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**The International Confederation of Midwives**

**REPORT**

**of the**

**Anglophone West African Working Party**

**Accra, Ghana**

**7th - 16th December 1972**

**USAID Grant Number CSO 2948**

*3411*

**In co-operation with the Joint Study Group of the  
International Confederation of Midwives and the  
International Federation of Gynaecology and Obstetrics**

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## INTRODUCTION

"The rationale given for family planning may be placed in three broad groups: improved health, respect for human rights and population control. Action by governments and other bodies is usually based on a combination of these rationales". (WHO Technical Report Series No. 467)

The International Confederation of Midwives (ICM) asserts that each individual and each couple must be equipped to understand fully the working of the reproductive system and through this understanding be able to exercise individual control of fertility.

It therefore follows logically that the midwife - that member of the health team who works so closely with the human unit of reproduction, the child - is critical to the transfer of the knowledge and methods of fertility control to the couple and to the individual.

It is abundantly evident that the numbers and spacing of children have a direct effect on the quality of maternal, child and family-unit's health. It is also abundantly clear that families and especially mothers, endeavour with whatever means possible to exercise personal control over their capacity to reproduce. It is therefore important that all members of the Maternal and Child Health team, especially the midwife, should be equipped to facilitate couples and individuals in acquiring the knowledge and skill required in use of methods for the control of their capacity to reproduce.

In assisting countries in the examination of approaches towards the restructuring of Midwifery Training Curricula, the ICM fervently hopes that family planning training will be included in the curricula for the training of all categories of midwives.

The midwife is in a pivotal position. She is in contact with expectant mothers and their families at a very critical and often very receptive time. She is a highly respected member of the team and as such has considerable influence, whether she works in urban or rural areas.

In the interest of the quality of life of the peoples of the world, the ICM is ready to place its resources of skill and experience at the disposal of each nation. In so doing the ICM hopes that the peoples of each nation - each individual and each couple - can acquire the knowledge and the skill in the use of methods which are sine qua non for individual determination of the use and control of that significant and tremendous force - the ability to reproduce.

Working Party of the Anglophone West African Countries

Accra, Ghana

7th-16th December 1972

THE TRAINING AND PRACTICE OF MIDWIFERY AND  
FAMILY PLANNING

PROGRAMME

Thursday 7th December

- Arrival of Participants

Friday 8th December

- Opening Ceremony

Chairman - Dr. M. A. Baddoo  
Director of Medical Services

1) Remarks by the Field Director,  
Mr. R. J. Fenney, CBE, BA (Admin.)

2) Opening of the Meeting by the  
Commissioner for Health.

Break for coffee

Auditorium

1) Report of the work of the Joint Study  
Group.

2) Election of Chairman

3) Election of Rapporteurs :-  
(a) Obstetrician  
(b) Midwife

2.30 p. m. - 5.30 p. m.

- Background Papers

1) "Maternity Care in the Developing Countries"  
Speaker:- Dr. R. H. O. Bannerman,  
Chief Medical Officer,  
Education in Family Health,  
W. H. O.

Auditorium

2) "Midwifery Practice by the Traditional  
Birth Attendant and the Training of  
Professional Midwife in Nigeria"  
Speaker:- Mrs. R. O. Sosanya, SRN, SCM, MTD:  
President,  
Professional Midwives Association  
of Nigeria

Monday 11th December

9 a. m. - 12.30 p. m.

Auditorium

1) "Family Planning in Midwifery Training.  
Speaker: Mrs. Comfort Akrofi

2) "Family Planning in-service training for  
Midwives of all categories"  
Speaker:- Miss W. Evans,  
Nurse-Midwife, United States Agency  
for International Development, (Liberia)

2.30 p.m. - 5.00 p.m.

1) "The Organisation of a Family Planning Service"

- Speakers: 1. Dr. A. A. Ampofo  
(Ghana)  
2. Dr. B. Williams  
(Sierra Leone)  
3. Dr. D. Collins  
(Liberia)

Tuesday 12th December

9 a.m. - 12.30 p.m.

