Electives and international midwifery consultancy

A resource for students, midwives and other health professionals

Tiger stripes and tears

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A division of MA Healthcare Ltd

About the author

Dr Gaynor D Maclean is an international consultant (maternal and newborn health) contributing to global efforts to promote safer childbirth. With more than 20 years' international experience and a background in midwifery practice, education and research she is an honorary fellow of Swansea University and has been awarded an MBE for her contribution to midwifery overseas.

Note
Healthcare practice and knowledge are constantly changing and developing as new research and treatments, changes in procedures, drugs and equipment become available.

The author and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

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Preface

Nothing ever becomes real till it is experienced.

(Keats)

Our 21st century world has become a place where global travel is increasingly widespread. In a matter of hours a person can be transported into a totally different climate, culture and time zone. Various experts with diverse professional backgrounds are in escalating demand worldwide and students are facing unique opportunities to receive some of their education and experience in a totally different environment through an elective period overseas. The fact that I have travelled extensively during a great deal of my professional life predisposes me, even if it does not qualify me, to write on the subject. In an academic and professional world where evidence is extolled, experience is sometimes under-rated. However, I would venture to claim that experience is valuable if we are resolved to learn through it. I would like to think that I am akin to that hypothetical type of person who can claim 20 years' experience rather than the one who has one year's experience 20 times over. I have therefore chosen to use my experience as a starting point in sharing some of the insights that I have gained through the years. Some experiences are shared within the country or regional context of the chapter. However, due to the nature of the event or the need to respect confidentiality, some experiences are shared in the first or last chapter in a more general context. I have then examined the available evidence on some of the topics relevant to cross-cultural experience, whether this is in the form of consultancy practice or student elective opportunity. The principles are very similar even though the practice will obviously differ.

It was my experience of following on after consultants who had seemingly caused more problems than they had solved that prompted me to focus on such issues in my doctoral research. I sought to examine the matters of acceptability and unacceptability in these cross-cultural contexts. Using a microscope or fine tooth comb is not inevitably a comfortable experience, but in countries that are always being examined, assessed, evaluated or rated, I found it a salutary exercise to turn the tables and examine instead how we are perceived. I received copious answers to my enquiries, as respondents seemed to find it especially cathartic to convey their experiences of unacceptable consultants. Unfortunately there seemed to be no shortage of this species, whom I dubbed 'nightmare consultants' in my original thesis. It is my hope that, in some small way, this book will help raise awareness of some of the critical issues that are best heeded in cross-cultural encounters and provide a resource for those who aspire to excel at it.

A book of this size could in no way share all the experiences of a professional lifetime, nor could it offer an in-depth resource of evidence that relates to the subject matter addressed. However, the reader is alerted to some of the issues that could impact his or her practice or study, in order to stimulate consideration of some of the critical issues that may take a lifetime to examine thoroughly. At the end of each chapter I share my own reflections on some of my experiences. Then I offer for your consideration some of the lessons I have learned, on the premise that you will make your own mistakes as I have, but maybe you will not need to make the same ones as me! The reflective exercises offer opportunities for you to consider some issues in preparation for the task that you are considering or may have recently completed. I offer them hoping that they may provide some signposts in an area that may well be for you a strange land. No one can walk your path, but someone has walked a similar path – and survived! References, resources and websites are also provided.

The focus is on countries where I have worked. This does not discount the importance or relevance of other parts of the world of course, but serves to provide a selection of examples and illustrate the situations with which the reader is likely to be confronted in cross-cultural exchange. *Chapters 2–9* contain background information on the country or countries considered therein. Such data are inevitably subject to change, but serve to paint the backcloth to the scene set within the ensuing text. As the book's subtitle conveys, each chapter contains a 'tiger stripe' and a 'tear'. The tiger stripes reflect the individuality of clients, consultants and students as well as well as the countries they represent. Examples of the diversities we meet are entwined in each tiger stripe. We are aware too that while some solutions have been developed from time-honoured experience or convincing evidence, just as the pattern of tiger stripes is unique to each animal, so individual situations demand unique attention. One size does not fit all. The tears share insights into what experience and evidence have demonstrated. Cross-cultural assignments offer a medley of joys and sorrows. The tears may be of joy, sadness or sheer exasperation, but the text is rooted in reality and is offered to fellow travellers along this road of mutual development.

Ralph Waldo Emerson urges:

Be an opener of doors for such as come after thee.

I trust that in some way this book opens a door for you.

Gaynor D Maclean

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I am grateful for the assistance and inspiration of numerous colleagues throughout the world and especially for feedback on specific chapters from the following on the regions with which they are most familiar: Theary Chan, Cleide Correia, Aggie Horne, Uzo Iwobi, Keumhee Kim, Jaesub Lim, Dr Christina Mudokwenyu-Rawdon, Enid Mwebaza, Dr Rosabind Nyar, Dr Shershah Syed, and Annie Wang-Evans. I am also grateful to Dr Julia Magill-Cuerden for her initial review of the book. I have appreciated learning and sharing with a number of consultant colleagues with whom I have worked over the years and especially Valerie Tickner, Betty Clement (nee Sweet) and Dr Barbara Kwast. I also acknowledge the skilled assistance of Clare Boucher (Subject Librarian: Health Sciences and Medicine, Swansea University) in carrying out my research in writing this book.

Technical art: Sheila D Maclean

Foreword

Globalisation has generated a culture whereby sharing of midwifery education, practice and research is strongly encouraged. However, few health professionals and academics from high income countries have the opportunity to gain first-hand understanding of the varying contexts of maternity care. This is a fascinating book that describes the author's journey as she navigates continents, countries and cultures, providing insight into midwifery challenges across the globe. Each chapter provides the reader with unique information on the multiplicity of factors that hinder or facilitate successful maternity outcomes. However, this book is not merely a narrative diary of events experienced by the author; it offers practical and emotional advice to assist others who may be embarking on similar work.

This book raises awareness of the unpredictable nature of working in different settings and provides many interesting examples that illustrate the diversity within and between nations. It encourages readers to suspend their own beliefs and be open to different perspectives. Uniquely, it provides readers with an opportunity to not only 'observe' the practice of others but also to reflect on their own practice; viewing oneself as others may do so is advised. This book has clearly been written from the heart and the author's passion shines through every chapter. However, what makes this book special is the way it has been written. The author draws on evidence where appropriate; she uses the words of those she has met to powerfully illustrate points; and describes not only her successes but also her failures. This latter point reflects the humility of the author, but also provides valuable information which may prevent others from repeating similar mistakes.

