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ROLE OF THE MIDWIFE  
IN  
FAMILY HEALTH.

REPORT  
OF THE  
FRANCOPHONE  
WEST AFRICAN WORKING GROUP  
DAKAR, SENEGAL  
17th - 23rd November, 1974  
US-AID GRANT NUMBER CSD 3411

Organised by:

THE INTERNATIONAL CONFEDERATION OF MIDWIVES

In Co-operation with:

THE INTERNATIONAL FEDERATION OF GYNAECOLOGY & OBSTETRICS

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## INTRODUCTION

The seminar of the French speaking countries of West Africa on the subject "The Role of the Midwife in Integrated Family Health Services" was held in Dakar, Senegal, from the 17th to the 23rd of November, 1974. Sponsored by the Joint Study Group of the International Confederation of Midwives/International Federation of Gynaecology and Obstetrics (ICM/FIGO), this seminar was the sixth of a series of such meetings which are being held around the world in order to assist nations in the formation of plans to achieve the ICM/FIGO aim :

"To continue the improvement of maternal and child care and the quality of maternal and child life through the inclusion of family planning among the services provided by midwives of all categories in their expanding role".

The rationale for this world wide project of the Joint Study Group is the need for the health professions, particularly midwives, to be well informed and well skilled in this increasingly important component of good maternal and child health care. Because of her intimate contact with mothers during their reproductive period, the midwife can be a particularly effective worker in all the preventive services which protect the health and improve the quality of life of mothers and children. The Dakar seminar was concerned with her expanding role in family health in view of priority health problems in West Africa.

Participants in the seminar were senior midwives and obstetricians from seven countries :

- Ivory Coast
- Dahomey
- Mali
- Mauritania
- Niger
- Senegal
- Togo

They were assisted by a group of experts, selected mainly from the participating countries; by representatives of the nursing and assistant social professions; and by staff of the ICM.

Several months before the seminar, visits were made to the countries of the region to explain the purpose of the meeting and to solicit official support and attendance. Of those invited, only two countries - Upper Volta and Guinea - chose not to send representatives. Mrs. Kone-Diabi, ICM Regional Field Director for Francophone Africa, was responsible for planning and organising the seminar. She was assisted by other ICM staff and consultants and by a local planning committee composed of :

- Miss Pellegrino
- Mrs. Siga Sene
- Mrs. Rama Gueye
- Mrs. Amanatou N'Daw

Professor Correa, Chief of the Department of Obstetrics and Gynaecology, Faculty of Medicine & Pharmacy Dakar, served as Chairman of the seminar.

## OBJECTIVES

The objectives of the Working Party held at Dakar were as follows :

1. To centralise all data concerning the present position of maternal and child health services and family planning and to outline the scope and training of midwives of all categories in their own country.
2. To identify the common basic maternal and child health problems and existing needs with special reference to nutrition, family planning, child care and health education and the means of reaching the people deprived of these services.
3. To examine what professional capacities of the midwives of all categories could be developed to provide for these needs.
4. To define broadly what should be included in the new professional training curricula of midwives in each category.
5. To consider the changes necessary for the implementation of a new professional training programme, including :
  - Government support on proposed changes,
  - Legislation,
  - Training regulations,
  - Curriculum amendments,
  - In-service practice or refresher course,
  - Professional association with the traditional birth attendants.
6. To work out a plan for the implementation in each country of the recommendations made at the Working Party.

## OPENING SESSION

Representatives of the Government, the University, the medical and paramedical professions and many international groups recognised by Senegal, attended the opening session.

Mrs. Kone-Diabi, the francophone Regional Field Director of the International Confederation of Midwives, gave in her address a summary of the topics and discussions of the Working Party and emphasised not only the complexity and controversies of the subject of family planning but also the advantages of finding a solution for the promotion of health and well being of the Family, taking into account socio-economic conditions.

Professor Correa, obstetrician-gynaecologist and Chairman of the Working Party, congratulated the International Confederation of Midwives for their initiative in organising such a meeting where seven African countries are given the opportunity to exchange their views and experiences on a number of ambitious and exciting current issues such as nutrition, sterility and family planning. Professor Correa is convinced that the midwife, the basis of our health structure and support of our culture and traditions, will know what material of foreign origin is to be accepted or rejected.

On behalf of the Faculty of Medicine and Pharmacy of Dakar, Professor Sankale quotes in his address ... "many factors have an influence on the quality of life but, chronologically and emotionally speaking, the love and care of the mother are crucial. The mother's role can only be enacted if she remains alive, is healthy, has time and has money. All that goes towards the improvement of her physical and emotional conditions will contribute to the future security of her children and her family. Family planning, and birth control as a contributory factor, are both irrefutably identical means of social and economic development and therefore of life" ...

... "but the spacing of children is a complex problem to be tackled with lucidity and tact" ...

Speaking on behalf of Miss M. Bayes, Executive Secretary of the International Confederation of Midwives, Mrs. Denison gave a brief history of this organisation, its objectives and world-wide plans to improve the quality of mother and child health services with emphasis on the training of traditional birth attendants.

In the concluding address, Dr. Papa Gaye, representing the Ministry of Health & Social Affairs of Senegal, stressed the importance of caring for the most vulnerable group in our society, the mother and child. He does not doubt the beneficial role of family planning but insists that professional ethics and public authorities are the decisive elements in deciding the policy to be adopted.

## METHODOLOGY

The programme of the seminar was organised around five themes:

1. Problems and Priorities in Maternal and Child Health in West Africa ;
2. Search for a Common Concept of Family Planning for West Africa ;
3. Organisation and Development of Family Health Services including Family Planning and the Role of the Midwife in these Services ;
4. Integration of Family Planning in the Training of Midwives of all categories ;
5. Place and Role of Traditional Birth Attendants.

After the opening session, the participants at the seminar spent a full day considering each of these major topics. Each day was divided into two parts. In the mornings, technical papers were given by specialists in each field and in two instances, field visits were made to pertinent projects in Senegal. These served as background for discussion by the participants each afternoon. For these discussions, the participants were divided into three working groups.

Each group included representatives from each of the seven countries as well as a male nurse and a social worker. These latter were invited to participate in order to make the groups more representative of the health teams which exist in the countries of the region. Reports of the conclusions of each group were given in daily plenary sessions by rapporteurs elected each day by their groups. These daily reports were summarised by the Working Party secretariat and formed the basis for the final report and recommendations. This final report was adopted unanimously by the participants on the final day of the seminar.

The conference secretariat, elected by the participants, was composed of Miss Pellegrin, Mrs. Siga Sene and Mrs. Fone-Diabi.

## REPORT OF THE WORKING GROUPS

### PROBLEMS AND PRIORITIES IN MATERNAL AND CHILD HEALTH IN WEST AFRICA

In his paper on maternal and child care in West Africa, Professor Alihonou emphasised the importance of maternal and child health within the basic health services and considered the problems on this issue from different angles.

#### COMMON ANGLES

There are problems of:

- undernourishment and malnutrition,
- infectious diseases,
- parasitism,
- anaemia,
- absence of reliable statistics,
- limited means, especially in rural areas,
- poor hygiene.

#### MATERNAL ANGLE

Although it is impossible to give an accurate percentage, the birth rate and maternal morbidity are high. The mortality rate is approximately 1 per cent against 0.6 per cent in Europe.

#### CHILD ANGLE

The main problems in this category are: neonatal tetanus, respiratory diseases, obstetric trauma, measles. A high-risk pregnancy leads to perinatal mortality more than to maternal mortality and Dr. Papa Gaye in completing Dr. Alihonou's statement emphasised the fact that maternal and child health was a Third World problem due to:

- low inland revenue,
- primitive working conditions,
- economic reliance on developed countries,
- poverty and ignorance

The reasons for high maternal and child mortality and morbidity rates are :

- lack of supervision at delivery,
- inadequate care of the baby born under these conditions.

The key to these problems is of a comprehensive nature including the establishment of maternity clinics open to all mothers, training of adequate personnel, education and instruction of the population and making plans for health. Although priorities are difficult to determine, a selection must be made to use what is best available.

Professor Vovor is of the opinion that, although family planning is necessary, it is not yet essential in our countries. There are demands but it is a problem of a personal nature.

During the group discussions that followed, members agreed that the main problems of maternal and child health in West Africa were the same, although certain local characteristics existed.

The common problems are :

1. SOCIO-ECONOMIC AND CULTURAL CHARACTERISTICS

- Ignorance of rural populations on health matters,
- Strong traditions prevent health education,
- Low percentage of school attendance by rural population,
- Influence of poor income and low purchasing power of money,
- Economic dependency.

2. HEALTH ASPECTS

- Inadequate health services especially in rural areas,
- Shortage of staff and uneven distribution of personnel allocated mainly to cities although 70 to 80 per cent of the population live in rural areas,
- Insufficient pharmaceutical preparations,
- The unfriendliness of the health centre brings women to choose the services of the traditional birth attendant.

- Insufficient transport facilities and poorly maintained vehicles,
- Absence of supervision.

#### ADMINISTRATION OF SERVICES

Health centres provide free care and most of the town hospitals are fee paying.

Services are reliable in:

- Permanent institutions,
- Maternity hospitals,
- MCH centres,
- Health clinics,
- Itinerant stations or mobile teams.

Nature of services:-

- Gynaecological care,
- Prenatal care,
- Baby care,
- Inoculations,
- Deliveries,
- Social services.

Care is provided by:-

- Physicians,
- Midwives,
- Nurses,
- Social workers,
- Traditional Birth Attendants.

The seminar recommended that traditional birth attendants be given a proper training and a close supervision as they take care of most deliveries in rural areas. In Togo, an attempt is being made to resolve the problem by giving an 18 months training period to young women with primary school education who will then work in rural areas.

## THE MOST DEPRIVED GROUPS

These groups are :

- Rural populations,
- Low-income people,
- Children from 0 to 5 years of age,
- Mothers.

Participants agreed that in areas with health centres, part of the population prefers the traditional birth attendant because of her availability.

## SOLUTION TO THE PROBLEMS

In order to promote a solution to the problems

- 1) The midwife must be represented in government decision making organisations,
- 2) The midwife must be given a polyvalent training,
- 3) There must be efficient supervision,
- 4) The midwife must have training in education, organisation and administration
- 5) Close co-operation between all members of the team is essential,
- 6) The traditional birth attendant should be integrated into the health team.

## REPORT OF THE WORKING GROUPS

### SEARCH FOR A COMMON CONCEPT OF FAMILY PLANNING FOR WEST AFRICA

The following people expressed their views :

- A population statistician,
- Representatives of the two main religions - Christian and Islamic,
- A journalist newspaper columnist,
- A sociologist,
- Specialists - obstetrician, midwife and paediatrician.

After hearing the viewpoints of the above, the following remarks were made in searching for a common concept :

- 1) Family planning, interpreted as birth control will not solve the problem of the rapid population increase in our region (2.6 per cent per year) especially as the value of such a policy would not be seen for a long time.
- 2) It is recognised that better standards of living and the improvement in the status of women are accompanied by smaller families.

The seminar then studied the basis and characteristics of an African family :

- 1) Broadly speaking, Africa is pro natal and couples are encouraged to reproduce : maternity means stability for the married couple - sterility leads to polygamy and divorce;
- 2) Traditional rites are part of sex education;
- 3) In our so called traditional societies, family planning in both the aspect of birth spacing and the treatment of sterility is in practice;
- 4) Rules of conduct dictated by religious beliefs or animism are accepted by all.

Some definite points emerge from these characteristics :

- 1) Breast feeding must be encouraged because it contributes to the establishment of a close mother/child relationship;
- 2) From the religious point of view, family planning has a positive effect when it brings happiness to the husband and to the family; the problem of the techniques used lies with the conscience of the individual;
- 3) The African family accepts family planning as :
  - a) Treatment for sterility;
  - b) Spacing of births,

and in this sense it forms part of the family health services.

Family planning is aimed at regulating fecundity and thereby pregnancy which must never be terminated except if the mother's health is at risk.

Family planning must :

- help to fight sterility
- respect the biological rhythm of the family,
- promote breast feeding,
- encourage the father to take a more active part in family life,
- educate youth and adolescents, understand and recognise their responsibilities in sex matters.

On the basis of the above facts, the seminar attempted to define the concept as follows:

Family planning is interpreted by the midwife as the sum of cultural, psychological, educational, socio-economic and technical means which are freely available to the married couple and the community - thus improving the quality of life and giving fulfilment and harmony - thereby leading to the birth of wanted children.

During the discussions that followed, the question was raised of the attitude of African governments to population growth control but in Mr. Savane's opinion

the African attitude is not easy to define since each country has its own views on the matter. The wish to limit is easier than the actual limitation itself and it takes 20 years to get results. Countries such as Egypt, Pakistan, Ghana and Kenya have had nothing but disappointment in their population control. Problems of development, different from those of limitation, are poverty and ignorance. The problems of population growth must be considered with a new approach if effective solutions are to be found. Cameroon believes that it can still let its population increase ; Ghana had a population policy but has since reviewed its programmes ; family planning and birth control are tolerated in Nigeria but there is no government population control policy. One does not advertise a population control policy. Problems must be reviewed in a broad way in order to achieve results.

The question was raised of the possibility of reaching an intervening attitude between the Islam and Catholic religions. Mr. Samb emphasised the fact that both religions have heavy responsibilities. According to Abbé Diouf, the difference lies in the means by which family life is promoted.

Mrs. d'Erneville stresses the fact that Africa has had the wrong introduction to family planning and that its ground was badly prepared. She underlines the needs for population information by broadcasting. The Senegal Broadcasting Corporation attempted to popularise certain issues by calling on the help of technicians, e.g. midwives, physicians, etc. in order to approach some taboo subjects. Broadcasting and popularisation of such delicate problems as sex education and family planning must be done with great caution.

Participants agreed that sex education should be given at school. Mrs. Savane pointed out that schools reach only part of the population. Only public authorities are able to act in a positive manner. Only if sex education is understood, can it function properly. Public authority must adopt a definite attitude. There is a psychological and pedagogical problem in that the young people of Africa are unaccustomed to a straightforward and natural approach to sex education.

## REPORT OF THE WORKING GROUPS

### ORGANISATION AND DEVELOPMENT OF FAMILY HEALTH SERVICES INCLUDING FAMILY PLANNING AND THE ROLE OF THE MIDWIFE IN THESE SERVICES.

The topic for the third day of the seminar concentrated on the organisation of family planning services and their integration within the structure of maternal and child health.

Dr. Sassoun Diop Leye outlined the arguments in favour of this integration and gave three groups of reasons :

1. MEDICAL

A close relation exists between the number of pregnancies and the maternal and child mortality and morbidity rates.

2. EFFECTIVENESS

Maternity services constitute the best opportunity for motivation.

3. PSYCHOLOGICAL

Integration within the existing structures ensures anonymity.

Dr. Bocar Sall gave an account of the national programme of control of births in Mali. He explained the reasons which brought the Mali Government to consider a family planning programme.

- Strong demand by the population,
- Multitude of criminal and illicit abortions,
- Exorbitant charges by practitioners which restricted family planning to the more wealthy women.

This expansion programme has been in action for only two years, a proper evaluation cannot therefore be made.

In her statement, Miss Nalder emphasised the necessity of making an inventory

of the existing means. It is essential indeed to make the maximum use of resources to meet the specific needs of our countries.

During the third day of the seminar, the group discussions were devoted to "the role of the midwife within the structures of the family health services".

From a first glance at the three group reports it appears that the midwives have considered their respective roles before determining the organisation of the various services.

A more detailed examination shows the following :

1. THE ROLE OF THE MIDWIFE

The midwives expressed their roles differently but the six following points were emphasised. The role of the midwife in :

- Information - Education,
- Administration,
- Medical and Paramedical services,
- Research,
- Evaluation.

2. ORGANISATION

With a view to increasing efficiency and allowing for poor financial resources and the infrastructure of our countries, the midwives recommended the integration of family health within the existing structures of their countries.

3. LEGISLATION

It is clear from these reports that the midwives at the seminar consider that a predominant place should be given to legislation to safeguard the mother and child by defining the responsibilities of each member of the health team ; they would also like to see the establishment of an insurance scheme for the protection of the practitioners in the event of complications arising.

## REPORT OF THE WORKING GROUPS

### INTEGRATION OF FAMILY PLANNING IN THE TRAINING OF MIDWIVES OF ALL CATEGORIES

The theme for the fourth day of the seminar was devoted to training.

Miss Pellegrin presented a training programme for midwives in which family planning was integrated. The reasons given for the need for this training are as follows : the evolution of our societies accompanied by an increased demand for contraception ; the development of the maternal and child care concept towards a broader aspect of care for the family ; the evolution of the role of the midwife, a role which is no more restricted only to delivery.

Miss Pellegrin described the objectives governing the training and gave an example of the training programme in Dakar. The objective in training is not focused on family planning, but the programme has been divided into sections with different themes in order to make the students respond to the problems of the family.

First Year : Anatomy, physiology, relationship, psychology, etc. of the human being;

Second Year : The family unit is an integral part of collective society in which humanity is replaced by reproduction. Obstetric, paediatric, legislative, psycho-sociological study of the family;

Third Year : Public health : Preventative measures, education, information. The programme for the third year includes education in contraception and sterility within the socio-obstetrical and paediatric concept.

In concluding, Miss Pellegrin emphasised the need for improvement and continuity in sociological training. She underlined the difficulty in finding paediatric training methods and, therefore, a frequent evaluation is essential.

When he presented his paper, Dr. Castadot outlined the principles to be followed for the implementation of a training programme for midwives of all categories.

It is vital to provide the population with proper care in the shortest time possible within the financial resources available. Each country must solve its

problems according to its characteristics and needs, its desired professional standards, the work to be done and its working conditions.

New dynamic methods should be used for training and memory should play a lesser part than thinking and judgment. A higher pedagogical value should be restored to in-service practice to prevent students from being used as free labour.

Evaluation is an essential feature of training. It is a continuing process, introduced first during school education and is later used by the midwife during service when she estimates knowledge, techniques and behaviour. It is not only the concern of the student but also of the teacher.

Dr. Martin deplores having to admit to the close link between family health and family planning. Special emphasis is given to rural areas. He underlines the importance of training polyvalent midwives to fulfil the needs in Africa. There are, however, some risks in trying to be too polyvalent. Wider training must not lead to diluted training. Polyvalency has its limits and might give rise to some superficial practices. Dr. Martin then gave the results of a pilot training programme in Lagos where family health was included in the programmes of basic training. He underlined the needs for a community approach and the establishment of schools "without walls".

During the discussions that followed, the question was raised as to whether family planning should be an independent service or should be integrated in other existing services. There was general agreement on the integration of family planning in the midwifery programme to be spread over the whole duration of the training.

There were differences of opinion on the subject of auxiliary training. For some participants, the training of different categories of personnel for one task is a danger. The problem of re-classification would no doubt occur should the country have enough qualified staff. In Dr. Castadot's opinion, there is no need for auxiliary staff in a country where health services are available everywhere, but this is not the case in our countries. In countries with inadequate health services, it is advisable to train auxiliary personnel to be responsible for certain tasks. This is an optional choice for each country.

On the subject of training programmes, a participant warned of the dangers of including more topics in the existing curriculum; in his opinion, the theoretical

part of the training programme should be shortened in favour of the practical one. This point of view was shared but with some restrictions. Longer programmes are essential but theoretical knowledge is vital to the training of senior personnel. It is important that the content of the training programme should vary according to the category of personnel to be produced ; that the training of auxiliary midwives be limited to a certain number of techniques which should be repeatedly practised, e.g. vaccinations.

There is a tendency to establish a basic training from which different groups of students branch off for a limited period during nursing or midwifery training ; this seems to be a more economical system likely to promote the team spirit. Some participants said that the grouping of students did not necessarily ensure team work and it could result in an exceedingly large number of students.

Mention was made of the imperative need for the publication of African pedagogical handbooks, especially manuals of practical care ; such publications were made by a group of monitors in Nigeria.

During the group discussions, participants examined the problem of continuity in the training and of refresher courses for the improvement of knowledge. Every group thought that the functions of the midwife should be considered in terms of the community's needs. But, evidently, the midwife had fulfilled some tasks for which she was not always trained ; it is therefore important to further her training on the following points :

- Intensify gynaecological training ;
- Add the teaching of sexual education ;
- Plan for teaching in organisation and administration ;
- Give pedagogical training ;
- Promote psycho-sociological training and the teaching of approach and communication methods ;
- Train in family planning, including contraceptive methods ;
- Include civic education ;
- Intensify practical training ;
- Promote the sense of responsibilities and the notion of being part of the health team.

All countries deplored the lack of continuity in training and the lack of refresher courses. Training cannot give everything to the student. The participants underlined the importance of the role the student plays in the desire for improvement and this is every individual's concern. It is necessary to promote and establish permanent systematic refresher courses :

- periodic refresher courses ;
- inter-departmental meetings ;
- conferences, seminars, informative travels, group discussions ;
- periodicals ;
- participation in writing articles for newspapers and journals.

Refresher courses are primarily the responsibility of the midwife supported by doctors and public health authorities and should be held within services, in training schools, counties, districts and at national level.

The participants insisted on the importance of continuing evaluation - by observation during training and during service :

- direct observation at ground level ;
- questionnaire ;
- activity reports ;
- reports on individual progress ;
- file on discipline and behaviour.

The participants would like to see the creation of an African Federation of Gynaecologists, Obstetricians and Midwives from the national associations already existing, or to be created.

The question was raised of whether the standard of general education required before undertaking midwifery training should be higher and if aptitude tests should be introduced. All answers were 'Yes'.

## REPORT OF THE WORKING GROUPS

### PLACE AND ROLE OF TRADITIONAL BIRTH ATTENDANTS

On Friday, 22nd November, all participants and observers travelled to Touba Toul, a small village in the medical district of Khombole, 100 kilometres away from Dakar.

Touba Toul's originality lies in the fact that it has a rural maternity service consisting of delivery huts built by its own population and managed by traditional birth attendants who are identified and periodically provided with refresher courses by the Government whose primary objective was to reduce the infant mortality rate caused by umbilical tetanus which was until then very high in rural areas.

Following the statement made by Miss Koates, social worker, on "Traditional Birth Attendants in Senegal" and Mrs. Nassou's statement on "Auxiliary Midwives in Togo", the groups made the following comments :

1. The Senegal Experiment - illustrated by the visit to the Touba Toul maternity centre.

The facts are :

- Traditional birth attendants exist in our villages ; they have the women's confidence and they assist mothers in more than 80 per cent of confinements;
- Their primitive methods of work can have grave consequences where there is dystocia and their ignorance of the essential rules of asepsis can cause infection;
- It is important to know them, to train them for simple tasks, to supervise and control them.

The first positive result was a great decline in the rate of neonatal tetanus.

2. The Togo Experiment

- Form an intermediate body of auxiliary midwives who would practice in rural areas.  
Recruit young women with CEPE general education level, train them to routine tasks (normal deliveries, pregnancy and infant care, preventive activities, statistical data) ;
- The objectives are :

- a. To eliminate traditional birth attendants, old and unable to adapt to modern concepts ;
- b. To reduce the shortage of qualified staff and rapidly provide the country with sufficient health services to assist women in their confinement ;
- c. To make more time available for the training of good quality midwives ; the standard of general education required for midwifery training must be raised and a reasonable number of midwives should be trained every year.

The participants pointed out that this is a good solution under the present conditions, but when enough qualified midwives have been produced the problem of rural midwives who could not attend refresher courses must be reconsidered.

The group discussions reached the following conclusions :

- Traditional birth attendants exist in all our countries ; they assist more than 50 per cent of women during confinement ;
- They have a great influence in their community ;
- Their advice on methods and traditional practice for conception or contraception is an advantage ;
- After training, the traditional birth attendant could help bring new health concepts to her own community.

They must be integrated into the health team with junior status and, as far as possible, must not be employed in institutions.

- The objectives for their training are as follows :
  - a. To abolish their inexperienced methods of practice ;
  - b. To give them a simple education in elementary hygiene and child welfare ;
  - c. To teach them some of the basic methods of conduct of :
    - pregnancy,
    - labour,
    - post-natal care.
  - d. To help the woman during delivery ;
  - e. To give elementary care to the new born and the mother (cut and dress the umbilical cord, care of the eyes, clean the vulva) ;

f. To report births and deaths in the village for registration.

- Their area of practice must be their own community ;
- Control over them must be by mobile health teams ;
- An on the spot evaluation of their practice will be done by the team according to certain criteria :

- Number of normal deliveries ;
- absence of complications during delivery and post-natal period ;
- absence of umbilical tetanus ;
- unannounced control visits.

The solutions for the future seem to be :

- 1) For certain participants, to form an intermediate body of auxiliary midwives who would mostly practice in rural areas ;
- 2) For others, to increase the number of pupils in midwifery training schools in order to provide sufficient health services as quickly as possible.

## FINAL REPORT AND RECOMMENDATIONS

### ADOPTED BY THE PARTICIPANTS AT THE END OF THE SEMINAR

The Francophone West African Working Party was organised by the International Confederation of Midwives and the theme was "The Role of the Midwife in the Family Health Services, integrated into Maternal and Child Health (MCH) Services". It was held in Dakar from 17th - 23rd November, 1974.

This Working Party was presided over by Professor Paul Correa, Chief of the Department of Obstetrics & Gynaecology at Dakar University and Gynaecologists and Midwives assembled from the following countries :

- Ivory Coast, Dahomey, Mali, Mauritania, Niger, Senegal & Togo.

During one week, papers, group work and discussions were related to:

- 1) Maternal and Child Health in West Africa - its problems and its priorities;
- 2) Research for a common concept of family planning;
- 3) Organisation and development of family health services and the role of the midwives;
- 4) Training and improvement of the practice of midwives;
- 5) Place and role of traditional birth attendants.

### PROBLEMS AND PRIORITIES

The Working Party underlined the common characteristics of our countries :

- a) Geography : hostility of the environment;
- b) Politics : subdivisions into states;
- c) Population : underpopulated (106 million people in 6,200,000 square kilometres).
  - Annual population growth very high, 2.6 per cent;
  - Mothers and children form 60 - 70 per cent of the population;
  - Deprived groups : rural population, low income group, children from 0 to 5 years and mothers.

d) Socio-economic and cultural factors

- Economy strongly dependent on industrialised countries;
- Low income;
- Primitive working conditions;
- Poverty, ignorance, illiteracy, low percentage of school attendance.

e) Health aspects:

- High rate of morbidity and mortality;
- Insufficient health services;
- Insufficient personnel made worse by bad distribution particularly in rural areas;
- Insufficient pharmaceutical products;
- Insufficient transport facilities;
- Absence of supervision.

Health problems can be summarised as follows :

- Poor hygiene;
- Pre-eminence of infectious diseases;
- Undernourishment and malnutrition;
- Parasitism;
- Anaemia;
- Absence of reliable statistics.

The participants pointed out that it was difficult to dissociate problems and to identify the priorities, as each country has its own peculiarities. They admitted that the fight in spite of all these negative factors is to promote family health.

To answer these health problems, the midwife, who is an essential member of the health team, must receive an adequate training which will later become evident.

RESEARCH FOR A COMMON CONCEPT OF FAMILY PLANNING

In order to do this, the participants made the following statements:

- 1) Family planning, which includes birth control or birth limitation, cannot be an efficient way to reduce the growth rate immediately. The effects of such

a policy are felt over a long term period (20 years) at a time when the data which motivated such policies are outdated.

The increase in standards of living and the improvement in the status of women are accompanied by a reduction in family growth.

On the other hand, the analysis of characteristics and structure of the African family was discussed and the following conclusions were reached:

1. Fertility is still very important in our culture ;
2. Traditional or religious beliefs dictate the behaviour of the group ;
3. Traditional Education includes a sexual education phase practised with initiative rites ;
4. Family planning, in the form of birth spacing and treatment for sterility, is still practised by traditional methods.

Participants thought that family planning is to :

- Fight sterility ;
- Respect the biological rhythm of the family ;
- Promote breast feeding ;
- Encourage the father's participation in family life ;
- Educate youth and adolescents to understand and recognise their responsibilities in sex matters.

The use of modern contraceptives, freely accepted by the couple, requires skill from the midwife which she acquires by technical training but especially by psychological and moral relationships between her and her patients.

#### ORGANISATION AND DEVELOPMENT OF FAMILY HEALTH SERVICES - ROLE OF THE MIDWIFE

For the organisation and development of Family Health Services, the participants made two decisions :

- 1) In order to be efficient new structures must not be created, because of poor human and financial resources ;
- 2) To develop neglected or non-existent services such as : systematic activities and integrate these activities in services already existing.

The role of the midwife can be expressed as follows:

- a) Information - Education ;
- b) Administration ;
- c) Medical and para-medical services ;
- d) Research ;
- e) Evaluation.

The Working Party recommends the establishment of legislation to study and define the responsibilities of each member of the team, standardise techniques and the minimum procedures which a midwife is permitted to carry out.

The Working Party recommends an insurance scheme for the protection of midwives where complications occur.

#### TRAINING AND IMPROVEMENT OF THE PRACTICE OF MIDWIVES

The participants thought that the functions of the midwife should be considered in terms of the community's needs. They noticed that the midwife was not always trained to fulfill some functions therefore it was necessary to augment her training in the following points :

- Intensify her gynaecological training ;
- Add the teaching of sexual education ;
- Teach organisation and administration ;
- Give pedagogical training ;
- Develop psycho-sociological teaching and methods of approach and communication ;
- Train midwives in family planning, including contraceptive methods ;
- Include civic education ;
- Develop practical training ;
- Develop her sense of responsibility and her awareness that she belongs to the health team.

All countries deplored the lack of continuity in the training and of refresher courses to improve their knowledge.

It is necessary to have regular refresher courses in an institution. These refresher courses are primarily the responsibility of the midwife supported by doctors

and public health authorities. The refresher courses should be held within services, in training schools, counties, districts and at national level.

The participants also insisted on the importance of a continuing evaluation during training and during service. They would like to see the creation of an African Federation of Gynaecologists, Obstetricians and Midwives from the national associations already existing or to be created.

The participants recommended their governments review the programmes in the light of the defined objectives.

Midwives should be associated with central organisations concerned with conception.

The participants suggested there should be a regional conference to study the problem of the co-ordination of the programmes and the validity of diplomas.

The participants were asked if the standard of general education required before pupils undertook midwifery training should be higher and whether aptitude tests should be introduced, and they concurred with this unanimously.

The problems of revaluing the profession were debated.

#### PLACE AND ROLE OF THE TRADITIONAL BIRTH ATTENDANT

The participants realised that the traditional birth attendant existed and still exists in all our countries. They assist mothers in more than 50 per cent of confinements. They are usually old and have a great influence in their community. However, the participants wished that their career should not be institutionalised as their number reflects on the obstetrical standards of a country adversely.

The majority of the participating countries found it indispensable under present conditions to register and train them for simple educational and technical tasks and to supervise them.

The future solution seems to be :

- 1) For certain participants, to form an intermediate body of auxiliary midwives who would mostly practise in rural areas ;

- 2) For others to increase the number of pupils in Midwifery Training Schools in order to reach precise objectives laid down in advance in a national planning framework and to make rural zones more habitable. The participants of the Working Party think that it rests with each country to experiment and apply solutions which are appropriate to their own needs.

The participants were grateful to other members of the health team - social workers, male and female nurses, etc. for their help in the work. A special thank you was made to Professor Corres, who during the week chaired the debates with objectivity, realism and lucidity. Most participants saw in him the teacher who, behind his paternal smile, knew how to motivate and make his pupils react.

Our thanks go also to the ICM who gave us the opportunity of confront each other and reach a better understanding.

The Dean of the Faculty of Medicine who afforded us such comfortable working conditions was also thanked.

Finally, our thanks go to the Minister of Health who gave permission for this Working Party and allowed midwives to update their knowledge in order to improve their practice.

EVALUATION

Before the close of the seminar, each participant was asked to give his personal impressions of the meeting and his evaluation of how well the objectives of the seminar had been met. Their replies have been summarised as follows :

1. DO YOU CONSIDER THAT WE HAVE ACHIEVED THE AIMS OF THIS WORKING PARTY?

- YES ..... 19  
 - NO ..... 0  
 - PARTIALLY ..... 3

COMMENTS :

Many of the participants mentioned the value of meeting together and sharing experiences and points of view; the importance of the new information presented; the richness of the discussions on the concept of family planning; and the new dimension given to the role of the midwife. One person said that more midwives should have been included among the participants and another felt that there had been an attempt to impose family planning on the group.

