:	
Qualification obtained:	
Date of qualification:	

Supporting Agency	

Employment History:

o	Name of Institution:	Employment timeframe:	Supervisor's contacts:	Position (title)	

Attach copy of certificate(s)letter from the current employer.

Signature of applicant: …………………………………………………..

Requirement for supporting the qualification:

- Identification letter written in the school's letter headed paper specifying area of specialization or qualification and signed by the principle/coordinator.
- Original certificate/statement of result.
- Original transcript.
- Three (3) recent passport sized photographs.

ANNEX 13: SOUTHERN SUDAN COUNCIL OF NURSING AND MIDWIFERY - DRAFT

Soft copy available on request.