At the end of each chapter there are sections on the author's personal reflections on practice, lessons learned and shared, and reflective exercises. These sections make a valuable contribution to the book and could be used individually or in group training. The reflective exercises are likely to take readers out of their 'comfort zone' but they will certainly emerge as more enlightened practitioners.

I have no doubt that this book will provide a valuable resource for many, including midwives, obstetricians, community workers, sociologists, anthropologists, students and volunteers. Anybody who reads this book should view it as a real privilege to share the lifetime experiences of such a compassionate and altruistic midwife.

Professor Dame Tina Lavender
University of Manchester

Dedication

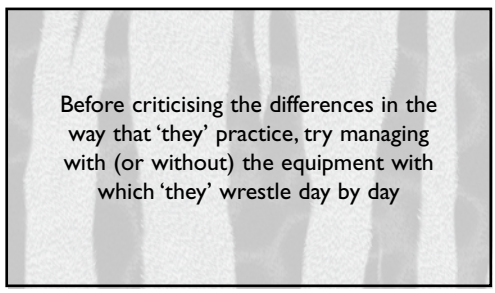
For my twin sister Sheila, my constant friend, support and inspiration, especially when I return from numerous sojourns across the world; and for young Erin and Seren Lim who call me ‘Nana’ and have that inimitable capacity of turning raindrops into rainbows.

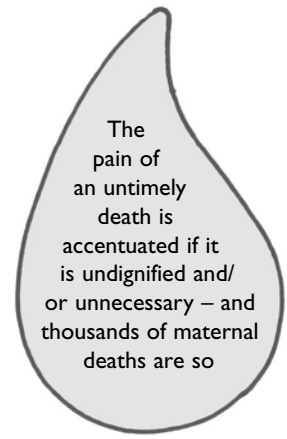
Chapter 1

Global dynamics in 21st century development

When a needle falls into a deep well, many people will look into the well, but few will be ready to go down after it.

(African Proverb)





Subject strands introduced

- Global health issues
- Maternal mortality
- The Safe Motherhood Initiative
- Skilled attendance during childbirth
- The 5th Millennium Development Goal
- Traditional healers and birth attendants
- Ethical dilemmas
- Elective issues
- Roles and responsibilities of the international consultant
- Policy makers, politics and political commitment

Practice points

- Essential preparatory actions
- Personal clinical skills
- Identifying the scope and limitations of practice
- Establishing reflective practice

Table 1.1. Background and international data

A tale of two worlds

Globally, it was estimated that 287000 women died from pregnancy-related causes in 2010, representing an MMR of 210; of these deaths 245000 (85%) occurred in two regions, sub-Saharan Africa (56%) and South Asia (29%). This represents a 47% decrease since 1990. At the same time, 40 countries were rated as having a high MMR (≥ 300); Chad and Somalia were rated as very high (>1000). Four countries in sub-Saharan Africa were rated as having a low MMR (< 99) – Mauritius, Sao Tome, Principe, and Cape Verde. Ten countries achieved MDG 5 by 2010 and nine more were considered to be on track at this time demonstrating the expected annual decline of 5.5% in the MMR during the preceding 20 years. Whilst 50 countries were considered to be making progress, 14 countries had made insufficient progress and 11 had made no progress. Most maternal deaths occurred during birth or immediately afterwards. The proportion of births attended by skilled health personnel in the developing world rose from 55% to 65% between 1990 and 2009. Globally more than 7.5 million children die before they reach their fifth birthday with 40% of deaths occurring within the first month of life. The majority of maternal and child deaths occur in the developing world and most could be prevented.

Developing countries	More developed/industrialised countries
In around 35% of cases of child death, malnutrition is an underlying cause. Around half of these children experience this deprivation in utero as their mothers are undernourished. The anaemia which can occur as a result is the most widespread nutritional problem affecting women and girls in developing countries. It is a significant predisposing cause of maternal death and is associated with premature and low birth weight. In the developing world exclusively breastfed babies are at least six times more likely to survive.	In these countries, malnutrition is rare, but infants are more likely to be exposed to the risk of obesity. Exclusive breastfeeding for the first six months is only 1% in the UK and Belgium, whilst Australia, Canada, the USA and several European countries achieve this in just 15%. It is estimated that in the USA low breast feeding rates add $13 billion dollars to medical costs and cause more than 900 deaths per year. In Britain it is estimated that a 10% increase in breastfeeding could prevent almost 3900 cases of gastroenteritis and a saving of £2.6 million.

Data indicating average figures in contrasting regions of the world

Developing countries	More developed/industrialised countries
• MMR: 240 (2010) – the highest is in Sub-Saharan Africa (average 500), the lowest is in East Asia (average 37)	• MMR: average 16 (2010) – the lowest is in Europe
• MMR: proportion related to HIV/AIDS = 91% of the global total occurred in Sub-Saharan Africa, 5% in S Asia	• MMR: proportion related to HIV/AIDS = 4% of the global total.
• Lifetime risk of maternal death*: 1 in 150, least developed: 1 in 52 (Sub-Saharan Africa: 1 in 39).	• Lifetime risk of maternal death*: 1 in 3800, (Europe: 1 in 4200; N America: 1 in 2600).
• Mothers index ranking**: Niger, Afghanistan, Yemen, Guinea Bissau and Mali rate lowest.	• Mothers index ranking**: European countries including UK, Australia and New Zealand rank within the top 10. Norway, Iceland and Sweden rate highest.
• Births attended by skilled personnel: Figures vary from 99% in Sri Lanka to 6% in Ethiopia	• Births attended by skilled personnel: 99-100%

MMR = estimated maternal mortality ratio per 100,000 live births; MDG 5 = Fifth Millennium Development Goal
*Assessed according to life expectancy, educational and economic factors
**Ranked globally (within three tiers: I = more developed, II = less developed, III = least developed) according to health, education, economic and political status of women

Sources: Black et al, 2008; Department of Health, 1995; Save the Children, 2012; United Nations, 2010; UNICEF, 2012; WHO, 2012a

Figure 1.1. Maternal mortality ratio (per 100 000 live births) 2010 (Reproduced with permission from the World Health Organization).

Exploring experience

Birth of a new era

At the birth of the new millennium the world was in an expectant state; hopes and fears, aspirations and dreads confronted many on the brink of a new era. I was, at that time, totally immersed in a literature search, seeking evidence that skilled attendance during delivery could be instrumental in promoting safer childbirth across the world. Warnings about millennium bugs and other sinister cybernetic threats were offered by the computer buffs. Vigilance bordering on paranoia could have described my frantic activities to protect precious data. Of course, for many, a new year, leave alone a new century or millennium, would go unnoticed. For some cultures marked by other timelines it had little relevance; for others, life's local or personal struggles superseded global issues.