2. WHICH SESSIONS HAVE YOU FOUND TO BE :

| Most Interesting  | Interesting                             | Least Interesting |
|---|---|-------------------|
| The concept of family planning (15)                         | Traditional birth attendants (4)        | None (22)         |
| Integration of family planning in training of midwives (11) | Auxiliary midwives (3)<br>Nutrition (3) |                   |
| Problems and priorities in MCH (12)                         | Training (3)                            |                   |
| Role of the midwife (10)                                    | All (3)                                 |                   |

Give reasons for your choice :

The most frequent comments were : the richness of the discussions on family planning; all the sessions have responded to the realities of our situations and

to our needs ; family planning is a new controversial and important subject ; traditional birth attendants are a reality in our countries and their integration poses real problems. One participant commented that contraception was an individual, rather than a general, problem.

3. DO YOU THINK THE CONTENT OF THE PROGRAMME WAS OF VALUE TO YOUR COUNTRY?

- YES ..... 20
- NO ..... 1
- YES & NO ..... 1

If no, please explain.

One participant said that family planning exists in his country. Another said that the problem of traditional birth attendants does not exist in his country.

If yes, please comment on how you plan to help implement the recommendations in your country.

The majority of participants commented on the need to encourage government officials to provide a structure wherein people can make a choice regarding family planning ; the need to encourage the development of maternal and child health services which integrate family planning and other important health services ; the need to inform and motivate the public, re : family planning and later, to create a pilot centre for family planning consultations and services ; the need to include family planning in the training of midwives ; and the value of organising midwifery associations to be concerned with their problems.

4. WHAT ADDITIONAL HELP DO YOU NEED IN IMPLEMENTING THE WORKING PARTY RECOMMENDATIONS IN YOUR COUNTRY?

Comments included : support of our governments ; money ; materials and assistance of experts ; training of key personnel in family planning ; legislation ; support of WHO and other external agencies ; and additional seminars.

5. HAS THIS WORKING PARTY PROVIDED A BACKGROUND FOR INTRODUCING FAMILY PLANNING INTO MIDWIFERY TRAINING PROGRAMMES?

- YES ..... 21
- NO ..... 1

The participants who said "no" explained that family planning has been included in his country's training programmes for the past two years.

6. HOW HAS THIS WORKING PARTY INFLUENCED YOUR OWN THINKING ABOUT THE EXPANDED ROLE OF THE MIDWIFE AND FAMILY PLANNING?

Almost all the responses were positive. Some said it had helped them to see the increasingly critical need to integrate family planning in the training of midwives. Other comments included : the harmonisation of births is not new - we only need to adopt more effective methods ; the discussions have given to the words "Family Planning" an acceptable meaning which conforms to our ethics ; I will return to work in family planning with more courage and determination. Only one participant responded "no influence".

7. HOW DO YOU FEEL ABOUT :

|                                | <u>Very Useful</u> | <u>Useful</u> | <u>Not very Useful</u> |
|--------------------------------|--------------------|---------------|------------------------|
| Organisation of the conference | 16                 | 5             | 0                      |
| Group discussion method        | 17                 | 3             | 0                      |
| Library and resource materials | 5                  | 8             | 1                      |

8. GENERAL COMMENTS :

Almost all the participants felt the programme was too full (we should have had ten days, and the time might have been better planned). Other comments included : appreciated the high level of discussion ; it served as a refresher course ; the recommendations should be sent to our governments ; a seminar of this type should be held every three - four years and should include both anglophone and francophone countries as well as additional categories of health personnel ; more preparation of the participants before the seminar would have been helpful ; the resource materials seemed to over-influence the discussion.

PARTICIPANTSIVORY COAST

|   |  |                    |
|---|--|--------------------|
| Dr. Kouadio BOHOUSSOU<br>Obstetrician & Gynaecologist             | Chief of the Department<br>Faculty of Medicine | B.P. 20043 ABIDJAN |
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| Mrs. Suzanne AMAND<br>Midwife-Gynaecologic<br>Consultation Clinic | TREICHVILLE Hospital                           | B.P. 5773 ABIDJAN  |

DAHOMY

|   |  |  |
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| Prof. Eusebe ALIHONOU<br>Obstetrician & Gynaecologist | Chief in Obstetrics &<br>Gynaecology of the Clinical<br>Department of the University | B.P. 188 COTONOU   |
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| Mrs. Justine KOUASSI<br>Midwife                       | National Health Service<br>Bureau of DANTOKPA  | Caisse Nationale de<br>Sécurité Sociale de<br>DANTOKPA COTONOU |

MALI

|                                    |   |  |
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| Prof. Bocar SALL<br>Senior Surgeon | Surgeon in Charge<br>du POINT G. Hospital | Hôpital du POINT G.<br>BAMAKO          |
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|  |   |  |
|--|---|--|
| Mrs. BA, née Khady SY<br>Child Welfare Midwife | Chief of the Department<br>of Maternal & Child<br>Health Services | Chief Service P.M.I. au<br>Ministère de la Santé et<br>des Affaires Sociales<br>NOUAKCHOTT |
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Prof. Mawupe VOVOR  
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Gynaecologist-Obstetrician

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MEDINA M.C.H.

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| Senior Prof. Fadel DIEDHIOU<br>Gynaecologist-Obstetrician      | H. le DANTEC Maternity<br>Hospital   | DAKAR   |
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| Mr. Amar SAMB<br>IFAN Director                                 | Islamologue  | DAKAR   |
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| Mrs. Annette d'ERNEVILLE<br>Journalist                         | Senegalese Radio &<br>Television Head Office                                     | DAKAR   |
| Mrs. M. A. SAVANE<br>Bachelor of Letters                       | Chief Editor of<br>"Family & Development"  | C.R.D.I.<br>Avenue République DAKAR   |
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COMPOSITION OF THE WORKING GROUPS

GROUP A

Prof. Mawupe VOVOR  
Dr. BARBA  
Mrs. SY  
Mrs. COCO  
Mrs. Suzanne AMAND  
Mrs. BA née Khady SY  
Mrs. Aminata SENE  
Miss Marcelle PELLEGRIN  
Mrs. TOURE née NIANG, Social Worker  
Mr. Ibrahima DIENG, Qualified Nurse-

GROUP B

Prof. Bocar SALL  
Dr. Kouadio BOHOUSSOU  
Mrs. Marie-Louise NASSOU  
Mrs. Justine KOJASSI  
Mrs. Amsou MAIGA  
Mrs. GUISSÉ  
Mrs. Rama GUEYE  
Mrs. Amanatou N'DAW  
Mrs. Liliane NIANG, Social Worker  
Mr. Lamine DRAME, Qualified Nurse

GROUP C

Prof. Eusebe ALIHONOU  
Dr. Diop LEYE  
Mrs. DIAWARA  
Mrs. Ramatou NIGNON  
Mrs. Camara KONE  
Mrs. Siga SENE  
Mrs. Fatou M'BENGUE

FRANCOPHONE WEST AFRICAN SEMINAR

Faculty of Medicine and Pharmacy

DAKAR

17th to 23rd November, 1974

THE ROLE OF THE MIDWIFE IN THE FAMILY HEALTH SERVICES  
INTEGRATED INTO THE MATERNAL AND CHILD HEALTH STRUCTURES

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Sunday 17th November

10.00

OPENING OF THE SEMINAR

Addresses were made by :

- Mrs. Kone DIABI : Regional Field Director of the International Confederation of Midwives ;
- Professor CORREA : Chief of the Department of Obstetrics & Gynaecology - Chairman of the Seminar ;
- Professor SANKALE : Dean of the Faculty of Medicine & Pharmacy ;
- Mrs. DENISON : General Secretariat of the International Confederation of Midwives ;
- Dr. Papa GAYE : Director of Public Health, representing the Minister of Health & Social Affairs of Senegal.

11.30

GREETINGS & REPORTS OF THE PARTICIPATING COUNTRIES

Methodology of the Seminar

Monday 18th November

8.30 - 9.30

"Maternal & Child Health in West Africa",  
SPEAKER : Senior Professor Alihonou - Dahomey

9.30 - 10.30

"Problems and Priorities in West Africa"  
SPEAKER : Dr. Papa Gaye - Senegal

10.30 - 11.00 Coffee Break

11.00 - 12.00 "Nutrition"  
 SPEAKER : Dr. Thianar N'Doye - Senegal - Chief Medical Officer of the Senegal Bureau of Food and Nutrition.  
 "Health Education, Preventive Measures"  
 SPEAKER : Mr. Beye - Senegal - Assistant Chief Medical Officer for Health Education in Senegal.  
 "Family Health"  
 SPEAKER : Prof. Mawupe Vovor - Togo - Gynaecologist-Obstetrician - Director of the Togo School of Midwifery.

12.00 - 14.00 Group discussions : "Problems and Priorities in Maternal and Child Health in West Africa".

Evening Reception

Tuesday 19th November

"Search for a Common Concept of Family Planning for West Africa".

8.30 - 9.30

PLENARY SESSION

View points of :

- Mr. Savane : Statistician - Senegal - African Institute for Development and Planning.
- Mr. Léon Diouf : Vicar General - Senegal.
- Mr. Amar Samb : Islamologue - Senegal - IFAN Director - Professor at the Faculty of Letters & Human Sciences - Director of the Islamic Institute of Senegal.
- Mrs. d'Erneville : Journalist.

11.00 - 11.30

Coffee Break

11.30 - 14.00

View points of :

- Mrs. Savane : Chief Editor of the magazine : "Family & Development" - Senegal

- Senior Prof. Mohamadou Fall : Paediatrician.
- Senior Prof. Fadel Diedhiou : Obstetrician.
- Mrs. Siga Sene : Midwife.

15.30 - 17.30

Group discussions : "Adoption of a Common Concept and Objectives for Family Planning in West Africa".

Evening

Films

Wednesday 20th November

8.30 - 9.30

PLENARY SESSION : Reports of the Working Groups

9.30 - 10.00

"Organisation and Development of Family Health Services Integrated into the Maternal and Child Health Structures"

SPEAKER : Dr. Diop Leye - Gynaecologist - Obstetrician - Senegal.

10.00 - 10.30

"Government Programme for Birth Spacing"

SPEAKER : Dr. Bocar Sall - Mali.

10.30 - 11.00

"The Expansion of Maternal and Child Health Services"

SPEAKER : Miss Nalder - Dahomey

11.00 - 11.30

Coffee Break

11.30

Visit to the Blue Cross

15.30 - 17.30

Group discussions : "The Role of the Midwife in the Family Health Services including Family Planning".

Thursday 21st November

8.30 - 9.30

PLENARY SESSION : Reports of the Working Groups.

- 9.30 - 10.00 "Integration of Family Planning in the Training of Midwives"  
SPEAKER : Miss Pellegrin - Senegal - Assistant Director of the School of Midwifery - Dakar
- 10.00 - 10.30 "Training Programme - Improvement in practice of the Health Personnel".  
SPEAKER : Dr. Jean Martin - Expert University of North Carolina Project.
- 10.30 - 11.00 Coffee Break
- 11.00 - 11.20 "Integration of Family Planning in the Training Programmes of Midwives of all Categories".  
SPEAKER : Dr. R. Castadot - Expert in Training - New York.
- 11.20 - 11.40 "Midwifery Training in Ivory Coast"  
SPEAKER : Mrs. Kone - Midwife-Teacher - Abidjan School of Midwifery.
- 11.40 - 12.00 "Integration of Family Planning in National Development and Social Welfare".  
SPEAKER : Mrs. Deves - Jurist of the Economic & Social Council of Senegal.
- 12.00 - 14.00 Group discussions : "Integration of Family Health in Midwifery Training".

Friday 22nd November

- 8.30 - 9.30 PLENARY SESSION : Reports of the Working Groups.
- 9.30 Departure for Khombole  
Visit to the Touba Toul Maternity Hospital.  
"Traditional Birth Attendants in Senegal".  
SPEAKER : Miss Koate - Social Worker

"Rural Midwives in Togo"

SPEAKER : Mrs. Naassou - Midwife at the Lome MCH Centre

12.30

Lunch

14.30 - 16.30

Group discussions : "Place and Role of the Traditional Birth Attendants".

Saturday 23rd November

8.30 - 9.30

PLENARY SESSION : Reports of the Working Groups.

9.30

Evaluation of the Seminar.  
Discussion for the Approval of a Final Report.  
Group discussions on plans for implementation by individual countries.

16.00

CLOSING SEMINAR

OPENING ADDRESS

Mrs. KONE-DIABI

Regional Field Director of  
The International Confederation of Midwives

As Regional Field Director of the International Confederation of Midwives, I am honoured to greet you this morning at the Faculty of Medicine and Pharmacy of Dakar for the opening of the Seminar on the subject of : "The Role of the Midwife in Family Health and the integration of the service into the Maternal and Child Health Structures".

I wish to welcome all the participants and observers who come from abroad.

During six days, 28 delegates - midwives, obstetricians/gynaecologists and other advisors - representing seven West African countries : Ivory Coast, Dahomey, Mali, Mauritania, Niger, Senegal and Togo, will study health priorities, family health, family planning and its direct implication in our countries.

We are all aware of the complexity and controversy of the topic of family planning but also of the advantage of finding solutions.

The aim of the International Confederation of Midwives is neither to impose its views on government policy, nor to recommend any special family planning methods but to help governments, who so desire, to train midwives of all categories in order to improve the quality of care given in the services to the vulnerable groups of our countries with a continuing view of improving the health of mothers and children to the highest level.

A dynamic plan of work has been adopted for this seminar commencing tomorrow 18th November, e.g. all important technical papers will be followed by working group discussions on five themes :

1. Definition of the Problems and Priorities in West Africa ;
2. Search for a common concept of Family Planning and its objectives in West Africa ;
3. Organisation and development of Family Health Services including Family Planning taking into account the defined objectives and the Role of the Midwife in these services ;

4. Integration of Family Planning in the training programmes of midwives and in the programme of refresher courses for qualified midwives;

5. And finally, Place and Role of the Traditional Birth Attendants.

Mr. Director of Public Health,  
Ladies and Gentlemen,

The International Confederation of Midwives would like to thank:

- The Senegalese Government, the Minister of Public Health and Social Affairs, the Director of Public Health who gave permission for this seminar to take place in Senegal;
- Professor Sankale, Dean of the Faculty of Medicine and Pharmacy of Dakar and his colleagues;
- Professor Correa, Chairman of the Seminar and his colleagues;
- All the National and International Experts;
- All the National and International Organisations;
- All the participants here present;
- All my midwives colleagues who, by giving so much of their time and encouragement, contributed to make this Seminar a reality.

Lastly, it will be the task of the participants at the West African Seminar to analyse the present situation of family health and family planning in our countries, to suggest new solutions to be adapted to our traditional socio-economic conditions and to determine the means of doing so, taking into account the improvement of the health and the well being of the family.

To you all, participants at the Seminar, I convey my best wishes for a complete success in your work and a happy stay in Senegal.

OPENING ADDRESS

Professor Correa

Chief of the Department of Obstetrics and Gynaecology

The International Confederation of Midwives is to be congratulated for its initiative in organising a six day meeting in Dakar for its members. The aim is to exchange views and talk about their respective experiences on a certain number of very interesting themes with medical specialists at their side. International Organisations who have all encouraged and made this meeting possible also deserve our thanks - Africans especially - whose interest in Maternal and Child Health matters may be very close or not so close.

I would like to tell Mrs. Antoinette Diabi, President of the African Section of the International Confederation of Midwives how deeply moved I am to have the honour to being chosen to preside over your work. I realise that it is entirely due to my age and to my seniority in the field of Gynaecology and Obstetrics in our African countries and also to a sort of generous loyalty to an old Master. Would you, Madame, convey my gratitude and my admiration to the members of your Confederation.

The essential themes for your sessions will be :

- Maternal and Child Health ;
- Family Health
- Training and improvement in the practice of midwifery in relation to the two above problems.

Three ambitious, exciting and up-to-date themes on which a lot, perhaps too much, has been said and done around the world during the past fifteen years.

The question of nutrition, sterility, still birth or "birth spacing" all have an effect on the well being of the Family and its happiness - its Health, as WHO describes it.

It is not my intention to impose upon you a lengthy dissertation on such serious and inflammatory subjects as Family Health but, very briefly, I would like to deliver you my thoughts as an African and gynaecologist/obstetrician who for more than 20 years has lived closely with, and experienced, all the problems from their various aspects :

1. It has become more and more evident that it is necessary to respect the independence and the freedom of option of each country, of each individual, to exclude any constraint and external pressure. On this subject, all people must think and act for themselves and by themselves in all supremacy, according to their political or social outlook and their own cultures.
2. Information from whatever source, is especially necessary in order to decide freely on our choice ; to act with full knowledge and without constraint. It is to this effect that meetings such as this - regional or international - have a vital impact and achieve real results.
3. Family Planning's chance of success in Africa depends, in my view, upon two conditions :
  - a) That it is really and honestly a comprehensive programme of planning for a family, e.g. a programme to fight sterility (so much demanded by our populations) as well as a programme for birth spacing, whichever the case may be.
  - b) That our African Governments first, and donor countries afterwards, always bear in mind that the regulating of births will not in itself resolve the serious problem of our under-development because it must necessarily and primarily be supported by a sensible Government policy, economic and social development and a basic sense of justice and of international solidarity. The primary task is to improve the standard of living of our populations, as Baudelaire said "The threshold of natality corresponds with the threshold of poverty ; one produces less children when one ceases to be poor".

It is my belief that our midwives, the basis of our health structures, support of our culture and traditions will know what of all this, especially what material of foreign origin, is to be accepted or rejected because of the wisdom and maturity which characterises them.

Ladies, I wish you great success in your work which is, I feel sure, a prelude to more meetings and confrontations of all levels in our large medical family.

OPENING ADDRESS

Professor Sankale

Dean of the Faculty of Medicine and Pharmacy

On behalf of our University and our Faculty of Medicine and Pharmacy, I am pleased to greet you and welcome you in our building. We are happy that our city was chosen as the venue for this seminar and we hope that your stay here will be fruitful and pleasant. We express our deep gratitude to the two promoters and organisers : the International Federation of Gynaecology and Obstetrics on the one hand and the International Confederation of Midwives on the other and also to our Regional Field Director, Mrs. Kone Diabi.

Our work will be devoted to a frank and difficult subject : the integration of family planning in midwifery activities with the view to the improvement of maternal and child health.

The characteristic of the practice of medicine is to serve the living, to fight for life in all aspects, to multiply it, it could appear paradoxical - almost an aberration - to expect medical personnel to advocate the reduction of procreation by limiting births. But scientific progress is not without this kind of false contradictions.

To unmask the one in which we are interested, we must prefer qualitative criteria to the numerical and quantitative aspects of existence without falling into the excess of eugenics. It must also be recognised that a physician must at the same time be concerned with life in its environment. Now, human lives should not be multiplied without defining beforehand the chances and conditions for a decent survival. Health becomes then a balancing factor between the individual and his environment, therefore between himself and his fellow-men.

Many factors have an influence on the quality of life but, chronologically and emotionally speaking the love and care of the mother come first. The mother's role can only be enacted if she remains alive, is healthy, has time and has money. All that contributes to the improvement of her physical and emotional condition will contribute to the future security of her children and her family. Family planning and birth control as a contributory factor, are both irrefutably identical means of social and economic development and therefore of Life.

But the spacing of children is a complex problem to be tackled with lucidity and tact. Firstly, because conditions are not identical in different parts of the world, not even in different parts of West Africa ; but especially because it brings into action a series of different criteria concerning man and society : biological, medical, religious, moral, economic and socio-economic criteria. To give birth is an act so straightforward, so full of consequences, thereby so full of responsibilities, that the educators must be constant reminders of the moral obligation of 'responsible paternity and maternity'. It is in the secret of our conscience that each individual, each couple, eludes and resolves the problem of its own progeniture.

Apart from the people involved, who can understand such intimacy better than their natural confidants, the midwives or obstetricians? Only you know what the Africans think of family planning : it is said that they are reticent, even antagonistic. In general medical services, however, we are more and more solicited in this field. What aims are to be reached? What is finally the scope of the demand? How will it develop? What are the motivations? The methods more readily accepted? Results of short and long term? How will the indispensable collaboration between the midwife and the physician be achieved? Many new answers are expected from this seminar. Through you, the voice of our countries will be heard on an international scene where too often they are spoken for without being consulted and where too often Economics come before Morals and Religions.

My colleagues and I feel sure that your work will be a success and will honour our University, especially because the survival of Africa, therefore the future of our planet, depends on the future well-being of our mothers and children.

OPENING ADDRESS

Miss Marjorie Bayes:

Executive Secretary of the International  
Confederation of Midwives

READ by Mrs. Micheline Denison, representing the  
International Confederation of Midwives

I am speaking to you this morning on behalf of Miss Bayes, the Executive Secretary of the International Confederation of Midwives who I represent at this Seminar.

With me, to represent the ICM are :

- Mrs. Kone Diabi, our Regional Field Director ;
- Miss E. Hilborn, our Consultant ;
- and Mr. R. J. Fenney, our Field Director and Director of Finance.

The International Confederation of Midwives celebrated its Golden Jubilee at its 16th International Congress which was held in Washington D.C. in 1972. Our global activities, however, really started in 1954 when the first WORLD congress for Midwives was held in London.

At this Congress, a very eminent American Obstetrician, the late Dr. Nicholson J. Eastman, gave a wonderful and inspiring inaugural address in which he told us of the world situation with regard to maternal and child health care. This address was a challenge to all midwives and especially to our newly reformed organisation whose activities had been in abeyance since the beginning of World War Two.

Dr. Eastman revealed that, in some countries, 90 per cent of women had no professional attendance during their maternity cycle and were delivered by traditional birth attendants, relatives, or just old women of the village.

In looking at the African Continent only, it appears that between 65 - 70 per cent of the women are treated in this manner at delivery. In other parts of the World, the proportion increases to 80 and 90 per cent ; this applies especially to the Philippines.

Dr. Eastman urged professional midwives to be prepared to do everything in their power to improve midwifery training and practice in the interest of mothers and babies. In the same interests, they should accept and help to instruct their less fortunate colleagues who have little or no training. This applies to almost every part of the world.

Fortunately, at the same time, the International Federation of Gynaecology and Obstetrics was thinking on the same lines. During its General Assembly held in Vienna in 1960, a study group was set up to examine in detail the training and practice of midwives. The ICM contacted the World Health Organisation to see what could be done to improve the health and status of women during their pregnancy and delivery as well as the health of their babies.

With mutual co-operation a JOINT Study Group was formed by the International Federation of Gynaecology and Obstetrics and the International Confederation of Midwives.

Our first joint effort was to collect data on the training and practice of midwives and maternity nurses throughout the world. After intensive research a report was published in 1966 under the title "Maternity Care in the World" giving information on 174 countries of the world and on 75 per cent of the world's population. This was the first time an international survey of midwifery training and practice had ever been published.

The Joint Study Group is a very representative body composed of an equal number of midwives and obstetricians from all parts of the world and where each continent is duly represented. Since its beginning in 1960, the World Health Organisation (WHO) asked to be represented, later followed by the International Planned Parenthood Federation (IPPF). More recently the International Paediatric Association have joined us and the United Nations Children's Fund (UNICEF), which we greatly admire, expressed their desire to be represented in our Joint Study Groups and have now also become associated with us.

The report "Maternity Care in the World" was presented to the 14th International Congress of Midwives in West Berlin in 1966 and was very well received.

A European Conference was held in London in March 1969 where 21 countries were represented by obstetricians, midwives, representatives of statutory bodies, paediatricians, etc. Although this was not a family planning conference, in most

of the papers presented, family planning had an important part ; this was a clear indication that our hopes of seeing this subject integrated into midwifery programmes were quite justified.

In African and in Asia, traditional birth attendants are highly esteemed in the communities they serve and they have a considerable influence on the inhabitants. This regard can only be enhanced by official recognition.

The work they do is of extreme importance in their own locality and to the nation as a whole. In the general interest of mothers and children who depend upon them, professional personnel must be willing to help and instruct those with little or no training in normal midwifery practice until such time as there is enough professional personnel to serve everyone.

It is essential that traditional birth attendants be included in the expression "Midwives of all Categories" ; they are a category of personnel which plays an important part in maternal and child health at this present time and will do for some time to come.

It is of supreme importance to the good of the community that all categories of midwives should be instructed in family planning methods and services available in this field.

Let us unite in our efforts now with the existing personnel - qualified or otherwise - to give the families we are responsible for the best services possible and the benefit of planned parenthood.

A lot has been said this year about population explosion in the world. We all have a role to play in this field. Over population inevitably brings social unhappiness, unemployment and food shortages. These conditions apply everywhere in the world and it is certainly the mothers and children who suffer most as a result of them.

Other working parties have been held since our European seminar - one in Ghana for the anglophone West African countries, one in Costa Rica for the Central American countries, in Cameroon for the francophone Central African countries and in Kenya for the anglophone East African countries. In 1975 we will have the great pleasure of going to Columbia to hold a seminar for the South American countries.

Our next International Congress of Midwives will be held from 21st-28th June 1975 in Lausanne, Switzerland. The theme chosen for this Congress is "The Midwife and the Family in the World Today". All aspects of this theme will be covered and this will thus give us every opportunity to discuss the improvement of family life through family planning.

The year 1975 will also be the "International Year of the Woman". I hope that we will have the opportunity to focus attention on her supreme role of "Mother" as this is her most important role in the World. I hope that this seminar will be an opportunity for all the organisations recognised by their governments to become members of the ICM so that the joint efforts of every country contribute to the promotion of health and of the quality of life of mothers and children throughout the World.

OPENING ADDRESS

Dr. Papa Gaye

Director of Public Health

Representing the Minister of Public Health and Social Affairs

At the beginning of this University year, the town of Dakar will have already been the focal point for thoughts on medical matters for a period of two weeks. Yes, during the past week it is here, in this lovely amphitheatre of the Faculty of Medicine and Pharmacy, that the first Session of Refresher courses in medical pedagogy for teachers of the French language took place. This intrigued our attentive population and gave them interest in the philosophy of Aesculapius.

Immediately afterwards, the midwives and gynaecologists/obstetricians of the West African countries take their place. They have decided to congregate as from today to discuss the improvement of their professional activities so that mothers and children, family and society, together combined in the same pious solicitude, may enjoy more security and more happiness.

Once more, Senegal - commonly called the land of meetings and dialogue - will have answered to its vocation.

The International Confederation of Midwives has already held a similar session at ACCRA from 7th - 16th December, 1972 for the anglophone West African countries and at YAOUNDE from 28th September - 6th October, 1973 for the francophone Central African countries.

The meeting starting today completes, so to speak, a vast enterprise of mobilisation of a professional body whose activities are decisive for today's society.

The President of the Republic at a recent European Council said: "In the midst of cyclones ascending from all horizons, the apparent fragile destiny of the World is in our hands, we must only believe and have the will to do".

To believe and to have the will to do! Ladies and gentlemen, your belief in Man's supremacy and your will to work bravely to relieve suffering in order to reach at last the promised lands, this is what brings you here today and ennobles you.

The Midwife is primarily the African feminine elite ; it is therefore her imperative duty to play an exemplary civic and social role. The deliverer of medical care, she constitutes a solid and irreplaceable link in our chain of work and the main support in our activities. Esteemed confidant, obstetrician and pediatrician at the same time, the midwife is the incomparable agent who prepares the venue for a future citizen and who does her utmost to steady his first steps into life.

Her active efforts are, therefore, essentially focused on the family, around individuals as fragile as mothers and children. Have we not recognised very early and almost unanimously in the Third World that mothers and children form the most vulnerable group whose protection must be our main concern in order to decrease the morbidity and mortality rates which affect this group rapidly?

Ladies and gentlemen, there are many indications that the Family Health concept was born by giving a lot of thought to the ways and means of resolving rationally the problem of public health, that is to say, as efficiently as is possible with limited resources and with modest facilities for intervention. I would like to say straight away that this term indicates without doubt a multi-disciplinary action with four aspects : curative, of course, but also preventive, educative and social. It is important, however, to underline the new concept in this approach for actual better family health, the ultimate objective being in fact the total happiness of the Family, the important unit of society. This new concept is linked with the difficult problems of human genetic and demographic expansion. But this needs to be explained : if we try to register the misfortunes affecting the vulnerable group represented by the mother and child about which I spoke earlier, what do we usually find? Obstetric risks and pregnancy complications for the mother. For the child : dystocia, the whole range of infant infectious diseases as well as the predominant problems specific to our countries, weaning and malnutrition. Until recently we have often forgotten, perhaps because of their complexity and also, it must be said, because they are a trifle sacrosanct - the serious problems which prevent, sometimes traumatically, the happiness of some families and which are related to sterility or to an excessive number of children (I am thinking of mothers of eight, ten or more) and also of too frequent births which ruin the mother's health and endanger the survival of the offspring. I will pass over the tragic series of unwanted pregnancies in silence ; as you know they lead to illegal abortion, to crime and to suicide ... what more can I say?

Human reproduction considered at individual and family level has some huge repercussions on the happiness and the well-being of our fellow-citizens. At the national and international levels this phenomenon assumes bigger dimensions when it is revealed that there are threats of overcrowding in the world where the population today is 3,500 millions and will double in 30 years time.

It is not for me to start a pro or anti natalist debate here. I leave this to individuals who can speak with more authority than I. I only notice that humanity is asking itself questions on the subject. The fact that the United Nations has made 1974 the World Population Year and that they organised recently in Bucharest the First World Conference on Population, points to a very obvious proof of the concern in everyone's mind.

My purpose - our purpose - since we have opened a week of study for midwives - is to look back and concentrate on the preoccupations of the members of the family, this sacred social unit which must be the object of our complete and loving solicitude. How can we efficiently assist it, either to fight an abominated sterility and thereby contribute in the consolidation of marriages by helping the birth of wanted children or to encourage mothers to space their pregnancies to avoid them being too close to one another or eventually to wipe out the nightmare many exhausted mothers have of the eighth, ninth or tenth pregnancies?

Ladies and Gentlemen, our valiant colleagues, under the dynamic impulse of the International Confederation of Midwives, will consider and consult on the best way to prepare this programme which cannot be without the co-operation of the physician, guardian par excellence of the physical health and mental balance of his fellow citizens. The true question is indeed a sort of planning of parenthood capable of contributing to the well-being of the family and thereby contributing to the real happiness of this fundamental unit which is the priceless crucible of our social values and our dearest ideal.

During these days of consideration and reflection and, later when our own Governments have decided on the best means of implementing the programmes, two fundamental considerations must constantly be in your thoughts and guide your action. The first is of an emotional nature : never must the new power which entitles our profession to use the means and techniques to intervention to modify the rhythm of births be used to bring about the dissolution of morals. This is simply a matter of professional ethics.

The second consideration is of responsibility : your action will not serve a

policy decided at national level. Such a policy must be prescribed by those who have official power to make decisions on the matter.

It will fall, I have no doubt about it, on those responsible for health services, helped by voluntary associations for the well-being of the family, to see that these principles of loyalty and professional conscience are respected.

Ladies and Gentlemen, on these recommendations and in the name of the Minister of Public Health, I declare the Francophone Seminar of West Africa on the subject : "THE ROLE OF THE MIDWIFE IN THE FAMILY HEALTH INTEGRATED INTO THE MATERNAL AND CHILD HEALTH SERVICES" open.

MATERNAL AND CHILD HEALTH IN WEST AFRICA

Senior Professor Alihonou

Chief in Obstetrics and Gynaecology of the Clinical  
Department of the University, Cotonou, Dahomey

I - CONCEPT OF HEALTH

Honoured delegates, "possession of the best state of health he is able to reach constitutes one of the fundamental rights of any human being whatever his race, his religion, his political opinions, his economic or social condition" and I am reminding you that "Health is an entire condition of physical, mental and social well-being and does not only consist of absence of illness or infirmity".

In the same series of the World Health Organization (WHO) from which I drew these first sentences for your consideration, one of the 22 functions allocated to the World Health Organization still is: "to promote action for the health and well being of mother and children and to encourage their ability to live in harmony in a changing world".

II - MATERNAL AND CHILD HEALTH ASPECTS (MCH)

Amongst the activities of the health services in every country, Maternal and Child Health (MCH) occupies an important place; and so it should, for different reasons:

a) For the children of today to become the adults of tomorrow, to give society the services it expects to receive from them, the State must be so organized to make them physically and mentally capable; human capital is and remains the primary wealth of a country. This brings us to the second group of reasons which militate for a leading place for maternal and child health in the health services.

b) In our countries there is a consistent waste of human resources due to infant morbidity and mortality, or with associated maternal morbidity.