1) "Developments in the Training of Midwives and Organisation of a National Maternity Service to include ALL CATEGORIES of Midwives"

- Speakers: 1. Dr. A. Akinkugbe  
(Nigeria)  
2. Dr. K.K. Korsah  
(Ghana)

2.30 p.m. - 5.00 p.m.

1) "The Role of the Paediatrician in Midwifery Training"

- Speaker: Dr. Carl Reindorf,  
University of Ghana  
Medical School,  
Senior Lecturer in Paediatrics.

Wednesday 13th December

9 a.m. - 12.30 p.m.

1) "Licensure and Control of Practice of Midwives of all Categories"

- Speaker: Mr. R.J. Fenney

2) General Discussion

Auditorium

2.30 p.m. - 5.00 p.m.

1) "The Role of the Midwife as a Family Health Worker"

- Speaker: Mrs. Joana Samarasinghe

2) "Training and Practice of Midwives of All Categories including Curricula"

- Speakers: 1. Mrs. Peace Acolatse,  
SRN, SCM, MTD.  
(Ghana)  
2. Mrs. K.G.A. Betts,  
SRN, SCM, MTD  
(Sierra Leone)  
3. Mrs. B. Barmadia,  
SRN, SCM  
(Liberia)

Thursday 14th December

8.00 a.m.

- Visits to Polyclinics and Private Midwives' Clinics.

11.00 a.m.

1) Reports from Group Leaders, followed by General Discussion.

2.30 p.m. - 5.00 p.m.

1) Compilation of Reports on Discussion.

**Friday 15th December**

8.15 a. m.

- Danfa Project

11.00 a. m. (Auditorium)

2) Recommendations and Future Action.

2.30 p. m.

1) Drafting of a Report

4.00 p. m.

1) Closing Session - Director of Medical Services  
and Chief Nursing Officer

**Saturday 16th December**

- Departure of Participants

N. B. There will be a break during the morning and afternoon, at the discretion of the Chairman.

**AIM and Objectives of the International Confederation of Midwives (ICM) in co-operation with the International Federation of Gynaecology and Obstetrics (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.

- Objectives:**
1. To identify the present situation in each country.
  2. To suggest practical improvements for the immediate future in each country.
  3. To agree to intermediate and long term guidelines suitable to the particular groups of countries under survey.

**Means of obtaining objectives:**

1. Discussion and exchange of information.
2. Research into existing demography.
3. A series of questionnaires submitted to individual countries, as follows:
  - a) Are there training programmes controlled by public or professional bodies for appropriate grades
    - i) Professional midwives
    - ii) Auxiliary midwives
    - iii) Traditional Birth Attendants?
  - b)
    - i) Who provides the maternity service at present, including support and care as well as delivery?
    - ii) Who provides care of the infant during the first 28 days of life?
  - c) Is there any public or professional control of these people (cf. b. supra)?
  - d) Is there a Family Planning programme in existence?
  - e) Are the individuals who provide the maternity service at present, including support and care during delivery, all known or recorded by public or professional bodies?
  - f) If a Family Planning programme is in existence, are the individuals who operate the programme regularly, all known and recorded by public or professional bodies?
  - g) If the answer to e) and f) is no, is some licensure procedure envisaged to give the present practitioners some status and control over the entry of future practitioners?

**Midwifery Training and Practice**

1. Are Midwives of all categories trained in the following:	Professional Midwife	Auxiliary Midwife	Others
Pre-natal care			
Intra-natal care			
Post-natal care			
Infant care			
a) In the first month only			
b) After the first month			
Health Education in relation to			
a) the mother			
b) the infant			
c) the family			
Preparation for Parenthood			
Family Planning: a) Motivation			
b) Techniques			
2. Are midwives of all categories required to register the following:	Professional Midwife	Auxiliary Midwife	Others
Births			
Peri-natal deaths*			
Neonatal deaths**			
Infant deaths***			
Maternal deaths****			

- \* **Peri-natal mortality includes all still births and deaths within the first seven days.**
- \*\* **Neonatal deaths include all deaths of children born alive who die within 28 days of birth.**
- \*\*\* **Infant deaths include all deaths during the first year of life.**
- \*\*\*\* **Maternal deaths include all mothers who die as a DIRECT result of pregnancy, childbirth or abortion during pregnancy, labour and forty two days after delivery.**

If the answer to 2. is no, what is the estimate of unregistered births, etc.?

