Memories of a WHO expert in midwifery

Joan Bentley

Much of the health infrastructure we now take for granted is the result of determined efforts made in the 1960s and 1970s. The objective was relatively clear: to help build up strong national health systems. But to do that an uncommon amount of energy and imagination was needed.

Once retired, one has time to reflect on the efforts and heartaches, the joys and miseries of working in the field. Whatever the outcome, I always had the sense of being where it mattered and at the core of WHO's purpose. Of course, WHO did have lots of other activities that were invaluable to international health, but its major aim was to improve the health of people through the development of national health services, and that is what we fieldworkers were trying to do.

Starting a new life

The shocks of a first assignment started with a visit to the imposing headquarters of the Organization, at that time housed in the Palais des Nations in Geneva, for briefing. This was to provide me with information about WHO, the country of assignment and activities there to date. But every time I began to get into reading through the mountainous piles of reports, I was called to Finance, to Administration, to Personnel, to Travel, to Medical, or to see the various people connected with my assignment. It was enough of a headache to find out where I was supposed to be and when.

I had expected to be told during this briefing exactly what the Organization wanted me to do, but to my horror I was told "Miss Bentley, you have been recruited as an expert in midwifery: it is up to you to decide what needs to be done, and find a way of doing it". I had never thought of myself as an expert. I left Geneva in a whirl of indecipherable information hoping there would be time to sort it out when I got to the Regional Office for the Western Pacific, in Manila, for my next briefing. As it turned out, there was not time, and there were still no directives, but I felt that there at least were sympathetic ears and expertise that were not too far away in case of need. Everyone was very helpful and I was readily included in meetings and social activities.

Two people made a great impression on me. The first was the Regional Director, Dr Fang. This kindly and wise man, responsible for a vast area, had time to talk...
to field staff, and to give generously of his knowledge of the country of assignment. He knew every field staff member there by name and by project responsibility – this at a time when field staff were numerous. The second was the Nursing Adviser, Miss Turnbull, who warned me: “Don’t go rushing in. Take your time. For the first three months, keep your eyes and your ears open at all times and your mouth firmly shut.” Brilliant advice, but hard to follow in view of all the things that needed to be said and done.

It is sometimes difficult for people today to realize or remember that when WHO began its work 50 years ago there were many countries that had few doctors, fewer nurses and even fewer sanitarians. Those that existed worked mostly in hospitals left over from various colonial services. Each variety of colonialism had left a different imprint on the nation it had occupied and it was necessary to work with this initially until enough nationals had acquired the skills needed to bring in the necessary changes. Part of the training strategy was to send them on short travel fellowships to see how things were being done in other countries. Once the fellows returned they could explore new ways of

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organizing services and teaching staff to function more effectively for national health service development.

Health statistics were frightful by today’s standards. Maternal, infant and child death rates were very high, to say nothing of the drain on a nation’s health of illnesses such as malaria, yaws and smallpox, and the appalling spectre of malnutrition in its various forms. Into this kind of situation I was launched as a midwife teacher in 1960. Of course WHO had had nurses and midwives, a well as other staff, in the field since the early 1950s, and intense efforts at improvement were being made nationally, but working conditions were still often indescribable. There was, for instance, little or no linen on the beds. The laundry service, if it existed, was minimal. If there were sterilizers there was insufficient power supply to boil water.

Typically, electricity and running water over a 24-hour period were unheard of. The equipment available was minimal, as was the supply of drugs and disinfectants. Without UNICEF as a major supplier of equipment at that stage, the work would have been well nigh impossible. The initiative and inventiveness of those early WHO nurses and midwives were remarkable. Of course, not all situations were so bad, but WHO’s major priorities were focused on the poorest countries, where health services were being started virtually from scratch. Once this was under way, the main concern was to train teachers in the health professions, create programmes suited to the national situation and have a regular intake and output of students to staff the health services. However it was done, it was going to take time, particularly as nursing was usually the last choice of young people entering education programmes, since nurses were paid so much less than other professionals.

WHO nurses usually functioned as teams. Team members were recruited and assigned on the basis of their qualifications and experience, then thrown together and expected to work together. Coming from
different backgrounds, with different training and experience, often with strong personalities formed during the trials of the Second World War, it was not always easy to work as a group. But the group was essential as a sounding board for ideas, for assistance in putting those ideas into practice, and for critical appraisal. When they got on well together and when one person’s strengths complemented another’s weaknesses and vice versa, great things could be achieved. This was usually left to chance, however. How much better it may have been if the team leaders had been selected more carefully from tried and tested experience in previous WHO assignments, and asked to choose their own teams. After all, Everest is not conquered by climbers haphazardly put together by some administrative authority.