My work during the latter part of the 20th century had taken me to many parts of the world where maternal, perinatal and child mortality rates remained unacceptably high. Responding to an unexpected need for a facilitator at an international workshop had led me back into a different world. The workshop was for midwives from developing countries and was held in Japan. I had had experience of working in India as a young woman and more recently in Botswana; this served to provide me with some insight into the situations with which my colleagues now wrestled. Together we worked on an educational framework considering prevention and management of

the main obstetric causes of maternal death. At the end of the workshop I was invited to take the framework and from it prepare a global template for safe motherhood modules containing resources that would assist midwifery teachers in their task (WHO, 1996, 2006).

Leaving my job as a midwifery teacher in the UK and taking a post as a consultant with the World Health Organization (WHO) in order to write the modules, I have subsequently continued in consultancy work. I have travelled to many parts of the world, mainly across Africa and Asia, and my experiences have included teaching, examining, assisting with curriculum reviews, evaluating programmes, and other advisory roles concerned with midwifery education and practice. My doctoral studies had caused me to reflect on what I was doing in this context and to evaluate it. It seemed to me that there was much to learn and hopefully much to share in this process of offering consultancy or technical assistance across cultural divides.

The way we do it

Professional practice in a totally different environment brings its own challenges. Having become accustomed once again to working in the National Health Service in a British hospital, returning to countries with low resources tests one's flexibility and fortitude, and most certainly calls for a sense of humour. Equipment can be faulty, flimsy or simply unavailable. While working in an antenatal clinic as part of a teaching programme in one country, I had to wrestle with an ill-functioning sphygmomanometer; it would not support a column of mercury beyond a certain level. The hospital matron, who was working alongside me as another 'trainer', offered her advice: 'Just add 20 and it will be about right' she instructed, adding, 'That's what I do!' Any hope of gaining accurate readings and acting on them diminished dramatically. Working with non-functional or faulty equipment hampers efforts by professionals in many situations.

In another country I was confronted with the dying form of a young teenager, tied to a metal stretcher with a spoon strapped into her mouth. The doctors accompanying me on a tour of the hospital wanted to show the disastrous lack of equipment that led to such levels of care. Seized with eclamptic fits the desolate and diminutive figure has remained etched in my memory as her life was snatched away, in a manner undeserved, undignified and untimely.

In most countries where I have worked, accessing a fetal stethoscope in the labour ward borders on the luxurious; learning to use it and interpret the findings, a distant aspiration for many who struggle to provide care. Evaluating one programme, I discovered that every fetal heart rate recorded on the immaculately completed partographs indicated total unison in their unrelenting 120 beats per minute. It was indeed not a national average but the

only reading that I could find across several centres. In a different setting the teaching of an obstetric life-saving skills programme had been designated to a dentist and a public health inspector. These men were literate and educated sufficiently to warrant their appointments for the job, and since the course was totally theoretical it proved difficult at first to convince the authorities of this unsatisfactory state of affairs. In some countries there is no organised system of recruiting, training, assigning and retaining adequate numbers of professional nurses, midwives or paramedics who usually form the backbone of a health service. In other countries, efforts to produce the required numbers of skilled staff become self-defeating where there is inadequate supervised clinical experience for large cohorts, or very short programmes that stand no chance of preparing skilled health professionals. I learned early on that where there is no political commitment to safe motherhood, there is no real progress. The lives of many of the most unfortunate in such societies hang in the balance and women continue to die or suffer disabilities that could have been prevented.

One must learn to expect the unexpected; in a labour ward preparing for the night shift, motorcycles were parked beside the beds. During the hours of darkness they were deposited there, apparently in the only secure place, their owners at least assured that they would have transport to travel home in the morning. In the same room, frogs hopped among the limited available equipment in the humid tropical climate.

Degrees of dexterity

In a desert environment in another continent, in a labour ward where equipment posed no problem, it was acquiring skilled medical assistance that proved challenging. A woman continued to bleed after giving birth and it became apparent that she had a cervical tear. However, the process of getting it repaired proved lengthy and the situation was further complicated by the fact that when the doctor eventually arrived, it was evident that he was not skilled in obstetrics. My colleague and I had not only to advise and instruct but also to assist him in the necessary interventions. Fortunately, the outcome in this case was good, but undoubtedly some women are lost in such circumstances.

I was reminded of a story which I included in the Safe Motherhood Foundation Module (WHO, 2006: 94–100) that questioned why a woman (Mrs Y) had died while giving birth to her fifth child. As a result of delay in finding transport, the lengthy admission process, delays in calling the midwife and arrival of the doctor, and lack of necessary equipment and suitable blood donor, Mrs Y died. This type of problem can confront students undertaking electives and can be particularly distressing when insufficient skilled help is available. University authorities make every effort to ensure adequate supervision of elective students, but in reality, some situations

may be encountered that sorely test the skills and the staying power of both visiting students and experienced professionals.

These incidents illustrate the real issues that confront those exposed to the sharp edge of practice in low resource settings. The issue of delay is explored further in *Chapter 9*. Education or training programmes led by those without the essential clinical skills themselves predispose to producing another generation handicapped by the same inabilities. On one occasion, evaluating the skills of midwives who had completed a national life-saving skills programme, I was encouraged to find a midwife who correctly identified a urinary tract infection in a pregnant woman. Having confirmed the diagnosis I then asked the midwife what she was going to do about it. 'I will tell her to come back after one month,' she replied. We were in an antenatal clinic attached to a large hospital and immediate referral and treatment posed no problem, yet there was clearly no understanding of the situation or any linking of the diagnosis to the need for treatment. Notwithstanding, the woman was clearly in considerable pain.

Evaluating programmes I have repeatedly encountered those who have completed a life-saving skills programme but cannot interpret a partograph. To the initiated, the chart provides a simple but comprehensive record of the maternal and fetal condition and the progress of labour. Discovering incomplete labour records in ill-equipped and grossly understaffed labour wards comes as no surprise, but at times I have discovered that it is associated not with lack of equipment or opportunity to examine a woman and assess progress but rather a total lack of clinical skills. Completing such a record, leave alone interpreting and co-ordinating the readings, calls for numerous clinical skills, an understanding of the physiology of labour and insights into the pathology so that there may be appreciation of the significance of deviations from normal with appropriate and timely action. Instruction provided by the unskilled, and theory without application in practice are therefore incompatible with the preparation of a skilled birth attendant. Certainly there are degrees of dexterity, but skill needs to be underpinned by a knowledge that can be applied and adapted to meet each demand.