3. Can any help be given from external sources and particularly FIGO/ICM on the following:
- a) Organisation including licensure and control including protection of the public in the widest sense.
  - b) Professional education
  - c) Family Planning

Under each of the headings listed, the primary concern should be to define minimum standards, rather than consider standards to be aimed at an elite.

The participants came from Gambia, Ghana, Liberia, Nigeria and Sierra Leone and in addition there were observers from World Health Organisation (WHO), the International Planned Parenthood Federation (IPPF) and the United States Agency for International Development (USAID). (For list of participants see Appendix A). Accommodation was arranged at the Ambassador Hotel in Accra, and participants arrived on Thursday, 7th December, 1972. Study sessions took place in the Ghana Medical School at Korle Bu, Accra.

#### The Opening Ceremony

The Commissioner for Health, Colonel J. C. Adjeitey, performed the opening ceremony and welcomed all the participants and observers. The session was also attended by disciplines concerned with the project, representatives from the Ministry of Health, Obstetricians, Paediatricians, Nursing, Midwifery and Public Health Nursing Tutors, Midwives, Student Nurses and Pupil Midwives, representatives of Family Planning Associations, WHO, IPPF and USAID. The Chairman at the opening session was Dr. M. A. Baddoo, Director of Medical Services, Ghana. In his opening remarks, Colonel Adjeitey said that the Seminar was being held at an opportune time when consideration was being given to the role and practice of the Traditional Birth Attendant in addition to that of professional midwives. He hoped that action would be taken to see that the best possible use was made of the service which Traditional Birth Attendants could provide.

#### Theme of the Working Party

The theme of the Working Party was "The Inclusion of Family Planning in the Training and Practice of Midwives", for the improvement of maternal and child care and of the quality of maternal and child life, in accordance with the AIM of the International Confederation of Midwives.

Mr. R. J. Fennoy, the Field Director, enlarged upon the theme and discussed suggested means of achieving this aim.

Miss Marjorie Bayes, Executive Secretary of the I. C. M. and Project Director explained the AIM and Objectives and the importance of family planning being incorporated in the training of the midwife of ALL categories. She referred to recommendations published in "Maternity Care in the World", in particular.

Through the generosity of USAID, the I. C. M. was now in a position to arrange Working Parties in developing countries throughout the World and help in the improvement of maternal and child health and the quality of maternal and child life and encourage the countries to include family planning in midwifery training programmes as a means of achieving our AIM.

#### Chairman and Rapporteurs

Dr. R. H. O. Bannerman, a member of the Joint Study Group and Chief Medical Officer, Education in Family Health at WHO was unanimously elected Chairman for the Working Party. Dr. Belmont Williams, an Obstetrician and Gynaecologist from Sierra Leone, and Miss Olga Roberts, a Midwifery Tutor from Gambia, were elected Rapporteurs.

#### Papers and Discussions

Background papers and other materials were provided and Dr. R. H. O. Bannerman and Mrs. R. O. Sosanya, President of the Nigerian Midwives Association spoke to their

own papers (Appendix B and C). Dr. Bannerman spoke on "Maternity Care in the Developing Countries" and quoted the Definition of Maternity Care as given in the WHO Technical Report Series No. 331 - i.e. "The object of maternity care is to ensure that every expectant and nursing mother maintains good health, learns the art of child care, has a normal delivery and bears healthy children. Maternity care in the narrower sense consists in the care of the pregnant woman, her safe delivery, her postnatal care and examination, the care of her newly born infant; and the maintenance of lactation. In the wider sense it begins much earlier in measures aimed to promote the health and well-being of the young people who are potential parents, and to help them to develop the right approach to family life and to the place of the family in the community. It should also include guidance in parentcraft and in problems associated with infertility and family planning".

After hearing Dr. Bannerman's paper and bearing in mind the above definition, it was obvious that there were deficiencies in Health Care Delivery Services, and that the training of personnel for the services was inadequate. In order to use existing services effectively, a suitable training programme must be devised for traditional birth attendants who were at present responsible for 70-80 per cent of births and were likely to remain a feature of African village life for many decades.