Working with national counterparts was a new experience for most of us. Before anything constructive could be done, we had to find out about each other’s experience and training. This involved visiting the hospitals, where much of the training would take place, and rural areas to learn about the people, the culture, the distances to be travelled and the problems to be faced by future graduates of the programmes. These visits helped to establish mutual confidence and prepare for future joint planning and decision-making. They provided the starting point for answering questions such as: how should the curriculum be shaped? How much theory and how much practice? How could the teaching hospitals be used for practical experience? How could practice take place in rural areas and what form could it take? Who would supervise all this practice? How many young people were leaving school and at what educational level? Should more than one category of staff be trained? We had to learn how to confront Directors and Ministers of Health with our ideas, which had to fit in with the plans for national health development and in any case had political and financial implications. Eventually, with much give

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and take on both sides, a curriculum emerged and was distributed among counterparts. Each class was prepared with the counterpart, and as rote learning had been the only previous method used, new approaches to learning had to be introduced at the same time. For some it was a challenge, for some it was a delightful adventure, and for others it was all too much and they became difficult to work with.

Major difficulties arose in wards and departments where students were to gain practical experience. The hospital staff saw the teaching staff as outsiders, and we had no authority to criticize or change things, however wrong we felt them to be. WHO staff always had difficulties with choosing between the practice field and the school as their main priority, as there just wasn’t time to do both. We could not automatically count on the support of medical staff either, in our attempts to improve the quality of care. I found that by and large the more recently qualified medical staff were, the more cooperative they were.

**Being an old hand**

As one became more familiar with the country as a whole and its midwifery problems, and as teaching counterparts became more confident, other approaches could be explored. For example, where I
was in Cambodia, rural midwifery aides were being trained in the hospital, learning theory by rote from notes copied from the blackboard, and getting their practice mostly at night with little supervision. This provided them with little knowledge or skill to take on the enormous responsibility of practice in isolation in rural areas. It would be much more realistic to do at least part of their training where prenatal, labour and postnatal care could be taught and demonstrated in a village setting. A proposal for doing this was formulated and approved by the government. A suitable area of 20 villages was selected in consultation with the senior provincial medical officer, the villages were consulted to ensure their cooperation, money was obtained from the private sector to build a teaching and residential unit for 16 students and a teacher, UNICEF provided midwifery kits, and the project started. The WHO counterpart to the teacher slept on a couch in the classroom-cum-dining room.

Two trained rural midwifery auxiliaries practising in the project area were enlisted as practical teachers and supervisors. Traditional birth attendants were identified early on in the village visiting, as their cooperation was essential if pregnant women were to be reached early enough to affect the outcome. Getting groups of students and their teachers to the 20 villages, some of them 10 kilometres away, posed a problem. Roads consisted of village lanes and were flooded in the wet season. Discussing the problem with UNICEF, bicycles were proposed. None of the local women had ever ridden a bicycle but it was acknowledged to be a potential solution, and ultimately 20 bikes arrived for the project. Nowhere in my job description did it say “Teach students and counterparts to ride bicycles” but it had to be done, and it was a hilarious experience. Villagers came in crowds to watch, and everyone enjoyed the entertainment. The students were keen learners and soon all were confident enough to ride without disastrous wobbling along the narrow banks between paddy fields.

The students were divided into groups. Group 1 were “housekeepers”. Their job was to take the day’s budget to market and buy and cook the food for all of us. They had to clean the house, kitchen and toilets and see the water jars were always full. Group 2 was “on call” in case of home delivery, and used the day otherwise to study or relax as there was no day off. Groups 3 and 4 made antenatal and postnatal visits to villagers, having first planned the route and the pattern of care. They were accompanied by a teacher. These responsibilities rotated on a daily basis unless one team was caring for a mother in labour or who had just given birth. The work day started at 6 a.m., and village visiting was completed by 1 p.m. Following lunch and a siesta, the afternoon from 4 to 6 p.m. was reserved for teaching or discussion, completion of assignments, and writing reports of visits. It was a rewarding pattern of activities for the students, the teachers and the WHO staff member. After two months the students returned tearfully to the hospital setting and the next group of 16 arrived. The enthusiasm generated by this project brought visits by other WHO staff, the
Minister and the Director of Health, and even the Head of State.