Cost-effectiveness

In one country it was common practice for midwives in rural areas to demand payment before intervention when dealing with a retained placenta. Women often gave birth with the local traditional birth attendant, a member of the family or even alone. However, if the placenta was retained a midwife would sometimes be called. In a poor community, having a qualified health professional to attend the birth was often not considered affordable, but some perceived it necessary and indeed possible when there were complications.

To many Western Europeans, the demand for payment upfront in such a life-threatening situation is a case of 'your money or your life'. However, it should be understood that the midwives themselves were also poor and that they, sometimes, along with medical colleagues, would have to wait many months before the government paid them. Given such a situation and the fact that these midwives also had families to feed, it can be appreciated why this happened, even if the ethics of the approach seemed unacceptable.

My longest wait for a pay cheque during many years of consultancy experience was nine months. This was difficult for me at the time, but nothing compared to these midwives, who literally did not know where the next meal was coming from. Poverty can be perceived as relative, but for many in the developing world it can threaten survival, particularly among the most vulnerable, i.e. women and children and the elderly.

What is affordable and what is justifiable can vary according to the cultural setting. In some situations, even life itself seems to be of very little worth where women are considered as commodities rather than being valued and cherished. I recall a young woman dying of puerperal sepsis. She had been brought to the referral hospital from a village in an advanced state of septicaemia. The medical staff had fought in vain to counteract the infection caused or at least exacerbated by the interference of traditional healers. A midwife explained the prognosis to the husband and uncle who waited at the bedside. Expressing her sorrow and regret that nothing more could be done to save this woman's life, she was met with the response, 'Don't worry sister, we can get another one.' The midwife was more distressed than the relatives who seemed to view the replacement of a woman in the family as a mere procedure. This issue is considered later in this book, notably in *Chapter 9*.

Mind what you say

Having an understanding of the working language of the country of assignment is, of course, critical. Universities will ensure that students are placed where they can communicate sufficiently, and consultants normally do not accept assignments outside of their linguistic scope or at least where there is no adequate arrangement for interpretation.

Learning to use basic greetings and terms in the local vernacular can be advantageous but fluency is hardly a realistic aspiration for the short-term visitor. However, skilled use of both spoken and written English is essential and cannot be assumed. I have on occasions been asked to interpret the meaning of an English colleague's report where local staff have struggled to discover form and meaning. It is important to remember that English is usually a second or subsequent language for local staff and ambiguity places them at an unfair and unnecessary disadvantage. Holding a higher degree does not always provide

immunity from this embarrassing and inconvenient affliction, but it needs to be addressed in those aspiring to serve overseas. Regional dialects can also pose problems and for those whose vernacular poses particular difficulties it is worth considering how one's spoken language can be simplified. Providing they are not too complicated, differing accents can usually be understood if speech is slowed and understanding periodically checked, but the use of idiom should be reserved for those with an advanced ability in the language.

In the past, I have helped those preparing formal presentations. On one occasion I was asked to write a speech for an overseas Government minister. I had to ensure that a significant message was delivered, getting it right for the country, and also presenting it in a culturally acceptable way. Not many countries would entrust a foreigner with putting words into the mouth of one of its politicians, but international travel and cross-cultural assignments are filled with surprises, challenges and opportunities.

Examining the evidence

Women's struggle for survival: The global situation

Worldwide, during the first decade of the 21st century, at least 1000 women died every day from pregnancy-related causes. For women of childbearing age this death toll lies second only to that related to HIV/AIDS. More than 80% of these women lived in sub-Saharan Africa or South Asia, the larger number in the former region (*Figure 1.1*). The lifetime risk of maternal death varies greatly across the world (*Table 1.1*), the toll on the health of survivors is also enormous and morbidities include anaemia, fever, fistulae, incontinence, infertility and depression. Four of the five main causes of maternal mortality account for 70% of these deaths (*Box 1.1*) and most such fatalities are deemed preventable (WHO, 2010).

In addition to the four major obstetric causes of maternal mortality, obstructed labour is responsible for the deaths of up to five women in every 1000 live births, mostly occurring in the developing world. Obstructed labour is also associated with a higher incidence of fetal death and is the cause of numerous maternal morbidities. These include obstetric fistulae,

Box 1.1. Four major obstetric causes of maternal death

- Haemorrhage
- Infection
- Hypertensive disorders
- Unsafe abortion

Source: WHO, 2010

estimated to affect between 50000 and 100000 women and girls each year (WHO, 2012b). About 16 million girls between the ages of 15 and 19 years give birth each year, representing 10% of total births. In many countries the overall risk of death from pregnancy-related causes is doubled in adolescent mothers by comparison with others (WHO, 2010).

The International Federation of Gynaecology and Obstetrics (FIGO) launched an initiative in 2011 focusing on the prevention and treatment of obstetric fistulae in one Asian and 11 African countries. The intention is to ensure high quality clinical training for the comprehensive care of women and the management of fistulae, implementing a structured surgical programme with a standardised training curriculum (FIGO, 2012). For this purpose FIGO has produced a training manual to enable physicians to acquire the knowledge, skills and professionalism needed both to prevent and surgically repair obstetric fistulae (FIGO, 2011). This issue is further discussed in *Chapter 9*. The drive across the world to train midwives who are able to provide skilled care during labour is a key initiative in preventing prolonged and obstructed labour, the precursors of obstetric fistulae. Those who can identify, prevent and manage complications in pregnancy, labour and the postnatal and neonatal periods are in considerable demand at the beginning of the 21st century. However, at the end of the first decade, still less than 17% of the world's midwives were available to care for women in the countries carrying the heaviest burdens of maternal and perinatal mortality and morbidity, and it is in these 58 countries that 91% of maternal deaths, 80% of stillbirths and 82% of neonatal deaths occur (UNFPA, 2011).

Global initiatives

It is no surprise, therefore, that excellent clinical skills have been regarded as a priority in addressing the unacceptably high incidence of death and injuries that persist in these vulnerable groups across the globe. The slow progress in reducing the maternal mortality ratios has been attributed to a lack of skilled health professionals and in the five years preceding 2015 it was estimated that 330000 more midwives needed to be trained if every woman was to be able to acquire the help of a skilled attendant during childbirth (WHO, 2010). The Safe Motherhood Initiative was launched 13 years prior to the drive to promote skilled attendance and the issues addressed in these global enterprises are summarised in *Boxes 1.2 and 1.3*.