To be convinced, one has to look at a graph where population is divided into age groups plotted against specific mortality rates according to age.

When reading this graph (which I would suggest you do with me) we note that:

- 28 per cent of the overall deaths occur in children under one year of age (0 - 11 months) which represents only about four per cent of the population.

- 13 per cent of the overall mortality occurs in children between the age of one and four, which represents 12 per cent of the population.

So, over 40 per cent of the overall mortality occurs in children between 0 and four years of age or 16 per cent of the population.

Other statistical sources assert that out of 1,000 children born alive, 300 may die before the age of five and the remaining 4/5 who pass this critical age drag out their lives suffering the sequelae of malnutrition or parasitosis.

c) The third reason comes from the establishment of facts reported this afternoon:

- the chances of survival of children born in developing countries are poor, especially in West Africa. The under one year age group is a very fragile group, highly subject to the sequelae of illness and to death brought about by these. But if children constitute the most vulnerable age group of the population, the parturient woman also constitutes a most vulnerable fraction of the population; let us think for a while of the heavy burden pregnancy and breast feeding impose on the system. Mothers and children go through some critical periods of life during which more attention should be given to them:

- Weaning period, 1 - 4 years;
- School age period, 5 - 14 years, decisive period for the physical and mental development of the individual;
- Adolescent period, 15 - 19 years, accompanied by hormonal disturbances;
- Period of full working life, domestic and sexual activity, 20 - 44 years (births, abortions, venereal diseases);
- Menopause period, more critical for women than the corresponding period is for men, 45 - 49 years.

d) Finally the fourth reason which is one of the most characteristic in the population of our countries consists in the strong preponderance of the young and the women.

Mothers and children constitute 2/3rd and possibly 3/4th of the population in certain African countries.

Finally we must point out that children, in the vulnerable age group, women, fragile at certain periods of their existence are both subject to extremely rough living conditions imposed by an unmerciful human ecology.

For these reasons, it is imperative that in Africa more than anywhere else maternal and child care is recognized as being a distinct entity which must have particular needs defined and assessed in order to establish, develop and maintain the services capable of satisfying these needs, which can be summarized as follows:

- to provide the best conditions for women to achieve happy motherhood;
- to put an end to the avoidable loss of human resources.

Honoured delegates, Ladies and Gentlemen, after this perhaps lengthy introduction showing the importance and the place of maternal and child health in health services, I will now start the third part of my talk:

### III - THE PROBLEMS OF MATERNAL AND CHILD HEALTH IN WEST AFRICA OR, THE CHARACTERISTICS OF MATERNAL AND CHILD HEALTH (MCH) IN WEST AFRICA

I will give the general characteristics leaving it to each delegation to tell us during the group discussions the characteristics relevant to their own countries.

Although mother and child have some specific characteristics which distinguish them from the rest of the population, they participate, however, in its health problems; we therefore consider the health problems common to the population as follows:

- Maternal health problems;
- Child health problems;
- Factors having an influence on the outcome of pregnancy.

1. Health problems common to all sections of the population

consist of:

a) Under-nourishment and malnutrition.

Nutrition plays a fundamental role in health- new born, children, adolescents, pregnant women and nursing mothers are particularly sensitive to the effects of malnutrition and under-nourishment.

The major part of avoidable deaths may be attributed to the combined action of malnutrition and infectious diseases.

b) Infectious diseases such as:

- Malaria which encourages prematurity and debilitates the mother;
- Measles and whooping cough predisposing to tuberculosis, more difficult to diagnose in a child;
- Parasitosis of the intestine.

c) Dental condition of the population.

d) Another aspect of the health problems of our countries common to the whole population is the absence of data and reliable statistics; it is only with an accurate knowledge of the situation that problems can be solved; this already stresses the importance of collecting data and the importance that should be given to this.

In addition to the absence of reliable data in order to evaluate the situation on the spot, we must add:

- the conditions in which our populations live: the major part of our populations live in rural areas with low incomes, a rudimentary education level and in very poor hygienic conditions;
- insufficient basic health structure;
- insufficient resources re. health personnel (quantity as well as quality).

## 2. Maternal Health Problems

These are:

- Maternal morbidity;
- Maternal mortality.

### a) Maternal morbidity

This group consists of the diseases linked to pregnancy and morbid conditions related to the puerperium.

#### Morbid conditions related to pregnancy:

- pregnancy sickness;
- toxæmia of pregnancy;
- antepartum hæmorrhage;
- shock
- infections;
- complaints associated with pregnancy (anaemia - infectious diseases):

Morbid conditions in the puerperium (neglected dysotoc and precipitate deliveries, pathologic postnatal conditions)

These are amongst the most common in our countries:

- traumatic complications during delivery:
  - rupture of the uterus;
  - vulvo-vaginal tears;
  - traumatic bladder injury.
- complications in the third stage of labour;
- pathological aspects of puerperium;
- anaesthetic accidents and inefficient resuscitation.

All these morbid conditions end, either by recovery, or permanent sequelae, or death and this brings us to the second problem of maternal health.

### b) Maternal Mortality Rate

is the number of women who die as a result of pregnancy per thousand live births:

$$R = \frac{\text{No. of Maternal Deaths}}{\text{No. of Live Births}} \times 1,000$$

We do not have figures concerning the maternal mortality rate in Africa; note for record that it was 1,4 per thousand in 1936 in France and that it is today 0,26 per thousand. It is most certainly above the rate of 1,4 per thousand in Africa.

### 3. Child Health Problems

#### a) Infant morbidity

The six main causes of infant morbidity in our region are:

- respiratory infections;
- gastroenteritis;
- malaria;
- parasitosis of the intestine;
- measles and other infectious diseases;
- caloric-protein malnutrition which endangers the intellectual development and the growth of the child.

To be thorough we must mention the risks caused by pharmaceutical products and ionization radiations.

#### b) Infant mortality

The number of infants who die in the first year of life per thousand live births:

$$R = \frac{\text{No. of Infant Deaths}}{\text{No. of Live Births}} \times 1,000$$

The average infant mortality rate is estimated at 24 per thousand in francophone West Africa (in 1973). It is estimated at 12,6 per thousand in Sweden and 21,7 per thousand in France.

The infant mortality rate indicates the state of health and hygiene of a definite population.

Infant mortality is divided into neonatal mortality covering the first 28 days of life and the post-neonatal mortality covering the first years of life.

The most dangerous conditions during this neonatal-post-neonatal period are:

- neonatal tetanus - responsible for half of the neonatal mortality in certain countries of our region;
- obstetric trauma;
- prematurity;
- respiratory infections;
- gastro enteritis;
- infectious diseases such as measles and whooping cough.

In the one to four year age group, the causes of mortality can be listed in the following order:

- respiratory diseases;
- malaria;
- malnutrition;
- gastro enteritis;
- tuberculosis;
- accidents.

If today infant mortality has decreased in industrialized countries it is because these conditions have been controlled, the environmental hygiene and infant nutrition have been improved. The remaining infant mortality rate is partly due to perinatal mortality which these countries now fight. Perinatal mortality affects the period between the 28th week of gestation and the seventh day of the life of the newborn; it is the sum of still births and deaths during the first week of life. In industrialized countries with a high socio-health level, the amount of perinatal deaths is used rather than the amount of maternal deaths to indicate the quality of maternity care.

It is for this reason that during the last years we have witnessed the definition of the concept of pregnancy at high foetal risk. We have not, unfortunately, gone that far in our countries; the infant mortality rate is still high because of the late aspects of postnatal mortality. We must however also adopt this new concept of identification of pregnancies at risk, justifying a routine treatment and more immediate attention.

Such a concept has the advantage of reminding us that child health has a close relation to mother's health and that is by giving the mother the necessary care that we can solve the health problems arising with the newborn and the infant even before its birth.

The perinatal mortality rate (PMR) given in 1965 varies between countries from 18,3 per thousand (Bulgaria) and 82 per thousand live births (Mauritius). In our countries, a 69,9 per thousand PMR has been registered in Gambia.

The rates of 40 to 80 per thousand live births are frequently found in developing countries when the 18 to 30 per thousand rates are those of industrialized countries.

Ladies and gentlemen we will now study the fourth element of maternal and child health problems.

They are:

#### 4. Factors Having an Influence on the Outcome of Pregnancy

Thanks to the statistical techniques of analysis with multiple variables, the following factors could be isolated as being elements of influence on perinatal morbidity and mortality as well as on the mortality rate. They are:

- socio-biological characteristics of the mother (height, age, parity, socio-economic conditions);
- poor past obstetric history;
- period of gestation;
- weight of the foetus at the time of delivery.

##### a) Socio-biological characteristics of the mother

They are essentially:

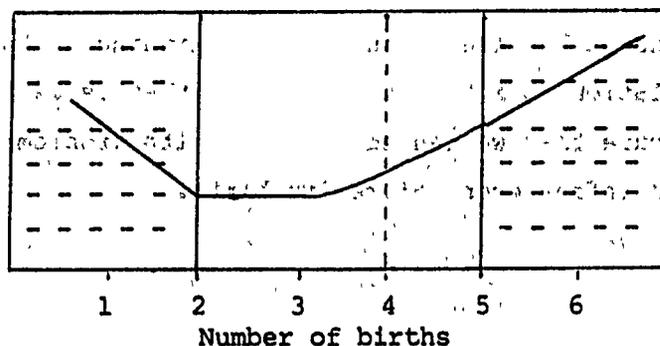
Height - age - parity and socio-economic conditions.

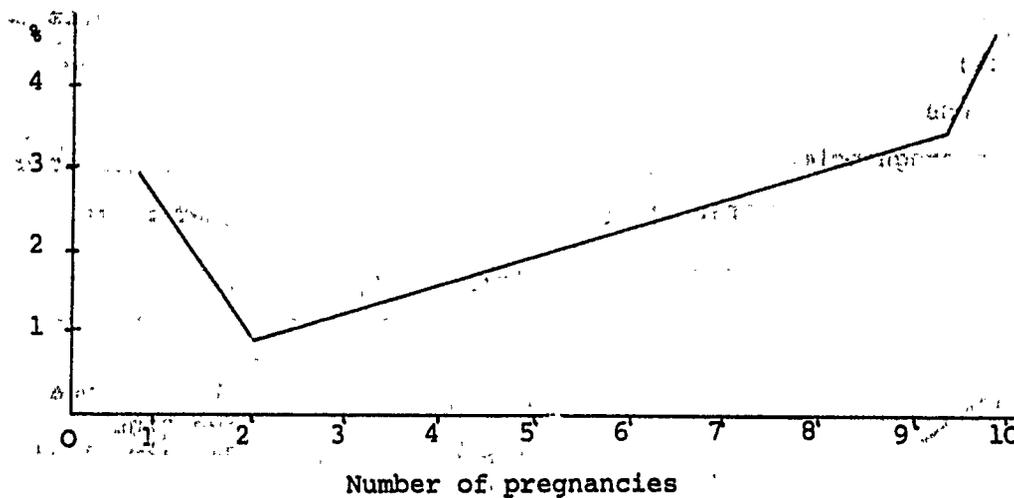
Height: The perinatal death risk is greater for children whose mothers are short.

Parity: At equal age, perinatal risk is lower for the second and the third pregnancies; it is higher during the fourth and the following pregnancies (except in higher socio-economic groups) and it stands at an intermediary level between these two positions for the first pregnancy.

RISK

Extract from  
"World's Health"  
Magazine,  
January, 1974





PERINATAL MORTALITY RELATED TO THE NUMBER OF PREGNANCIES.  
(Merger)

In Great Britain it has been shown that perinatal mortality increased by 54 per cent from the fifth pregnancy; this is partly explained by a high proportion of premature births.

In Korea, the perinatal mortality rate increased from 68 per thousand at the second birth to 168 per thousand at the ninth birth. In Canada it is shown that the mortality rate increases regularly with the number of births.

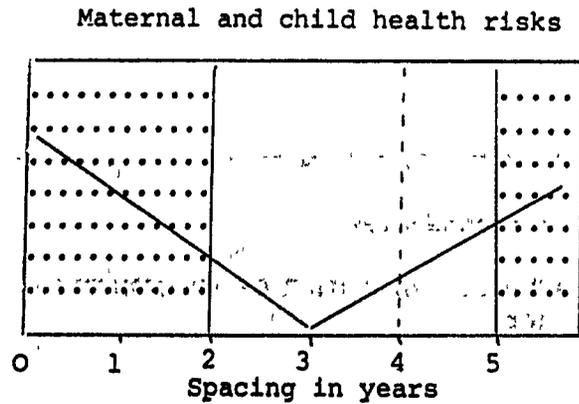
The maternal risk is also increased by the number of births; this risk is slightly higher during the first pregnancy than during the second and the third; it increases for each of the subsequent pregnancies and very rapidly from the sixth.

It has also been shown that a correlation exists between a high parity and complications of pregnancy: placenta praevia, haemorrhage, obstetric trauma complications, prolapse of the umbilical cord, attitude of the foetus or mal-presentation.

The incidence of certain disorders such as diabetes mellitus is likely to increase with parity; as would poor nutrition and difficulties in breast feeding, the interval between pregnancies or the Intergeneric interval.

Perinatal and infant mortality rates are at their lowest when the

gap between the end of one pregnancy and the beginning of the next one is two to three years; the infant mortality rate increases as the Intergenerie Interval shortens; the rate is at its highest when the gap is below 24 months between pregnancies (inadequate weaning, malnutrition). Other studies have shown that interval of more than six years can bring about higher risks.



"World's Health"  
Magazine  
January, 1974

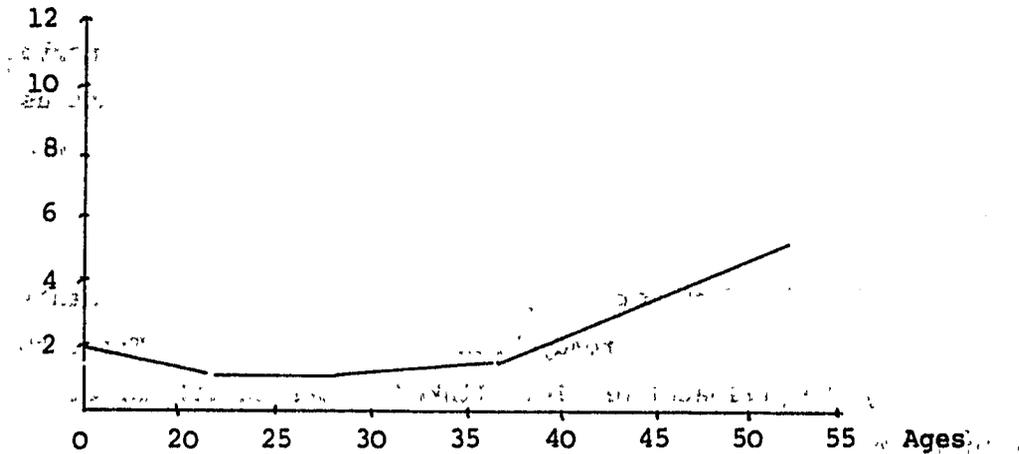
Greater risk with spacing below two years and over five years.

There is a correlation statistically significant between the number of pregnancies and the maternal and child mortality rate. A high infant mortality rate is associated with too frequent pregnancies; because of this high mortality there is a desire to increase the frequency of pregnancies; this weakens mothers and makes them more vulnerable; it is a vicious circle which must inevitably be broken up,

The age of the mother: At equal parity, the perinatal risk increases rapidly when the mother is over 30 years of age.

Infant mortality is higher when mothers are below the age of 20 and over the age of 34. Whatever the parity, the late intra-utero mortality rate increases with the age of the mother.

Some congenital anomalies are associated with a relatively advanced age. Mongolism or Down's syndrome has an average incidence of one case in 2,000 to 2,500 live births, but one out of 300 in the case of women between the age of 35 and 39 and one out of 50 for women particularly older.



For the mother the mortality risk is higher before the age of 20 and after the age of 30-35. It is minimal between the ages of 20 and 30.

**Socio-economic conditions:** The maternal and perinatal risk is higher in the less fortunate classes of society; it decreases with the improvement of the socio-economic level and under the influence of the development of the medical social and administrative infrastructure.

b) Past Obstetric History

With an abnormal past obstetric history (abortion, foetal death, toxæmia, low birth weight) there may be a risk of perinatal mortality in subsequent pregnancy.

c) Period of Gestation

- complications occurring during pregnancy increase the perinatal mortality risk (toxæmia of pregnancy, ante partum hæmorrhage);
- prematurity and post-maturity are factors which increase the perinatal risk;
- an unfavourable intra-uterine environment (maternal infection and toxic conditions) predisposes to foetal perinatal risk, and this especially if there is a subsequent difficult labour.

d) Infant Birth Weight

The perinatal mortality of babies weighing 2,500 gr. or less is 30 to 35 times higher than that of babies weighing over 2,500 gr.

Ladies and Gentlemen; Members of the Health Team, at the end of this third part of my talk, it appears that Maternal and Child Health problems

are numerous and of variable importance. The maternal and child mortality rate which we are studying are the results of avoidable causes such as malnutrition, under-nourishment and the complications linked with pregnancy and the puerperum.

The high rate of infant mortality is also due to later components which industrialized countries have already been able to overcome. These countries are now fighting the perinatal problems linked to congenital malformations and genetic problems.

This shows us what our priorities must be in the search for solutions to these problems.

The study of factors influencing pregnancy show us and help us to understand the improvement which birth control can bring to maternal and infant morbidity and mortality rates.

#### IV - SOLUTIONS

Mr. President, it is our duty as members of the health teams as much as it is the duty of our governments to find solutions to maternal and infant health problems which have been stated.

These solutions will consist of comprehensive methods through which the objectives of maternal and child health can be reached e.g. on the one hand to improve the outcome of pregnancies and the health of women of childbearing age, and on the other hand, to increase the chances of survival, growth and development of children. So, we now reach the fourth part of my lecture in which we contemplate the following:

- Maternal and child health activities;
- Organization of maternal and child health services especially on the improvement and better conditions for a successful outcome.

##### 1. Maternal and Child Health Activities

These are classical specific activities, already customary and common.

to various health sectors and also more recent activities.

a) Specific and classical activities:

- care and supervision of the parturient woman;
- supervision of delivery;
- postpartum care;
- immunisation against certain infectious diseases;
- supervision of the growth and development of the child;
- treatment of the sick;
- referral of sick patients to well-equipped health centres;
- record keeping.

Care and supervision during pregnancy: Prenatal supervision and consultation should occur during pregnancy if possible at monthly or twice monthly intervals at the beginning and the end of pregnancy. This consists of recognising and treating the pregnancy complications, anaemia, threatened abortion and infectious diseases.

Supervision of delivery: Ideally, deliveries should take place in maternity hospitals. We must aim for this as socio-economic progress permits but actually we are far from it; we are therefore forced to admit that non-risk deliveries (i.e. undiagnosed previously) be carried out at home by an auxiliary personnel, integrated into the health team, trained and supervised. Priority maternity beds will be given to cases where risk is anticipated; let us remember that the risk factors are: age, parity, weight of the mother (minor risk between 50 and 70 kgs), height of the mother (high risk if the height is below 1,50 m.) socio-economic factors; poor past obstetric history, pathology associated with pregnancy, complications occurring during pregnancy.

To follow our enumeration of the maternal and child health activities, I quote:

Immunisation against certain infectious diseases

This means primary vaccination as well as re-vaccination. It is the administration of BCG, anti-smallpox vaccine, of immunisation against diphtheria, tetanus, whooping cough and poliomyelitis at the third month of life; it is also the immunisation given against measles and yellow fever.

This vaccination service is available to the mother in case of tetanus.

### Supervision of the growth and development of the child

This constitutes one of the maternal and child health activities. It consists of checking the weight graph.

All the above activities constitute preventative activities; they must be associated with:

#### Treatment of the sick

as treatment of the sick promotes attendance at health centres.

#### Record keeping

enables a rational follow up of mothers and children; the file must be simple and open to the personnel; it is important because it will make the planning of future activities easier.

In considering these important specific activities we must not forget certain particular aspects of the maternal and child health activities.

They are:

- the promotion of an informative health programme in order to identify the problems of mothers and children, to plan, establish and evaluate the current activities;
- school hygiene;
- common institutions: creches, organizations for handicapped children and adoption.

### b) Health Activities common to various Health Sectors

The maternal and child health benefit from activities which help resolve the health problems of the whole population.

They are:

#### Health Education

The health education of the family is one of the most efficient instruments of reducing the maternal and child morbidity and mortality rates. There are many different possible methods (integration into different school education programmes or active discussion by social groups). I must point out that in our countries, personal contact is the best means of

influencing concepts, attitudes, behaviour; mass media has only limited efficiency.

It will be mainly focused on nutrition, breast feeding, hygiene of the environment (habitat, water, evacuation of refuse), fight against infectious diseases.

I must insist, even if it bores you, on health education which constitutes a short cut for us; it will enable us to reach the lowest health level in the shortest time, taking into account our limited means.

Other activities of which maternal and child health benefit:

#### The Development of Personnel Resources

Training schools must be developed; the number of personnel must be increased, diversified, taking our resources into account (there must be no hesitation in training and integrating the traditional birth attendants into the health team); in-service training must be established and promoted. The training given to the members of the health team must guide them directly towards the problems of public health, particularly towards those of their own countries.

Research must aim at finding immediate solutions applicable to our health problem.

Amongst the services common to various health sectors, we must finally quote:

#### Legislation

which, by reinforcing, must improve the quality of services.

Legislation relating to maternal and child health covers the following areas:

- registration of births and deaths and notification of cases of diseases;

- qualification of the personnel and authorisation to practise, on approval of health institutions;

- public health measures to protect the population (medical consultation at the beginning of the school year, legislation for working mothers).

Honoured participants, you will allow me to end this chapter on maternal and child health activities by touching on the subject of recent activities in maternal and child health.

I would like to talk about the health aspect of family planning.

c) Recent Maternal and Child Health Activities (Health aspect of Family Planning)

I have named the health aspects of family planning and the subsequent services maternal and child health activities. The health aspects of family planning are linked with changes in reproduction rates; some pregnancies are avoided or postponed, others are made possible by the treatment of sterility.

Indeed, the health aspects of family planning comprise the following activities:- spacing of births - which must take into account the health of the mother as well as that of the father and the other children;

- sterility;
- preparation for parenthood;
- sex education.

and the administration of other services of which members of the family can benefit during family planning consultations (detection of certain genital diseases; direction of the patients to specialised health centres; genetic counselling).

2.2.2 Organization of Maternal and Child Health Services

Honoured audience, it would be vain to enumerate maternal and child health activities, and to establish them without providing them with a solid organization.

I will not go into the detail of the organization, but I shall simply emphasize the conditions required for a good organization, in other words, the conditions necessary for the success of maternal and child activities. They are:

- a) The necessity for a preliminary inventory of resources, the country's potential, as well as the identification of the needs of the families.
- b) The adaptation of the services within the country to meet these needs.

The health services for mothers and children will be more favourably accepted by the population if they are adapted to its socio-cultural heritage.

One must always try to choose the type of services best suited to fulfil the identified needs within specified financial limits which, of necessity, leads to a third condition:

- c) The need for plans to define the priorities from which the short, medium and long-term objectives can be drawn. We will determine these objectives more precisely in quantitative terms.
- d) The necessity to revise the structures periodically in order to adapt them constantly to the socio-economic standard of the country and consequently to the new needs which might occur in the population.

The systematic and continuing research for the best possible means for action - adapted to different situations - is a guarantee of success.

- e) The necessity for a multidisciplinary approach to the maternal and infant health problems.

This multidisciplinary approach must be realised within the health services as well as within other sectors of the nation; it can become a reality by creating consultative groups including members of the various medical specialities (pediatricians, gynaecologists, nurses, midwives, social workers) and members of various governmental services (ministry of education, agriculture and information, of planning and finance).

f) The necessity for the integration of maternal and child health services into health services; the maternal and child health services must be the kernel of other health services and must not be isolated from them.

It is within the existing health services that maternal and child health activities must be organized; by doing so we will avoid the wastage of the inadequate human and material resources available; in doing this, a unique network of equipment, personnel and transport can be used in the most economical and comprehensive manner.

The same concern for integration creates the fusion of the curative and preventative services, the maternal health services with those of child health, and produces improved efficiency.

The last two of the above mentioned conditions are easily explained because maternal and child health problems extend beyond the framework of gynaecology, obstetrics, pediatrics, child welfare and genetics. Mothers and children, although they have some specific characteristics, participate in the health problems of the whole community.

g) Necessity to work in a team and to have good management of the health team.

The functions of each member of the team must be well defined so that the various members are not in each other's way and so that their usefulness is equally distributed. Each member of the team must be able to assume full responsibilities for their work and to take the necessary measures when the problems occurring are within their field; this conception of the health team makes everyone an equal partner.

h) The necessity to have enough polyvalent personnel resources capable of satisfying the needs of the mothers as well as those of the children.

i) The necessity of a good administrative organization of the services including well defined functions at central, intermediate and peripheral levels.

## V - RESULTS

Ladies and gentlemen, it is not enough to recognize the health problems and to find solutions even if they are the best possible ones, but we must always try to evaluate the results obtained. Without evaluation, it is not possible to know if the above objectives have been reached; the parameters which enable us to evaluate the activities are:

- the extension of the health services, this means the geographical coverage of health activities in addition to the number of individuals receiving these services.

- the maternal and child morbidity and mortality rates. In order to appreciate these parameters an empiric observation of the data accumulated by the record system of registration of births and deaths may be used. Such information must be given by regular reports. The data collected by sampling system must be established within the norms of viability and validity.

Finally, some controlled studies can be done. This is the only way for the above hypothesis to be carried out with certainty. (A public health measure is applied to a particular situation and a comparative study is made between the experimental area and other control areas).

Mr. President, honoured delegates, members of the health team, what will be the conclusion at the end of the survey of such a vast and specific subject?

In our countries, the identification of the maternal and child health problems is almost achieved, even if it is not accurate.

The answers to these problems are also foreseen. What we are missing is correct information and this is due to the lack of well organized statistical services. We also lack the means, but do we use those available rationally? It appears not. It is for this reason that it is urgent at this time to establish for ourselves a more efficient health service administration. The lack of evaluation is another crucial gap in our system.

Honoured delegates, the establishment of a health service capable of fulfilling the minimal needs of the major part of the population must be our constant concern and nothing must be spared to protect our human capital. We must search for new contributions, new activities which may help to improve the standard of health of the age group and the section of the population which is most vulnerable, I mean by this, mothers and children.

Mendouse said, and I quote:

"The quality of a population varies in direct ratio with the amount of dedication spent on its youth" end of quotation.

Mr. President, honoured delegates, let us act for our governments and ourselves to bring our maternal and child health services closer everyday to our declared aim, and I quote:

"In the best available way, every child should live and grow in a family atmosphere, feel loved and secure in a healthy circle, should be properly nourished, his health cared for by providing him - among other things - with the necessary medical attention and he should be taught the elementary elements of hygiene" end of quotation.

Allow me to add that it is desirable that every expected pregnancy should be a wanted and well-conducted pregnancy.

# PROBLEMS AND PRIORITIES IN MATERNAL AND CHILD HEALTH IN WEST AFRICA

Docteur Papa Gaye  
Director of Public Health, Senegal

## INTRODUCTION

1. West Africa is part of the Third World which is often represented with the following characteristics:

- low national revenue
- illiteracy of the majority of the population
- primitive instruments and poor working conditions
- economic reliance on more developed countries etc. etc.

This situation is often reflected in medico-socio aspects by the persistence of the pathetic triad:

- Poverty
- Ignorance
- Illness

2. West Africa comprises roughly 16 countries with a surface of 6.200.000 km<sup>2</sup> and 106.000.000 inhabitants.

3. The Countries of West Africa have certain characteristics in common:

a) The environment: Nature is in some parts still wild and uncultivated, hardly touched by human hands; the environment is favourable to the breeding of vector agents in infectious diseases.

b) Political aspect: It is a group of small republics, some territorially vast, some of a rather average surface area but almost all, except Nigeria, have a small population and with the exception of Liberia have only recently acceded to independence.

c) Socio-economic aspect: All countries are backward in social matters (education, health) and in economic affairs: very low standard of living, production of raw materials exported at a low price and import of manufactured goods at a high price.

d) Mothers and children form a very vulnerable group representing from 65 to 70 per cent of the population. It is in this light that health problems must be examined. To identify these problems as a whole, in order to determine the global level of health of the nation, numerous and various health indicators are used. They can be classified into three categories: indicators of resources, indicators of results, socio-economic indicators.

(i) Indicators of resources

- Nutrition Indicators
  - (- food ration (quantitative indicator)
  - (- percentage of animal proteins against overall proteins (qualitative indicator)
  - (- percentage of starchy-cereal calories in the overall consumption (qualitative indicator)
  
- Indicators of Medical Equipment
  - (- percentage of the population supplied with drinking water (equipment indicator)
  - (- number of people per physician (medical rate)
  - (- number of hospital beds per 1,000 habitants)
  - (- public health expenditure per inhabitant)
  
- Indicators of Health services utilisation
  - (- percentage of deliveries in maternity hospitals)
  - (- percentage of deaths medically recorded)

(ii) Indicators of results (or of situation)

- Strictly Health Indicators
  - (- specific mortality rate per disease)
  - (- morbidity rate per disease)
  - (- parasitism index)
  - (- average index of the gravity of trachoma (classification in T2, I, II, III - Mac Callen and classification of Assad & Maxwell - Lyons)
  
- Indicators of the state of nutrition
  - (- Average birth rate)
  - (- gross mortality rate)
  - (- average weight increase of the woman during pregnancy)
  - (- infant mortality rate)
  - (- still birth rate and infant mortality rate from 0 to 27 days (or neonatal mortality rate)
  - (- post-neonatal infant mortality rate (28 days to 12 months)
  - (- mortality rate from one to 5 years)

- percentage of recorded deaths of children between one and five years
- mortality rate due to infectious diseases
- proportional mortality rate (Swaroop index)
- expectation of life at birth
- expectation of life at a certain age
- health indicator of mortality

The easiest and most important indicators in under-developed countries are:

- the infant mortality rate (completed, if possible, by the one to five year old mortality rate)

(iii) Socio-economic and cultural indicators

- national revenue per inhabitant
- school attendance rate
- percentage of the population able to read and write
- percentage of the male population working in agriculture

I - MATERNAL AND CHILD HEALTH : THE PROBLEMS

Since one sector of the medico-health activities must be considered in this talk - e.g. the health of mothers and children - we will limit ourselves to only a few problems. We could for instance keep the morbidity and mortality rates. Our statistics are still not perfect (no services rationally organised exist). But we know that these rates are high for mothers as well as children. These facts constitute problems that must be resolved.

To do this, we must know the cause of death. It is therefore important to raise questions in order to make this task easier:

1. Morbidity and mortality rates are high

Why?

Because:

a) Most mothers are delivered without proper supervision.

Why?

b) The children born under these conditions do not in addition receive proper care.

Why?

c) Important mistakes of general and nutritional hygiene are made everyday.

Why?

2. Let us answer those three questions:

a) and b) because our health coverage is poor.

Health coverage means the overall basic structures, the mobile units, the personnel responsible for the implementation of these services. This results in providing care, e.g. the administration of services.

Here we must explain the S.S.O. and its reorganisation.

c) Important mistakes are made because:

- on the one hand parents are ignorant
- on the other, they are not informed

In this way we immediately and clearly see the steps to follow. We must:

- (i) establish an adequate medico-health coverage
- (ii) educate and inform the population

II - MATERNAL AND CHILD HEALTH : THE PRIORITIES

Now, everything becomes difficult. Once the problems have been set out, we must act and in order to act we must have resources. It is therefore important to record the resources available and to establish a hierarchy of the problems to be solved (which will be called the sifting out of priorities). These priorities will receive most of the resources available.

It is difficult to sift out explicitly the priorities in maternal and child health matters because the problems are almost always linked and interfere with each other.

Let us suggest an order of priorities:

- enable the maximum number of deliveries to be supervised, this means:
  - maternity centres within reach (Touba-Toul)
  - adequate personnel (midwives, traditional birth attendants, UNICEF → training of traditional birth attendants)

- health education and preventive medicine
- vaccination
- dietetics
- family planning counselling
- improvements of the standard of living.

#### CONCLUSION

But it happens that these facts must be conducted in accord because a programme must be harmonious, especially when medico-health is concerned.

This means we must adopt a relatively new step which happens to be the only one to solve our problems. It is planning:

- planning in space
- planning in time

You may well imagine that each of our African countries has an appropriate programme of activities jealously guarded. I refer you to it.