Mrs. Sosanya's paper dealt with "Midwifery Practice by the Traditional Birth Attendant (TBA) and the Training of the Professional Midwife in Nigeria". She stated that the high infant mortality rate in Nigeria was due, amongst other things, to bad treatment of the cord at birth by the TBA's and to poor infant feeding. There were communication and transport difficulties and these with under developed health programmes did not enhance the practice of midwifery. It was hoped that midwifery training programmes would be constantly reviewed and adapted to local needs.

Following the presentation of these two papers, there was a very lively discussion.

A great deal of time was devoted to Family Planning in association with the training and practice of midwives of all categories and the establishment of Family Planning services. This session was opened by Mrs. Comfort Akrofi, Deputy Field Director for the Working Party. Mrs. Akrofi gave a comprehensive paper covering the Family Planning Services in Ghana, the personnel involved in giving the service and plans for the future. This included the introduction of family planning into the training programmes for midwifery students and post-basic training for senior qualified midwives.

Miss Winifred Evans, an American Nurse-Midwife representative of the United States Agency for International Development (USAID) in Liberia, presented a paper on "The incorporation of Family Planning in the Training of Midwives" (Appendix E), and Dr. D.A. Ampofo of Ghana, Dr. Belmont Williams of Sierra Leone and Dr. D.S. Collins of Liberia all presented papers on "The Organisation of Family Planning Services" in their respective countries. (Precis of papers Appendices F, G and H). Animated discussion followed each of these papers and it was unanimously agreed that Family Planning should be an integral part of Maternal and Child Health (MCH) Services and should be included in the syllabus of midwifery training for all categories of midwives and include the TBA.

Dr. A. Akinkugbe of Nigeria and Dr. K.K. Korsah of Ghana both gave papers on "Developments in the Training of Midwives and Organisation of a National Maternity Service to include ALL CATEGORIES of Midwives". (Precis of papers Appendices I and J). Both these papers were once again followed by lively discussion.

Dr. G.A. Reindorf, a Paediatrician spoke on "The Role of the Paediatrician in Midwifery Training" (Appendix K) and this was again followed by discussion. The Chairman for this session was Dr. Susan de Graft-Johnson, the Paediatric representative. Mr. R.J. Fenney

then gave an interesting talk on the important topic of "Licensure and Control of Practice of Midwives of all Categories".

Mrs. Joana Samarasinghe, Senior Public Health Nurse Tutor in Ghana, spoke on "The Role of the Midwife as a Family Health Worker" (precis of paper Appendix L) which was followed by discussion,

Mrs. P. Acolatse of Ghana, Mrs. K.G.A. Betts of Sierra Leone and Mrs. B. Barmadia of Liberia presented papers on the Training and Practice of Midwives of all Categories. Mrs. Acolatse spoke of the "Training and Practice of the Professional Midwife in Ghana" (precis of paper Appendix M), Mrs. Betts on "The Training and Practice of the Auxiliary Midwife in Sierra Leone" (precis of paper Appendix N), and Mrs. Barmadia on "The Training and Practice of the Traditional Birth Attendant in Liberia" (precis of paper in Appendix O). All these papers were very interesting and aroused valuable discussion.

There was considerable discussion prior to arriving at certain Recommendations (see page 10) and planning future action. A preliminary draft report was also prepared.

#### Educational Visits

During the week educational visits were made to polyclinics, the homes of private practicing midwives and the Danfa Rural Project where in four areas, research is being carried out in more than 60 villages in each area in MCH and Family Planning. The Health Personnel in these villages are identifying the TBAs and giving them some training in basic hygiene. There was appreciation of the work being done by midwives of all categories and recognition that the TBA suitably trained, had much to offer in the improvement of MC

#### Closing Session

Participants of this Working Party felt that they had had a very useful and worthwhile week. In the presence of all participants, the Chief Nursing Officer, the Deputy President of the Ghana Registered Midwives Association, the closing session was conducted by the Director of Medical Services, Dr. Baddoo

Unfortunately the President of the Ghana Midwives Association was ill but an address prepared by her appears in Appendix O. She mentioned her own experiences in a rural area of Ghana and suggested that governments should create opportunities for the midwifery training of girls who had complete primary education in order to fill the many vacancies in villages and rural areas. Midwives would render all possible assistance in the education of men and women to accept family planning.

