A MIDWIFERY MODEL FOR TRAINING TRADITIONAL MIDWIVES IN GUATEMALA: A REPORT FROM THE FIELD

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ABSTRACT

Objective: To describe the specific characteristics of one model of training traditional birth attendants (TBAs) in Guatemala.

Design: Participant observation, unstructured and semi-structured interviews undertaken between 1997 and 2003 to gather the data to report on the characteristics of this training program as it is evolving in the field.

Setting: The birth center site of IXMUCANE in Antigua, Guatemala, as well as community sites in the Departments of Saquetepequez, Chimaltenango, and Quetzaltenango in the western highlands of Guatemala.

Participants: Traditional midwives, certified nurse-midwives and certified professional midwives, as well as many allied health professionals and volunteers.

Intervention: Training philosophy, participant selection, curriculum content, intensity, and planned follow-up are the key components of the training program described.

Measurement and Findings: 93 traditional birth attendants have received training through the development of a 150 contact course for self-selected TBAs in the Midwives for Midwives Program. Formal evaluation of this training is underway but results are not yet available.

Key conclusions and implications for practice: The value of incorporating midwifery philosophy and praxis in TBA training has received scant attention in the TBA literature. This report suggests that TBA training program characteristics are important considerations in any evaluation of training efficacy of TBAs to improve maternal-child health.

Key Words: Traditional midwives, Guatemala, TBA training, maternal-infant mortality

Introduction

Maternal and infant mortality rates in many parts of the developing world continue to be alarmingly high. When implementing programs to improve maternal-infant outcomes, international public health experts must contend with limited resources and multiple priorities. An early effort in the 1970s to reduce maternal-infant mortality led by the World Health Organization (WHO) called for the integration of traditional birth attendants (TBAs) into public health care systems. Many countries developed training programs for TBAs, and WHO has documented the potential of the TBA in improving health (Mangay, Maglacas, & Simmons 1986; WHO 1992).

More recently, in the 1990's, resources have been refocused to improve the quality of training and equipment for personnel at referral hospitals, and to increase professional, skilled attendance at birth (Starrs 1998). Further, the concentration of biomedical health services in major urban areas, along with the persistence of maternal and infant mortality in these areas, has shifted emphasis in resource allocation by international funding agencies and national ministries of health away from training TBAs. As public health resources are limited, the need for more knowledge about TBA training and the impact on maternal-infant outcomes has become critical.

A review of the literature presents conflicting evidence. Gloyd et al. (2001) report that an outcome evaluation of TBA training in Mozambique did not provide compelling evidence of a reduction of delivery complications. In contrast, a study from Angola by Schaider et al. (1999) indicates a decrease in maternal mortality among women attended by trained TBAs in comparison with historical data. Bailey et al. (2002) used a quasi-

experimental design to assess the effect that a training intervention for TBAs in Guatemala had on the detection of complications, referral and utilization of services. The results of this study showed a positive effect of training on the rate, detection and referral of post-partum complications only, with a negative effect on referral rates or utilization with antepartum or intrapartum complications. A recent meta-analysis of the effectiveness of training of TBAs has been revealing (Sibley & Sipe, 2002). The authors report their findings with caution because of individual study limitations, but nonetheless conclude that in the aggregate the literature on TBA training indicate significant, moderate to large improvements in TBAs knowledge, attitudes, behavior and advice. They also found a small but significant decrease in perinatal mortality overall and a significant drop in neonatal mortality due to birth asphyxia.

While there is a focus in the public health literature upon the outcomes of TBA training, there is little known about the philosophy, approach and acceptance of such training by the TBAs being trained. Even less is known about whether TBAs initiate the request for training or public health experts mandate the training. There is also a need for more knowledge about the characteristics and curriculum of TBA training programs in order to better assess their effectiveness. Such knowledge could provide comparative data about what program characteristics produce better outcomes. Key program characteristics would include training philosophy and methodology, the curriculum content, the training intensity, and the provision of follow-up support and continuing education of trained TBAs.

This paper describes these four characteristics in relation to a training program for TBAs in Guatemala known as Midwives for Midwives (MFM). The challenges of evaluating the effectiveness of this training are also discussed. While policy makers and

public health professionals are understandably in search of the scientific evidence that midwifery training is a "best buy," this article cannot, nor would it claim to, conclude that training traditional midwives is a "best buy." Rather, this article highlights the work of MFM as *an example* of the training characteristics of TBA training, an account which we believe is prerequisite to any scientific evaluation of the comparative value of training or other interventions to reduce maternal and infant mortality. The literature has shown that the characteristics of training programs are neither homogeneous nor widely disseminated. The purpose of this article, therefore, is to illuminate why the characteristics of training is central in the discourse about training TBAs.