# ROLE OF THE MIDWIFE IN THE FRAMEWORK OF NUTRITION IN WEST AFRICA

Dr. Thianar N'Doye

Director of 'BANAS' in Senegal

## I - TOPIC

### A. NUTRITION

In this statement, we will confine ourselves to adequate nutrition, services and programmes, referred to as adequate nutrition programmes, and set aside nutritional research which has been done for almost 20 years to make nutrition a functional and effective discipline in this Western part of our Continent. However, adequate nutrition proceeds from experimental action which calls for the cooperation of the midwife, wise woman, wife, mother, practitioner. In the same way, teaching has not, up to now, for reasons, to which we will return later, given all the results we might have expected. As for applied research and experimental action, it does not exclude the participation of the midwife. So, to summarize, pure spontaneous routine is one of the limiting factors which characterizes our under-development.

My intention is not to lecture you on nutrition; it would not come up to your expectations. It seems to me, however, useful to link it with activities which are part of your role and support it. Adequate nutrition services are numerous and increasingly varied. In this particular sphere which we are at the moment considering, we must mention the most usual aspects.

Investigations and enquiries: These are about food consumption, dietary habits, their evolution and tendencies, costing and minimum diet to support life and nutritional clinics. These investigations and enquiries are very important, with particular reference to the manner of feeding children; these investigations and enquiries have been, for example, the basis of our work entitled: "Guide on weaning diet in Senegal" conceived with the invaluable cooperation of Mrs. Aicha N'Doye, State Midwife, the Misses Diatou and Fatou Camara, State Registered Nurses, Mr. Alphonse Coulibaly, Secretary and Dietary Investigator. Above all, they give us the opportunity to increase our knowledge to enable us to teach others.

My acquired knowledge of nutrition is not so different from what has always been done in the village. Why didn't I recognise it sooner? Because the point is not only to know but to be aware of it.

Experimental action: Firstly, the study of educational efforts into a well-balanced diet rich in calories to support life, diet during pregnancy and the perfection of the technique of nutritional supervision particularly during pregnancy and infant feeding especially during the first three years of life in order to aid nutritional recovery and prevent malnutrition.

Consider the growth curve of the child and his psychomotor development as like the path of a rocket in orbit with the same chances of success and the same risks of failure according to the initial strength of propulsion. Our grand-mother relied on "n diao" and compared with it the "bourget" is of little consequence. This experimental action with the cooperation of all of you has helped in the creation of our national technical standard chart of applied nutrition, adequate for maternal and child care in Senegal.

Dietary technology: is a domestic experiment, a rationalisation of traditional recipes, industrialised and individual, to improve new food, local food for the children such as the "ferelin" now being developed in Senegal, "superamine", "fifa" elsewhere, the purpose being - once the value of its scientific content is proved - to re-establish in this field our spirit, our traditional genius without which it is futile to hope and protect the health of the African Family.

Let us enumerate the other activities: training of teachers, education of the population through radio, television, studies with audio-visual apparatus, brochures, films, slides, etc... nutritional education, more especially as lacking fuller master-data and because of the habits and traditional feeding habits of the populations, the teaching methods used up to now remain inadequate. I intervened about this subject at the UNESCO meeting which has just come to a close. It will be quicker to mention them, rather enlarge on them.

From the grouping of activities on adequate nutrition programmes, we will retain:

- The programme of nutritional and health protection for the vulnerable groups in Senegal;
- The programmes: women - mothers - children "UNICEF" in Senegal in the Thies region, UNICEF - TOGO";
- Health, drought, nutrition UNICEF-WHO-CILS, Mrs. Marie T., a UNICEF Nutrition Consultant who has previously helped me in BANAS;
- Nutrition, basic health service in Senegal (Fatick), Nutrition (SSP);
- Nutritional recovery IPS-BANAS in Senegal. Aristide Le Dantec Hospital;
- School meals (kindergarten and canteens) in Senegal;
- Communities: boarding schools, sports clubs, jails, etc... calling upon the midwife as a community worker.

The growing number of these programmes in many of our states, explains and justifies the policy of our respective governments which tends to amalgamate them in one coordinated national work, under the same technical supervision as is the case in Senegal. Relationships with the population: are most vital. We may remember from Boston, three years ago, that the best argument to persuade a mother against a new pregnancy is the reassuring knowledge that the two or three children she already has will be well fed and in good health.

#### B. ENVIRONMENT : WEST AFRICA

If the division between forest and savannah, the micro-ecology, the ethnical differences, the dietary customs oppose unity of identification of the activities and programmes we can still establish progressive standardization of methods, made easier by technical exchanges between our states and the excellent relations which are established and are improving between the dieticians of our district and even of the whole of Africa during our frequent meetings. In fact, African nutrition is one, Africa is one. Only variances exist.

At the same time, in the field of nutrition, accepted efforts and means used to put these into effect, the English-speaking countries are as a rule way ahead of french-speaking countries. This must be emphasized as the latter occupies the Sahel. The six countries concerned which share the vast Sahel, whose populations were recently thirsty and hungry and whose children died

in great numbers of marasmus depended, at times, on dietetic aid. It has rained, with God's help, but the children will continue to die of dehydration on the banks of rivers which overflow - ironic destiny. But why?

Although we, as a profession, know how necessary it is to give a child a drink more than the population, we know nothing about the efficient conservation of pure water in the tropics.

Most certainly, the full diet intake of the savannah region is better than the intake of the forest region because the cereals are four or five times richer in protein than tubers are, but the sauces made more expertly and being richer in the forest region compensate for this. The Dahomean sauces are the most advanced in the world. After all, it might be better for us to live in the forest region.

## II - THE MIDWIFE

### A. WOMAN - WIFE - MOTHER

This image is from my teacher, Professor Tremolieres "that the family is united around the father who is the provider, the mother who is the feeder, the children who are essentially the consumers" - I might add though in Africa the mother is too often the provider, the father feeds his family very little and the children are too numerous.

The African, bringing herself up-to-date, knows these reversing roles: mother becoming provider, father feeding his family very little and children being even bigger consumers. And so, the woman's responsibility is to be the feeder with her breasts, her hands, her heart and her love. And with care she will make the child, not an object, but a token of love. He stakes his whole life on his feeding habit, his behaviour - present and future. A baby cries more for love than because it is hungry. Do we always think about the consequences that arise from a scene where the mother feeds her child, smacks him, raises her voice and where the father is angry. What more could I say? Only that the pregnant woman who often cries will see her child unhappy all his life.

## B. PRACTITIONER

It will be enough to say in this paragraph that every good pediatrician is a dietician. That the contrary is not true is to the pediatrician's benefit. In all cases, every midwife is a dedicated pediatrician and dietician.

## III - ROLE OF THE MIDWIFE

### A. IN HEALTH-CARE

The activities and programmes mentioned above point out to you the level of the specialized services of the hospital, services of basic health, maternal and child health centres where the midwife does not make the mistake of confusing artificial infant feeding and weaning, complementary feeding and supplementary feeding. Without doubt, there is so much to do to increase the number of these posts and, in due course, to draft the midwife there. It is time that the hospital and the maternity hospital adapt themselves to the medical needs of our countries and cease to be tumours in our national provinces. So far as nutrition is concerned, pregnancy is marked by under-nourishment, anaemia, if it is not the immaturity of the young girl married at an early age before developing all the physical and physiological proofs of her maturity. Consequently, there are numerous miscarriages, observed in the primagravida and also many deaths of first-born and second-born children. We prevent these abortions with Ephynal Roche and Luctoglyen, not forgetting that these products belong to the vital fatty acids. I shall not talk about vitamin therapy as preventive medicine because they are found in your food. As we can see, the preparation and dietary supervision during pregnancy is at stake. At this point, the sacrifice of the pelican, legendary or otherwise, would be too much and not enough.

On this point, our awareness is such that in future we will consider our various ills to find remedies by going back to the inexhaustible source of our African medicine.

### B. EXTERNAL COOPERATION

Everything which concerns the family must be familiar to you. The

best cooperation must involve you with the social workers and educationists, primarily with the grand-mothers, guardians of so much ancestral knowledge but whom we distrust if they interfere too much, with motivators, school-masters, agents of rural development, in short, not only with many other agents, but also with all.

### C. NECESSARY TRAINING

We are far from it. Whereas the midwife remains the woman looked upon with authority by the population, she is in process of becoming less informed about nutrition. Here the credit goes to the instructors and social workers who number in their training close to thirty hours per year, per grade, compared with ten hours for the midwives. Fortunately, pediatrics lessens this deficiency. The glory will also go to the domestic science teachers and the rural instructors.

Refresher courses should be more appreciated by those who are more responsible, the senior midwives. Nevertheless, there are exceptions too well-known to be mentioned, too numerous enough to even "prove" the rule.

### D. REFORMS AND PERSPECTIVES

The competent authorities are actually well aware of all the above. Three chapters will hold our attention: radical change of the programmes, specialization and post-university training.

Programme changes: Neither tradition nor the desire for equality of diplomas can resist the necessity for change. The problem is to envisage this reform before it is promoted. Indeed, these changes must be patiently elaborated and do not occur spontaneously. They are beginning to take shape in the field which concerns us.

Specialization: Nutrition allows for a higher and higher variable basic diet. The model here is Latin-America with the school of nutrition, INCAP in Guatemala which trains dietician nutritionists to the standard of a bachelor's degree in three years. As for the midwife, it would mean a reconversion because of the personnel needs demanded of us. There are no regular nutrition courses opened to her. To my knowledge, there is a one-year course in the

Netherlands, a two-year course at the University of Ibadan in Nigeria for English-speaking people, a short term course of nine months in Israel, which a country like Senegal could copy. Another possibility, often unknown, is of external programmed training courses; an attractive possibility, on condition that the trainees have beforehand been impregnated with the problems in a specialised department in their native country.

Post-University Training: has to be differentiated from specialization in that, for our countries, it must meet more clearly defined requirements for our needs. Training suited to our needs does not exist and specialist teachers in that field are lacking abroad as well as in our own country. Multi-disciplinary nutrition which has become so functional in our country retains its fundamental principle in the Faculty of Science rather than in the Faculty of Medicine as it is in Sorbonne. In France, some Faculties of Medicine have at their disposal a "nutrition unit" like the one at Nancy. Ours offers an optional module to the fifth-year students. We have every reason to be satisfied.

#### IV - CONCLUSION

I am aware that, all things considered, we kept to the limit of theory and application. Was it not necessary to explain the part of the midwife on the subject of nutrition within the framework of Western Africa? However, the questions and answers in which we are going to proceed will be, I am sure, more edifying.

## HEALTH EDUCATION

Ibrahima Beye

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### I. INTRODUCTION

I was asked to prepare, in a relatively short time, a talk on Health Education in your honour. Even at the risk of being incomplete in preparing this talk I could not refuse such an offer which is the proof of a certain awareness of the importance of the educative aspect of medicine, therefore of Health Education.

The term is not new; during the decades that preceded our national independence, those who held the power at the time took steps to safeguard their health.

We have not forgotten the endless circuits made by the teams of general hygiene mobile service and prophylaxis (SGHMP) aimed specifically towards prospecting and the treatment of large endemic diseases which decimated the population of our African countries: malaria, trypanosomiasis, onchocerciasis, cerebro-spinal meningitis, small-pox, yaws, tuberculosis ...

We also remember the health agent of urban centres with coercive power who visited houses to impose a fine on such women who had neglected to clean the canary or to fill in a puddle in which some mosquito larvae floundered.

We finally remember this field worker with no proper training who rambled about the town spreading panic within families.

We cannot totally condemn the acts of those teams, of this agent, of this field worker who, during the critical periods of the existence of our societies brought assistance in the conditions we all know.

These ideas already indicated a new form of action in health services that was not only to ensure the protection of the health of some privileged people, but also to supply a whole community with health education necessary to its survival.

## II - DEFINITION OF HEALTH EDUCATION

What is health education?

Pierre Delore, one of the pioneers in this field, gave this definition: "Health Education is not so much the transmission of certain ideas, documentation... than an integration of the data on hygiene in everyday life; it is a behaviour an attitude towards life."

It is an integral part of the general education and being so important it has first place within its structure because one must live and especially one must learn to live even before intellectual education is started. According to Delore it still remains: "the learning of laws leading to a healthy life" to make the whole Man whose somatic components and psychological aspects do not betray the World Health Organization's concept of total health as being physical, mental and social well being.

My own definition would be: a process whose final goal is to change attitudes and behaviour, in order to acquire the physical, mental and social well being.

## III - JUSTIFICATIONS

There is a quadruple aspect to the justification for Health Education:

1. From an economic point of view, the expenses incurred to safeguard health constitute a fruitful investment and the best of savings as it is for the protection of man against the aggressions likely to affect his well-being which would thereby reduce his capacity for economic development. Let us think of this peasant who by ignoring the benefit of preventative quinine

therapy is subject to ceaseless attacks of malaria which leave him helpless for several days, preventing him from any effective participation in the economic improvement of the nation.

Let us also think of this woman constantly preoccupied by the health of her child stricken with the dangerous measles developing in an undernourished system. Her contribution to the economic development is therefore annihilated by the fact that she devotes all her time watching over this child.

2. Health education is also justified because of its efficiency; a propaganda sensibly conducted encourages the individuals to improve their attitude and their behaviour.

3. It is further justified because preventative medicine, which is its essential substance, is less costly than curative medicine. Georges Duhamel formulated this concept in striking and picturesque terms: "Every therapeutic act is a battle and a battle costs a lot, even to the winner. To destroy the enemy; that is to say the infectious germ, it is sometimes necessary to ravage the invaded territory. Most of the active medicaments are horrible: they bring calm and safety but at what price! Some of them stir up our afflictions before they rescue us; they travel through the system chasing the enemy, ransacking, burning, and consuming everything on their way like an army of old troopers. There will always be sick persons to look after but the future of medical sciences, however, is in the prevention of disease. Prevention is not an I.O.U. to the system; it is a victory won over frontiers; it satisfies science and ethics at the same time."

4. Finally, for our countries, it is justified by the insufficiency which have been recorded in many fields: budget, personnel, health structures, medicaments.

It is evident that in the actual context of these countries, a national budget entirely devoted to the Department of Health would not be sufficient to stamp out the diseases that assault us. The volume of the budget allocated to health services is therefore not as important as the action taken by those services in order to practise a policy of preventative medicine sensibly conceived; it is crucial to encourage the individual to change his attitude

and behaviour as we know that it is useless to spend extravagantly on care if, when he is cured, the individual goes back to the conditions that were the cause of his illness.

#### IV - PRINCIPLES

Health education follows some rules and principles whose violation inevitably brings failure:

1. It must have a realistic and practical aspect as it concerns man's life; it is built on truth even if it hurts private interests. It is a science of action which refuses to be confined to routine, alienating conformity and sterile policies.

2. The mission of health education is to confer on individuals a positive outlook to health, to inculcate the notion of responsibility for his own health and other people's, to inculcate the notion of solidarity in order to bring him finally to participate in an active way in the protection of the health of the community of which he is a member.

3. Health education is not "revolutionary"; it takes into account the traditional values, exploits what is practical in them to try to improve living conditions of the population.

4. It is supported by methods and means adapted to the conditions of the environment, its psychology and the level of its education. We are concerned with learning, with making one understand by explaining as many times as is necessary. We must convince, change the minds in order to have the cooperation of the population. For this, the health educator must have a deep knowledge of the environment and of the psychology of the community to be educated.

We realise that this work is not one of the easiest; there are no immediate results and they are not spectacular. Many difficulties will have to be faced, they are called: ignorance, scepticism, indifference, routine, prejudice, egoistic interests. It is a long term work aimed at building a healthy society for the future.

## V - OBJECTIVES

In order to reach this aim, the Health Educator proposes the following objectives:

1. To enable those who ignore it and to remind those who have forgotten it to acquire sufficient knowledge of the human body, its harmonious functioning, the principal diseases and their causes, the ways of maintaining good health, of training the system to be resistant, of fighting against the causes of diseases.

2. To create a new concept of health and illness within the community.

3. Eventually to bring everyone to change his behaviour, his habits, to take the right step in order to maintain good health and to participate towards the improvement of the health-capital of the nation with the observance of the basic rules of healthy living.

## VI - THE HEALTH EDUCATION AGENTS

This health education mission falls on all the persons who are in contact with the population and who, because of their activities, play an educative role towards them: physicians, midwives, nursing personnel, school teachers, intermediary senior personnel, senior personnel of youth organisations and of structures for community development, they are all concerned and they must fulfil their role in which educative activities will be integrated.

It is in the hospital, at the health centre, the maternity hospital, the maternal and child health centre that the ill and those who accompany them are proved to be more receptive. It is there as well that physicians, midwives and nursing staff can exert an unquestionable influence upon those who have placed their entire confidence in them.

We now reach the theme of your seminar: Place and Role of the Midwife in the Maternal and Child Health Services and in the Family Health Services. The role and place of the midwife are defined in terms of the actual health needs.

The most ancient of the medical professions is most probably midwifery as it is contemporary with Man's venue on Earth. Some traditional birth attendants imbued with their empiric knowledge associated with an astonishing skill have sometimes being successful in dealing with dystocia, cases that should have been the concern of specialist surgeons.

With the accession of modern medicine, their younger sisters, the midwives, have taken over by bringing the changes so desired in the care of parturient women. But the midwives of old times were more characterized by their obstetrico-gynaecological competence - objective of the training programme of the past - than by their genuine disposition to look after the health of mothers and children. Seen in this light, the role of the midwife is obviously contrary to our actual concept of public health in this field. A new generation of midwives has emerged; without trying to start a quarrel between past and modern, one must recognize - at least for Senegal - the happy adaptation of the training of our generation to the health problems of the nation. A midwife is no longer only a deliverer of babies practising in a maternity hospital, she is rather a polyvalent agent of the health team within the fundamental health services. Equipped with a sound knowledge in pedagogy, her contacts with the community have become more open; she goes on practising her speciality but she is also a preventative agent. Her new qualification broadens her possibilities of intervention. She is now able to organise group discussions, to lead educative talks, to use a whole range of audio-visual aids in order to communicate with the masses. She knows how to receive and elaborate a straightforward educative programme, discuss its contents and ensure its implementation. In this manner she becomes the qualified agent for the promotion of family health. Is this not the essential role of a health educator?

## VII - CONCLUSION

I will end on a sentimental note but also one of hope by calling for your help from the bottom of my heart because I believe in educative health action; you also believe in it, I am sure. Africa which is waking up after a millennial sleep needs more than ever your contributions of which she is already assured to raise her up to the level of strong Nations where men, liberated of health problems thanks to a sensibly conducted educational programme, will devote all their efforts to build a better society.

# POPULATION, DEVELOPMENT AND FAMILY PLANNING IN WEST AFRICA

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The rapid demographic increase of African populations constitutes one of the main subjects of controversy of the past years.

The problem is to know what effects such an increase will have on economic and social development aspects.

In West Africa, there are three different attitudes to this problem.

Some countries (Ghana, for example) consider that the rapid increase of their population constitutes a major slow down in their development and have decided to adopt an official policy of birth control.

Other countries (Gabon, Cameroon, Ivory Coast, for example) consider that the rapid increase of their population constitutes a favourable factor to their economic expansion and they have a pronatal policy.

Most countries of the Continent and of the West African region do not officially show any major preoccupation in population problems and do not try to influence demographic levels and tendencies.

Our purpose here will be to discuss in a comprehensive way the population/development relation and from there we will identify what place family planning must occupy in our countries.

Firstly we will outline the better aspects of demography and demographic tendencies in Africa and the factors explaining them.

We will then identify the problems population brings to the economic development in various countries. Finally we will outline the role of family planning as we understand it in the African environment and more generally the role of population policies.

## I DEMOGRAPHIC LEVELS AND TENDENCIES IN AFRICA

In the field of demography, what is characteristic in Africa is the particularly rapid increase of its population.

Indeed, with an annual increase rate of 2,6 per cent, Africa comes second at World level, behind Latin America (2,9 per cent). There is however an important difference between these two countries: in Latin America, the birth rate is nearing the level of developed countries whereas in Africa it remains very high (31 per thousand); this means that if this tendency persists we may expect in the future a demographic increase rate to exceed that of Latin America and to reach or exceed the record rate of 3 per cent.

May I remind you that a rate of 1 per cent means that population will double in 70 years, with a 2 per cent rate it doubles in 35 years and with 3 per cent it doubles in about 23 years.

We will now outline the two main components of the annual increase of the population, e.g. natality and mortality.

### a. Natality

It varies enormously between countries and regions. Natality rate per country reaches a maximum of 50 per thousand in Niger and a minimum of 25 per thousand in Mauritius.

All the surveys made in Tropical Africa confirm the existence of a large disparity between fecundity levels in different regions.

In one of his studies, R.A. Henin concludes that "the possibility of an increase in fecundity must be considered when a modernisation process starts". To this effect he quotes some factors which actually limit fecundity: malnutrition, poor health, a hard working life, hard rates of abortion and sterility, traditional practice of birth spacing etc.

On this subject, another demographer, Romanink, had already estimated that the normal fecundity rate that could be recorded for the future in Africa is more likely to correspond to a natality rate of about 60 per thousand.

## b. Mortality

It is also characterized by a large disparity and varies between eight per thousand for Mauritius and over 29 per thousand for Guinea, Bissau and Zaire.

The general use of vaccines, sulfonamides and antibiotics can help decrease this mortality rapidly to a level near that of developed countries. Fifteen years of independence however have not enabled the African countries to make decisive progress in improving the health of populations. We may even face an increase in the mortality rate in some countries (especially the countries of the Sahara coastal region) which is connected with insufficiency and decadent health services as well as particularly unfavourable ecological conditions. In spite of this it is certain that if public health policies are sensibly rearranged, the different countries of the region could succeed in bringing down the mortality rate rapidly.

Indeed the indications linked with mortality confirm the amplitude of the tasks to be accomplished (mortality in general and infant mortality the highest in the world, expectancy of life at birth the lowest of all, etc.) but it is certain that recovery is possible and recovery could lead, without birth limitation policy, to an annual increase rate of three to four per cent, which is enormous.

Although demographic data is not quite accurate in Africa, the levels and tendencies indicated above seem, in the opinion of all the researchers, near enough the truth. We may therefore expect that at the end of this century the population of our Continent, which was 257 million inhabitants in 1960, will exceed 600 million.

In the light of these perspectives of demographic evolution plus the actual difficulties of development, a certain number of African countries have been brought to adopt or tolerate a programme of birth control. Without going that far, an increasing number of countries tolerate family planning activities more and more. It is as well to understand why and to try to define the concept of family planning in Africa so that it is really at the service of the population without having too much hope of development and improvement of family health.

## II POPULATION PROBLEMS IN AFRICA

The two main demographic phenomena which one usually relates to certain important development problems are as follows:

- The rapid demographic increase had a tendency to aggravate certain social problems (education, health, work, etc.).
- The rural emigration which tends to depopulate the country to the benefit of the town thereby prejudicing the development of agricultural production and worsening the socio-economic problems already great in cities.

The second aspect is usually analysed in the context of the strategy of development as a whole and more especially of the ability of governments to urge efficient rural development.

It is more and more recognised that by improving the standard of life in rural areas significantly so that it more nearly approaches the conditions existing in towns and also by gradually eliminating socio-economic disparities between countries and social groups, it will be possible to resolve the rural emigration problem.

In this respect, the experiences in the UJAMA villages in the United Republic of Tanzania present a true picture with certain limitations.

Inter-African migrations in the Sahara countries without littoral drainage off their population in the same way. The first aspect (rapid demographic increase) has been apparent for a long time and still appears to the eyes of many economists and demographers as being not so strictly relevant to comprehensive politics. Although it is more and more recognized that it is necessary to place population problems at the centre of the comprehensive policy of economic and social development, the emphasis still remains on specific measures to be taken in the field of demography and the belief in a solution to development problems which must be primarily demographic.

Emphasis is put on the fact that with a rapid increase of the population, a larger amount of economy will have to be devoted to social needs (accommodation,

schools, roads, methods of production, etc.) instead of investing it on a larger scale on the improvement of productivity.

It must also be emphasized that the active group of the African population (people between the ages of 15 and 64) is relatively small in comparison with the dependant group which constitutes a relatively high percentage; this means that dependence rates are high because children do not work and their output would not balance their consumption.

A policy of birth control as a main element of an efficient strategy for development is finally suggested.

Besides these neo-malthusian points of view, other researchers have adopted a completely different approach. Mr. Samir Amin, Director of I.D.P., maintained that "Africa is underpopulated and has proved that the failure of development strategies actually implemented in the Third World countries is primarily due to their insertion in the World capitalist system. From this angle, it is the World capitalist system which by its control over the economy of African countries imposes a kind of inoperative development whilst it exploits our raw materials as well as our cheaply paid labour to the sole benefit of Western capitalist societies."

Under development appears then to have political and economic causes rather than social and cultural.

In order to recreate real dynamics for development and break away from the actual halting place which is essentially a period of "development of the under development" we must start to break off the dependence relations which link us to the West, to stimulate solidarity between Third World countries and to implement a development policy primarily based on the maximum utilisation of all the material and human resources available for the benefit of the country itself and the population. An effective priority should also be given to social justice in every particular country.

We are therefore faced with two entirely different approaches, each of them involving a specific strategy on population matters.

### III FAMILY PLANNING AND POPULATION POLICY

In Africa, family planning generally means the use by couples of contraceptive methods in order to space or limit births. On the other hand it means to fight sterility.

This definition appears more acceptable from the ethical, social and cultural point of view.

The fact is however, that more and more young women assent to contraception outside marriage: more and more countries accept birth control methods (abortion, sterilisation, etc.) that we dare not speak of yet in our West African countries.

The fact is that on a social aspect, unwanted pregnancies create dramatic situations of which the multiplication of illegal abortions is but one aspect.

In spite of all this, there is more and more evidence of evolution in the countries of the region. Private clinics are tolerated and initiatives are sometimes taken at official level for the promotion of family planning services.

At international level, relatively important funds are available to encourage all initiative in favour of family planning.

In these circumstances, it is more than ever important to define what we - Africans - understand by family planning and what kind of programmes we would like to promote.

At national level, the demographic objectives of a country can be achieved by the definition of an adequate population policy.

"Population policies can be defined as legislative measures, administrative programmes and any other governmental action assigned to modifying the tendencies and the actual composition of the population and the interest of the community and the national welfare. Numerous aspects of the public policy and its social changes in general have an impact on demographic tendencies. A

population policy covers above all the aspects of the policy meant to oppose undesirable demographic incidences in a world policy and in other social forces." This definition from the International Encyclopaedia of Social Sciences emphasizes the fact that we are dealing with a conscious attempt from public authorities to act upon the demographic variable.

Mr. Leon Tabah, Director of the Division of the Population at the United Nations states as far as he is concerned that "the lack of action" or "laissez faire" can be a method of action by abstention, and therefore a policy".

And in fact in Africa, our population policies in almost all the Western countries are limited to a "laissez faire" policy which originates fundamentally from the conviction that no demographic solution to our development problems is possible. We must admit that the failure of such policies in many countries of the Third World is a concrete example of a negative attitude.

In this way, family planning programmes appear more and more as social programmes whose main objective is to help women to space or avoid the pregnancies they do not desire for various reasons.

However, in Africa, it is emphasized that these programmes should be integrated into the maternal and child health services and that the access of women to these services should be controlled. There is especially a desire to give an important place to the fight against sterility.

But beyond all these problems which are the subject of a consensus, other problems must also be raised which are just as controversial. Can a woman alone decide to practise contraception? Should young women under certain circumstances (which remain to be defined) assent to family planning? What place Sex and Family Education should be given within our changing societies?

It is for us to have discussions on all these points in order to find the solutions conforming to the wishes of the African masses and to the requirements of a harmonious development.

## VIEW POINTS ON FAMILY PLANNING

Mrs. d'Erneville

Journalist and Director of Broadcasting  
and Television Programmes in Senegal

When they hear the words "family planning" the large majority of African women automatically see dismal, morbid pictures - not to generalise - they think of abortion, risks, death! ... But still, the word planning should inspire ideas of harmony, method, quite contrary to anarchy and disorder; as for the word family it should on its own reassure since, without children, this word is meaningless.

In Africa, a child is a gift from God, a blessing to the family and happiness of the parents. In a traditional family, the father is always proud to count his offspring especially his sons, who will carry his name and continue the line of descendants but he also relies on the girls for future alliances with 'houses' of good descent, influential or rich men. Children, as extra labour, increase the father's wealth especially in rural areas because they help to cultivate supplementary land gained from the bush. Even in cities, where they are at the moment a source of hard social problems, children are psychologically well accepted because some old superstition well anchored in the minds, even modern ones, prevents the subject of family planning to be put clearly; family planning was not well introduced in Africa by its promoters and was often mistaken for a rigorous control of births.

Nevertheless, the concept of birth limitation is not new in Africa; in many societies, different methods are used, the most common being the separation of husband and wife during the breast feeding period, generally two years, which the mother uses to recover her health after the strain of pregnancy and delivery and also to feed the baby well, massage him, cuddle him, teach him to walk and speak; somehow, the utero-symbiosis goes on and the child flourishes ... When she goes back to the conjugal couch, the wife is psychologically and physically prepared for another maternity. Polygamy enables the man to support this lengthy absence.

Infant mortality, more often caused by ignorance of the most elementary rules of hygiene, devastates families but it is almost always attributed to

the jinn's malevolence, the evil spirit, the bad eye or the spell cast on the mother to be or the new born (yaradal in Senegal). In these cases, the woman's main worry is to regain her psychical balance by a new pregnancy, a baby being not only the guarantee of an accomplished femininity but also and chiefly the symbol of luck and prosperity. When the planning system is less rigid, too frequent pregnancies (neff in Senegal) can weaken the mother's health and make the baby fragile as he must relinquish breast feeding to the advantage of the baby still in utero. It is said that he has "stolen the milk that does not belong to him" and this explains the effects of rickets or of kwashiorkor.

It may seem pretentious of me to speak of all these facts in front of an audience of specialists but, as we are searching for a method of harmonization for the African family, of its adaptation to modernism without going against the fundamental principles of our society, the positive and negative aspects supporting favourable activities for the popularization of family planning in Africa should be identified.

It is first of all a matter of intuition, tact and thorough knowledge of the environment. The special characteristics of family planning aspects in Africa must be seriously studied and the women's attitudes, their outlook on life, their prejudices and even their reserve must be respected. The success of the operation depends upon first contacts. Any misunderstanding on the aim pursued - planning of births and not their limitation - must be avoided by clear and precise explanations. The arguments for economy generally bear no weight on women who, being religious and fatalistic, believe that "every mouth God has opened, He will fill!" They must therefore be convinced with concrete examples taken from their own environment; one must appeal to their common sense and they must not have imposed on them what is contrary to their ethics.

Sex education exists in Africa but it is practised in an almost esoteric way, in the same conditions as Initiation. Those in charge of young women's education have the community's confidence and thanks to their great experience in social matters of the group they are above suspicion of misinterpretation of the principles to be taught. This is never the case when an outsider is concerned however willing he is and however knowledgeable in these critical fields of sexuality and of male/female relationship.

It is probably too early to advocate sex education at official level in schools, social centres. We know that even in Europe, in France for example, the parents and the public's reactions to sex education integrated into school programmes are not always favourable and that the uncertainty, reserve and disagreements make it difficult to implement these reforms. For our children - girls and boys - however, it would be desirable to awake them to sex realities and the problems created in this field at an early age because ignorance of these matters, and especially hypocrisy conceals some truths concerning the life of a couple. The primary notions of family planning must be given to the youth, not by a lecture on ethics, but by advice on "the precautions to take not to have a child" and especially by explaining the responsibility assumed by two persons who decide to bring a child into the world. It is not enough to conceive in good physical condition, one must think of the future of this new human being in a world primarily hostile where the chances of survival are minimal. The mothers-to-be must be taught of the obligation they have, from the very beginning of their pregnancy, to be responsible for the life of this little man, the most fragile amongst the new born in the world. The wonderful story of the transformation of the embryo to a real human being - a genius or a modest citizen - this lovely realisation of nature, can become a tragic event if all the rules are not respected. The primary objective of a meeting such as this and of confrontations between professional and lay people must be the education of the largest number of these essential problems. Everyone seems to know the facts but some are surrounded by theories right or wrong which makes it difficult to popularize the principles accepted by the medical profession and especially by those in charge of promoting family planning in Africa.