The proportion of women who are attended by skilled health personnel is one of the indicators used to determine progress towards the fifth Millennium Development Goal (MDG 5) that aims to improve maternal health and enable universal access to reproductive healthcare (UN, 2011). Whilst the incidence of skilled attendance has increased from 55% to 65%

Box 1.2. The Safe Motherhood Initiative

The Safe Motherhood Initiative (SMI) launched in 1987 represents a global effort to reduce maternal mortality and morbidity. It has become a unique partnership of governments, non-government organisations, technical agencies, women's health advocates and donors cooperating to raise awareness, set priorities, stimulate research, mobilise resources, provide technical assistance, and provide and share information. Such co-operation and commitment has enabled governments and non-governmental partners from more than 100 countries to take actions at national level aiming to make motherhood safer. The SMI aspires to enhance the quality of the lives of girls and women through numerous strategies. It highlights the need for better and more widely available maternal health services including the extension of family planning education and services, as well as effective measures aimed at improving the status of women.

Sources: SMI, 1987; Family Care International, 1998

Box 1.3. The skilled attendant and skilled attendance

A skilled attendant is an accredited health professional, such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

Skilled attendance implies care provided within an 'enabling environment' which includes:

- a functioning health system
- appropriate training and support for skilled attendants
- evidence-based policies, standards and protocols
- essential supplies and equipment
- ample numbers of staff and the right professional mix
- adequate buildings
- satisfactory terms of employment
- supportive supervision
- effective monitoring and evaluation
- a functioning referral system

Sources: WHO, 1999, 2004

in the decade preceding 2009 in developing countries, inequalities remain (UN, 2011). Socio-economic inequity and women's education were among the factors highlighted in a study in Bangladesh influencing whether women seek skilled care (Anwar et al, 2008). Even in a country such as Namibia that made marked progress in increasing the numbers of women attended by skilled healthcare professionals, inequality has been implicated. Zere et al (2011) identify socio-economic disparity, residential location and differences in levels of education as determinants influencing the uptake of skilled care in that country. These issues have repeatedly been associated with health

disadvantages (Houweling et al, 2007; Starfield and Birn, 2007; Marmot et al, 2008; Ahmed et al, 2010) and it is evident that any approaches to make childbirth safer must therefore incorporate a multitude of factors that go beyond the preparation of skilled healthcare professionals.

Traditional healers and birth attendants

The acceptability of traditional birth attendants has been debated with increasing ardour since the advent of promoting skilled attendance for all (Bergström and Goodburn, 2001). For decades the issue as to whether traditional birth attendants can contribute to reducing maternal and perinatal mortality has remained controversial. The consensus has surrounded the need to integrate them into healthcare systems, to gradually replace them with skilled attendants and to ensure the existence of an effective referral system to access quality essential obstetric services (Yadav, 1987; Wollast et al, 1993; Fleming, 1994; Alisjahbana, 1995; Kwast, 1995, 1996; Koblinsky et al, 1999; Jokhio et al, 2005).

There is evidence that traditional birth attendants have been receiving some training since the end of the 19th century although this increased during the latter part of the 20th century only to decline later (Sibley and Sipe, 2006). Whereas in 1972 only 20 countries had any form of traditional birth attendant training programme, 20 years later this had increased to include 85% of developing countries (Fleming, 1994). When the Alma-Ata Declaration was made in 1978 (WHO, 1978), WHO was fully supportive of traditional birth attendant training, but by 1997 the focus had moved from training traditional birth attendants to an emphasis on training skilled attendants.

In an analysis of studies including more than 2000 traditional birth attendants and 27000 women, Sibley et al (2009) conclude that when combined with improved health services, traditional birth attendant training offers promising potential for reducing perinatal mortality. However, they concede that lack of evidence ensures that the effectiveness of the actual traditional birth attendant training cannot be verified. Evidence from Guatemala suggests that staff attitudes towards traditional birth attendants can be more influential in facilitating referral than whether or not the latter have received training. In that country, the referral rate increased by more than 200% through incorporating two basic strategies. These involved training hospital staff in improving standards of obstetric and neonatal care, along with stressing the importance of being understanding and supportive towards women and traditional birth attendants (O'Rourke, 1995). In a rural district in East Java, a government scheme providing financial incentives to traditional birth attendants for referring women to skilled attendants succeeded in promoting cooperation between midwives and traditional birth attendants. It also dramatically reduced the numbers of women giving birth with traditional birth attendants from 86% to 1% between 1984 and 2007 (Analen, 2007).

Attitudes towards traditional practitioners vary with time and between different people and professional groups. Traditional birth attendants tend to be the preferred choice in rural communities and some poor urban districts. However, choice may not feature in the available assistance for women in many communities where traditional practitioners are the only resource.

Following an extensive review of the evidence, Bergström and Goodburn (2001) acknowledge the psychosocial and cultural support that traditional birth attendants provide for women during childbirth. They stress that the cultural competence and empathic skills of traditional birth attendants make an important contribution to the care of women and their newborns. Attitudes toward traditional healers and traditional medicine have experienced turning points at the beginning of the 21st century. The Beijing Declaration (WHO, 2008) recognised and promoted several issues concerning traditional practice. These include the injunction that the knowledge of traditional medicine and practices be preserved, respected, promoted and widely communicated and that governments should regulate practice to promote safety and effectiveness. Furthermore, it is urged that traditional practice should be researched in order to develop further, and be integrated into national health systems. Qualification, accreditation and licensing of practitioners were also recommended. Collaboration between conventional and traditional practitioners and between governments, international organisations and stakeholders was encouraged.

There is some evidence of efforts to establish recognition and approval. For example, during July 2012, Angola recognised 54000 traditional healers in an attempt to integrate their knowledge into the national health system. In that country traditional medicine is believed to be the sum of all practices, treatments and methods incorporating the experience and spiritual dimensions of generations and of particular importance to rural populations (Annual Action Programme, 2012). This topic is pursued further in *Chapter 3*.

It would seem that where skilled attendants are able to embrace the cultural competence and sensitivity evident in the best examples of traditional practitioners, there might be a greater meeting of minds and actions for the ultimate good of the childbearing woman and her offspring. The visiting student or professional is likely to encounter these polarised approaches to care during childbirth and witness the evolution or revolution that ensues.