The staff of Midwives for Midwives refers to TBAs as traditional midwives. Traditional midwife is a term that respectfully recognizes the work of these practitioners as midwifery work. The term also acknowledges the self-identify of these practitioners, while differentiating their training from a midwife who has undergone higher levels of education (such as a nurse-midwife or certified professional midwife). Hereafter in this paper, TBAs will be addressed as traditional midwives (TMs). The purpose of highlighting the work of MFM with TMs is to engage with the ongoing international discourse about the efficacy of their training.

Maternal-Child Health in Guatemala

Guatemala is a country of almost 12 million people rich in geographic, biological, and cultural diversity. Guatemala has a large indigenous Mayan population divided into twenty-one separate language groups and concentrated primarily in the western highlands. The Ladino population, who are a mixture of peoples of Spanish and indigenous ancestry,

make up 39-49 percent of the population and dominate the political and economic system (Fisher & Brown 1996). Maternal and infant health for indigenous Guatemalans, particularly those concentrated in the rural areas, is dramatically poorer than those of urban ladino populations. Of the total population, 75 percent live in poverty, but among the indigenous population, those living in poverty total 93 percent (PAHO 1999) a reflection of the widespread social inequality suffered by indigenous Guatemalans.

National maternal mortality statistics range from 248/100,000 reported by the Ministry of Public Health and Social Assistance (Hurtado & Saenz 2001) to 190/100,000 reported by the Pan American Health Organization (PAHO 1999). Maternal mortality among indigenous Mayan women in certain rural areas, however, may be as high as 446/100,000 (Hurtado & Saenz, 2001). The causes of maternal mortality in Guatemala, according to PAHO, are postpartum hemorrhage, puerperal sepsis, eclampsia, and abortion (PAHO, 1999). Infant mortality is listed at 49/1000 live births (PAHO 1999).

The National Health System in Guatemala is made up of two large sectors, the public Ministry of Health (MOH), and IGSS, the Guatemalan social security institute. The MOH administers public health services and programs, serving the most impoverished. The MOH absorbs approximately 40% of health care expenditures. IGSS serves workers and their families in the formal labor sector and serves 22 percent of the population (PAHO 1999). Additionally there is an extensive, loosely organized network of private clinics, hospitals, pharmacies and laboratories serving 10 percent of the population regularly, although most Guatemalan citizens will use private services at some time in their lives. Private providers do not have coordinating or regulatory links between them. As a result there is no supervision, evaluation, or control of service delivery by private providers.

Continuity of care is difficult to achieve, and women go to different locations to see different providers. All the public health sectors are overloaded and understaffed, so people often wait for hours or days to be seen .

In the rural areas, TMs attend 53 percent of the population, whereas in urban areas, they attend 31 percent of the births (PAHO 1999). According to staff at the Ministry of Health (personal communication), there are some departments where TMs attend 75% of the births. There are approximately 20 TMs for every 10,000 Guatemalans; 70 percent of these TMs have received some formal training (Acevedo & Hurtado 1997). The MOH currently requires enrollment in an ongoing education program for the TM to be able to obtain birth certificates for the women they attend. This program consists of a 6 hour meeting each month where TMs are instructed how to identify risk factors, good hygiene and transfer complicated cases. The program does not provide learning materials, equipment, continuing education, or any professional organizing skills (Cerezano 2003). There is currently no standardized mechanism to evaluate how TMs function. TMs in Guatemala play a crucial role in the care of mothers and babies, nevertheless, because they attend approximately one half of the births in the country. Appropriate ongoing training and support, therefore, is extremely important.