A close collaboration should exist between those who, in the secrecy of their surgery, search untiringly for the most suitable formulae for the improvement of human life and those who will be their spokesmen so that they all feel involved in these researches and they implement the results for the improved well being of the family.

Periodical meetings between specialists of the medical profession and journalists make it possible to keep the public informed on up-to-date health education matters. We all know that in our countries everything new and which might seem in opposition to the rules of tradition or Religion is suspicious.

In order to avoid confusion between the ideas of contraception, planning and control of births, physicians, midwives, family planning advisers and journalists must, without discouragement, cooperate and persuade through the use of newspapers, films and broadcasts.

In our changing society where there is disintegration of the family unit, where anxiety replaces placidity, where materialistic aspects have become more important, the mission of enthusiastic educators is to be lucid.

SEARCH FOR A COMMON CONCEPT OF FAMILY PLANNING FOR WEST AFRICA  
CATHOLIC VIEW POINT

Abbé Léon Diouf  
Vicar General - Dakar

AIM

First, how do we interpret the question asked of us?

We understand we must search for agreement on the meaning to be given to family planning and on the consequent action to be taken in collaboration with all the people involved in the development of our countries.

I - WHAT IS THE PLACE OF THE CATHOLIC POINT OF VIEW IN THIS SEARCH

The catholic point of view cannot and does not ignore the analysis of the situation. The analysis and prospectives of the economist, the psycho-sociologist, the physician, the jurist, the journalist, etc. even constitute an indispensable basis for catholic thoughts on the matter.

These analyses and prospectives raise however a problem: the morality of behaviour towards family planning. In other words, the question is to know if the behaviour adopted or advocated, whatever the merits of its economical, psycho-sociological or political motivations, is morally justified according to human credibility.

II WHAT IS THE CATHOLIC'S RESPONSE TO THIS MORAL PROBLEM

Above all, the actual idea of family planning is for us highly positive. The place of birth and growth of the human being is the family and this should be made a perfect environment favourable to the integral development of each of its members and to the individual in each member. This implies the use of all the means contributing to the happiness of people, body and soul, including the management or control of all the means for an harmonious development.

Where human fertility does not run into its specific obstacles, which are sterility or the selfishness of the couple, family planning embraces a right and even a duty of control over fertility.

The moral question we have to answer concerns then the manner in which this control is operated to conform to man's entire credibility.

You know the catholic point of view on this subject which radically excludes contraception from the control of human fertility, that is to say any act directly opposed to the conception of a human being as well as abortion and any sort of homicide: infanticide, euthanasia or suicide.

To be still more precise as far as contraception is concerned you know that our catholic point of view only accepts as morally valid the method based on the rhythm inherent in the genetic function of the human being.

### III - ON WHAT IS THIS POINT OF VIEW FOUNDED

It is dependent on the catholic concept of humanity and of conjugal love which is specific to it, such as:

1. A fully human love, that is to say both sensual and spiritual, a life of instinct and sentiment but also of will;
2. A complete love by which "the married couple share generously everything without undue reservation or selfish calculations";
3. A faithful and exclusive love till death "for better, for worse";
4. A fertile love "which does not end in the communion between husband and wife, but which is destined to continue the creation of new life";
5. Finally, a love which has responsibility towards fertility.

Conjugal love reflects the Love of God, the primary Source of Existence. Morally, a married couple must respect the characteristics of conjugal love as linked with fertility and the creation of new life.

Put this way, the question of contraception can be interpreted as a single fundamental problem raised by divorce, abortion and infanticide, each in its own way.

The question of divorce is indeed that of rights or rather of the absence of rights husband and wife have over continuing love which is the pre-requisite for procreation. The question of abortion concerns the illegality of the couple's disposal of the fruit of their love still in utero. And that of infanticide is the illegal disposal by husband or wife of a newborn child. Going still deeper, the question of contraception is whether or not husband and wife have the right to obstruct the essential connection between making love and the possibility of creating life, although human love is more than just the transmission of life.

As you know, our catholic teaching denies the individual, either as a private person or as a political power, the right to make an attempt against the essential connection between human love and procreation. And this because Man is not the Master of this essential relationship, but God, and human love is a reflection of His Love which is given freely.

CONCLUSION : A FUNDAMENTAL OBJECTIVE MUST BE PURSUED : HUMAN EDUCATION

This teaching on family planning is proposed by the Catholic Church not only to its members but also to any individual as the road to authentic and integral Development of Man. As a moral teaching it is not a restraint but a call: a call for integral positiveness in the individual and integral genuineness of his love.

Having regard then for the specific conclusions of scientific disciplines in family planning matters and laying foundations on these conclusions as scientific data of the problem, the Catholic Church makes an appeal to all for man's education in conformity with his credibility.

It is a matter of universal education, adolescents discovering humanity, but also adults who must constantly readjust and check themselves in the face of multiple and rapid changes affecting humanity.

By doing so, the Catholic Church, with concern for all the specialists in family planning matters, is aware of the great obstacles which may occur and do occur on the road to human reality. The Catholic Church, therefore, does not condemn the people but refuses in the name of the individual to justify herself morally on the failures that the acts of contraception, abortion, infanticide and divorce constitute.

Indeed, these failures are no others than stages, painful ones really, on a progressive advance towards realistic living.

**ISLAM AND FAMILY PLANNING**  
(Report of the Seminar held in Rabat)

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Under the aegis of the International Federation of Family Planning - Middle East Region and North Africa a seminar was held in Rabat (Morocco) from 26th to 30th December 1971 in order to examine the Islamic point of view on the social changes faced by the Muslim family, as well as on family planning, abortion and sterilization. There were 69 specialists in attendance from 23 Islamic countries and representing the various juridical schools and muslim sects: orthodox theologians, doctors in Shiite legislation, physicians, sociologists and demographers.

This is the statement published during this seminar and which seems to accept the principle of birth control:

"Work papers dealing with various fields of specialization were presented. Members of the congress discussed and deliberated at length. A number of opinions stated by learned Islamic theologians and specialized scholars in this field were heard. The deduction was that there are laws in the Islamic religion that, from permanent concepts and undoubted convictions, give the family the possibility to acquire adequate happiness and to preserve its integral existence which constitutes a solid foundation and the true kernel of a powerful Muslim nation.

From the belief in such a mission where responsibility fell upon the participants and, through a well balanced view which unites the provisions of the Sharia, the essence of the Islamic legislation and the undeniable scientific realities at the same time, the Seminar considers that:

a) Islamic legislation, thanks to its provisions regarding family entity, takes into consideration the necessity to protect, organise and guarantee its well-being so that weakness or incoherence do not affect or threaten its structure.

Besides the arguments from the Koran, the Hadith and the statements from famous theologians, the group in favour convinced the opponents that the ways and means permitting the realisation of Islamic objectives change, develop and improve in time as well as in space and that they do not affect the unchangeable character of the essential Islamic principles.

They examined the problem from the point of view of polygamy, the new conditions resulting from modern industrialization, the dangers inherent in unrestrained growth of the World population (six milliards in the year 2,000), and the progressive decrease of economic resources. Some said: "It is preferable to have happy, healthy and educated children than to have melancholic, ill and illiterate children".

They made us understand that the essential purpose of Islam is the happiness of the individual in this world and his felicity in the world beyond, the well-being of the family, the security, strength and stability of the government and that well-managed family planning would insure the implementation of these objectives.

The discussion, which was lively, dealt with the social, legal, religious, demographic and medical aspects of the question. Verses from the Koran and statements of the Prophet were interpreted and emphasized differently by both sides: the detractors and the partisans. But the justifications brought by the partisans clearly prevailed; let us quote as an example the justification from the representative of Lebanon:

"There is no doubt that the immobility of civilisation is contrary to the spirit of Islam and to its philosophy of rightful ambition which is well-known. An example of this is the powerful influence of Islam on a primitive Arab society transforming it into a model society of human progress, at the level of human relations in addition to materialistic improvements."

The representative of Indonesia, after quoting the verse 185 Chapter 2 of the Koran, e.g.: "God wants you to be well off, not hard up" draws from this fundamental principle the following remark:

"Family planning which is designed to make life easier for people cannot be considered as prohibited under the Islamic faith. As a matter of fact, to our knowledge, there is no verse in the Koran or text which forbids explicitly a married couple to limit the number of children they can have ... The well being of the family is the essential condition for a health social existence ... It is not difficult to imagine and to think that those who have grown in a health family - materially and morally - are happier in many ways than those who have lived in an unhealthy environment or in a disunited family."

Some participants reminded us that a new definition should be given to the family which has become more condensed rather than diffuse as previously. In reconsidering this concept, the family is seen as a unit composed of the parents and the children when at the beginning, apart from those, it included grandparents, brothers, sisters, relatives and parents-in-law. With re-structurization due to evolution, the family is the basis of the structure of the nation and the great community.

From the arguments of the partisans of family planning, various solutions can emerge which we will examine successively:

1. The Azl Method - coitus interruptus. The existence of this anti-contraceptive method practised at the beginning of Islam was recognised by all participants at the Congress at Rabat. It is, although limited, synonymous with birth control. This corporal union without emission was meant to avoid a pregnancy or to postpone it in order to have a wider spacing between births.

To a fellow who did not want to have children with his wife, the Prophet would have said: "Unite yourself with her without going to the end". Al Jabir told the Imam Malik: "We practised the Azl, that is to say the unfinished union, in the Prophet's time. He taught us this and did not forbid it.

The Azl was the way to limit the birth of children. Mahomet permitted it explicitly. If his contemporaries had known - as men of the twentieth century do - more efficient methods, the Prophet would be entitled them to use them.

2. Tying of the Fallopian Tubes - "Shortly after the beginning of the Islamic era", says a delegate of West Pakistan relying on the opinion of a learned jurist Chaff ed-Din Abidin, "the Muslims heard of a new method which consisted of stitching

the tubes. Muslim jurists raised no objection against this method which was considered similar to Azl and was even approved."

3. Prolongation of the Breast Feeding Period - This remains a relatively safe anti-contraceptive method. It is an indirect invitation to observe spacing between births. The child "is weaned only after two years of age" says the Koran verse 14, Chapter 21, "the mother", verse 15 Chapter XLVI, "carries him from conception until after the weaning period, when she has fed him at the breast for a total of thirty months". These announcements of the Koran indicate once more how Islam is anxious not to endanger the security and the health of the mother through too frequent births.

The Prophet emphasizes this holy recommendation in the following terms "Al-Ghal (relation with a woman while she breast-feeds her child) is similar to a rider thrown off his horse during a battle and crashed under the feet of other horses. Do not therefore kill your children in secret." Consequently the fact that a child is conceived while his mother is rearing another one is considered by Mahomet to be a crime.

4. The Practice of Monogamy - Many participants mentioned that polygamy must remain an exception based on man's capacity to act with justice towards his wives. According to Islam, a man may marry simultaneously four women at the most, on the condition that he treats them fairly and impartially otherwise he must marry one woman only. It is an injunction of the Koran (Chapter 4, verse 3): "If you are afraid of being unjust to orphans do not marry many women, two, three or four, amongst those that you like. If you are still afraid of being unjust, marry only one".

Commenting on this verse, one of the delegates of Lebanon affirmed: "Equity consists in the absence of preference, in the way the women are treated". This is impossible for a human being. Furthermore, this is confirmed in verse 28 which says: "Even if you are very careful, it is impossible to be equally fair to your wives". This is why the Druzes keep to monogamy which is in accordance with the verses of the Koran as it is impossible to be impartial with more than one wife ..wives who do not get on together can turn a home into an inferno."

He adds that this disagreement may directly or indirectly influence the whole community, its composition and its criteria of existence as well as the politics and the economy of a nation.

According to the same delegate, some Arab countries such as Egypt, Syria, Tunisia and Lebanon have imposed monogamy. Turkey has also declared polygamy illegal.

However, a woman's sterility or her inability to have sexual relations is considered to be a valid reason for the justification of polygamy.

The delegate for Nigeria declared that Muslims who believe it is their duty to marry simultaneously various women simply manifest their ignorance of the Islamic religion and that another proof of their ignorance would be to attribute this false belief to Islam.

Other Muslim countries require from the polygamous man to produce a written consent from his first wife for another marriage. With the absence of this evidence, the husband cannot take other wives.

One of the participants said: "Although polygamy is rather more an exception than a rule in Islam we must point out that many, perhaps the majority of the Muslims who practise it, have grossly abused it ... The worst is that there are polygamous Muslims who share one bedroom with their wives and their children. Quite often, the wives must cope with life on their own and more especially the children suffer enormously from lack of care and attention. They are deprived of an education and good maintenance which usually leads to poor health."

5. Abortion - This means of birth control raised a lot of controversy and passionate discussions. The delegate of Western Pakistan said that the following question was put to Muslim jurists: "Is abortion permitted after conception?" This is their answer: "Yes, it is permitted until the embryo is completely developed and this occurs 120 days after conception."

They based their theory on a Hadith of the Prophet who said that it is after the fourth month that the angel insufflates spirit to the child in his mother's womb.

b) Islamic legislation, thanks to the provisions - registered in the Holy Book and the Sunna, in addition to those that can be deducted in accordance with authentic methods and effort, the Ijtihad - enables the family to examine all the renewed conditions and to find in them some sound and positive solutions.

c) Islamic legislation enables the Muslim family to be self-critical in dealing with the problem of birth of children, if it either leads to an increase or reduction in the number of children. In this way it will have a right to treat sterility and to determine the non-fertile periods by sure, legal means.

d) Re: sterilisation, the seminar adopted the opinion of the Islamic Research Centre and of the Honourable Ashar (Islamic University of Cairo - NDRL) which is that the recourse to sterilisation is not permitted to married couples or to others.

e) Re: abortion, defined as being the act of taking the foetus from the uterus in order to dispose of it, all the learned Fakirs of Islam are unanimous that after the fourth month of conception, abortion is forbidden, except in case of absolute necessity to safeguard the life of the mother. However, even within the four months of gestation, the general view is that at whatever the stage of conception abortion is forbidden, except to save the life of the mother.

Therefore, there is only one question: what is the Islamic position with regard to human ecology, habits, traditions, social values, behaviour towards family problems and the judgement this religion makes on evolution? Does it approve, tolerate or adopt evolution whether or not it is contrary to God's orders and rules, or whatever the degree of opposition to Islam in so far that the fundamental rules and principles of this religion, as well as its objectives, remain unchanged?

According to the nature of the answers given, the participants split into opposing groups on one of the aspects of this changing life, e.g. family planning. Both parties drew their arguments from the Koran, the Hadith (statements attributed to the Prophet) or from statements of well-known theologians.

I read 13 of the papers presented at the Rabat Seminar and the group favouring family planning constituted the majority by far. There were, for example, four Lebanese who presented a paper each and only one was against.

One of the representatives of Kuwait, Dr. Hathout, devoted all his address to this problem on the medical, social and religious aspects.

For him, abortion must be performed to save the woman's life and also to avoid the spreading of diseases or of hereditary defects. It would be a prevention against the birth of monsters or of anencephalics due to uterine infection. He recalled the too sad catastrophe of thalidomide, this pharmaceutical product created to relieve pregnant women but which consequently proved to cause deformity or mutilation of the foetus. Indeed, thousand of babies came to this world with missing limbs.

He advocated abortion in case of incest, rape, abduction of minors or mental deficiency. On the other hand, abortion is permitted when the health of the mother is endangered by the frequency and the closeness of births as well as by material and domestic worries increased by the growth of the size of the family.

He quoted Tunisia where a mother of five live male children may have an abortion if she is pregnant again.

However, he mentioned the opinion of the great Imams of Islam, Malik, Abu Hanifa, Chatif Ibn Hanbal and even El-Ghazalf which is that any form of abortion is wrong whatever the state of the foetus. He therefore concluded in these terms: "The valid reasons justifying an abortion must be reduced to two: if the life or the health of the mother is at stake and if there are great chances of the baby having some monstrous malformation or suffering from indelible defects as the Islamic legislation and jurisprudence give priority to the life of the mother; when she is in danger, abortion is permitted." He therefore retained the medical and foetal causes and rejected the human causes (rape, incest, safeguard of the honour of the woman or of her family) and the social causes (inability of the parents to feed and educate a large number of children, demographic explosion etc...)

It would have been very interesting to hear the point of view given by the Tunisian delegate, Mrs. Fathiyya Mazalf, as her country seems to have adopted a very favourable attitude to well-controlled abortion.

On the subject of abortion as a means of limitation of births, the opponents

to family planning won their case. To them "the sin is bad, as bad as murder and involved the necessity for the sinner to give alms to 60 poor people or, failing this, to observe lent during 60 days."

6. The Practice of Sterilization: Contrary to other anti-contraceptive methods, the theologians found no detail connected with it in the Muslim Law, except for one reference in the Koran (ach-Chura, verse 50): "Etil (God) makes whoever he wants sterile. He is knowledgeable and mighty."

In meditating on this verse, however, they made an analogous study as follows: "When God - for whatever reason, sublime or with wisdom - creates impotent and sterile persons, no objection can be raised when others are sterile for sheer necessity and for public interest. These theologians believe that if sterilization involved the least danger for the human race, the teaching of Islam would be explicitly forbidden it."

They answered the antagonists to sterilization who consider it as a form of castration, which is condemned by Islam, by explaining that they are two very different things; in the case of sterilization the testicles are left intact and carry on their natural function, the man remains capable of sexual relations, but it is quite the opposite with castration where testicles are amputated or crushed.

The only result of male sterilization is that the seeds cannot in future provoke pregnancy because they do not contain sperm.

Another objection, this one carrying weight, is that sterility makes the man lose his ability ever to become a father, and this is clearly contrary to the teaching of Islam and to the functioning of nature which is to preserve the species.

Those in favour replied that this objection carried more weight some time ago because reversal of sterilization was not possible. On one hand, they said that most of the critics do not think it is bad to allow sterilization to people suffering from incurable mental, psychic and sexual diseases, especially if they are infectious diseases and can affect the offspring through heredity. On the other hand, this objection does not hold anymore since reversibility of

any method of sterilization has become possible and that any person who has been sterilized can be "unsterilized) at will.

"I do not see", said the theologian Cheikh Ahmed Ibrahim of Egypt, "any religious objection against sterilization because it is also a treatment which prevents children by avoiding the element that produces them. It is not a crime against a human being."

Most seem to be in favour of sterilization so far as it can be on a temporary basis.

7. Use of Pharmaceutical Products in order to Limit Birth Temporarily:  
We are talking of the pill, the intra-uterine contraceptive device, the condom and any other means of contraception.

These were the contraceptive methods discussed at the seminar of Rabat on Islam and Family Planning. If most of them were adopted and approved, "they necessitate - as the delegate from Pakistan wrote - a certain degree of instruction to understand fully the precautionary measures ... the only way to enable family planning to be efficient is the application of a simple method which could be easily adopted by the illiterate masses."

The participants agreed that, for as long as the principles considered in the resolution are adopted, any change towards the well-being of society, such as limiting wives and children, the dangers which threaten the family therefore the community and the nation, would be acceptable within the limits of religious laws and the independence of Muslim families.

Briefly, Pakistan, Egypt, Turkey and Iran advocate contraception; Kuwait and Saudi Arabia advise it for medical reasons. Indonesia and Malaysia encourage it too. Jordan, like Pakistan, has approved of family planning since 1958, Egypt in 1960 and Saudi Arabia elaborated some plans at Mecca for the poor classes.

Let me remind you of the wish of this Egyptian delegate, e.g.: "we desire a unanimous policy, a solid cooperation of the Islamic countries and more efforts at international level towards this vital problem. Senegal, highly Islamised, should bring to light the importance that family planning deserves."

## SEX EDUCATION WITHIN FAMILY HEALTH

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### SEX EDUCATION INTEGRATED INTO FAMILY HEALTH PROGRAMMES

The Western literature of the past twenty years described demographic growth as being the number one problem of the contemporary world. "Demographic growth is the biggest obstacle to economic growth in the major part of the under-developed world". During a meeting in Salzburg (Austria) in February 1974 it was concluded: "We must also consider the fact that this demographic pressure will slow down the process of development, since each generation must invest and save, not only for itself but also for the inactive 50 percent of the population inherent to any rapid extension of the demography." Unemployment, poor school attendance, malnutrition, poverty are attributed to the "demographic explosion" happening in the Third World.

The Egyptian economist Samir Amir, however, gives us a more realistic explanation of the situation: "Agricultural stagnation, insufficiency of industrial growth and increase of unemployment in the Third World are due to causes which have nothing to do with demographic growth; the mechanisms of the Third World's dependency are the source of its under-development which is revealed by increasing population which results in unemployment, under-employment, under-nutrition giving the impression of relative over-population whether or not demographic growth is high or low.

So, in concrete circumstances, an authentic strategy of development can incorporate action over demography, either to slow it down or speed it up, for the process of inducing development is above all, of a political nature. The decrease in natality will result from the evolution of the variable factors such as "public health, education, full employment, women's emancipation, a good distribution of revenue and social advantages, etc.

But the object of a neo-malthusian approach is the maintenance of a status quo favourable to rich nations; this approach expresses the fears of the "Developed World" in the danger of reconsidering international economics by people who are the first victims of the world economic disorder. This is why the control of births is presented as the miracle answer to underdevelopment problems.

We believe that a population policy must primarily and especially be a policy of fundamental reform to enable a start on economical matters. If family planning is desirable as a maternal and child health institution because it is an important factor of women's liberation and of the balance in the lives of the families we, however, consider that birth control is dangerous and inefficient. Economic problems are not solved by demographic solutions whose effects are, by the way, very long-term effects.

Family health defined by WHO as a "perfect state of physical, mental and social well-being" must be primarily understood as an educational work. The primary role of any medical agent is to teach the population how to prevent illness through healthy nutrition and good hygiene. In this way, sex education is harmoniously integrated into family health programmes if the reason given is to make every individual responsible for his own sexuality.

#### WHY SEX EDUCATION?

Sex has invaded our social universe. It has become one of the merchandises that sells best. Publicity gives it first place; all products must be "sexualised" in order to sell well.

Motion pictures come next; cinemas are full when an X film is being shown. Pornographic magazines circulate in schools. Illustrated novels leave many young women in a dream.

The influence of all this drives youth to search for unrestrained pleasure and into the belief that one should "live one's life". There are, therefore, nightly outings; boys make girls believe that their emancipation depends primarily upon a sexual liberation; those who are not convinced are sentimentally bribed. Some boys give the girls the 'so-called pills' before intercourse, thinking that they are safe in all eventuality.

Young women, whose parents cannot satisfy all the wishes, start semi-prostitution in order to buy fashionable clothes. To show that one is 'with-it' sexual intercourse is practised at every opportunity.

The consequences of this are undesired pregnancies, induced abortion which sometimes have damaging or even mortal effects. Venereal diseases spread in an alarming manner. Suicidal attempts, suicides, nervous breakdown, which until now were rare, are encountered more and more frequently. Youth seems anxious to "enjoy" the pleasures of life. Pre-marital pregnancies are not shameful any more. On the contrary, some young men are proud to have children before marriage; it confers on them a "virility licence". These christenings are an opportunity for great celebrations.

The parents' attitude is often puzzling. Some have changed from a dictatorial attitude to complete "laissez-faire". Others, thinking it is for the best, become real martinets towards their children. A minority, on the contrary, encourage their daughters to a kind of prostitution in order to ensnare the maximum number of suitors.

This is all very disturbing and it should bring us to locate the causes of such changes in order to find the means to solve this short-term problem.

#### THE PATH FROM TRADITIONAL SOCIETY TO MODERN LIVING

Even in present times, traditional society offers some criteria in matters concerning sexual behaviour which are on the whole followed by all. Sexual life is integrated into social and moral life.

Because of the sexual initiation he receives when he is circumcised, or during another kind of ceremony, a child is prepared for his adult sexual life. This initiation is seen as an essential stage in life; the festivities that commemorate the end of such ceremonies prove their importance. For the newly-initiated it means getting into adulthood, becoming responsible. These youngsters are then capable of reproducing. The primary aspect of this sexual initiation is to prepare the child for his procreating role; this initiation differs according to the sexes: boys will learn to protect themselves against impotence and girls against sterility. These initiation practices, when they are described, may shock either because of their violence (excision, for example) or because of the sexual liberalism that derives from them (freedom in sexual relations). We believe that if the giving of life is fundamental in African philosophy it does not exclude the search for enjoyment. Numerous songs praising sexual enjoyment are performed during the ceremonies.

We more or less all know of some aphrodisiac, sexually stimulating games or erotic dances. However, it all happens in a healthy atmosphere because each society has established some rules which enable the control of abuses by establishing taboos. For instance, pre-marital sexual intercourse is not penalised in each community because only the child is important. Therefore, at sexual level, African traditional societies reach a balance that industrial societies do not know. Cases of sexual deviation, for instance, are rare in traditional Africa. But in urban environment, especially since independence, a rapid collapse of traditional morals has occurred under the combined influence of a speeded-up urbanisation, of servile imitation of Western sexual images (through great love-novels), the impact of mass-media (cinema, pornographic newspapers - "sexualised" publicity, etc.), of expanding tourism which develops and encourages feminine, but also masculine, prostitution, but, above all, because of economical needs (semi-prostitution of young women) and changes in family life (lack of control from the parents over their children.) A sort of sexual "freedom" followed, which expresses the disorganisation of youngsters left to themselves more than through intentional choice. The youngsters, disillusioned by sexual taboos, by rigid and often blind morality of adults, rebel by transgressing the interdict. They feel the need to identify themselves from the adults and to show that they also have their "personality". The girls like to show that they are "emancipated" and free from all socio-cultural restraint by disposing freely of their bodies.

On the other hand, misled by magazines and films, they idealize certain Western sexual behaviour; at times they honestly believe that these attitudes are due to a normal development of society. This is the reason why they call their parents "old-fashioned". African youth is in the middle of a complete growth crisis. Many young people are very pessimistic about their future. The actual society does not offer them the ideal which would enable them to flourish fully. The young feel frustrated; they have little responsibility and a very small participation in the nation's future. They are left to themselves. What is offered to them nowadays is the consumption of products that they could well do without. Therefore, youngsters live deliberately on the fringe of society.

Such refusal of social standard rules is expressed differently by:

contesting the "establishment";

an anarchist search for pleasure aimed at a reward to prove that one is liberated (anarchist sexual relationship, drugs, etc.).

These reactions are not to be under-estimated because they have an impact on the political, economic and social life of our countries. The educators who are in direct contact with the young recognise the amplitude of the problem and realise that it is critical to search for a solution, especially as these problems spread to villages. Youngsters bring to the country, during their holidays, their urban ideas and habits which often lead to conflicts with the older people.

#### THE BAMAKO SEMINAR

It was in order to answer the anxiety of parents and educators that the Ministry of National Education of Mali, together with the Society of Friends, in April 1974, organised the first Inter-African Seminar on Sex Education. This Seminar grouped representatives of eleven countries of Black French-speaking Africa.

The primary aim of this meeting was to open discussions on a problem as complex as sex education. The crisis of sexual behaviour of the young of Africa, although it is part of a larger world crisis, becomes more important in Africa because, among others, of the brutality and the suddenness of its extension; it adds up to other problems which weaken the newly-acquired strength of the countries.

A girl who stops her studies because of a pregnancy for which she is not alone responsible is an enormous investment wasted. Such stoppages in schooling restrain the possibilities of women's promotion; and often, an unmarried young mother who has no financial means, turns to prostitution. The recurrence of venereal disease impairs the physical and moral health of our youth who cannot efficiently participate in the tasks required for our economic and social development. It is to this aim that the seminar in its recommendations has approached the problem of sexual education within the global context of education, which role is to enable the young to integrate happily in social life.

## WHAT KIND OF SEX EDUCATION?

It is not any more a question of knowing if sex education has to be carried out because the young themselves feel the need for it. They all try to gather information where they can, not only to protect themselves against any eventuality but because they are anxious to know what the adults refuse to tell them. But the question remains: how are we to do it?

Unquestionably, an African pattern of sex education, taking into account cultural data, socio-economic structures and the psychology of the populations concerned must be elaborated. We must innovate; European problems cannot be adopted in a field where there are so many cultural interdicts. It is necessary to go back to the sources of African culture. So, sex education must be an attempt to resume the educative practices widely known until recently and which must be restored under modern methods. Each of our ethnic groups has highly developed rituals of initiation. A study of the methods and concepts is crucial.

However, this sex education must not be limited to a simple information on contraception, that is to say, to give the young the recipe to avoid pregnancies. It must instruct the young on the physiology of human reproduction, on relationships between men and women, on sexuality etc.... It is certain that this education will be done within the framework of standard ethn. groups. In fact, sex education starts at a very early age, the parents being the first educators who will, by their attitudes, by their answers or their silences to the child's questions, have an influence on the formation of the personality and the sexuality of the child. Freud revealed the existence of an early infant sexuality. But the parents are often obstructed by their own education and cannot satisfy the child's curiosity.

With the parents' inability, it seems that the school is a way to compensate for this deficiency. School, as a social institution and a way of life, can contribute to the establishment of a certain sexual language common to all and to the search for attitude towards sexuality. To this effect it is advisable to amend the contents of education and pedagogic methods.

The objective of sex education is to create the African human being bodily and emotionally. It must lead man to dignity, liberty of choice, not to destroy but to build, to procreate with the object of producing. So, this education must not be done with the view to repress the sexual instincts of the young but to make them RESPONSIBLE for their sexuality.

## ACTUAL POSSIBILITIES

Sexual education must be integrated into a comprehensive collective system of education enabling the adolescent to be happy and to escape emotional unbalance and the anguish of the future. It is therefore important to give an ethical orientation to sex education and to invent a pedagogy and working tools.

We could now:

- Implement research on traditional sex education and on the psychology of the African child;
- Organise seminars for talks on the problem;
- Introduce sex education elements into the training of schoolmasters and teachers;
- Promote pilot experiences on sex education in high schools and colleges, in maternal and child health centres and in social centres;
- Inform parents of the necessity for sex education;
- Make it possible for pregnant girls to carry on their studies after delivery.

## SEARCH FOR A COMMON CONCEPT OF FAMILY PLANNING FOR WEST AFRICA

### THE MIDWIFE'S POINT OF VIEW

Mrs. Siga Sene

Midwife and Vice-President of the Economic  
and Social Council of Senegal

It may seem paradoxical to solicit a midwife's opinion on family planning matters because she is, according to WHO's definition "a specially trained and qualified person to care for women during pregnancy, delivery, the post-natal period and to care for the newborn".

Health care has different aspects: prevention - health education - recognition of abnormal conditions in the mother and child - reference to a doctor - application of emergency treatment in the absence of a doctor.

The profile of the physician changes with evolution and progress. We may state that in Africa the midwife, who is considered as the privileged female 'elite' amongst these illiterate masses, must devote herself to educational, pedagogical, cultural and even political tasks having a direct or indirect incidence on the practice of her profession. She is to have a good training and be qualified to help and assist the married couple and the community to create the best possible conditions for the birth of children into this world, their survival and their happiness.

#### I - THE MIDWIFE AND FAMILY PLANNING

The socio-cultural environment envisages the fertility of the married couple as a sign of happiness and prosperity. The non-fertility of the married couple is very often attributed to the woman alone.

The child is considered as a richness; it is a guarantee against abandonment and solitude, especially in a polygamous family.

## 1. Traditional Practice of a Population Policy

- The treatment of sterility by local massage, absorption of infusions, practice of offerings and rites in order to ward off the evil spirit;

The spacing of births by:

- Abstinence from intercourse during breast feeding period;
- Absorption of infusions or of mixtures prepared with plants or roots;
- The wearing of amulets, roots or strings around the loins;
- The practice of specific scarifications on the chest, the stomach, the back and the loins.

Let us point out that definitive sterilisation was never contemplated.

We note that in these so-called traditional societies the vision of the world was limited; the mass media, the means of communication did not enable people to have a global, territorial or national view on demographic problems. Economic matters were opposed to those of to-day and all traditional methods were inspired by a natalist ideology at individual level.

## 2. The Midwife - Natural Confidant and Witness of Family Drama

- a). The case of sterile women whose life within the family group is a true drama; they are considered to be "men" (word used in a deprecating sense to indicate the woman's complete lack of femininity) - not to mention their repudiation and polygamy;
- b). The multipara whom we have known during her six - seven - eight pregnancies and who dies in our arms during a postpartum haemorrhage for instance;
- c). The young woman victim of questionable practices who dies in our arms;

- d) The spectre of "dehydrated" children, cachectic children who fill our pediatric beds, etc....

These pictures and visions bring the midwife to search for solutions.