On behalf of the Working Party, appreciation was expressed to the host Government by Mrs. K.G.A. Betts of Sierra Leone for the facilities made available to us and for their co-operation; to observers and guest speakers; to the other Governments for releasing their participants and to WHO and IPPF for their support and personnel; to the Ghana Registered Midwives Association and individuals for their wonderful support and hospitality. She paid special appreciation to USAID for their personnel and financial support without which the Working Party could not have taken place.

## Recommendations

As the Working Party was a small one it was agreed not to divide into small discussion groups but discussions took place after every session. The rapporteurs together with Mr. Fenney had several discussions but a most important part of such a meeting is the interchange of information and ideas at informal gatherings outside the formal venue.

At the final session, chaired by Dr. Bannerman, the following recommendations were made:-

1. It was desirable that family planning should be an integral part of MCH services and that it should be included in the syllabus for midwifery training of all categories including the Traditional Birth Attendant. Refresher courses should be organised for qualified midwives to include family planning. It was stated that training facilities for midwives in family planning were available in some of the countries and these should be reviewed as early as possible, with a view to further development and expansion.
2. a) Immediate consideration should be given to the Traditional Birth Attendant, who still provides care for most births in the area. Where appropriate the TBA should be identified, supervised and trained to help continue the improvement of maternal and child care and the quality of family life. As more midwives are trained to cover the whole country, the TBAs should be replaced by such trained personnel.  
b) It is important that a well designed study of the methods used by the TBAs, the strength and defects of such methods should be undertaken by a group including obstetricians, sociologists, midwives and health administrators. It is hoped that this will enable some legal and social recognition to be given to the TBA or strengthen their replacement if the study shows this to be possible and desirable.
3. In the West African context the midwife (including the TBA) is an appropriate person to act as a motivator, educator and counsellor for Family Planning, she is also in a unique position as a family health worker, especially in the fields of nutrition and post-natal care. Her training therefore should be designed to reflect all these aspects of the practice, e.g. it should not be hospital based only, but should provide greater emphasis on her community role and the child health content.
4. The definition of the proper sphere of practice of the Midwife in each country will determine the type of training she should have. There was need therefore for flexibility of training programmes, to suit different circumstances of practice and the conditions in the part of the country where the trainee is to work, e.g. manual removal of placenta and other emergency procedures in the absence of medical help.
5. Appropriate measures should be considered by Health Authorities for the services of private midwives to be fully utilised and for them to be regarded as part of the entire maternity service. Already there is acute shortage of midwives in all countries and the few available should be fully utilised to effect better maternity care for the mothers and babies.
6. It was desirable to consider common standards for midwives in neighbouring countries to permit reciprocity in licensure and common practices.
7. It was recommended that for efficient discharge of the duties of the midwife, in the interest of the public, accommodation, good communication and other social amenities should be provided for the midwives and some form of incentive worked out for the midwife in rural areas.

8. In the interest of a country, consideration should be given to the feasibility of including education for family life in the general education system at all levels; thus majority of both sexes will readily accept the concept of Family Planning and practise it.
9. At the present time pressure of work and shortage of midwives result in the midwives being pre-occupied almost exclusively with deliveries. It is therefore difficult for them to undertake their very important responsibilities as health educators and supportive counsellors. There was an urgent need for a large increase in the number of training institutions for midwives and measures should be taken to effect this.
10. It would be an advantage if Family Planning programmes were supported by Government in each country.

## Evaluation

Every participant completed an evaluation form and each was asked to make suggestions for future Working Parties. The majority felt that in discussing the problems of the individual anglophone West African countries, some of them were on the way to being solved. It was hoped that the recommendations would be implemented by the appropriate Ministries. All aspects under the terms of reference in relation to the countries represented and their differing health problems were discussed. One of the most substantial contributions was the recognition that Family Planning is a most important factor in any comprehensive Maternal and Child Health Service.