Midwives for Midwives and Ixmucane

The data for this descriptive report has been collected in the form of observations, notes, journal entries, informal interviews, and tape recorded semi-structured interviews of TMS, collected by both the professional staff of the MFM and members of its Advisory Board. The physical center for MFM is Ixmucane, a privately owned and operated women's health and birth center in Antigua Guatemala that opened in 1997. The intent of

the founders of Ixmucane was to establish a birth site to model professional midwifery outside of North America or Europe. Ixmucane was named after the Mayan Goddess of creation from the Mayan creation myth the PopulVul. Located in a comfortable old house in Antigua Guatemala, Ixmucane has become a place where women of many cultural backgrounds and socioeconomic levels have felt welcome to come for care. Ixmucane is a full scope midwifery clinic and birth center. It is also a center for learning. Students, midwives and volunteers from many nations come to apprentice at Ixmucane and participate in the project. Classes with various health and wellness themes are taught at the center. There is a lending library available for clients, facilities for viewing educational videos and a meeting place for midwives and other groups.

Early community outreach established a link between the professional midwives of Ixmucane and the TMs of the department of Saquetepequez. One of the founders, a Certified Nurse Midwife (CNM) from the United States began to attend the mandatory monthly meetings for the TMs held at the local health center. As each of the TMs reported their births to the public health nurse, the midwife from Ixmucane noticed that many of the TMs wanted to talk in detail about their experiences but were not given the opportunity at these meetings. The TMs were invited to come to Ixmucane to share their stories and attend a non-hierarchical support group not associated with the Ministry of Health (MOH). Eighteen Sacatepequez midwives arrived the following day. This group of TMs and Ixmucane staff went on to co-develop and pilot the curriculum for the first training in 1999. This cooperative effort led to the formation of Midwives for Midwives.

MFM, now the mother organization that encompasses both Ixmucane clinic and the training program, is a United States non-profit agency and a Guatemalan non-governmental

organization (NGO). The training program that became the work of MFM thus began out of an identified need by the TMs who came to Ixmucane to have some ongoing professional training and support. The self-perception of midwives as a community health promoter and change agent is an important component the MFM trainings. MFM recognizes that midwives must feel empowered to proactively intervene on behalf of the women and families under their care.

At the time of this writing, 93 TMs have undergone training through MFM. The first group of 18 Sacatepequez TM's completed their training in November of 2000. MFM was subsequently approached by a Guatemalan NGO, PAVA (Proyecto de Ayuda de los Vecinos del Altiplano), loosely translated as the Helping Project of the Neighbors of the Highlands). PAVA contracted with MFM to train 28 TMs from the Department of Chimaltenango; this training was completed in November of 2002. The most recent training, completed in October of 2003, consisted of two groups of 25 TMs each from the Department of Quetzaltenango. These groups sent representatives to MFM to negotiate for training. The TMs who have completed training attend between 1 to 7 births each month, with an overall average of 3 births per month. Currently over 400 TMs from all over Guatemala have requested training from MFM and are awaiting funding.

Training Philosophy and Methodology

The MFM training program is grounded in midwifery philosophy. Midwifery philosophy in this context includes the recognition and facilitation of natural processes, use of intervention only when appropriate and necessary, advocacy and education of women and their families, promotion of health care, disease prevention, and the reduction of

maternal and infant mortality. The underlying framework of the midwifery model is the understanding and value of connection; the understanding of relatedness of the body and mind, mother and infant, midwife and woman, and woman and her social context. This model is rooted in the concept of personal knowledge and power as it relates to women's capacity to birth and shares information horizontally. This framework draws relationship and relevance between the individual woman's customs, beliefs, preferences, and values about birth and her body. Midwives seek to empower the women they serve with information and respect her personal right to make decisions regarding her own health, birth and body.

MFM recognizes the TM as a respected and influential figure in the community. The TM is an educator, an agent of change and technology transfer, and can facilitate the mobilization of community resources to ensure better outcomes for mothers, infants, and their families. The TM is also uniquely situated to be a bridge between the community and emergency services. The TM thus has the ability to impact and improve the wellbeing of the community as a whole.

Motivated by the interest of the local TMs and in order to understand the knowledge, behaviors, and beliefs of these TMs, data was gathered by conducting semi-structured interviews with fourteen of the TMs from the Saquetepequez Department in 1999. These interviews were intended to provide background information to MFM about practices that were beneficial, neutral or harmful to the safety of mother and infant from a biomedical perspective. Just as important however, these lengthy interviews enabled the

TMs to speak about their practice of midwifery in the socio-cultural context in which they worked. In many ways, the narratives of these midwives were indictments of the local implementation of the health care system in their Department. In her classic work, *Birth in Four Cultures* (1993), Brigitte Jordan called for a purposive intent for the mutual accommodation of cultural systems. Recording these narratives was thus an attempt to understand Mayan practices according to the criteria of medical obstetrics and to understand medical obstetric practices according to the criteria of the indigenous system. The approach to training this group of midwives was informed by these narratives.