### 3. Attempt to Define Family Planning

All the reasons given above make family planning appear to the midwife as the summing up of cultural, psychological, educational, economic, technico-scientific means available to the married couple and the community to improve their quality of life, their happiness and harmony through the birth into the world of wanted babies.

## II - FAMILY PLANNING AND THE PROMOTION OF WOMEN

The midwife, because she is a woman, a wife and a mother, must sense that family planning as we have defined it is a factor helping the promotion of women and their aptitude to participate in an efficient way to the life of the community. There certainly exists a relation between the promotion of women and the spacing of births.

## III - IDEA OF INTEGRATING FAMILY PLANNING ACTIVITIES INTO EXISTING STRUCTURES

The experience has proved in my country that private or isolated initiatives would not, in any way, solve the problems of public health.

Planning (in its widest sense) is by nature "an organised, conscious, continuous effort with the aim of choosing the best means in order to reach the objectives carefully identified".

It is necessary that our governments define exactly their doctrine in family planning matters when they elaborate plans for development at national level.

For us midwives planning means essentially the harmonisation of births in order to safeguard the health of the mother and of the child and to ensure that they are fully happy.

INTEGRATION OF FAMILY PLANNING INTO MATERNAL AND CHILD HEALTH CENTRES

AND PUBLIC HEALTH PROGRAMMES

Dr. Diop Leye

Gynaecologist/Obstetrician at Lubke Hospital of Diourbel - Senegal

I - INTRODUCTION

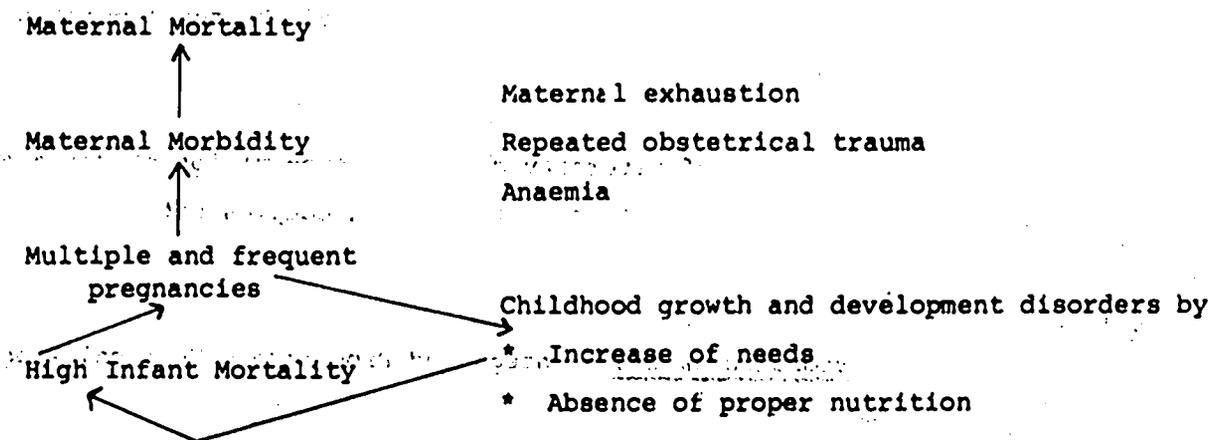
The question is to integrate family planning into maternal and child health activities ; there are common objectives in these two fields.

Family planning has been in existence for a long time but it is only since the discovery of the pill by Pinus in 1956 that so much has been said about it. Having the efficient and scientific means to prevent a pregnancy, it became for some the ideal weapon against demographic explosion and for others it became a reliable and efficient way to complement maternal and child health activities.

II - ARGUMENTS IN FAVOUR OF THE INTEGRATION OF FAMILY PLANNING INTO MATERNAL AND CHILD HEALTH ACTIVITIES

a) Medical reasons

There are common objectives in these concepts. Indeed, a close relation exists between the number of pregnancies and the high rate of maternal and infant mortality.



By breaking this vicious circle, the spacing of births allows :

- For the Mother : better health.
- For the Child : better health, better education and better nutrition.
- The avoidance of a sudden weaning due to a new pregnancy.

Through planning, pregnancies in young adolescents are avoided. Its objective is also to fight sterility and illicit abortion.

b) Reasons for its efficiency

Planning will be more efficient and profitable by :

1. Better diffusion of family planning programmes ;
2. Methods of approach by direct contact : the contacts established by health workers in maternity clinics and hospitals are more productive than visits at home - maternity care is a unique opportunity to grasp the needs for family planning - (recruiting on the spot). This personal contact is the best way to bring about changes of behaviour on target individuals. In Hong-Kong, out of the 23,000 families having accepted family planning, recruitment is as follows :

- 48 per cent through health personnel ;
- 38 per cent through encouragement by satisfied patients ;
- 8 per cent through propaganda.

It is a very efficient means if we consider that the number of women delivered per year is 4 per cent of the total population of 24 per cent of the fertile adult couples.

3. The continuity of maternity care, the supervision of children constitute a way of keeping in touch with married couples either as a follow-up or a control.

c) Reasons of economic nature - Integrated Programme - Vertical Programme

- Existence of a health structure with its premises, its personnel, its supply system.

d) Reasons of psychological order

Some women, although willing to use family planning services, would like to do this as discretely as possible ; they would favour this integration not to have to go through a family planning clinic.

III - HOW IS FAMILY PLANNING INTEGRATED INTO MATERNAL AND CHILD HEALTH SERVICES

a) Integration at Professional level

- Information, refresher courses for the actual practitioner ;
- Training for future practitioner, (integration into training programmes).

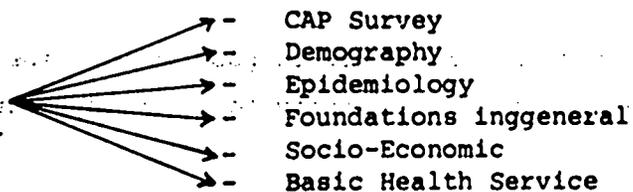
The support of the medical profession is very important. If the personnel is not motivated and does not give its support, there will be lack of public support.

The co-operation of the traditional birth attendant is very important because in rural areas the majority of parturient women are not delivered in maternity hospitals.

b) Integration at Target Level Women through direct Approach Contacts with Health Personnel during any Action Connected with Maternal and Child Health Services.

- Premarital examination
- Prenatal examination
- Post-Natal examination : mother very receptive at this period
- Supervision of children.

c) Integration at Population level.



- Inform the population through mass media;
- Personal contacts;

- Discussions - Lectures ;
- Newspapers ;
- Enlist the help of influential personalities such as : Ministers of Religion, Politicians, Civil Servants, important people.

d) A Government Policy in favour of this integration

IV - PROBLEMS RAISED BY THE INTEGRATION OF FAMILY PLANNING INTO MATERNAL AND CHILD HEALTH SERVICES

- a) There must be a balance between these two types of activities otherwise family planning will lose its health aspect and will be seen as a control system of the population. There are, therefore, three urgent priorities :
- Family Planning must not be a predominating factor ;
  - Family Planning must not precede the creation of a maternal and child health centre ;
  - Family Planning must only be integrated when the Maternal and Child Health Centre has proved itself to be effective.
- b) Extra personnel must be designated to reduce the tasks of the existing personnel owing to, extra family planning activities. A new time table per day and per person must be defined.
- c) The implementation of the programme will require doctor, midwife, nurse, educator and statistician.
- d) The remuneration must be as attractive as that of other health programmes.
- e) The help of traditional birth attendants will complement the service. Without their help the success of a programme might be jeopardised.
- f) Premises must be accessible to populations especially rural populations, therefore there is a necessity to establish centres at their level.
- g) Financial resources - supplies,
- Either by government contribution ;
  - or by outside contribution (private agencies) which will in fact be on a short term basis.

V - CONCLUSION - IMPLEMENTATION - SERVICE PROJECT PLAN

Family Planning and maternal and child health follow a common objective. The integration of family planning into maternal and child health activities, although it is feasible, creates some problems to be kept in mind - (personnel and their training, modification of behaviour, financial contribution, geographical obstacles - means of communication, transport facilities, high infant mortality, socio-economical and cultural structure).

PROJECT PLAN

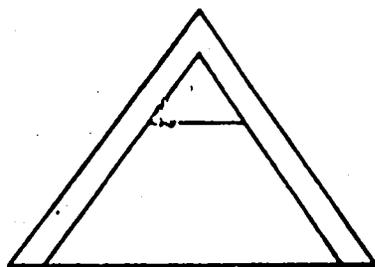
| Stages  |   |   | Means   | Aims  |
|---|---|---|---|---|
| <p>↑</p> <p>Informations</p> <p>↑</p> <p>Activities to be created</p> | <p>↑</p> <p>Education</p> <p>↑</p> <p>Activities</p>              | <p>↑</p> <p>Population Behaviour</p> <p>↑</p> <p>Action</p>       | <p>Services</p> <p>Services</p> <p>Services</p> <p>Services</p> | <p>Demographic Impact</p> <p>Social</p> <p>Health</p> |
| <p>Resources</p> <p>Material</p> <p>Personnel</p> <p>Premises</p>     | <p>Resources</p> <p>Material</p> <p>Personnel</p> <p>Premises</p> | <p>Resources</p> <p>Material</p> <p>Personnel</p> <p>Premises</p> | <p>Services</p> <p>Services</p>                                 |   |
| <p>Evaluation of the Cost of the Project</p>                          | <p>Evaluation of the Cost of the Project</p>                      | <p>Evaluation of the Cost of the Project</p>                      | <p>Services</p>   |   |

**Role of International Consultants:**

- To help countries to be technically independent, as quickly as possible

TYPE OF PROGRAMME

a) Integrated into an existing organisation



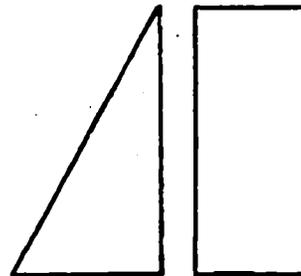
Services

Ministre

Director

Integration

b) Vertical Type



Programme with  
- its Director  
- its Services  
besides existing services.

Programme easy to realise but weak if resources are poor.

NATIONAL PROGRAMME OF BIRTH CONTROL IN MALI

Professor Bocar Sall

Senior Surgeon - Surgeon in Charge

at the Du Point G. Hospital - Mali

Since June 1972 a Pilot Centre of Family Planning has been in operation in Bamako, capital of Mali. Three years elapsed before this centre was created and the Malian authorities devoted this time to become informed, judge, deliberate and finally take a decision.

It was in 1969 that responsible Malians became interested in family planning problems and sent official delegations to different international meetings. There were four delegates at the Montreal Seminar in August 1971 organised by the C.R.D.I. of Mali : a doctor, an engineer, a statistician and a high civil servant at the Ministry of Foreign Affairs responsible for the social commission of women.

During this time in Mali, magistrates, physicians, midwives, tradesmen and eminent important people discussed and eventually created the Malian Association for the Protection and the Promotion of the Family. This private type institution desired :

- The implementation, within the framework of a pilot project, of a limited network of family planning services ;
- the necessity for research on needs and health and social and economic implications of family planning ;
- the provision of clinical services for sterile women and childless married couples.

This cluster of activities led to the signature on the 15th October 1971 of a Convention between the Government of the Republic of Mali and the Research Centre for International Development (C.R.D.I). This Convention was followed eight months later by an Act which established the national Malian project of birth control. This Act stipulates (and I quote) :

## Article 1

The following are permitted in the Republic of Mali under the reservations and conditions determined by decree :

- a) The practices, others than induced abortion, leading to the regulation of births when they conform to the official norms of Science and fit within the limits of a national programme jointly controlled by the Ministry of Health and the Secretariat of State for Social Affairs ;
- b) Information and training concerning the methods and means of controlling births ;
- c) Information, manufacturing, distribution of contraceptives authorised by the government.

## Article 2

A Medical Council in charge of compiling a list of legal contraceptive methods and products will be established at the level of the Ministry responsible for Health and Population matters.

## Article 3

Any Act violating the provisions of the present Act or its application decree will be punished according to the provisions of Article 171 of the Penal Code and according to the discriminations laid down in the above Article.

## Article 4

Repeals any contrary dispositions, especially those of Articles 3 & 4 of the 31st July 1920 Law on anti-contraception propaganda.

## Article 5

The present ordinance will be enforced as a State Law".

Let us immediately point out that this Ordinance was preceded by an introductory presentation note which restrained the three-fold wishes of the Malian Association for the Protection and the Promotion of the Family. We will refer to this subject

later.

The motivations of this law are numerous and we will enumerate them briefly :

- Strong demand by the population for birth control services witnessed by different Malian midwives and doctors ;
- in the absence of legal authorisation it is well known that these services are practised for exorbitant remuneration by doctors and midwives which means that these services are accessible only to the wealthiest women ;
- alarming increase - as everywhere else in the world - of criminal abortions and the accompanying drama ;
- high risks, worldly recognised, for the mother and the child of multiparity and too frequent pregnancies ;
- higher infant morbidity and mortality in large families especially as this high natality is mostly found in poorer families which are the most numerous ;
- economic and cultural effects unfavourable in families with high natality ;
- finally, it is not at all proved that a well thought and nationally controlled policy of birth control could have an unfavourable effect on the demographic development of a country.

The Malian authorities with this imposing cluster of arguments in mind and many others as well, have legislated and they are not on their own in this field ; they are numerous in the Third World and more than ten nations have adopted the same position.

To conclude, we will talk about the practice of family planning in Mali.

Following the adoption of the Ordinance :

- A medical council in line with Article 2 was set up ;
- A pilot centre for family planning in Bamako was created ;

This centre, at the moment under the authority of the Ministry of Public Health

and Social Affairs, is managed by a Malian doctor. Its activities fall under three specialised sections :

1. A Medical Section

composed of about 15 doctors, midwives, social workers, male and female nurses, all Malians.

These personnel trained in Family Problems during in-service practice, either in the country or abroad, assumes three main tasks:

- a) Information and training to patients at the Centre during talks by doctors and midwives;
- b) Distribution of contraceptive services; this could go from the loop to simple advice on periodical abstinence of intercourse or from coitus interruptus to the pill or vaginal foam.

The medical council and the medical team have considered at length and are still studying the indications and the contraceptive methods. At the moment, two ideas are strongly considered :

An indication for choice = a woman who has six children alive, and a woman who has had nine successful pregnancies.

In any case, the presence of the husband and wife, or a written agreement from the husband, is required. On the other hand, when illness of the woman has been eliminated, many other factors must be taken into account:

- A method which is imposed = the loop; the pill, which has more contra-indications (cardiac, renal, metabolic, phobic) is on the other hand more compelling. We must point out, however, that acceptance and subsequent rejection of the loop are much more frequent than with the white race.

c) Examination of the sterile couple

It is an important sector of our family planning. We see sterile women and childless married couples during free of charge medical visits. We are trying

to have some para-clinical sterility tests carried out free of charge (vaginal mucosa, spermogram, hysterosalpinography and in this field we have added a biologist doctor to the team).

2. A Research, Information and Education Section

This section comprises :

- An expert on family planning of Canadian nationality ;
- A Malian healer in charge of co-operation between the team and the traditional Malian doctors ;
- A person responsible for Malian Health Education ;
- A person responsible for the Malian Red Cross.

The first two listed are mainly concerned with research (contraceptive practice, traditional management of statistical services, etc.) All four are involved in information and education in all aspects.

3. A Statistical Section

Managed by an engineer statistician, it comprises two other high Malian civil servants. There is no need to give details of the activities of this section at this stage.

Finally, to conclude, let us say that our centre has already been extended by the opening of secondary branches in some Maternal and Child Health Centres in Bamako. We hope to provide :

- Branches in all the Maternal and Child Health Centres of Bamako and near the health centres of the chief towns of the departments.
- The addition this year of family planning courses into the training programmes for midwives.

## INTEGRATION OF FAMILY PLANNING IN MIDWIFERY TRAINING

Miss Pellegrin

Superintendent Midwife at the School of Midwifery - Senegal

### INTRODUCTION

Family planning is now considered as being integrated into the basic health services and more especially into the maternal and child health services with a degree of importance and practical applications which vary according to continents and countries.

This is a new concept whose integration within the traditional health structures will require that all categories of professional personnel of the health team, destined to work at the level of these structures, should receive a training in this field to cope with the specific needs of the community for which they will be responsible ; this specially concerns the midwife who constitutes a fundamental element in maternal and child health services.

The amplitude of the subject and the multiplicity of its aspects have been brought to light by the various speakers : economical, demographic, social, religious, medical aspects, etc. but also, and more especially, the African aspect. In the evolution of our societies and the evolution of the concept of maternal and child care towards a broader idea of family health it is crucial in the orientation of the medical and paramedical professions, to give adequate training to all those who will serve the community.

### FAMILY PLANNING TRAINING

In the Midwifery School of Dakar, there is no official family planning training. However, for five or six years with the recognition of the problem and the more and more important role of the midwife in this field, some knowledge has been added to the third year programme but without practical application. Family planning is a new element and its incorporation into actual training requires without doubt a lot of caution and frequent evaluations. The management of this training must be arranged so that it is placed in the Public Health context to which it belongs. It is for this reason that it is important before any programme is elaborated to know beforehand :

- 1) What the government options are in health policy and more especially in family planning matters ;
- 2) To what type of populations will these services apply :
  - urban population
  - density - demographic tendencies
  - socio-cultural characteristics
  - health conditions
  - specific needs for family planning
- 3) What professional categories of personnel exist and what are their respective functions ;
- 4) How is health coverage carried out ;
- 5) What resources are available :
  - in educators
  - in in-service fields.

#### TRAINING OBJECTIVES

They originate from the above analysis and will of necessity join the public health programmes. They must be explicitly formulated and made known to all those who are responsible for students.

The future midwife must be trained to :

- 1) Identify individual, family and community health problems and the desired method of assistance : sterility treatment or spacing of births ;
- 2) Understand the influence family planning has on the health of the mother and the child in the meaning given by WHO and thereby promote the well-being of the family ;
- 3) Create an educational action based on the understanding of the socio-cultural and psychological factors adapted to each individual, each married couple and each family and which does not conflict with their personal

convictions, their beliefs and their aspirations";

- 4) Evaluate the changes in attitudes ;
- 5) Take some technical or therapeutic initiatives within the limits of her competence and to refer the cases that require it for specialist consultation ;
- 6) Organise a family hygiene service and participate in research activities.

#### TRAINING PROGRAMME

Above all, the existing programmes already overloaded must not have too many additions. It is not so much the contents of the programmes, whose concept is general, is on the whole satisfactory, but the orientation and the use made of these programmes as well as the working methods chosen. It is, therefore, important that the student integrates her knowledge and that training be adapted to the needs of the community as well as to those of the student.

The choice of the method of training depends upon the possibilities of each school : instruction, the standard of pupils, the duration of training, the quality of the places for practical instruction and the teaching methods. It is desirable, whenever possible, to give preference to integrated training. What do we mean by this? The word 'integrated' derives from the Latin - complete - which means that training must form a whole, contain all the aspects of the problem through a multidisciplinary and harmonious approach. Too often our programmes lack homogeneity and family planning is the subject of isolated lectures leading pupils to relate it solely to contraception. This creates tight divisions between the various disciplines and prevents the students from seeing health problems in their entirety. The programme is not always to blame ; indeed, the way care-practice is taught is, most of the time, specifically focused on the patient, the pregnant or parturient woman or the baby ignoring the familial repercussions of the conditions and of the delivery. It is not always easy to make the student aware of psychological, familial or social implication. The following are not sufficiently emphasised :

- The repercussions that sterility can have on the equilibrium of the married couple ;

- Psychological aspect of an undesired pregnancy or of an abortion ;

- The impact of a maternal death or of the chronic pathological state of a mother on the education of the children;

Family planning integrates perfectly into the majority of the disciplines taught. The multiplicity of its aspects is clearly emphasised by the point of view adopted by the Twenty-First World Health meeting in 1968 : "Family planning assumes a certain way of thinking and living, freely accepted by the individual and the married couple with the object of promoting their health and that of their family and thereby contributing to the social progress of the community".

How could we therefore conceive its teaching if we ignore the way of thinking and of living of the populations to which the midwife will give her care? The ways of thinking and living vary from one region to another, from one ethnic group and even one sub-ethnic group to another. It explains how important it is to give education in :

- Anthropology;
- Sociology;
- Psychology.

The teaching of these three disciplines will enable the student to use efficiently, in her work with the individual and the family, her understanding of ethnic, psychological, cultural and religious factors which will have an influence on the rejection or acceptance of family planning by the family. It is the knowledge of the motivations of the individuals which will be the basis for the educational action of the midwife and which will give its meaning to the training in:

- Health Education.

But, if the knowledge of the behaviour and deep motivations of the individuals as well as the knowledge of the means which will bring about a change in attitude is crucial to success, the student must know that other factors can influence these behaviours, it therefore leads to the teaching of :

- Existing legislation by giving legal basis to the work of the midwife. This teaching will aim at making the student understand the impact that the laws have on population and how they influence :

- Demography in itself very closely related to training ;
- Statistics ;
- Public Health.

The legal aspect will be completed by another aspect from which it cannot be dissociated and which is specific to our profession : it is the ethical aspect of our profession which the student will grasp through the learning of :

- Deontology which will enable the student to understand the limit of her rights and duties. She must never, whatever happens, forget that she is part of a team.

Medical subjects are certainly those which integrate more easily, or to be more exact, those that we feel are better suited for integration. They are, on the other hand, those which fill the major part of the programmes. Indeed, when one talks about family, one must start from its origins. This is where the training will intervene on :

- Anatomy and physiology which in studying the structure and the functioning of the human body will necessarily study the structure and the function of the reproduction system of men and women.

It is evident that any anomaly, either general or local, will have a repercussion on the biology of reproduction, therefore it demands the study of :

- Genetics ;
- Pathology - general or surgical,
- genital

The biology of reproduction finds its natural continuity in :

- Obstetrics
- Pediatrics

These two disciplines are closely linked ; through important biological links the child develops from what the mother has been. Any disturbance in the mother or in the father will have repercussions on the child whose survival depends particularly on the mother's condition.

There exists an inter-dependence between different medical disciplines ranging from factors of reproduction to the measures of:

- Public Health, implemented for the protection of the family and nursing care given within the framework of this family, ranging from counselling to purely technical care in the curative or preventative field, brought about by the teaching of:
  - Social obstetrics and pediatrics;
  - Special education in family planning.

At this stage all problems related to sterility, its repercussions on the life of the family, its treatment, will be raised, as well as contraception for the women who desire it or when it is necessary for their health.

#### IN-SERVICE TRAINING

It constitutes an essential part of training. It must be carried out in hospitals, maternity clinics, maternal and child health centres and in the home.

In-service practice training aims at:

- Enabling the student to acquire practical experience;
- Having contacts with family problems, identifying the needs of the family and trying to find solutions.

It is regrettable that home visits are not organised, though they are an opportunity for the students to tackle the problems within the family and see the mother in her everyday environment and to give her the necessary advice.

#### DIFFUSION OF FAMILY PLANNING EDUCATION THROUGHOUT TRAINING PROGRAMMES

The diffusion of family planning education during the three-year training course is left with each school. For some, education will be the object of a special course during the third year only - others prefer to spread this education during the whole length of the training. As far as the school of Dakar is concerned, the main object of the training courses is not family planning. By regrouping the teaching themes under topics of interest, the programme we have created, with the addition of psychosociology education, will make the pupils progressively aware of the problems of the family and the community and not to associate family planning with the common practice of contraception. The division is as follows:

## 1) The First Year

The first year focusses the teaching on the knowledge of the human being.

It is aimed at:

- Helping the student discover the meaning of the human person in its entirety, not only the individual as an isolated organism but the human being in his environment;
- helping her understand what health is in the wide sense of the word, making her identify the factors influencing the health of the individuals, and making known to her the means of promoting, maintaining or restoring health;
- discovering the biological basis of the behaviour of the individual and understanding the influence of the environment on his personality;
- identifying the needs of the individual in order to give him the nursing care required by his condition.

Training covers the following disciplines:

- Anatomy - physiology including reproduction;
- Psychology: effects of psychological factors - the individual faced with illness how is he different from an ill person?
- Sociology: the individual in the family and social groups.

## 2) The Second Year

The second year is focussed on the family, fundamental unit of the community through the mother and the child : the instruction completes that of the first year and replaces the individual in the family context.

The family is seen from:

- The purely obstetrical and paediatric angle with the study of pregnancy and delivery and the care of the child;
- Psycho-sociological : role of the family in the development of the personality and the behaviour of its members; the customs related to marriage and delivery as well as the beliefs and the taboos linked with fertility or sterility; the child and its value; psychology of the gravid, the parturient or the postpartum woman;
- Legislation: Family as a social institution with the filiation and adoption problems, etc...

### 3) The Third Year

Emphasizes family health and public health : prevention, information, education. The training of the third year is aimed at the synthesis of the knowledge previously acquired by making the student:

- Identify the problems and priorities of families and communities;
- Understand the social effect of a pathological condition;
- Know the means implemented to satisfy the health needs of the family, especially in the field of maternal and child care;
- Enforce a plan for individual or special care to satisfy the particular needs of the individuals, the married couples and the families in family health matters;
- Act as counsellor and educator;
- Participate in the organisation of maternal and child care services;
- Maternal and child care : the laws concerning the protection of the mother and the child; antenatal, intranatal, postnatal care including contraceptive methods with their advantages, inconveniences, indications and contra-indications as well as everything connected with sterility; high-risk aspects;
- The laws concerning the family (the family code, family allowances; anti- and pro-natalist laws;
- Organisation of family hygiene services;
- Psycho-sociology : psychological and social aspect of unwanted pregnancies.

Practical training will not reach its rewarding objectives and will be profitable only when the personnel has been emotionally involved and when human relationship structures have been organised to this effect.

#### TEACHING METHODS

Teaching does not differ from the methods already used for the rest of the training, but they are not all possible because of the lack of means. The choice of active methods must be given preference because they raise interest in the student and bring him to observe and discover progressively. They aim at developing various aptitudes:

- Aptitude to communicate (talks with patients, listening to patients, play roles, solutions to problems, home visits, case presentation);
- Educative aptitudes (supervision of younger students, training of the precious auxiliary traditional birth attendants, preparation of simple training courses for univalent personnel, preparation of posters and broadcasting propaganda);
- Clinical aptitudes (report on clinical observations, survey of medical history, gynaecological examinations, effective participation in practical contraceptive methods, participation in the treatment of sterility);
- Aptitudes for organisation and research.

#### ADVANTAGES AND DIFFICULTIES OF INTEGRATED TRAINING

Integrated training presents many advantages:

- it avoids useless repetitions;
- it encourages synthesis;
- it enables a greater collaboration between teachers;
- it enables a better co-ordination between theoretical and practical training.

Integrated training is in favour at the moment. It is certainly very attractive in its concept, but the practical realisation could be made difficult. Indeed, it necessitates:

- a close co-operation between teachers to form common objectives, which is not always easy because of the differences in personality and opinion;
- that every teacher know the subject of his lecture to avoid dilution of teaching;
- a great availability of teachers; integrated training requires preparation and frequent evaluations;
- continuity; the interruption of services of a teacher could disturb the whole system.

## CONTINUOUS EDUCATION AND REFRESHER COURSES

We cannot talk of training without raising the problem of continuous education and of improvement which are part of it. Because of the progress made in various fields during the past years, especially those in medical science and the rapidity in the evolution of our societies, the acquired knowledge is often out of date when it is put into practice. The basic training must give the student the wish to improve and to take the appropriate steps. For the midwife it is a matter of professional ethics and of personal effort. On the other hand, the implementation of a training programme on a new subject will necessitate that the organisers develop a structure of adequate training and supervision of the pupils, the methods of which will be determined by each country.

Continuous training and refresher courses should be made a systematic institution. Periodic refresher courses should be compulsory. Let us remember the re-instruction in-service courses our elders had to attend before reaching senior level. The "refreshment" may be different if organised at national or local level or at the level of health care-institution, in-service practice, discussions, seminars, working shops or other courses, etc.....

## CONCLUSION

Our task is not easy because in training matters there is no easy solution or method which is absolutely infallible or definitive. It explains why training problems are always with us and constantly challenged, especially when the subject is family planning whose concept raises so much controversy and brings with it complex and intricate factors, individual as well as collective.

The teaching of family planning is imperative in the training of our future midwives because we cannot ignore a problem that preoccupies the world at the moment. However, it is not enough to inculcate learning upon students, but it is important, once knowledge is acquired, to make them understand what is expected of them in the health team. If they have enough understanding and maturity they will make good use of their experiences and know how to adapt themselves to the environment they serve.

The midwife's behaviour is dependent on how we have trained her. It is on her activities that the familial behaviour will depend, either through delivery, infant care or through health education measures. Her future role in family planning goes beyond the malthusian framework of birth control, the prescription of

the Pill or the insertion of the loop, because many underlying factors intervene in the demand for contraception.

We have expressed our thoughts briefly. The similarity of problems in our respective countries, the identity of our options should help this Seminar find solutions whether it is a question of fundamental training or of continuous and improvement of education.