There was need to identify and train traditional birth attendants as they would for many decades have a substantial contribution to make in the Maternal and Child Health Services and in family planning within that service.

## Deputy Field Director

The Deputy Field Director, Mrs. Comfort Akrofi, discussed follow-up visits with participants and made preliminary arrangements for visiting each country to discuss the implementation of recommendations and in particular to advise where necessary on the introduction of family planning into midwifery training programmes and for the post-certificate training of practising midwives.

LIST OF PARTICIPANTSRepresentatives

<u>Country</u>	<u>Midwives</u>	<u>Doctors</u>
Gambia	Miss A. Lusack Miss O. Roberts	
Ghana	Mrs. P. Acolatse Mrs. L. Osei-Kofi	Dr. K.K. Korsah Dr. S. de Graft-Johnson (IPA)
Liberia	Mrs. B. Barmadia Mrs. I. Faulkner	Dr. D. Collins
Nigeria	Mrs. R.O. Sosanya Mrs. K. Delano	Dr. A. Akinkugbe
Sierra Leone	Mrs. K.G.A. Betts Mrs. E. Smith	Dr. Belmont Williams
W.H.O.		Dr. R.H.O. Bannerman

Observers

Miss Elizabeth Barton, WHO Regional Office, Brazzaville  
 Miss E. Johnsen, USAID, Washington D.C.  
 Mrs. Marie Kirby, USAID Regional Office, Ghana  
 Dr. G. Roane, Director USAID Regional Population Office, Ghana  
 Dr. F.T. Sai, IPPF London  
 Miss A. Kennedy, WHO Regional Office, Nigeria

Project Director: Miss M. Bayes, International Confederation of Midwives  
 Field Director: Mr. R.J. Fenney, ICM  
 Deputy Field Director: Mrs. Comfort Akrofi, ICM

Speakers

Mrs. P. Acolatse, Ghana  
 Dr. A. Akinkugbe, Nigeria  
 Mrs. C. Akrofi, Ghana  
 Dr. D.A. Ampofo, Medical Faculty, Korle Bu Medical School, Ghana  
 Dr. R.H.O. Bannerman, WHO  
 Mrs. B. Barmadia, Liberia  
 Dr. Belmont Williams, Sierra Leone  
 Mrs. K.G.A. Betts, Sierra Leone  
 Dr. D.S. Collins, Liberia  
 Miss W. Evans, USAID, Liberia  
 Dr. K.K. Korsah, Ghana  
 Dr. G.A. Reindorf, Medical Faculty, Korle Bu Medical School, Ghana  
 Mrs. J. Samarasinghe, Senior Public Health Nurse Tutor, Ghana  
 Mrs. R.O. Sosanya, Nigeria

**"Maternity Care in the Developing Countries"**

by

Dr. R.H.O. Bannerman, F.R.C.O.G., Chief Medical Officer,  
Education in Family Health,  
WHO, Geneva,  
Switzerland.

In reviewing briefly the role and functions of the midwife and other categories of midwifery personnel engaged in the health care of mothers and children, including family planning, and in discussing education and training needs to assist in extending the services to the more needy rural communities in developing countries, it must be realised that the midwife and her auxiliaries are very important members of a health team which includes doctors, nurses, health educators, sanitarians and others.

Since 1959, WHO has published about 20 reports of meetings of Expert Groups. These include:-

- a) The Midwife in Maternity Care
- b) Midwifery Training
- c) Maternal Care and Mental Health
- d) Health Aspects of Family Planning
- e) Teaching of Human Reproduction, Family Planning and Population Dynamics in Nursing and Midwifery Education Programmes
- f) Health Education in Health Aspects of Family Planning.

Changes in the health care delivery system have been brought about by tremendous increase in scientific knowledge and technological advancement during the last two decades particularly in the fields of human reproduction, human genetics, nutrition, immunology, health education and health manpower development. An estimated 70 per cent of women of the Third World receive no professional services during the maternity cycle. It is therefore our immediate task to make the advanced knowledge and technology available to everybody.