In addition to the initial interviews of the TMs, notes were kept over the course of the 3 years of biweekly support meetings at Ixmucane. These notes reveal both the ordinary and extraordinary concerns of the TMs in their work. Stories of losing a mother to a postpartum hemorrhage, the shame they felt facing members of her family in the street, and wishing they could have done something more to save her life were not uncommon. Almost everyone had a story of disrespectful treatment when transferring women to hospitals; they were yelled at or ridiculed in front of clients and families and not allowed to accompany their client into the hospital. These accounts mark the barriers they face in their ongoing struggle to achieve access to what they need to practice safely as well as some level of respect and legitimacy for what they do.

The MFM training program began out of an expressed desire by the TMs who came to Ixmucane to receive ongoing professional training and support. This quest for knowledge from the TMs was fostered by a relationship of collegiality with the professional midwives, a relationship characterized by respect for each others' work – a unique aspect of this

training. The training was informed by the principles of adult learning and built from the knowledge base of the TMs.

Curriculum Content and Training Intensity

MFM reviewed many sources of curriculum available to train traditional midwives. The curriculum selected was the Hesperian Foundation's, *A Book for Midwives* (Klein 1995). Components from the WHO IMPAC (Integrated Management of Pregnancy and Childbirth) manual and from TM training curriculum from ASESCA (Asociacion de Servicios Comunitarios de Salud, or the Association of Community Health Services), a Guatemalan NGO, were also used. These were selected for relevant and thorough content coverage, and because they both address the underlying social causes and medical consequences of poverty.

The training team is currently led by a North American CNM. Content includes components of history taking; management of normal pregnancy, labor, and birth; identification and management of complications; infant resuscitation; good nutrition; breastfeeding information; family planning; reproductive tract infections; and sexually transmitted infections. In addition, TMs are taught how to accurately take and record vital signs and perform hand skills. Course content is delivered by lecture, by audiovisual aids, group participation and skill demonstration. Training by MFM consists of over 150 contact hours developed around the scheduling needs of the TMs. TMs are given weekly homework and tested on previous course content at every class. Upon completion of the program, each TM gets a Hesperian guide, written course materials, a safe birth kit, gloves and other health monitoring equipment.

As many of the midwives speak a Mayan dialect as their first language and do not speak Spanish well, trainings have been conducted with appropriate interpreters. Level of literacy is also an issue. All content and tests were given both in oral and written form. The TMs from the second and third trainings completed a pre and post-test interview consisting of identical open ended questions conducted by an interviewer in the appropriate language (see Figure 1). Each midwife was also asked to evaluate her experience of the training program.

Follow up and ongoing support

The clinic Ixmucane is an integral piece of the MFM training program. The TMs have an open invitation to bring women under their care to Ixmucane for cooperative prenatal care, obstetric and gynecological consults, and for transfer during labor when appropriate. Phone consultation is a 24 hour option. The biweekly support meetings continue, and the staff at Ixmucane is available to answer questions as well as to conduct workshops on requested topics. The opportunity to work with international professionals, other midwives, and volunteers from the areas of public health and anthropology, has reportedly provided TMs with the gratifying perspective that there is global concern for maternal-child health in Guatemala.

TMs trained through MFM's program also receive professional support through advocacy and collaboration. ACAM (Asociacion Comadrona de Area Mam), translated as Association of Mam Speaking Midwives) is an organization that recently achieved official non-profit status so that it may legally receive donations. Staff from MFM has worked with ACAM and other Guatemalan NGOs to promote unity among organizations of midwives and those concerned with midwives.. The TMs currently serving as president and vice

president of ACAM traveled to conferences in San Miguel de Allende, Mexico in June, 2002 and to Wakefield, Massachusetts, USA, in October, 2002 to attend the Annual Meeting of the Midwives' Alliance of North America (MANA).

Monitoring and evaluation: difficulties encountered

Recognizing the need to comprehensively document the effectiveness of training, MFM developed a preliminary instrument to serve as a data collection tool, a reminder of appropriate patient care and a form of monitoring and evaluating midwifery actions. This four-page instrument developed from the curriculum content contains both text and pictorial symbols. MFM hoped that such documentation would also provide information to assist physicians in the event of women or babies being transferred to their care and serve to improve physician perception of the trained TMs. This intervention was ambitious because the TMs had never before kept records on their clients. Field testing indicated that it was too difficult for non-literate TMs to use. This tool still holds promise for use with TMs who have basic literacy in Spanish.