In the needier countries WHO staff were quite numerous. Not only was there a nursing education team but a maternal and child health team, a rural health team working with health centre staff, a malaria team, sanitarians, and teams for other diseases such as tuberculosis, yaws and leprosy. In fact some places were awash with experts. I always felt that though we knew each other socially, we had too few opportunities to coordinate our activities. As WHO developed, these problems were overcome to some extent by regular meetings which brought us all together to share problems and achievements. These meetings helped to make us aware that we might gradually be getting somewhere in our efforts to solve local health problems.

The coordinator of all efforts and the formal link between field staff and the Government was the WHO Representative (WR) for the country concerned. Most good WRs had themselves been fieldworkers, and in my experience they were good communicators to whom I could turn for advice and support. Through their good offices with Ministers and Directors of Health, many a rough path was made smooth. The WR was also the intermediary for contact with other United Nations bodies, such as UNICEF for project supplies, and UNESCO for information on school leavers. In the early days there were few nongovernmental organizations in the field. As their presence grew they saw the WR as a focal point for health and we were encouraged to visit them and share information.

Relations between field and Regional Office staff were excellent. The latter made regular visits to see projects and counter-parts, and took up pressing issues with government officials, so that activities could be planned on a realistic basis. The Regional Director made an annual visit and insisted on meeting all field staff before his meetings with the Government.

On home leave, which was every two years, we were expected, if at all possible, to travel via Geneva and stop there for a couple of days. Headquarters staff rarely made country visits, so it was useful for them to get a firsthand account of what was going on, and helped to bring our quarterly reports alive. As my experience in the field grew, I became more confident about discussing strategies for strengthening midwifery nationally and selecting candidates for fellowships.

By the 1970s WHO policy had changed, and a stronger emphasis was placed on extending health services and developing management strategies. Sadly, the return of new graduates from the WHO fellowship programme coincided with a severe reduction in WHO field staff. This left the graduates with little support for applying their newly acquired aptitudes. Following my own postgraduate studies, I was assigned to a group of small island countries in the South Pacific, working from the Fiji office. These countries were too small to make a resident WHO nurse or midwife economically feasible. Instead, with a colleague responsible for education and myself responsible for health outreach and management, we visited each country according to need.

During the first visit we could find out from health officials just what was needed, draw up together a draft programme, designate a counterpart to supervise it, and agree on dates for future visits. Subsequently, in-country visits would be
planned with the counterpart to assess the quality and quantity of care selected health centres were providing. Corrective measures had to be devised and sometimes the counterpart had to be helped to carry them out. After that, visits were made for the purpose of solving problems, and became less frequent as the counterpart became more competent.

WHO staff covering these countries were a close-knit group and we worked well together. As we returned to Fiji or set out for another island, a great deal of information was exchanged between the educator, the nutritionist, the sanitary, and of course the WR. Each country had different problems and they had to be solved in different ways, given the many differences of culture and living conditions. Our initiative and inventiveness were taxed to the limit but at least we could never complain of boredom. The many challenges we had to grapple with kept counterparts on their toes as well, and they were often rightly proud of what they had achieved during our absence. Mutual respect was of the highest order and we felt that senior health officials genuinely appreciated our efforts and those of their own staff. It is my belief that if this sort of activity had been possible in more countries, much more would have been achieved in getting quality into expanding rural health services.

In short, it was hard work but it was extremely satisfying. I did not feel like that all the time – for instance soaked to the skin in a tropical rainstorm in the New Hebrides (now Vanuatu), having to paddle a canoe across an inlet with a sick counterpart, not knowing if the thing would keep afloat long enough to get us back to the mainland; or trying to help a student in the Gilbert Islands (now Kiribati) to deliver a primigravida in a hut at night with only a candle for light and far from any medical help; or discovering that a counterpart had let me down, or that a lesson planned was totally inappropriate for the level of understanding of the students concerned. Also, living conditions were difficult, but then, none of us expected the Ritz. All such things were compensated for by knowing that we were at the heart of a serious international effort to improve the health of the ordinary people leading a gruelling life in some of the least developed countries in the world.