Ethical dilemmas

Not only in respect of traditional practitioners, but short-term visitors to another country may well experience a very different value system in operation throughout a national health system. It is not difficult to appreciate therefore that in a contrasting culture their pre-existing ethical codes of practice may be challenged. Benatar et al (2003) maintain that discourse on formal ethics

remained in the realm of philosophical and theological studies until the 1960s. Until that time professional groups and individuals held their own personal ethical views, but these were not generally discussed. Increasing concern about individual freedom and human rights along with advances in medicine and technology brought biomedical ethics into the public domain as issues such as the doctor–patient relationship and withholding or withdrawing treatment became matters of general concern. The writers conclude:

> *Education and the development of such human values as empathy, generosity, solidarity, civic responsibility, humility and self-effacement require an interdisciplinary space to thrive…*

and they propose that

> *…global health ethics offers such a space, and that it can help to catalyse crucial improvements in global health.*
>
> *(Benatar et al, 2003: 138)*

Global health may be easy to define in idealistic terms, but not so easy to achieve in vastly different settings. Global ethics is by no means a homogenous concept and the science may not be transferable across cultures. The challenge arises for short-term visitors in the professional context when they encounter a totally different cultural environment enshrined in a set of values that seem alien to the outsider. In addition, the institution in which they work may not have adopted an institutional code of ethics that is compatible with previous experience and the code of national and public health ethics may also appear alien to the outsider. Issues surrounding personal choice, informed consent, the rights of the individual, dignity, privacy and prohibitive costs that prevent life-saving interventions are but a few of the challenges that may be handled very differently in other countries, especially those at a different stage of modernisation and development.

In an extensive consideration of medical ethics from a cross-cultural perspective, Veatch (2000) points out that anyone faced with an ethical dilemma is working, at least implicitly, from within a certain framework. He goes on to explain that pre-existing frameworks have been designed to deal with normative questions that seek to clarify, for example, what principles and norms are in use and 'whether morality can be reduced to rules' (Veatch, 2000: xvii). Health professionals in many countries work from within a framework that may be derived from the Declaration of Geneva (World Medical Association, 2006). This declaration or one of a similar genre is affirmed by emerging professionals on graduating from many of the world's schools in medicine, nursing, midwifery and other health sciences. In

making such a declaration, the graduate avows, for instance, to practice the profession with conscience and dignity, regard the health of the patient as the first consideration and treat teachers with due respect and gratitude.

The British General Medical Council (GMC), in its responsibilities for medical practice, adopts the approach based on the ancient Hippocratic Oath from which many doctors through the ages have derived their ethical stance. The GMC expects doctors to treat patients as individuals, be honest and open and work in partnership with them (GMC, 2006). The Nursing and Midwifery Council (NMC) declares the similar shared values of all the UK healthcare regulatory bodies in expecting the practitioner to abide by principles that respect and protect patients or clients as individuals (NMC, 2010). International consultants and elective students are likely to be confronted by issues that demand ethical judgements. The WMA has produced a manual of medical ethics that has been translated into numerous languages and distributed throughout the world (WMA, 2009). The volume contains case studies which the student could find useful to discuss with supervisors before leaving for an elective. Obviously, there are no easy or standard answers to the ethical dilemmas of practice, but reflecting on some cases with the help of an experienced and trusted teacher or supervisor can only be advantageous in preparation. The WMA (2006:11) maintains

> *The study of ethics prepares medical students to recognize difficult situations and deal with them in a rational and principled manner.*

It is in this spirit that preparation is encouraged not only for clinical practice, but also for the ethical conflicts that may arise in cross-cultural encounters.

Perkins et al (1998) urge all health professionals to show sensitivity and respect towards the values expressed by colleagues from other cultures in matters affecting patient care. In an attempt to bridge the gap between Western and Chinese systems of medical ethics, Nie (2011) offers an ethical paradigm designed to traverse different cultures. The theory purports to uphold the primacy of morality and resist the temptation of stereotyping cultural norms while appreciating the dynamism, richness and internal plurality that can be evident in different systems of medical ethics. The matter of conflicting ethical standpoints has been raised repeatedly as a matter of concern in connection with student electives and evidence is considered in this context below.

Elective issues

Confrontation by clinical dilemmas in unfamiliar and ill-equipped settings can be a particular issue for elective students as the instances related above

have illustrated. Unless addressed adequately, such concerns may penetrate beyond initial culture shock into an area involving ethical conflict as well as very real risks to personal safety and health.

Elit et al (2011) carried out a study designed to explore the ethical issues that confront medical students undertaking electives in low resource settings. They report that five main themes emerged and these include uncertainty about how best to help and the issue of moving beyond one's scope of practice. They conclude that students would benefit from some formal preparation before departure and that this should embrace an evaluation of their expectations and motivation as well as exploring and discussing professional and ethical issues. They advise that preparation should also include learning about the local context of their placement which needs to be carefully selected. An onsite supervisor or colleague is considered advantageous and maintaining contact with the home institution is also recommended along with a formal debriefing on completion of the assignment. Hanson et al (2011), drawing from a critical analysis of relevant literature, also express concerns about ethical issues as well as the content of the curriculum and the pedagogical strategies deemed necessary if equitable engagements with participating countries are to be achieved. In addition the writers express concern that current approaches to international medical electives are at risk of nurturing colonialist ideas in the relationship between countries in the north and south.

Acknowledging the lack of evidence concerning the effectiveness of preparatory programmes, Xu et al (2011) identify five essential components of pre-departure training for elective healthcare students. These comprise personal health, travel safety, cultural awareness, linguistic competency and ethical considerations. The findings of Jeffrey et al (2011) share the concerns expressed above about personal health and travel safety as well as the limited resources and faculty inexperience in supporting elective students. Nevertheless they claim that electives contribute to a well-rounded training and help medical students to become culturally competent. Lough (2011) warns that acquiring such competence requires certain preconditions and these issues are discussed further in *Chapter 2*.

Decades earlier, Ruben and Kealey (1979) identified several interpersonal communication skills deemed important in acquiring cross-cultural adaptation. These include empathy, respect, role behaviour flexibility, orientation to knowledge, and tolerance of ambiguity. These attributes could well serve in helping with both selection and preparation of potential elective students and healthcare consultants who aspire to cross cultures.

Emanating from examining issues affecting the health of Dutch medical students undertaking electives, Sharafeldin et al (2010) recognise that limited medical experience and an unfamiliar healthcare setting combine to expose

students to health risks including blood-borne viral infections and malaria. They report the development of an integral set of measures including a mandatory global health module designed to prepare and protect the health of all their medical students planning electives overseas. Some of the main issues to consider in preparing for an elective or overseas assignment are summarised in *Table 1.2*.