Discussion

There are three attributes of training that make the midwifery model used at MFM distinctive from other training models. First, traditional midwives are respected sources of authoritative knowledge. Medical anthropologists have long documented the ways in which the export of western biomedical/obstetrical knowledge devalues local forms of knowledge and perpetuates hierarchies among birth attendants (Davis-Floyd & Sargent 1997). These hierarchies inform most training processes but are often not acknowledged. Documenting and sharing local knowledge within midwifery training both acknowledges traditional

midwives as a source for legitimate knowledge and serves as informal cultural exchange between midwives from different places.

Second, training in the midwifery model strives to create non-hierarchical relations between the trainer and the trainee and solidify the bonds between midwives from different national, educational, socioeconomic, and cultural circumstances in their common avocation. One of the selection criteria for trainers at MFM is that they be clinicians themselves, allowing for an interactional flow of information. This model demonstrates respect for difference, encourages critical thinking, and supports trust and intimacy. These characteristics are necessary to provide a learning environment conducive to the preparation of individuals to be independent, critically evaluative practitioners who intervene when appropriate and transfer care when necessary.

Third, the MFM model continues to provide support and ongoing training through contact with the professional midwives at the clinic Ixmucane. This continued relationship is an important step in the personal development of TMs as participants in a formal health care system. Eventually TMs need to participate in the development and naming of their own values, goals and standards of care and regulation. MFM is attempting to build bridges between several different midwifery groups in Guatemala to create unity between midwives and have one voice in public policy.

TMs are the essential connection in Guatemala between community members who need medical or obstetric care and the providers of such care. From MFM's standpoint, TMs are the agents of that connection, and with the information and encouragement provided by the MFM course, they are capable of identifying areas of concern and taking appropriate action. No matter how well trained and proactive the TM, links with essential

obstetric services in the nearest available health facility are critical for emergencies. Currently MFM is attempting to strengthen those linkages and develop working relationships with the public health sector so that TMs may transfer their emergency cases in a timely fashion without fear.

While the approach to training is distinctive, MFM still searches for the most effective way to evaluate its training program. Data is recorded on all clients who come to Ixmucane clinic in Antigua escorted by their TM; in these cases maternal/infant outcomes are recorded. Discussions among staff are ongoing regarding how to systematically document improvements in practice beyond anecdotal reports by the TMs themselves. The instrument to measure the effectiveness of MFM training will continue to be refined, particularly to address reliability and validity. Future research needs to focus on evaluating the referral rates during maternal-infant complications with TMs trained from this model in comparison to controls not trained in this model.

In summary, the urgency to document the outcomes of training traditional midwives has placed little focus on the characteristics of the training programs. This article has described the characteristics of one training program and the challenges encountered in assessing and documenting the efficacy of that training. Training based on a midwifery model, using adult learning techniques with provisions for ongoing support offers an approach that has not been emphasized in other programs from our literature review. We hope the MFM model is successful in improving maternal and infant outcomes in Guatemala, that the work of MFM inspires other professional and traditional midwives to work together, and that the nature of training contributes another essential dimension in the discourse about training efficacy.

Figure 1 Midwives for Midwives Post Test/Final Exam

Pre/Post-Test Interview Topic Guide

Midwife's Identity and Characteristics

Review with her personal information: where she lives, how many years midwife, how many deliveries….

What makes you a good midwife?

What are the characteristics someone needs to be a good midwife?

Clinical Assessment: Prenatal Care and Pregnancy

What do you do when a pregnant woman comes to you for her first visit?

Do you do anything different at prenatal visits since your training?

History Taking
What personal info do you ask a woman when she comes for her first visit?

Do you take a full medical history? What questions do you ask?
(Probe: medical, surgical, menstrual, gyn, ob, family, soc/psych)

What do you do with the answers?

How do you encourage good communication between you and your women?
Probe: communication problems - how solve?

Do you make plans ahead of time with the patient and her family in case she has serious complications or needs to transport to the hospital? What questions do you ask? Do you talk to anyone in the family about this?

Healthy Behavior and Nutrition

What foods do you recommend for pregnant women?