The WHO Expert Committee in 1966, defined maternity care as follows:-

"The object of maternity care is to ensure that every expectant and nursing mother maintains good health, learns the art of child care, has a normal delivery and bears healthy children. Maternity care in the narrower sense consists in the care of the pregnant woman, her safe delivery, her postnatal care and examination, the care of her newly born infant and the maintenance of lactation. In the wider sense it begins much earlier in measures aimed to promote the health and well-being of the young people who are potential parents, and to help them to develop the right approach to family life and to the place of the family in the community. It should also include guidance in parentcraft and in problems associated with infertility and family planning".

Common factors linking the countries of the Third World are financial poverty, paucity of educational services and educated manpower reservoirs, high and wasteful fertility patterns resulting in maternal depletion, epidemiological recurrent infectious diseases particularly severe amongst children under five years old, undernutrition and malnutrition and an entrenched traditional and conservative peasant culture. Similar conditions appear in certain communities of developed and industrialised countries and these communities are designated as deprived, disadvantaged or underprivileged.

There are certain questions we must ask ourselves.

- a) What is wrong with our performance as health workers ?
- b) How can we set ourselves on the proper course ?
- c) How can we apply swiftly, smoothly and wisely the organisational, scientific and technological know-how of the developed nations to the Third World ?
- d) What reforms must the citizens of the Third World make in their social and cultural institutions in order to achieve social maturity, economic and political stability and good health ?

### Health Care Delivery

Gaps in knowledge and lack of resources are not always the main reasons for deficiencies in the health care delivery system. Unfortunately limited resources are frequently not utilised to the full.

National health planning is defective in many countries under review. The small number of professional groups, relatively ineffective in the rural areas where their services are most needed, are, in the main, unwilling to delegate responsibility and to allow non-professional health workers to take over parts of their traditional roles. In some communities, non-professionals are accepted unwillingly, the health services not utilised and health personnel responsible for primary health care inadequately trained for the work which needs to be done. The end result is that the return for the resources and human effort is poor and well below expectation, but it must be remembered that the professional health worker has invariably been trained in Western Europe and delivers a Western European type of health care to communities that are essentially rural, traditional in outlook and with very different cultural backgrounds. Communications in such circumstances may be very difficult and it is necessary that a doctor, or nurse/midwife must be resourceful, easily adaptable, imaginative but above all, human and sympathetic.

In every way, the delivery system must meet the health needs of the family and the community. Health care should not be confined to major hospitals, clinics, or even health centres and smaller health posts in rural areas, but should reach out into the homes of the families. The needs and resources can all be determined at national and local level and existing health programmes may be adapted. Resources are not difficult to determine in terms of money, equipment and manpower but we must continue to ask

- a) What are the needs ?
  - b) What are the resources ?
  - c) What should be the realistic objectives ?
  - d) What organisational structure will be most effective in meeting these objectives ?
- and e) How can the effectiveness of the system be measured ?

In one country in East Africa, where 90 per cent of the population live in small townships or villages, professional personnel staff the health services in the major cities. Elsewhere, health care is almost exclusively carried out by auxiliaries. In another area, one physician, one nurse and their auxiliaries provide a service for 100,000 inhabitants.

In June this year, I visited a state in West Africa with an area of 65 000 square miles and an estimated population of 7,250,000 of whom 85 per cent lived in rural areas. The birth rate was said to be 50 per thousand population. This state was part of the largest and perhaps the wealthiest country in that Region. There were 34 Physicians (one of whom was a national); 46 medical assistants; four dentists; nine assistant dentists; 163 professional nurses; 44 auxiliary nurses, 34 professional midwives with no recorded auxiliaries and 18 laboratory technicians. In this vast territory, roads and communications are poor, and

small villages are dotted all over arid land. It would appear that the health manpower situation makes hardly any impact on the lives of the rural community.

Seventeen of the midwives undertook Maternal and Child Health activities in the state. It was estimated that only 10 per cent of deliveries were conducted by trained health personnel and the remainder by traditional birth attendants. It is the aim of this state that all pregnant women should be attended by professional midwives. Assuming that 17 professional midwives are in active field practice, in order to give full state coverage, each must undertake 20,000 deliveries per year.