FAMILY PLANNING PROGRAMME

| OBJECTIVES OF THE LECTURE   | CONTENTS OF THE TEACHING  | DISCIPLINE                         | SPECIFIC OBJECTIVES   |
|---|---|------------------------------------|---|
| <p>1. Bring the student to use efficiently in her work with the individual and her family her comprehension of psychological, cultural and religious factors which influence the different concepts of family planning.</p> | <p><u>FAMILY CONCEPT</u></p> <p>Different types of families:</p> <ul style="list-style-type: none"> <li>- Western type</li> <li>- Traditional African type</li> </ul> <p>Role of the family<br/>                     Role of the woman<br/>                     History<br/>                     The woman in traditional African societies.</p>  | <p>Psychology</p> <p>Sociology</p> | <p><u>At the end of training the student should be able to:</u></p> <ol style="list-style-type: none"> <li>1. Compare the family in a Western type of society with the family in a traditional African society.</li> <li>2. Analyse the role of the family in African society.</li> <li>3. Analyse the role of the woman in an African society.</li> <li>4. Describe the customs related to marriage in the country.</li> <li>5. Analyse the effects of polygamy.</li> <li>6. Define what the child represents in an African society.</li> <li>7. Explain the reasons why the African considers fecundity an honour.</li> <li>8. Explain the beliefs in sterility matters.</li> <li>9. Study the repercussions of sterility on family life.</li> <li>10. Describe some customs related to pregnancy and discuss their meaning.</li> </ol> |
|   | <p><u>MARRIAGE</u></p> <p>History:</p> <ol style="list-style-type: none"> <li>1. Marriage in traditional African societies.                             <ol style="list-style-type: none"> <li>a) Rites and customs.</li> </ol> </li> <li>2. Polygamy and its consequences on:                             <ul style="list-style-type: none"> <li>- Man</li> <li>- Woman</li> <li>- Children</li> </ul> </li> </ol> |                                    |   |

| OBJECTIVES OF THE LECTURE | CONTENTS OF THE TEACHING   | DISCIPLINE | SPECIFIC OBJECTIVES  |
|---------------------------|--|------------|--|
|                           | <p><u>THE CHILD IN THE AFRICAN SOCIETY</u></p> <ol style="list-style-type: none"> <li>1. What he represents</li> <li>2. Father/Mother/Child relationship.</li> </ol>   |            | <ol style="list-style-type: none"> <li>11. Take socio-cultural factors into consideration in professional practice.</li> <li>12. Give the necessary advice to answer the real needs of the individuals.</li> </ol> |
|                           | <p><u>FERTILITY AND MOTHERHOOD</u></p> <p>Socio-cultural and economic aspects of fertility.</p> <ol style="list-style-type: none"> <li>1. Rites and customs               <ol style="list-style-type: none"> <li>a) Fertility</li> <li>b) Conception</li> <li>c) Psychological and social aspects.</li> </ol> </li> <li>2. Rites and customs to fight sterility.</li> <li>3. Pregnancy and delivery in traditional societies.</li> </ol> |            |  |

| OBJECTIVES OF THE LECTURE  | CONTENTS OF THE TEACHING   | DISCIPLINE  | SPECIFIC OBJECTIVES  |
|--|--|---|--|
| <p>2. Understand the impact that the laws with regard to family and natality have on populations and how they can influence decisions.</p> | <p><u>LAWS WITH REGARD TO FAMILY</u></p> <p>The Code and the family in Senegal.</p> <p>Laws encouraging natality:</p> <ul style="list-style-type: none"> <li>- Abroad</li> <li>- In Senegal</li> </ul> <p>Laws having a tendency to limit natality:</p> <ul style="list-style-type: none"> <li>- Laws on adoption</li> <li>- Repression of abortion</li> </ul> | <p>Legislation</p> <p>Public Health</p> <p>Social<br/>Obstetrics and<br/>Pediatrics</p> | <ol style="list-style-type: none"> <li>1. Explain the laws in operation in the country concerning the family.</li> <li>2. Define and discuss the legislation in operation for the protection of children.</li> <li>3. Define the role of organisations for the protection of children.</li> <li>4. Discuss in groups the laws repressing induced abortion and its repercussions.</li> <li>5. Discuss in groups the pro and anti-natalist laws.</li> <li>6. Teach individuals their rights in family planning matters.</li> </ol> |

| OBJECTIVES OF THE LECTURE   | CONTENTS OF THE TEACHING   | DISCIPLINE  | SPECIFIC OBJECTIVES  |
|---|--|---|--|
| <p>3. Make the student understand that her knowledge of the environment in the practice of health education is one of the factors for success. She will then have to adapt her teaching to each category of individual without clashing with their personal or religious convictions.</p> | <p><u>DEMOGRAPHIC &amp; EPIDEMIOLOGIC STATISTICS</u></p> <p>Maternal mortality and morbidity</p> <p>a) In the world<br/>b) In Africa</p> <p>Means for fighting maternal mortality</p> <p>Public Health organisations serving the Populations</p> <p>Means and methods used in Health Education</p> <p>Role of the Midwife as a counsellor in family planning matters</p> <p>Youth and contraception</p> <p>Information on sex matters for adolescents</p> <p>Enquiry techniques used in sociology</p> <p>Methods for approaching individuals</p> <p>Presentation of dynamic ideas of the group</p> | <p>Nursing Care</p> <p>Psychology</p> <p>Sociology</p> <p>Public Health</p> <p>Health Education</p> <p>Pedagogy</p> <p>Psychology</p> <p>Sociology</p> <p>Public Health</p> <p>Health Education</p> <p>Pedagogy</p> | <ol style="list-style-type: none"> <li>1. Identify the needs of the individuals and communities in family planning matters.</li> <li>2. Collect data for a sociological survey:             <ol style="list-style-type: none"> <li>a) Questionnaires</li> <li>b) Guided discussions</li> <li>c) Free discussions</li> </ol> </li> <li>3. Analyse the factors which make the acceptance of family planning difficult.</li> <li>4. Identify the factors which help family planning to be accepted.</li> <li>5. Be aware of the situation and identify oneself with individuals in order to find solutions:</li> <li>6.             <ul style="list-style-type: none"> <li>- psycho-drama</li> <li>- socio-drama</li> </ul> </li> <li>7. Prepare a simple lecture explaining the anatomy and the functioning of the genital organs.</li> <li>8. Prepare a radio broadcast.</li> <li>9. Explain the different methods of contraception.</li> <li>10. Explain the acceptability, the contra-indications and the advantages of each method.</li> </ol> |

| OBJECTIVES OF THE LECTURE  | CONTENTS OF THE TEACHING   | DISCIPLINE   | SPECIFIC OBJECTIVES  |
|--|--|--|--|
|  |  |  | <ol style="list-style-type: none"> <li>11. Establish a list of questions likely to be asked, and discuss in groups the different types of answers that could be given.</li> <li>12. Suggest methods which do not clash with beliefs and the personal ethics of the individual or of the group.</li> <li>13. Give information so clearly that the individuals may choose freely with complete knowledge the method of their choice.</li> <li>14. Take into consideration the knowledge on family planning matters.</li> </ol> |
| <p>4. Teach the student enough theoretical and practical knowledge of general pathology so that she is able to understand its incidence on fertility and sterility. She will then be in a position to help efficiently in family health matters.</p> | <p>Various practical gynaecological examinations</p> <ol style="list-style-type: none"> <li>a) Pelvic examinations (PV + palpation)</li> <li>b) Breast examination</li> <li>c) Examination with the speculum</li> <li>d) X-Ray examination</li> <li>e) Pelvimetric X-Ray</li> <li>f) Hystero-salpingography</li> </ol> | <p>Obstetrics</p> <p>Gynaecology</p> <p>Nursing Care</p> <p>Legislation and Deontology</p> | <ol style="list-style-type: none"> <li>1. Describe the various clinical and para-clinical examinations carried out in gynaecology.</li> <li>2. Explain the utility and necessity of the various smear samples.</li> <li>3. Explain the conditions for each smear.</li> </ol>   |

| OBJECTIVES OF THE LECTURE | CONTENTS OF THE TEACHING   | DISCIPLINE  | SPECIFIC OBJECTIVES   |
|---------------------------|--|---|---|
|                           | <p>Endoscopic examinations</p> <p>a) Colposcopy<br/>b) Caelioscopy</p> <p>Gynaecological samples</p> <p>a) Salt biopsy<br/>b) Endometrial biopsy<br/>c) Vaginal mucosa</p> <p>Involuntary sterility</p> <p>a) Male sterility<br/>b) Female sterility</p> <p>Voluntary sterility</p> <p>a) Contraception<br/>b) Means and methods used:</p> <ul style="list-style-type: none"> <li>- mechanical means</li> <li>- hormonal means</li> <li>- surgical means</li> <li>- other means</li> </ul> <p>Indication and contra-indication of the different means</p> <p>Induced abortion:</p> <ul style="list-style-type: none"> <li>- World and African statistics</li> <li>- Regulating of Pregnancy tests</li> <li>- Repression of induced abortion</li> <li>- Evolution of legislation</li> </ul> | <p>(Report)</p> <p>Obstetrics</p> <p>Gynaecology</p> <p>Nursing Care</p> <p>Legislation and Deontology</p> <p>Special lectur on family planning</p> | <p>4. Make a concise interpretation of the results.</p> <p>5. Examine the pelvis and the breasts</p> <p>6. Analyse the causes of involuntary sterility.</p> <p>7. Take a complete and correct medical history which could help in diagnosis and treatment.</p> <p>8. Define the method of action of the different ways of contraception and discuss their repercussions at short and long term.</p> <p>9. Describe the accidents consecutive to an illegal induced abortion and list the traditional methods.</p> <p>10. Take measurements and fix a diaphragm.</p> <p>11. Practise the insertion of a loop.</p> <p>12. Evaluate the maternal and foetal risks.</p> |

| OBJECTIVES OF THE LECTURE | CONTENTS OF THE TEACHING  | DISCIPLINE | SPECIFIC OBJECTIVES |
|---------------------------|---|------------|---------------------|
|                           | <p>Regulating of the sale of contraceptives</p> <p>The aspect of high risk pregnancy</p> <p>Medical guiding on contraception.</p> |            |                     |

INTEGRATION-OF-FAMILY PLANNING IN THE TRAINING  
OF MIDWIVES OF ALL CATEGORIES

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DEFINITIONS:

What is to be integrated?

a) Knowledge: that is to say a certain amount of knowledge regarding sexuality of the individuals, their fertility, medical and social pathology resulting from fertility or lack of fertility, e.g. sterility, the means of preventing unwanted pregnancies and sterility, and lastly the treatment of excess of fertility and of sterility.

b) Ability: that is to say an ensemble of techniques that the student must learn to master in order to apply to the individuals and to the community the knowledge that she has acquired.

c) Good behaviour: it is the behaviour of the student after her training which will enable her to let the populations she serves benefit efficiently from the techniques she has acquired.

WHY ALL THESE CATEGORIES?

The main problem facing the people responsible for health matters results in the essential contradiction existing between the two following proposals:

"do the best possible"

and

"do as much as possible".

The opposition between quantity and quality is the result of society not being able to or not wanting to provide enough financial resources for the health services so that our medical knowledge may be applied both in quality and in quantity to produce the best results possible.

The philosophy of the "islets of excellence" where the best medicine is practised by highly specialised personnel has a corollary which is the existence of an ocean of mediocrity where the populations do not benefit by the minimum of techniques at a time when the meaning of social responsibility is in constant development. For the whole of the populations to benefit by the application of medical techniques, students with good previous knowledge must be recruited, many technicians must be trained rapidly with a budget made available by the government or any other community which will obviously be limited. The problem to be resolved is as follows: with a defined budget how is the entire population of a country provided with maternal and child health services to ensure the health of a maximum number of mothers and children with relatively short delay (5 to 10 years)? Alternatively, the same budget could be invested in the training of a limited number of more qualified senior personnel who will require for their work a more complex foundation, which means more cost for the community and who, because of the level of their education, will tend to stay in urban environments where they will eventually serve a minority of the population. This problem has to be resolved in each country, taking into account various local characteristics and needs: number of births per year (40 to 50,000 births per year and per class of inhabitant), amount and distribution of doctors and midwives already in practice, amount of students qualifying every year from midwifery schools, amount and proportion of the young women with college certificates who will choose to train as midwives and, finally, an estimation of the percentage who will settle in rural areas. I am convinced that the need for midwives of various categories will emanate from this analysis. One could have a secondary school education or a high school education and undertake lengthy studies (three years) and will then play a key role in supervision, teaching, research and specialised care. Another might be a pupil who has received only part of the secondary teaching and who will get a mixed obstetrical-nursing training in two years.

Finally, there is a third category, e.g. the obstetrical auxiliary and the maternal and child health auxiliary who, after she has passed the Junior School certificate can be trained for a year to practise simple techniques (uncomplicated multiparous delivery, vaccination, weighing of the child, home visits, restocking of contraceptives) under the control of the midwife and the doctor. In some areas it might be necessary to train the traditional birth attendant, to teach her elementary hygiene and to integrate her under the supervision of the public health team.

## PLAN FOR THE INTEGRATION OF FAMILY PLANNING TRAINING

### I - Selection of the Objectives

Any teaching requires formation of objectives. The contents of the teaching, as far as knowledge, techniques and behaviour are concerned, will depend upon the choice of the objectives and so will the criteria for the evaluation of this teaching. The following factors must be taken into consideration to determine the objectives:

a) The health policy of the country, and especially its policy regarding birth control:

- Integration or specialisation policy?
- If integration .....integration into, what? Into MCH or into all health services?
- Integration at what level? The Ministry, Province, Hospital, Health Centre or Clinic?
- Legislation and availability of abortion;
- Degree or priority of family planning within health programmes.

b) Type of Personnel to be trained:

- The lower the level of education at admission and the shorter the duration of the training, the higher the priority which must be given to techniques and behaviour in relation to knowledge.

c) Tasks to be given to this category of personnel:

- Insertion of IUD or simply control?
- Prescription of oral contraceptives or re-supply-only?
- Distribution of traditional contraceptives?
- Education of the population in family planning matters?.
- Selection and history of childless couples?

d) Working conditions of the personnel:

- In town or in rural areas;
- In the hospital environment, in health centre or at home;
- What language should be used and which social classes should be reached.

e). Level of work of the personnel:

- Should the personnel work as "generalized practitioners"; in this case the tasks would be mainly information and education;
- As "clinicians"; in this case family planning techniques must be well known;
- As "supervisors and administrators"; apart from the techniques, the personnel must know the administration of a programme, its evaluation and the supervision of personnel.

II - Teachers

Teaching is the element on which the success of any educational process is mainly based. Through personal attitudes the motivation of students is conditioned. We must, however, remember that the educator is also a human being with his opinions, his preconceived ideas, his attitudes and the values to which he is attached.

When giving his lecture, the teacher will influence his pupils in the interpretation of facts and he will communicate his own attitudes; for example, IUD is bad because it has three percent failure rate or, on the contrary, it is excellent because it protects in 99 percent of cases.

It is therefore essential that the teacher is free of any interior conflicts and is objective in his approach. It is also important that the teacher is familiar with the environment in which the pupil will work later and especially with the needs of the local population. Finally, the teacher should be permanently in contact with the users of his product, that is to say, the health administration and the population served.

III - Selection of the Students

The teaching will be in line with the level of education and the quality of the students. There are generally three categories requiring a different teaching and a different level of education:

- a) Auxiliary personnel to be trained to simple and limited techniques which will be applied under the supervision of the midwife, the nurse or the doctor.
- b) Paramedical personnel close to the doctor and whose care will vary according to their judgment; this type of personnel has responsibilities, and thanks to his initiative will adapt the care to various situations.

- c) Specialised personnel who receive an advanced teaching to enable them to assume responsibilities in clinical organisation, administration, evaluation, teaching or research.

The socio-cultural origin of the pupil will have to be analysed and the pupil should especially be encouraged to outline the pressures exerted by his environment; for instance, submission to elderly persons who are often unwilling to accept new ideas or attitude towards the rights of women, sexuality and family planning.

At the same time, it is important to require only that level of previous education which is sufficient for the training. An auxiliary only needs the Junior College Certificate; a paramedical will need a secondary education more or less complete according to the development of national education in his country.

#### IV - Training Contents

The training will depend upon the objectives selected and consequently will vary from one country to another to suit the local needs. It is therefore difficult to establish a universal system. The teaching of family planning, if carried out as a special course, or if integrated into other teachings, must:

- Supply sufficient knowledge;
- Convey a psycho-technical education;
- Develop attitudes.

##### 1. Knowledge

According to the level of education chosen, the training will be more or less elaborated in the following:

- a) Anatomy and physiology of reproduction, sterility;
- b) Sexuality;
- c) Epidemiology of the populations: mortality, natality and especially maternal, perinatal and infant mortality, morbidity measures;
- d) Effects of family planning on family health, for instance: repercussions of the spacing between pregnancies on mortality and morbidity of the mother and child; excess of mortality and morbidity in mothers under 18 years of age and over 30;
- e) Organisation of family planning programmes;

- f) Contraceptive methods: advantages, disadvantages, efficiency, causes of failure - sterilisation and abortion.
- g) Techniques of education and information in family planning matters;
- h) Obstacles to the practice of family planning, in particular: legislation, cultural, religious, socio-economic aspects, attitude of the population;
- i) Role to play in recruitment, responsibility and eventual treatment of complications.

The above subjects can be integrated into the following:

- Reproduction, fertility and sterility into fundamental sciences and pathology;
- Contraceptive methods into obstetrics/gynaecology;
- Psychology, sociology and family planning statistics can be taught in social medicine, hygiene or in community medicine.

## 2. Aptitudes

The psycho-motive training includes the teaching of techniques to resolve certain problems:

- a) Communication techniques which enable the pupil to understand problems and to communicate solutions;
- b) Clinical techniques which will include for:
  - i. Paramedical Personnel:
    - Insertion and withdrawal of IUD
    - Selection of users and prescription of contraceptives
    - Fixing of the diaphragm
    - Papanicolau smear
    - Diagnosis of complications and referral to a doctor
  - ii Auxiliary Personnel:
    - Re-supply of oral contraceptives or others
    - Selection of users
    - Supervision of complications and complaints
    - Home visits.

### 3. Attitudes

The teaching will aim at developing the student's sensitivity and her understanding of other people. The teaching will specially aim at:

- a) Understanding of physical, psychological and social needs of each individual-
- b) Developing respect towards other people's feeling and dignity;
- c) Making the student become aware of her own reactions towards sexuality and the methods of family planning she uses;
- d) Making the student aware of her abilities, but also of her limitations.

### V - Methods

Teaching must be, as far as possible, dynamic, include important participation by the student and call upon thinking and judgement more than upon memory.

Naturally traditional lectures, questionnaires, practical demonstrations, reports and study of cases have an important role so long as there is a shortage of teachers trained in active pedagogical methods and audio-visual apparatus. But the importance of other techniques must be emphasized:

1. Group discussions in which everyone expresses his point of view, becomes aware of his feelings and overcomes his reserve. This technique is very important to help the students think about the problems and find solutions which will influence their thoughts and their behaviour.
2. Play roles or simulation which put the student in similar situations to those she will meet during her work.
3. Programmed teaching which assumes a complete coverage of the subject and a progression tuned to the rhythm of each pupil, especially useful where there is a shortage of teachers.
4. In-Service Practical Instruction which must be beneficial to the student, not to the establishment seeking for free labour. This is the first contact with real life, where one learns to observe, understand, apply the techniques, register the results and especially when the opportunity arises to converse with the patients.

The in-service practice during home visits is particularly important in the understanding of family problems and of the factors which have an influence on the adoption of family planning and its practice.

#### VI - Evaluation

This is a process which starts with education, goes on during courses and continues after training when the student is in practice. She must be objective and must carry on valid and viable tests. The aim of training is to bring the pupil up to date in new knowledge, psycho-motive techniques and emotional behaviour. Evaluation will make the measuring of these types of changes possible:

- a) Knowledge: Interrogation, reports on in-service practice, etc.
- b) Techniques: Observation of the student during the in-service practice and demonstrations;
- c) Behaviour: Observation of individual and group behaviour.

The students must know the objectives and criteria of evaluation and know the results. Evaluation of the student involves evaluation of the teacher.

#### CONCLUSION

Integration of family planning in the training programmes of midwives of all categories is important for an efficient promotion of the health of the mother and child. It can be realised if all parties involved: teachers, administrators and consumers, understand that the woman's health is incomplete in spite of the absence of pathological conditions and adverse psychological and social aspects, unless she is in control of her own fertility.

THE MIDWIFE IN FAMILY HEALTH  
THE ROLE AND FORMATION OF THE HEALTH SERVICES -  
THE NEED FOR EVOLUTION

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First of all, allow me to make a preliminary remark on the terms "Family Health" and "Family Planning" which have both been used a lot during this seminar. I would like to say that I believe it is important to avoid the confusion that could settle in the mind on their account and especially it is important to avoid the use of these terms as synonyms. Let us admit that for Mr. Everybody and at the present time family planning commonly means the essential regulation or harmonization of fertility, that is to say, fight against sterility on the one hand and spacing of births or even limitation of births on the other.

The concept of family health (mainly popularised by WHO) is - as has been said abundantly here - much broader and takes into consideration the increased well-being of the various members of the family, with an emphasis on a certain number of priorities: care of pregnant women and of mothers, care of children, nutritional education and rehabilitation, general health education, prevention and treatment of infectious diseases including vaccinations, improvement of hygiene of the environment; these are the headings for family health. We are all in agreement to say that family planning is an integral part of family health, an essential part of it, but that it is only a part of it.

My following talk will refer to the workpaper presented at the Seminar held in Dakar in November 1974 on the Theme: "Role of the Midwife in Family Health Services integrated into the Maternal and Child Health Structures".

On this subject, I think, just as some have remarked, that the general title of the Seminar can lead to confusion; this title refers to the family health services integrated into the MCH structures, when in fact MCH is part of the family health.

I will now make some remarks on training (basic training and continuous training) of the midwife for family health care, including family planning. These remarks are based on what I witnessed during the past six years in Latin America, South Asia and in Africa. My major interest during this period was the administration of "basic" family health care services, especially in the peripheral rural areas. We have been reminded during this seminar that the population of these regions are those least provided from medical health care point of view, and everyone agrees that health services should strictly put an emphasis on the distribution of services in rural areas (even if the practice does not always correspond to the expressed wish).

Consider then the role of the midwife in family health care of supreme importance to the peripheral areas, in view of what we now call community doctor, we must define the objectives and define them as far as possible in terms of behaviour. In this respect, why and for what do we want to train the midwife?

Here we must reconsider an important element which emanated from the discussions which have taken place during the past few days: various speakers and participants emphasized that it was necessary to broaden the role of the midwife and to make her into a more polyvalent agent. We all know the medical health care conditions and the environment in general in the rural zones, especially in the Third World; it is no longer possible to accept that the role of the midwife is restricted, as it is in Europe for example, only to the supervision of pregnancy and delivery. If the midwife really wishes to have efficient positive action on pregnancies and deliveries for which she is responsible and care of the children brought into the world, she must broaden her scope of action. In all humility, allow me here and now to answer the remarks which might be made that such an "enlargement" will mean a diminution of the strictly obstetrical qualities of the midwife who would have knowledge in a wider field but who might not be trained properly in a specialised field. We certainly must take this possibility into account. However, let us emphasize that a broader training does not necessarily mean "diluted" training.

The polyvalency at which we aim is relative and in each field must aim at precise and limited objectives, objectives with regard to the knowledge of actions of major importance that the midwife is or should be in a position to accomplish. In other respects, are we absolutely convinced that everything constituting the actual programmes is of irrefutable utility and that certain elements could not be omitted or cut down to leave space for others more important or practical?

I now refer to the results of pilot programmes of administration of family health care by nurses/midwives in developing societies (see bibliographical references). In Africa, for instance, the Child Health Institute of the University of Lagos in Nigeria (directed by Professor O. Ransome-Kuti, Chief of the Department of Paediatrics) has implemented a training programme for family health nurses. These nurses/midwives who have been trained in a "Traditional" school have been trained mainly for hospital activity and not enough for community work, follow a complementary training of four-and-a-half months with major components of obstetrics and gynaecology, periodic supervision of children, normal care of sick children, family planning and community health/public health.

In what follows we will use the term nurse/midwife although we realise that it does not correspond to the actual situation in the countries where the training systems of health personnel have been influenced by the French type (where midwives and male and female nurses are agents whose functions and schools are separated). We therefore think in this discussion of an evolution towards the nurse/midwife such as is known in the British, German or Swiss systems for example, while particularly emphasizing what the "profile" of such an agent should be in developing countries.

The training that they receive is outside the conventional pattern of the functions of the nurses/midwives and it follows that such a programme is likely to be anathematized by some insofar as it could be interpreted as trying to make midwives "mini-doctors". This is a difficult question, and problems raised must be very seriously considered. However, Professor Ransome-Kuti and his team in Lagos, and others elsewhere, reserving academic dogmas, have wanted to test honestly and practically the possibility for nurses/midwives to be competent "producers" of maternal and child health care (up to a certain level).

The reasons behind such a test, as you may well imagine, are the immensity of non-satisfied needs, the lack of doctors, especially in deprived areas ("bidon-villes" and rural areas) and perhaps more especially the fact that in practice nurses and midwives are asked every day to act as doctors, to serve in the capacity of a doctor without our having prepared them for this and without wanting to prepare them for this because such functions are outside their province.

You know as well as I do the reputation of the University of Lagos which guarantees that the training and supervision of these family health nurses/midwives corresponds to strict standards. Moreover, if the programme implemented some years ago has been maintained and if it has been extended to other States of the Nigerian Federation it is because it is clear that the maternal and child health of the populations served has improved and that health agents do not incur any increased risks on their patients. At the same time, it is proper to emphasize that these nurses/midwives regularly benefit from the supervision, the encouragement and the assistance of the physicians to whom they may at all times refer the cases outside their competence. It is clear that such doctors/nurses/midwives' co-operation is the sine qua non condition for the working of the system.

Programmes similar to that of the Child Health Institute of Lagos have been recently implemented, or are planned in various countries, developing ones as well as industrialised ones (so we know that the paediatric Nurse Practitioner trained in the U.S. renders great services). Generally, for what "supplementary" medical-health actions are nurses/midwives going to be trained? Let me name the most important amongst them:

#### I - OBSTETRICS

- Good training in recognition of "high risk pregnancies", taking into account previous obstetrical history of the patient in addition to the history of the present pregnancy, and of certain important characteristics (such as size);
- Control of a normal pregnancy and good knowledge of the signs necessitating referral to a doctor;
- Health education of pregnant women, especially on nutrition. When necessary, precise and practical advice concerning the essential preparations if the patient is likely to be delivered at home (in

certain countries the existing conditions do not allow the women who have had a normal pregnancy to be delivered in hospital ; this is particularly the case in rural areas) ;

- Management of a normal delivery (including episiotomy and suturing), some practice of obstetrical pathology (breech, twins, low forceps, vacuum extractor, artificial rupture of membranes). Emergency treatment in case of complications in the absence of a doctor ;
- Resuscitation of the newborn and of the mother ;
- Supervision of women in the postpartum period, emphasizing especially the importance of ensuring the establishment of breast feeding in good conditions and of its continuation;
- Health education regarding the care of the newborn during the first months of life, its diet, the traditional practices (not to contradict those that are beneficial or those unimportant and explain why others are harmful) and when needed, on desirable spacing of births ;
- Supervision and collaboration with the traditional births attendants.

## II - GYNAECOLOGY

- Practice of gynaecological examination (vaginal and speculum examination) to confirm the normal state or to detect pathological conditions (then referred to the doctor).
- Digital curettage ;
- Ability to give adequate advice in the most common cases of gynaecological conditions (infections for instance).

## III - FAMILY PLANNING

- Ability to inform and advise couples on the various aspects of family planning ;
- Ability to make a preliminary diagnostic study of cases of sterility or sub-fertility coming for consultation and aptitude to eliminate some obvious causes (there are 'sterilities' due to non-cohabitation). Ability to give general advice (period of the cycle when fertility is at its maximum, etc.). Referral of 'true' cases to the doctor;
- Knowledge of the contraceptive methods commonly used in the country, their indications and contra-indications.

This includes:

- The rhythm method (calendar);
- Condom (it is not always necessary to give precise indications on its use);
- Oral contraceptives: an increasing number of studies show that these may be prescribed by non-physician health agents if the answers to a number of determined questions (connected with the factors favouring complications) are negative. We may point out that statistically, the risk that a woman runs by taking oral contraceptives is 20 to 100 times less than that incurred during an 'average' pregnancy (mortality rate due to oral contraceptives: 3-6 per 100,000 year-women. Mortality rate of the gravid-puerperal women: 100-300 and more for 100,000 pregnancies in most of the non-industrialised countries);
- Practice of the vaginal and speculum examination (see above);
- Intra-uterus devices: in a certain number of countries the midwives who have had a complementary training decide the indication and insert the IUD (especially the Lippes loop). Certain studies show that results of introduction by midwives are as good as those done by doctors. However, it now appears that in several countries (Asia especially) oral contraceptives (according to the method mentioned above) are in fact managed more easily by non-doctors;
- Sterilisation: ability to give to the couples interested adequate information and education regarding this method (male or female sterilisation);
- Periodic supervision of women using a contraceptive method. Ability to distinguish the undesirable minor and common side-effects that are serious and necessitate the attention of a doctor. Ability to give adequate advice on this subject (observation, test, therapeutic treatment in minor cases, referral to a doctor in serious cases).

#### IV - PERIODICAL SUPERVISION OF CHILDREN AND COMMON CARE TO SICK CHILDREN

This section of activities of the family health nurse-midwife is more and more recognized as essential. Its importance and the remarkable effects it can have have been demonstrated by the lengthy, well documented experience of David Morley and his team at Ilesha in the Western State of Nigeria. Their philosophy and their practical experience of the under-five clinics have acquired a large audience in the whole world (including the systematic use of the weight and growth graph for children).

Regular supervision of children, especially during the first three years of life, enables a long term action with regard to a better nutrition and the prevention of malnutrition; vaccinations; advice on hygiene; treatment of common complaints: parasitosis, respiratory and gastro-intestinal complaints, skin diseases, etc. and one must recognize that they have accomplished miracles wherever they have been implemented.

Many MCH specialists therefore think that it is extremely desirable that nurses-midwives receive an appropriate practical training on the growth and normal development of infants up to the age of five and on the recognition and simple therapeutics of common complaints (including knowledge on high risk children). Once more, the idea is not to make them cheap doctors but to answer the most important needs where they occur. Let us remember that, as one of my WHO's colleague says: "With five types of medicine (which would be quinine, sulphonamides, etc.,) and five types of vaccination, even an auxiliary member of the health team can do more nowadays than a professor of medicine could 40 years ago."

As for child care within the family health framework, let me underline that in many countries of the world, industrialised as well as developing countries, it is the paediatricians who have the most clearly and precisely put the emphasis on the contribution that well managed family planning may bring to the improvement of infant health. The fact that they have noted it first comes from their vocation to the type of social medicine which is inherent to their discipline. And it is proper to mention here that there are a great number of paediatricians, practitioners and University teachers, in Africa and elsewhere, who would not agree with the opinion expressed two days ago at this Seminar that family planning is of no help to paediatrics and that the paediatrician is not to be concerned with family planning.

#### V - PUBLIC HEALTH - COMMUNITY HEALTH

It is not necessary for me to insist in front of this audience on the fact that a new approach to the community by medical-health agents is one of the essential elements of the adaption of services to Africa that you, leaders in health fields, wish to accomplish. It has become a cliché to underline that the types of imported medical health services (especially those of French and British inspiration) are not suitable as far as the African Continent is concerned. The view prescribed is in fact that the patient to consider is the community rather than an isolated individual. It has been recognized that to be a health agent

(whoever she or he is) does not simply mean to look after those who knock on your door - such as is the tradition in Europe but it is, after the medical health diagnosis of the community has been established to go to the populations where they live and to deal with the major health problems from which they suffer.

On this point we must praise the implementation of faculties of medicine, nurses and midwives schools which desire to be 'without walls' who want their students to learn their profession not only in the relatively artificial environment of a hospital but also in health centres, clinics and in the patient's home. And it is only then that we will really be able to talk of family health.

In Africa, allow me to name for example, besides Professor Ransome-Kuti already mentioned, the Professors J.M. Muncai and N.O. Bwibo, Nairobi, the Doctor Gladys E. Martin of Yaounde, the Doctor Mohamed I.A. Omer of Khartoum and the Doctor Domissie Habte of Addis Ababa. Various well known paediatricians of Latin America and Asia have the same problems.

In practical terms, as far as training is concerned, this approach will require of the nurses midwives a good knowledge in the following fields:

- Health education, as it has been underlined many times here (including sex education);
- Inter-personal communication (including the importance of active participation in group discussion);
- Practice of home visits (itinerant). Periodic home visits have proved to be essential 'tools' for efficient health services in many countries. Its importance derives from the primary influence of the immediate environment (lodging, food preparation, sanitary installations, etc.) on the health of the family. Let us emphasize that to have its maximum effect, the home visit must not be an exceptional event, only in case of emergency, but it must become a regular activity and structurised during which a certain number of actions and of specific supervision are carried out;
- Theory and practice of team work (health team);
- Learning of pedagogy (to prepare them to their teaching functions especially the supervision of the traditional birth attendants).

In conclusion, it is important to underline that the 'new' knowledge, attitudes and behaviour described above should not only be incorporated in the basic training of the midwife but also be the subject of a continuous, regular and well planned training which would particularly emphasize the specific functions of the various members of the health team and the constant collaboration which must be established between them.

I seem to have drawn the main lines that many consider as a necessary evolution of the health services in which the nurse-midwife is obviously one of the masterpieces, if not the master piece. I must repeat that this is not the result of personal idealistic thoughts but it is a summary of the essential aspects of inovating efforts which have been implemented for a few years, especially in Nigeria, Ghana, East Africa, Ethiopia, India (especially by the Rural Health Research Centre, Narangwal, Punjab, created by the International Department of Health of the Johns Hopkins University), in Latin America and elsewhere. From these comprehensive principles, it is clear that it rests with each country to train the personnel it needs according to its medical-health priorities and the objectives assigned to the various members of the health team.

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## INTEGRATION OF FAMILY PLANNING IN NATIONAL DEVELOPMENT PLANNING

Mrs Madeleine Deves

Jurist of the Economic and Social Council of Senegal

Most of the African countries have recognised the necessity to utilize family planning in the organisation of techniques for their economic and social development.

Whether flexible or authoritarian - according to the political system of the State which implements it - economic and social planning is regarded as a necessity measure on the one hand and on the other as a demonstration of responsibility in the development of the whole State in which it is practised.

The plan is therefore to recapitulate and sum up the various options of development which a country has chosen and also the methods it intends to use for implementation of these options.

There is therefore an indicative and stimulating value which is not always appreciated by the various economic agents.

Almost all the African countries have since their independence established a plan; but this essential document often remained without real impact on the citizens. It is explained by the fact that technologists conceive, elaborate and execute the plan or have it carried out.

This must be accepted but there is an ulterior phase of popularization of the plan which is often suppressed; if it were not, there would be better dissemination of the economic and social options which would finally ensure information, education and participation of the citizens in their own development.

As for family planning, it is a technique of the arrangement of the family in time and space. It is in this manner that it should essentially be presented. The term which has been degraded and has been diverted from its real meaning, is nowadays accepted by the public - especially of our countries - to mean population control, a term which will be difficult to forget.

Clearly seen and presented as a technique, that is as a means for arranging the family in time, family planning should be, in a specific country, the pivot for national planning of economic and social development.

It is necessary and crucial therefore, once family planning has been chosen, to integrate it into national planning as a major component.

Why and how can family planning be integrated into national planning?