What are healthy foods that have: Iron
Calcium
Protein
Folic Acid

What behaviors do your recommend to a woman to maintain good general health during pregnancy? (hygiene, rest, clean water, avoid contamination, wash food)

Reproductive Anatomy and Physiology

Do you have a good understanding of the parts of a woman's body?

If a woman wants to know about her menstrual cycle what do you tell her?
Probe: What's a normal cycle like
First and last day
When is she fertile, ovulating?

Prenatal Exam
How do you know when a woman is pregnant? What questions do you ask her?

How do you assess her due date?

When are you concerned about a woman's weight gain?

Do you determine the position of the baby?
What positions are there?
What do you do if the baby is malpositioned?
(Do you turn it? When is it a problem? When is it okay?)

How do you examine the mother?
Probe: weight, blood pressure, fetal position, uterine growth, (want to see uterine growth at each visit?)
lab tests: ever done and why?

What are some common complaints during pregnancy? Which ones are normal/serious?

What do you recommend if she complains of:
Nausea or vomiting
Elimination
Mood changes, nightmares, sexual feeling and fears
Varicose veins
Thick, white fluid (when is this abnormal?)
Sore breasts
Small contractions during first 3 months

Any other complications that can occur? What have you seen? What did you do?

Labor and Delivery
How do you prepare for labor?

Tell me everything you do when you arrive at a labor
Probe: what questions do you ask, advice do you give?
What is important to know about the mother, about the baby?

How do you know when labor starts?
How do you determine if it is a real vs. false labor?

What are natural ways you maintain a normal birth?

Do you remember the step-by-step method of problem solving discussed in the training?
When you have a problem in labor how do you solve it?

How do you prepare for a delivery?
How do you know baby is ready to be delivered?

What are the labor positions most women use? What do you recommend?

Explain what you do when deliver the Placenta?
Probe: Signs to deliver
Normal vs. too much time
Examine it? Why?
Normal vs. too much blood
Action if it doesn't come

Labor complications

At what point is labor considered too long?

What are the signs of some complications during labor?
*Probe for experiences /actions....

(Probe: prematurity, fetal distress, meconium during labor, bleeding during labor, prolonged labor, stuck baby (shoulder dystocia), breech, twins, retained placenta, too much bleeding after birth, imcomplete placenta, vaginal/perineal tears, postpartum infection)

What do you do if a complication is very serious?

Specifics:
PPH

Tear
Retained Placenta

What are the signs that a baby is healthy when it is born?
What do you do if the baby does not cry? Isn't breathing?

Post-Partum

What happens after the birth?
How long do you stay?
What info do you give the mother? Give the family?
How often do you make visits? Do you do exams? Explain.

Breastfeeding/Lactation

Do most women nurse?
What are the advantages of breastfeeding?
What advice do you give about breastfeeding?
    How do you stimulate milk production?
    Any problems women have nursing? How do you help?
    How long do you recommend they nurse?

What are the signs of a breast infection?

STIs and Family Planning

What is your experience with women with STI's?

    Probe: What are the most common STI's that you see?

    How do you treat STI's?

Do you provide family planning for the women?

    What methods do you teach?

    Modern vs. traditional methods?

Community Empowerment

What are some of the reasons women die in childbirth/pregnancy? Do you know how many woman die out of every 1,000 births?

What are some of the resources available in your community? How do you use them? Any resources that you don't use? Why not? (probe for positive/negative. experiences)

Transfer or Referrals: Since you've completed the training, what types of things have your referred women for? Was the care/attention received helpful?
How do you think care from hospitals could be improved?

MFM Training

- How have the trainings made you a better midwife?

- What did you learn from the training?
  What did you: like/ not like
  using/not using?

- What things are you doing that you didn't do before the training?

- Before the MFM training, did you participate in trainings held by Centro de Salud? (If yes): How were these trainings different then those you received at Ixmucane?

- Did you attend all the classes?

Do you come to the follow up meetings (why? what do you learn there? Do you think they are important)

Do you think it is important to have meetings with other comadronas apart from the ministry of health meetings?

Basic Concepts

Now I'd like to talk about some of the things you learned in the training.....

Do you remember the difference between traditional and modern methods?
How do you recognize if a method is beneficial, harmful or without effect?
Can you tell me about a beneficial modern method? (harmful)
a beneficial traditional method? (harmful)

General Satisfaction

What do you have to say overall about the training you received at Ixmucane?
Any changes you would make?

What was the most important thing you learned? What do you want to learn more about? Any suggestions for topics at future trainings

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