Table 1.2. Preparing for an assignment or elective in a low resourced or developing country

Subject	See chapter	Subject	See chapter
Essential insights			
Cross-cultural competence	2	Linguistic ability	1, 3, 4, 7, 9
Major cultural contrasts	4, 5, 6, 9, 10	Adapting interpersonal and communication skills	3, 5, 10
Minimising culture shock	4	Minimising reverse culture shock	10
Political awareness and correctness	3, 4		
Professional ethics	1, 4		
Survival and safety			
Travel safety, personal security	7, 6, 9	Travelling and working alone	7
Personal health	2, 8	Personal support	2, 6, 10
Minimising jet lag	6		
Background knowledge			
Locality data: Historical, geographical, political	throughout	Skilled attendance	1, 2, 3, 6, 8, 9
Millennium Development Goals	1, 6, 8, 10	Management of change	2, 8
The Safe Motherhood Initiative	1, 5	Tropical health and medicine	8
Modernisation and development, bridging the 'epoch gap'	2, 6, 10	Traditional approaches to health and medicine	1, 3
Gender issues	1, 3, 5, 7–10	Cultural differences in educational approaches	2, 4, 5, 7
		Essentials of team work	8
		International consultancy	1, 10
Practice issues			
Clinical skills	1, 2, 6, 9	Coping with the 'quality gap'	6, 7, 10
Evidence-based practice	3, 5, 7–9	HIV/AIDS	1, 2, 8
Administrative issues			
Terms of reference, contracting, accountability	10	Reporting back at conferences, study days	2, 10
Report writing and making recommendations	1–3, 5, 8–10		
Additional knowledge and skills useful to consultants			
Evaluation skills	10	Evidence-based advocacy	8, 9
Capacity development	2, 7	Rights-based approaches	3, 8
Sustainable development	7, 10		

International consultancy: Facets and functions

International consultancy is a multifaceted occupation and requires those who embark upon it to function in countless and sometimes contrasting capacities. Various titles have been used to describe health and other professionals who cross international borders to share their specialist knowledge, skills or expertise in the cause of development. They may be known as consultants, development workers, technical advisers or assistants and may be required to fulfil a complexity of roles in this process (*Figure 1.2*).

In addition to their specialised knowledge and experience, international consultants are usually expected to possess the personal attributes that not only qualify them to advise or assist in this context, but also commend them to their clients. The task calls for personal as well as professional qualities. A number of qualities that make short-term consultants acceptable or unacceptable as they work in an international context have been identified (Maclean, 1998) and a number of these are shared in this book, particularly in *Chapters 2, 3, 6 and 10*.

In carrying out my research, when posing two direct questions concerning the acceptability of consultants, without exception respondents addressed the issue of unacceptability first. Evidence suggests that history as well as experience accounts for some of the pre-existing attitudes towards development workers apparent today. Benavides (1992) passionately declares his animosity towards oppressive colonial powers dating back centuries, regarding them as invaders, imposers and robbers, claiming that their real intention was 'to make us like them'. In offering advice and making recommendations, consultants dare not assume that such an interpretation of their intent will not occur. Wherever appropriate, nurturing indigenous innovation and creativity may go some way towards denying any inclination or indication of attempts to impose one culture upon another. This issue is raised in *Chapter 5* and considered in some detail in *Chapter 8*.

Nonetheless, pathways into cultures that at first present as alien have been made and successes have been noted. An example is cited from within a Mexican society where outsiders were dubbed 'coyotes', however, an indigenous population discovered that such people were not inevitably evil. A Nahua Indian gives this explanation:

> *There are individuals who manage to bridge the cultural gap between the two social realities. They know the good and the bad. Where it is safe to tread and where not. At the beginning of this present century a coyote came and settled down in my community. He respected our traditions, our people and our Nahauti culture in general.*
>
> *(Hernández, 1987: 187)*

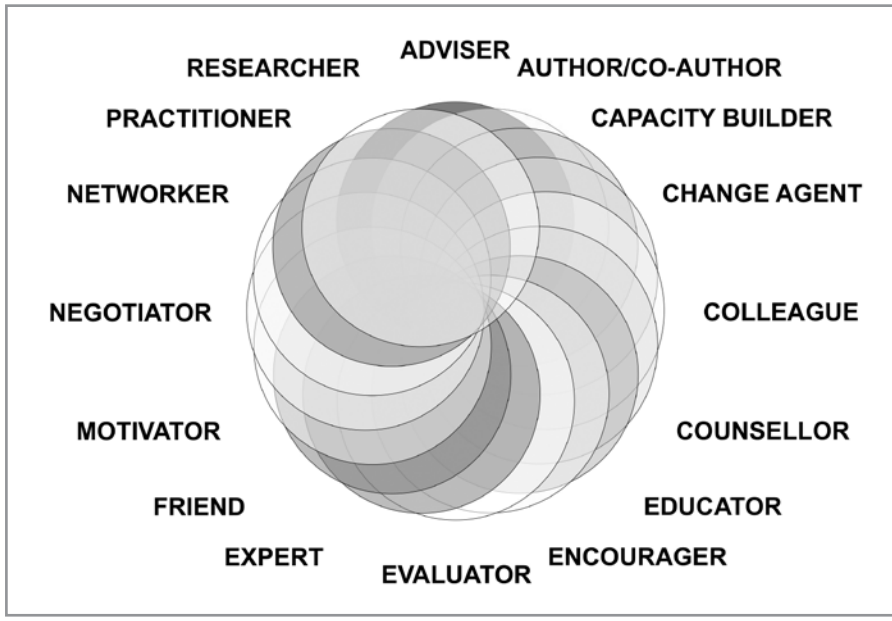


Figure 1.2. The complexity of roles required of an international consultant. Sources: Bingham, 1954; Bruner, 1975; Goldhamer, 1978; Fry and Thurber, 1989; Forss et al, 2006; Maclean, 2011.

The aspiration of both consultants and students must surely surround being able to discern the good from the bad and know where it is safe to tread. Maybe the key is veiled within the three 'R's of cross-cultural acceptability: an ability to show and earn respect, establish and maintain relationship and provide evidence of reliability. The key should help interpret a route map into the unknown. Such a map needs to identify the areas that are safe to tread and those that are best avoided (*Figure 1.3*). The wisdom needed to discern these issues is a precious commodity.