A recent and remarkable publication of UNICEF with conclusions drawn from eight national studies conducted in Mauritania, Mali, Niger, Ivory Coast, Chad, Togo, Cameroon and Gabon has been entitled 'Childhood - Youth - Women and Plans for Development'. It has emphasized the necessity for the Governments to reconsider, in their various projects, their main options related to their policies in fields as vital as those of Childhood, Youth and Woman.

UNICEF is therefore inviting a definition of national policies for effective integration into the projects.

The lack of a global strategy in the fields mentioned above can only bring about repetitions and overlapping of specific actions.

In order to start, there must be an elaboration of a demographic policy.

But, let us consider the logical succession of actions: a demographic policy leading to family planning integrated into a plan for development.

It is from the definition of a demographic policy that it will be proper to start to justify and apply a policy of family planning.

This demographic policy should be at national level, that is to say, defined in respect to the growth objectives of the country and be relatively little influenced by the malthusianist thesis that industrialised countries actually develop in order to safeguard their own interests.

In reconsidering development plans, the advantage of the insertion of various options - in particular concerning family planning in accordance with government policies - allows not only for the use of external contributions for their implementation but also the mobilisation of internal resources.

In this way, government authorities can better control and supervise the real motivations of the 'investors' who are at present very numerous and generous in this matter.

How is this integration into the Development plan to be implemented?

It is certain that technicians (either demographers, doctors or para-medical personnel) have an essential role to play at the level of technical groups and national or regional planning commissions.

At this point it is necessary to discuss adhesion to adequate implementation of the option and the means which will have to be searched for.

The composition of the planning organs has therefore an unsuspected importance in addition to the choice of the individuals to put them into action.

The subject of integration of family planning into development planning seems to have reciprocal and complementary inter-actions to which these brief remarks are meant to draw attention to all those responsible for decision making at whatever level.

It is obvious that apart from the doctors themselves, the para-medical personnel - in which the midwives and obstetrician nurses have a privileged place - have a special role to play towards the government officials to urge and convince them to prescribe demographic policy and harmonious planning of the family into a national development policy.

THE EXPANSION OF MATERNAL AND CHILD HEALTH SERVICES

Miss Susan Nalder

Public Health Nurse-Midwife

Doctor George S. Walter

Obstetrician - Director of Public Health

Maternal and Child Health Project of the University of  
California, Santa Cruz - Dahomey

The expansion of maternal and child health must result from team work; this is why this work paper has been realised by a team composed of a public health nurse-midwife and an obstetrician-gynaecologist also in the public health field. Dr. Walter regrets that he is unable to be here to present part of this talk himself but he sends you his best wishes for the success of this seminar.

If we were to ask each of you today what is required to extend your services, you would certainly start by listing a number of things that you need. "We need a new building, more personnel, instruments, pharmaceutical preparations. Without these, it will be impossible to extend our service". But what are we in fact talking about? All the needs mentioned are only objects .... things. Are these essential to a maternal and child health programme? Let us try together, if you don't mind, to answer this question: What do we mean when we talk of a maternal and child health service?

Usually, when we talk about MCH we always start by giving statistics on maternal and infant mortality.

The speakers have exposed in detail the risks predisposing mothers and children to death and morbidity. You have then studied proposals to reduce these problems.

We cannot limit ourselves to talk about mortality rates and the way to reduce them. What interests us is maternal and child health, and WHO defined it as: "A positive state of complete physical, mental and social well-being, not only the absence of illness and infirmity".

Consequently, we must talk of other things than mortality statistics.

All health structure problems can practically be divided into three categories:

Firstly: An environment naturally unhealthy or made unhealthy by society, economy and health policy;

Secondly: An inadequate health organisation characterised by:-

- a) Its inefficiency;
- b) An unfair distribution of the resources already limited;
- c) A professional class consciousness which jeopardises the training of teams capable of resolving the problems;
- d) The fact that focus is more on cure than on prevention.

Thirdly: The means of communication and transport which do not enable the patients, even those informed, to make contact with health services.

If we accept the definition of maternal and child health given above and the reality of these worldwide problems, how do we then conceive MCH expansion?

What do we understand by the word 'expansion'? It has two aspects. Firstly, the expansion which consists in developing the contents of MCH services; that is to say, to improve the quality. Then, the expansion which consists in enlarging the service to individuals which have not yet been reached by its action.

You have studied it together at the beginning of the seminar, you have recorded what exists and the essential activities that should be added.

The second aspect of the expression 'expansion of the MCH services' which consists in spreading these improved services to the individuals not yet served. But is this expansion really necessary? To this effect we will ask you the following question: "In your opinion, do you think that the role actually played by your health service corresponds exactly to the needs of your community? to the women? to the children? to young men? to families?"

If the answer is no, then there is no doubt about the necessity for such an expansion.

At the beginning of this talk we underlined the fact that one has a tendency to think of things, of objects, when we speak of extension of maternal and child health. We will ask you to forget for a while your premises and your equipment. It is difficult. What is it possible to do with what we have got?

We must start from our health service and then, extend to the level of organisation which will finally include the whole health structure.

But what are we to do and where do we start?

1. First of all you must examine your service.

a) What kind of clients attend your service?

What are the principal health problems?

What are the principal problems of health education?

b) Enquire why certain people do not call upon your services?

c) What are the governmental, private and traditional resources existing in the community?

What role do they or could they play in MCH field? How could you cooperate better with these resources?

d) What are the limitations and possibilities of your service? or its potential?

e) What health records are available to you?

These should be an instrument helping you to give better care in MCH services and should help in setting up MCH statistics which are crucial to the establishment of your programmes and your evaluations.

f) What personnel are available to you? What do they do? Have they received the necessary training to do what is expected of them? Or, are they employed beyond their ability?

g) What supply system do you have? How can you improve it?

2. After checking the service, it must be reorganized so that it meets the needs on the one hand and on the other is in alignment with resources available. It will require:

- a) A redistribution of the personnel's functions and personnel supervision;
- b) Changes in the layout of the furniture and the use of the premises;
- c) A revision of the time table and activities to meet special problems;
- d) A development of the orientation system of the patients;
- e) The appeal for the cooperation of community, individual or agency resources;
- f) The participation of traditional practitioners (such as traditional birth attendants, auxiliary midwives, healers);
- g) A good reorganisation of supplies to avoid starvation due to errors of bad evaluation of your needs.

The midwife must see her role differently: she must not solely be a distributor of care but she must be a coordinator, an educator and the captain of the team.

It rests with the midwife to plan how much time should be devoted to clinical care and what reasonable time should be spent on supervision, health instruction and coordination. This is what I am told every day: "I have not got enough time for planning or I have enough work as it is. Planning is a luxury". Planning is not a luxury, one is disorganised if one does not follow a pattern.

The midwife's ability as the captain of the team will be decisive. It is by delegating responsibilities that the midwife will be able to use the abilities of the members of her team at their maximum. If she tries to do everything herself she will greatly reduce the scope of her activities and reduce her efficiency to the same extent and eventually fail.

Although these remarks concern the midwife as a captain of the team, they also concern other members of the team - from the doctor to the orderly - because everyone will be asked to appreciate, use and intensify other people's ability.

The responsibility for the practice of the MCH service is not only that of the local service but also of the whole organisation of the health services, social services, agricultural and training services.

In such an organisation, the role of leader naturally falls upon the Ministry of Public Health. This leadership must be expressed by:

- 1) An explicit declaration of the policy of the priorities of the national MCH services.
- 2) The rules and norms to be respected in a MCH service (Standards of Practice).
- 3) An administrative structure which promotes and supplies efficient communications.
- 4) Senior personnel in charge of the supervision of the MCH services.
- 5) The synthesis of demographic and health data and its use as the basis of the evaluation of the functioning services as well as the planning of eventual activities.
- 6) A coordinating group responsible for the MCH activities in its wide sense, such as liaison with education and agriculture, private and voluntary agencies and special bilateral MCH projects.
- 7) A functional system for the supply of the MCH centres.
- 8) The inclusion of basic concepts of family health, hygiene of the environment work in team, community development in the programme of all training establishments which prepare personnel at all levels.
- 9) The continuous improvement of the MCH practice by periodic refresher courses.
- 10) A training, in medical, paramedical school as well as in post-university courses, which will emphasize the principles and the practices of planning, organisation, supervision and evaluation. This training will concern the midwives and the doctors who will be allocated posts responsible for MCH services for a community or a region.

These remarks prove the inter-dependence between the structure at local level and the global structure of the Ministry of the Public Health.

Consequently, the expansion of MCH services does not rest with one individual only or a group of individuals but with the whole nation. It is obvious that we cannot reach every family but those that we will reach or will be able to reach will receive a service of a better quality. Moreover these families will themselves become agents of change and, thereby, will broaden our action.

We have not spoken today of material things but of a philosophy, attitudes and organisation. The personnel of the less equipped service can adopt a new philosophy, develop the work in team and involve the whole community.

## RURAL MIDWIVES IN TOGO

Mrs M.L. Naassou

MCH/Family Health Midwife - TOGO

### INTRODUCTION

For about 15 years the services of the Ministry of Health have planned for action for a total delivery coverage of the country.

The question is not only to reach all pregnant women but also to educate rural masses; to supervise all deliveries in various sectors of the country, even in the village where delivery is conducted by a medically qualified person; to follow the children regularly in order to refer them rapidly; to take preventative measures against illness specific to the region and to be in close contact with the health subdivision and the health general headquarters. Delivery in a rural area in Togo is performed by three groups of people:

- The State Midwife to whom no reference will be made in this workpaper;
- The Traditional Birth Attendant;
- The Auxiliary Midwife.

### A - TRADITIONAL BIRTH ATTENDANTS

They may sometimes be:

- Neighbours, parents who are in the house to assist the parturient woman; often they are middle-aged women who have experience in their profession;
- Multiparous women, their function often developed by experience from their own mother.

The activities of traditional birth attendants are numerous and undeniable. They have an influential role in the life of the families, in the village communities but if their action is successful in most of the normal deliveries, bad results can be observed where there have been interventions for which they have had little preparation.

#### ACTIVITIES OF THE TRADITIONAL BIRTH ATTENDANTS

During delivery and postpartum.

Complete dilation is indicated by:

- Spontaneous rupture of the membranes;
- Stronger contractions;
- Expulsive efforts.

At the time of expulsion, the rites are most interesting: the woman crouches, knees apart, a 'pagne' rolled as a cushion on her joined heels on which she must sit. Behind her an elderly woman or her mother is seated holding her tightly between her thighs, with her arms under the armpits supporting the woman under her breasts. At each push the assistant helps the parturient woman by pressing on her abdomen in order to assist the expulsive contraction.

The new-born baby is wrapped in a 'pagne'. The cord is cut with a strip of bamboo or with a ritual knife or the broken end of a bottle and is tied with some raffia. The length of the cord left equals the length of the new born's thigh.

In prolonged delivery, a string is tied to the umbilical cord and the other end of it to the mother's leg in order that the placenta should not be 'lost'.

Dangerous postpartum haemorrhage can be mortal despite traditional therapy (ceremony, plant infusion).

#### THE RETENTION OF THE PLACENTA IS TREATED BY VARIOUS METHODS

- Shake the delivered woman energetically holding her by the waist;
- Make her blow in a bottle to loosen the placenta;
- Provoke vomiting by tickling her throat with a wooden spoon; this produces abdominal contractions which loosen the placenta;
- Take an oxytocic local drug;
- Manual removal of the placenta can be performed after the hand has been covered with 'gombo' to ease its introduction in the utero-vaginal canal;

#### TECHNIQUES OF RESUSCITATION OF THE CHILD

Clearing up of the respiratory system by suction of the mucus in the new-born's nose; phlegm in the throat is taken away with the finger.

- Keep the head low;
- Smack the baby;
- Rub his body with diluted arrowroot to act as an irritant.

#### PREVENTION OF OPHTHALMIA OF THE NEW BORN

This is done by the application of palm oil or lemon juice to each eye.

#### RITUAL PREPARATION OF THE BABY

It lasts between two and two and a half hours. First of all the vernix caseosa is cleaned off with palm oil and thinly ground cornflour. During this cleaning, the baby is washed and soaped several times; the skull is massaged to give it a round shape and so are the joints to make the child supple. At each wash the cord is soaped and rinsed. The quickness of the separation of the cord is ensured by the administration of an herb crushed with lump salt at the base of the cord which then falls off in three days. During the first month, baths are the responsibility of a specialist chosen by certain criteria to preserve the new-born from malevolence; for the same reason he will wear consecrated beads.

The future, the character and the beauty of the child depend upon the care given during the first few days and on the choice of the person giving it.

#### CARE OF THE MOTHER

This is done by traditional specialist in obstetrical care; the mother is washed with soap and water, massaged, and the vulva is treated with great care, the eventual vulvo-vaginal wounds are washed with healing plant infusions. Pressure is exerted on the abdomen to evacuate lochia. This cleansing is done twice a day until complete healing of the vulval wounds and until the disappearance of the lochia. Plant infusions are given every day to the mother either to hasten the healing of the placental site or as a galactogen.

So, delivery is conducted in almost the same way in a traditional environment where the consequences (infection, toxic conditions, perineal breakdown, haemorrhage, rupture of the uterus caused by ignorance, superstition, unorthodox manoeuvres) are sometimes mortal. We may however underline the undeniable effectiveness of plants used as oxytocics, the remarkable effect of bark on lactation and the fight against oedema, the astonishing effects of purgative infusions, anti diarrhoeics, sedatives, anti-anaemics and the vermifuges used.

This is an experience in the field of authentic Togolese pharmacy.

It would be interesting to study the role of the traditional birth attendant; because of her perfect knowledge of the environment in which she exerts her authority in the village. She can - at least temporarily - cooperate with some efficiency with the Public Health programme especially in the fields of maternal and child health and family planning.

She should deserve, at least in our opinion, to be given a training specially created for her.

Unfortunately in Togo she is an elderly and illiterate person whose comprehension and assimilation of the problems are very limited.

It is indispensable, after identifying her, to supervise her in her practice:

- 1) Teach her principles of hygiene;
- 2) Teach her to recognize symptoms and anomalies and to refrain from inopportune interventions during her practice.

This will not be easy and could be done in stages allowing enough time for her to understand each simple element before tackling the next; the traditional birth attendant could be allowed to assist at delivery by the professional midwife and be integrated into the health personnel and especially she could be given a 'kit' containing:

- A minimum of material, e.g. bandages, drops for instillation to the eye, disinfectants.

The difficulties in implementing such a programme are easily conceivable:

- Remuneration, even small;
- Integration into health personnel;
- Ignorance - for two years Togo has strongly implemented a programme to fight against it in the whole country;
- Recognition of all the traditional birth attendants because they are difficult to know and to reach.

It is evident that by teaching them their role and their limitations the traditional birth attendants (whose knowledge comes from empiric experience) could call upon the help of the qualified midwife or take their client to the maternity hospital if need be for the well being of the village where their action still remains very powerful.

It is with these difficulties in mind that Togo has chosen the way to train young Togolese auxiliary midwives.

## B - THE MODERN TOGOLESE AUXILIARY MIDWIFE

It is an auxiliary person, unmarried or married young woman from the village where she will serve, recruited at C.E.P.E. level or up to the end of primary schooling, selected at district level and with an 18 months theoretical and practical training in obstetrics and in Public Health in a rural maternity hospital. A certificate for professional aptitude is allocated at the end of this period. She is responsible for MCH services in basic health centres and in MCH centres.

### WHY AN AUXILIARY MIDWIFE?

Some facts are severe handicaps for the implementation of the coverage of the nation in delivery matters:

- 1) Insufficient number of professional midwives:
  - 60 in 1960;
  - 78 in 1966; they are almost all centred in Lome or in secondary towns;
  - 105 in 1969; following the opening of a midwifery school in Togo, the distribution seems better. Today, there are 187 professional midwives in Togo;
- 2) Female population which increases at a rate of 2.6 per cent will reach 52 per cent of the entire population of Togo in 1980;
- 3) High maternal mortality;
- 4) High infant mortality;
- 5) 19 maternity hospitals in the whole country;
- 6) Insufficiency of the level of health education of the population.

The Togolese budget cannot in a short time provide professional midwives to cover the whole territory.

Some figures speak for themselves - they are extracted from the report on maternal and infant hygiene, 1960:

60 professional midwives cost 30 million CFA francs when 150 traditional birth attendants cost 50,000 CFA francs and one professional midwife costs 500,000 CFA francs.

#### REPARTITION

There are more than 317 auxiliary midwives in maternity hospitals, clinics and MCH centres of the territory when the number of professional midwives is only 187.

#### RECRUITMENT AND TRAINING

Conditions of aptitude for the examination: married or unmarried young woman between 18 and 20 years of age, born and bred in the village where she will serve.

- Birth certificate;
- Health certificate;
- Residence certificate delivered by the chief of district of the locality;
- Certificate of non-dismissal from a public employment.

#### TRAINING CURRICULUM

- 1) Female genitalia;
- 2) Pelvis;
- 3) Menstrual cycle;
- 4) Pregnancy;
- 5) Examination of a pregnant woman;
- 6) Anomalies of pregnancy;
- 7) Antepartum haemorrhage;
- 8) Conditions necessitating referral of the woman during pregnancy and during delivery;
- 9) Supervision by the rural auxiliary midwife of antenatal, intranatal and postnatal women;

- 10) Professional ethics;
- 11) Care of the new-born;
- 12) Vaccinations;
- 13) Hygiene of the pregnant woman;
- 14) Delivery hygiene;
- 15) Hygiene of the postpartum woman;
- 16) Breast feeding;
- 17) Prenatal consultations;
- 18) Hygiene and consultations of the new-born;
- 19) Home visits;
- 20) Health education;
- 21) Delivery techniques;
- 22) Civil status;
- 23) Elementary notions on diagnosis of diseases common to Togo  
(Malaria, Parasitosis, anaemia);
- 24) Comments on instructions for the intervention of rural  
auxiliary midwives;
- 25) Reports: they are taught how to write a maternity report  
a MCH report.

MONTHLY MATERNITY HOSPITAL REPORT

Month ..... 19

Made by ..... the ..... 19

| <u>CONSULTATIONS</u>                               | New<br>Consultants<br>(A) | Previous<br>Consultants<br>(B) | Total<br>(A+B) |
|--|---------------------------|--------------------------------|----------------|
| Prenatal consultations<br>(Women before delivery)  | .....                     | .....                          | .....          |
| Post Natal consultations<br>(Women after delivery) | .....                     | .....                          | .....          |
| Newborn consultations<br>(up to 1 year)            | .....                     | .....                          | .....          |
| Infant consultations<br>(one to five years)        | .....                     | .....                          | .....          |
| Consultations at home                              | .....                     | .....                          | .....          |
| "    of pregnant women                             | .....                     | .....                          | .....          |
| "    of babies                                     | .....                     | .....                          | .....          |
| Total  | .....                     | .....                          | .....          |

| <u>HOSPITALISATION</u>                | Number |
|---------------------------------------|--------|
| Remaining on first day of the month   | .....  |
| Entries during the month              | .....  |
| Deaths                                | .....  |
| Discharged on last day of the month   | .....  |
| Days in hospital                      | .....  |
| Women coming from another institution | .....  |
| Women going to another institution    | .....  |

| <u>VACCINATIONS</u> | Number |
|---------------------|--------|
| Antitetanics        | .....  |
| Antipoliomyelitics  | .....  |
| Anti-smallpox       | .....  |
| B.C.G.              | .....  |

| <u>HEALTH EDUCATION</u>        | Number |
|--------------------------------|--------|
| Health Education classes held: |        |
| - At the maternity hospital    | .....  |
| - Public                       | .....  |

| <u>BIRTHS &amp; DEATHS</u>                                     | Number |
|--|--------|
| Live births  | .....  |
| Still births   | .....  |
| Deaths during first ten days of life<br>of which only one twin | .....  |
| Premature: one child only                                      | .....  |
| Premature twins  | .....  |

REMARKS

SIGNATURE & TITLES

They are asked for a monthly report:

MCH MONTHLY REPORT

Month of ..... 19      Made by ..... the ..... 19

| <u>CONSULTATIONS</u>                              | New<br>Consultants<br>(A) | Previous<br>Consultants<br>(B) | Total<br>(A+B) |
|---|---------------------------|--------------------------------|----------------|
| Prenatal consultations<br>(Women before delivery) | .....                     | .....                          | .....          |
| Newborn consultations<br>(up to one year)         | .....                     | .....                          | .....          |
| Infant consultations<br>(one to five years)       | .....                     | .....                          | .....          |
| Consultations at home<br>(Pregnant women)         | .....                     | .....                          | .....          |
| Babies  | .....                     | .....                          | .....          |
| <b>TOTAL</b>                                      | .....                     | .....                          | .....          |

| <u>DELIVERIES AND DEATHS</u>                                       | Number |
|--|--------|
| Normal deliveries  | .....  |
| Abnormal deliveries  | .....  |
| <b>TOTAL</b>   | .....  |
| Deliveries at the clinic   | .....  |
| Deliveries at home   | .....  |
| <b>TOTAL</b>   | .....  |
| Live births  | .....  |
| Still births and abortions   | .....  |
| Deaths of newborn (after birth)                                    | .....  |
| Death of women during labour<br>(before, during or after delivery) | .....  |

| <u>MISCELLANEOUS</u>           |       |
|--------------------------------|-------|
| Antitetanics vaccinations      | ..... |
| Antipoliomyelitis vaccinations | ..... |
| Anti-smallpox vaccinations     | ..... |
| B.C.G.                         | ..... |
| Health Education classes held: |       |
| At the clinic                  | ..... |
| Public                         | ..... |
| At home                        | ..... |

|                |                  |             |
|----------------|------------------|-------------|
| <b>REMARKS</b> | <b>SIGNATURE</b> | <b>DATE</b> |
|                |                  |             |

## EVALUATION

A Test ratifies training

Some of the questions asked at the test:

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### Standard Questions

- What vaccination is currently given to the woman during the second half of pregnancy?
- How do you recognize the onset of labour?
- How do you recognize pregnancy?
- A woman is nearly at term, what should she prepare?
- What should the traditional birth attendant do immediately the baby is born?
- Placenta is slow in coming but the mother is bleeding a lot, what do you do?
- When do we refer to the transverse position of the child?
- When it is not possible for a mother to breast feed her child, what do you do?
- What is your opinion of breast feeding?
- Apart from breast feeding what other milks do you know?
- You notice a weight decrease in the child, what do you do?
- What is the vaccination given to the baby within the first eight days of life?

### PROGRAMME:

Is solely based on the practice of a spontaneous delivery - directives are given for immediate referral - e.g.:

- Long labour (over 10 hours);
- Haemorrhage;
- Transverse position of the foetus;
- Poor physical condition of the pregnant woman, etc....

## EXAMINATION AT THE END OF TRAINING

An examination ratifies the theoretical and practical training.  
This is a type of standard examination questionnaire:

- 1) How do you recognize pregnancy?
- 2) What do you do during a prenatal consultation?
- 3) What vaccination should commonly be given to the woman during the second half of pregnancy?
- 4) How do you recognize the onset of labour?
- 5) A woman is nearly at term - what should she prepare?
- 6) Name the equipment of the rural auxiliary midwife?
- 7) What are the conditions for referral of a woman during pregnancy, during delivery and the postpartum period?
- 8) Conditions for referral of the newborn?
- 9) " " " " " infant?
- 10) What should the auxiliary midwife do immediately the baby is born?
- 11) The placenta is slow in coming but the mother is bleeding profusely, what do you do?
- 12) When do we say that the child is in a transverse position?
- 13) What are the indications when a mother cannot breast feed her baby?
- 14) When a mother is incapable of breast feeding her baby, what do you do?
- 15) What are your views on breast feeding?
- 16) Besides breast feeding, what other milk feeding do you know?
- 17) You notice that the child loses weight, what do you do?
- 18) What is the vaccination given to the newborn during the first days of life?
- 19) In case of haemorrhage, what do you do?
- 20) What do you do when the pregnant woman is in a poor physical condition?
- 21) What do you do if a woman is in labour for more than ten hours?
- 22) What do you do if a woman has amenorrhoea for eight months without signs of pregnancy?

## ROLE OF THE AUXILIARY MIDWIFE

Her essential role is to:

- 1) Conduct normal deliveries in aseptical conditions for the 90 per cent of the Togolese women who do not live in cities;
- 2) Supervise women before, during and after delivery and supervise children until school age at the clinic and during home visits to detect and refer the sick at an early stage;
- 3) Give health education and advice to help mothers safeguard their own health, that of their children and sometimes of the whole family and
- 4) Give preventative vaccinations.

These are her preventative and curative activities.

## THE ROLE OF THE AUXILIARY MIDWIFE IS PRECISE (1)

### I - PREVENTATIVE ACTIVITIES

- 1) Prenatal consultations:
  - Name and surname of the pregnant woman;
  - Name of the husband;
  - Address;
  - Previous pregnancies - previous deliveries;
  - Live children;
  - Weight of pregnant woman - height of uterus;
  - Examination of pelvis;
  - Position of the foetus;
  - Urinalysis - albumin, sugar;
  - Health education - preparation of the pregnant woman for delivery.

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(1) Report of Dr Gabagbe, MCH Medical Officer in Charge.

2) Postnatal consultations

a) Care of the newborn;

- First care during delivery
- Referral of malformed infants;
- Umbilical care;
- Remember to have BCG done;
- and other necessary care.

b) Care of the parturient woman for at least three weeks:

- If haemorrhage is heavy call nurse for help for treatment and eventual referral;
- If placenta is slow in coming (one hour); refer the woman to the maternity hospital as quickly as possible. Check the condition of the placenta. Report any abnormality;
- Supervise the condition of the uterus for eight days;
- Supervise lochia - Investigate if repeated haemorrhages;
- Check that lactation is normal - if not refer.

c) Infant consultation:

- 0 to one year - once a month: Weight - height - general condition - any necessary treatment;
- One to two years: Health and nutritional education of mothers;
- Two to five years: every three, then six months - weight - height - general condition - any necessary treatment - health and nutritional education of mothers.

3) Home visits

- Identification of pregnant women (send an appointment card for prenatal consultation - register them, plan for vaccination);

- Identification of infants (send an appointment card for infant consultations - register them, plan and advise on vaccinations to be done);
  - Advice on general hygiene and diet for the pregnant woman and also to mothers individually or collectively;
  - Referral of sick pregnant women, infants or sick mothers to a health post and in addition other sick family members.
- 4) Health and nutritional education:

- Individual or collective;
- At the health centre or at home;
- What can a pregnant woman do safely;
- How is a mother supposed to look after her child;
- What should she eat - what should she feed the child on at different ages;
- Advice on general hygiene.

5) Vaccinations:

- Newborn: remember to send him to have BCG done and skin test afterwards;
- Infants: advise on the various necessary vaccinations;
- Pregnant women: it is important to vaccinate against tetanus; check that small pox vaccination has been done.

II - CURATIVE ACTIVITIES

- 1) Either at the clinic or at home, conduct of normal deliveries presenting no difficulty;
- 2) Refer quickly any primigravida in labour for more than 12 hours to a maternity hospital if the descent of the baby does not progress;
- 3) Refer rapidly any multipara to a maternity hospital in labour force more than eight hours if the descent is not progressing.
- 4) Refer immediately any woman in labour who presents an anomaly of pregnancy;

- 5) Refer immediately any woman in labour who is in a state of exhaustion, is anaemic or has oedema;
- 6) Refer immediately any woman in labour who loses a lot of blood per vaginum;
- 7) Help the nurse give medicaments to the woman in labour or the newborn when necessary.

### III - DATA COLLECTION FOR HEALTH AND DEMOGRAPHIC STATISTICS

1. At the health centre:
  - keep up to date records of prenatal and infant consultations, and of deliveries;
  - keep up to date registrations of pregnant women and new born babies;
  - keep up to date records of time tables, activity graphs, dates of home visits;
  - make the monthly report every 26th of the month.
2. At home:
  - always keep handy daily reports and the book for the registration of pregnant women and the newborn;
  - Mention all information on:
    - maternal and child hygiene;
    - health and nutritional education;
    - detected and evacuated sick;
    - non-supervised births at home;
    - death at home.

### ADVICE ON HYGIENE

The auxiliary midwives are given an education in hygiene and sanitation. A precise text for the teaching of the population is available to them.

EXAMPLE: ADVICE ON HYGIENE AND SANITATION OF THE ENVIRONMENT ITINERENTS  
AND AUXILIARY MIDWIVES

1. Body and clothes must always be clean. Wash often with clean water;
2. The hut, the house and its surroundings must be clean at all times;
3. The hut must be aired;
4. Water the floor of the hut before sweeping it;
5. Drinking water must be clear, limpid and odourless;
6. Always cover the drinking water receptacle;
7. There must be a cover to protect the opening of the well;
8. Always prepare food with care;
9. Keep food away from flies and in a cool place;
10. It is important to eat often man, fish, eggs, vegetable, fruits beside maze paste, gari, manioc, igname, etc;
11. Always wash hands before eating;
12. Rinse mouth and hands after eating;
13. Teeth must be cleaned every morning with a tooth-stick and charcoal;
14. Rubbish must be collected, piled up and burnt or buried;
15. Always wash the hands after bowel movement;
16. Always get rid of old receptacles, broken bottles, containers with stagnant water;
17. Always fill in water puddles in and around the house;
18. Soiled water must be thrown far from the huts on light soil;
19. It is advisable to sleep under a mosquito net;
20. Always make a deep hole, well protected and outside the village to collect excrement. There must be a hole for the men, one for the women;
21. Domestic animals must be kept in an enclosure;
22. Cut the bushes often in public places and around villages;
23. Protect the feet with sandals or shoes.

We must emphasize that all complicated cases she will encounter during her practice should be directed towards the nearest large centre provided with professional midwives.

In a primary health centre, she will work under the constant supervision of a professional midwife. She will help give most of the maternity care. In a

secondary health centre, she is under the direct supervision of a nurse responsible for the post. She is indirectly supervised by the professional midwife of the nearest maternity hospital and by the chief doctor of the district, the technical supervisor or the midwife-supervisor.

Annual or occasional refresher courses are attended regularly or in case of mistaken judgement. At the end of training each auxiliary midwife returns to her rural post equipped with the kit provided by UNICEF. Thanks to the auxiliary midwives it is now possible to supervise satisfactorily 60 per cent of normal deliveries in the Togolese Republic.

But the training of the auxiliary midwife must not be limited to delivery; in our view it must be completed by a knowledge, even elementary, of harmonization of the family, and be useful to rural families ignoring scientific methods of family planning.

Here is an example of the summary of dangerous and inefficient contraceptive methods used by the women in rural areas from the report of refresher courses of the rural auxiliary midwives held in Togo in 1970 in the framework of maternal and child health and family health.

Methods used to avoid pregnancy:

- "Blue solution" + potassium (oral);
- Tobacco + water + potassium + lemon (oral);
- Introduction of leaves crushed in the shape of ovule;
- DDT solution (oral) - woman died;
- Nivaquine - 40 tablets (death);
- Large dose of soda-sulphate (oral) - woman died;
- Koumakate solution (oral) - woman died;
- Aspro solution + lemon + potassium;
- Solution of concentrated quinine + wine;
- Beer solution + dried, crushed Ebe root;
- Infusion of water + potassium + salt in large quantity;
- Evacuating toxic enema;
- Kneading of the abdomen with the feet;

- Permanganate tablets in the vagina;
- Intra-muscular injection of high dose of quinine;
- Absorption of a high dose of glycerine;
- Dilatation of the cervix with manioc sticks;
- Solution of carbolic;
- Petrol + paraffin (oral) - death;
- Koumate + soudabi - death;
- Manual dilatation;
- Heavy load;
- Excessive dancing;
- Long walk;
- Repeated fall;
- Tight bandage.

Here is a summary of the reasons given by these women:

a) Health reasons - To avoid:

- fatigue and rapid ageing of the mother;
- high infant mortality, malnutrition;
- predisposition to illness.

b) Welfare reasons - To avoid:

- anxiety of the mother faced with another pregnancy too close to the last one;
- discord of the couple in the home;
- unhappy and puny children;
- juvenile delinquency;
- consequences of adult delinquency;
- polygamy.

c) Economic reasons:

- poor lodging;
- school expenses;

- debts;
- restriction of individual liberty of the women;
- child-beggars.

It has been difficult to identify the traditional birth attendants in Togo unlike Senegal but the training of auxiliary midwives remains very efficient in Togo.

WHO has given subsidies to allow increases in their salaries.

The regarding of some, according to the years of service, is done by the Government. The creation of a school for rural auxiliary midwives with WHO's collaboration has been decided upon.

An expert is now on site to study the implementation of this school which, we hope, will open very soon and whose future prospectives are very promising.

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