Policy makers and political commitment

In my research, policy makers confided that the consultants they found most unacceptable were those who were critical, bossy or argumentative. It was also the emotional, culturally insensitive or inflexible consultants and those who could not work independently that posed problems. Sending agencies, responsible for the selection, support and specifics of the task of the consultant expressed concern about the acceptability of recommendations offered on behalf of their organisation. Creativity and innovation needed to take second place to usability, with the latter depending not only on the content and context but also on the spirit with which the suggestions

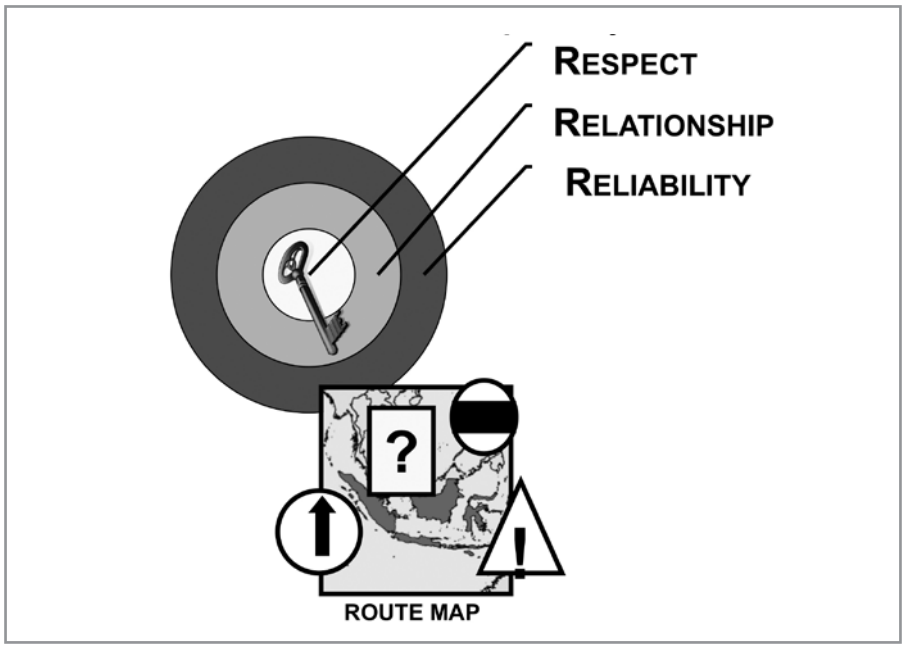


Figure 1.3. The three 'R's that are key to cross-cultural acceptability.

were offered. Recommendations that are in harmony with the policies and practice of the stakeholders were deemed desirable (Maclean, 1998). Democratic governance, gender issues and poverty alleviation were high on the international aid agenda a quarter of a century before the advent of the Millennium Development Goals and have not lost significance in a more recent context (Arthur et al, 1996; Sveriges Riksdag, 2005; UN, 2011). The aspiring consultant would be wise to consider formulating recommendations within a framework of history, culture and the prevailing emphasis of national and international stakeholders. The art and skill of making recommendations is further discussed in *Chapters 8 and 10*. Acquiring a timely and appropriate approach as well as the correct emphasis is a prime task for national professionals, and consultants frequently have opportunities to augment the efforts that their colleagues are making in this respect.

Soon after the launch of the Safe Motherhood Initiative, Royston and Armstrong (1989) highlighted the paucity of government inactivity:

> *It is only very recently that people have started to challenge – loudly and clearly in international forums – the stifling mix of personal fatalism and political disregard for women's needs that has condoned inaction in many poor countries.*
>
> *(Royston and Armstrong, 1989: 9)*

Yet apathy towards addressing maternal mortality still needs to be challenged. Fathalla (2006), echoing the sentiment of his challenge 15 years earlier, categorically claims that pregnancy-related deaths occur not because of difficulty in managing the causative conditions but because societies do not find it fitting to invest in the required resources to save lives. He maintains that the question revolves around whether the lives of women are considered worth saving. Framing the issue within the human rights context, he concludes that a woman's right to safe motherhood is attainable 'with political commitment and international cooperation' (Fathalla, 2006: 419).

There is considerable evidence that political commitment is essential in successfully addressing maternal mortality (Araujo and Diniz, 1990; Department For International Development, 2007; Gill et al, 2007). Countries such as Malaysia and Bolivia with maternal mortality up to 400 per 100000 halved their death tolls in less than 10 years. Chile, Columbia, Egypt and Sri Lanka similarly reduced their maternal mortality in 6–7 years and Honduras, Nicaragua and Thailand halved their maternal morality at an even quicker pace (WHO, 2005). Indeed, securing political commitment is not just fundamental, it is crucial to making progress in reducing this shameful and largely preventable death toll. In the absence of such commitment, women continue to die and suffer needlessly.

Personal reflections on practice

- Standards of practice may be severely challenged by numerous issues including a lack of equipment, limited clinical skills, staff shortages and pressures of an overstretched health service.
- My personal and professional ethical framework may not find resonance within a very different culture and setting.
- Colleagues may not have had the same opportunities that I have had in receiving teaching and supervision during clinical practice to enable them to acquire the necessary skills.
- Delay can be a deadly foe and it appears in numerous forms, denying many life-saving interventions.

Some lessons learned and shared

- Learning to avoid making snap judgements of the reasons for inefficiency, ineffectiveness or seemingly unethical decisions is needful. The truth may not be immediately obvious and such matters often do not respond to simple or easily attainable solutions.

- Ignoring our own weaknesses will only allow them to be accentuated in another culture and practice environment. You may never feel ready, but attempt to prepare yourself as thoroughly as possible for your elective or assignment by dealing with those areas of your practice which you know you need to address.
- Consultants may be required at short notice, but keeping a reflective diary and learning from experience as well as availing oneself of any preparatory courses can be advantageous. Students would do well to aim at allowing time for preparation by planning an elective as far ahead as possible.

Reflective exercises

- Reflect on the clinical skills that you anticipate being required of you during a forthcoming elective or assignment. Identify any that you may wish to learn, enhance or update. Prioritise them and compile an action list to address them during your preparation.
- Think about a recent incident in practice which called for an ethical judgement.
  - What personal and professional frameworks did you, your colleagues or supervisors use from which important decisions were made?
  - How might the final decision have varied if the responsible practitioner had been using a very different ethical framework within a divergent legislative and practice environment?
- You might find it useful to consider one of the case studies cited in the World Medical Association's medical ethics manual (WMA, 2009). Select a case relevant to your practice area that you anticipate could be viewed differently within a contrasting culture and discuss your reflections with a colleague or supervisor.

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