For most of these territories the proportion of population to physicians and professional nurse/midwives in rural areas is seldom below 30,000 in the more developed of the developing countries, and in many instances is usually in excess of 100,000 and in some cases approaches the million mark.

Professional people prefer to live and work in larger cities. This is related to the lack of resources and the inability to practise the skills acquired in training schools. The Physician, for example, does not usually possess the type of knowledge and skills required to meet the health needs of these rural communities.

The other major constraint is finance. Health, unfortunately does not have the high priority it deserves in many areas. Some countries spend seven to ten per cent of their total budget on health services, which is well below the figure for defence, communication and agriculture. The more meaningful figure is health expenditure per capita. According to Bryant, there is a fifty fold difference between Indonesia and Jamaica, and a 250-fold difference between Indonesia and the United Kingdom. These differences are reflected in planning priorities and programmes of these countries. Expenditures on health are linked to the national income and on a per capita basis average about two point three per cent for the less developed countries.

#### Education and Training

Technical knowledge is essential, but unless the customs, beliefs and traditional practices of the people for whom family health services are to be provided are understood, its application is less effective. There are many variations in practices relating to pregnancy, childbirth and care of the newborn dependent on traditional beliefs. Respect for traditional beliefs which are harmless and utilisation of those which are valuable gives the best opportunity for gaining the confidence of the mother and her family. These factors should be considered when designing a training programme.

The main objective of an educational programme in family health should be to relate personal behaviour to more general social needs, and to inform people about the biological, psychological and social aspects of human sexuality, thus enabling them to take responsible decisions about their sexual behaviour and the planning of their families for an improved quality of life.

Community health is the most relevant branch of medicine in the developing countries and these departments have assumed a major role in the training of health personnel for family health activities. The nurse/midwife requires special orientation in this field.

The Department of Community Health could co-operate in co-ordinating effectively the presentation of the subjects of human reproduction, family planning and population dynamics to health personnel. The basic sciences of anatomy and physiology would be involved, the clinical departments of nursing, medicine, surgery, obstetrics and gynaecology or midwifery, paediatrics and psychiatry; and in the faculty of social sciences, anthropology, sociology, bio-statistics and human ecology. Experts from the fields of philosophy, law, theology, ethics and metaphysics would also share in the teaching programme.

The nurse/midwife acts as a link between doctor and patient, by her close association with families in their homes, and through the health care of family members in health centres and hospitals, she is in an excellent position to relate family planning activities to the health and welfare of the whole family. The core of any Maternal and Child Health Service is formed by the nurse/midwife and no Maternal and Child Health service can be complete without a family planning component, and the nurse/midwife has many advantages over the physician although, like the present generation of senior physicians, the senior nurse/midwife has had no basic training in family planning activities.

The acceptance or rejection of family planning practices by the community will depend largely on the advice given by the nurse/midwife and her activities in this field. In the countries under review, she would need also to take on greater responsibilities as an educator, to help in the training of more nurse/midwives for field work.

Admission requirements of training schools would have to be reviewed so that students not at present eligible could be prepared for admission through short, intensive orientation courses. The curriculum should be adapted and designed to meet the special health needs of the country and the length of training shortened in many cases. Obsolete and essentially academic subjects would have to be eliminated to make room for instruction in community health practice, family planning methods, nutrition and weaning in infants and children, and health education of the public. This type of more practical nurse/midwife is already being developed in certain countries of Africa, Asia and Latin America.

#### Auxiliary Health Personnel

The health auxiliary is the chief counsellor for the 75 to 85 per cent of people living in rural areas of developing countries. In order to understand their role and communicate with them adequately, doctors and nurse/midwives should be given instruction in the training and supervision of auxiliaries. The training programme should specify what tasks the auxiliaries should be able to perform at the end of their training, which should include field experience.

#### The Traditional Birth Attendant (TBA)

Most health administrators agree that the TBA is an important person in the community and if properly orientated could be effectively used in MCH and family planning services. She develops a peculiar type of rapport and provides a unique brand of utility service within the community which no other member of the health team can emulate at present. Because of this, care must be taken not to damage the relationship when proposing to use her services in an integrated health programme. Under present conditions, the TBA will be a feature of African and Asian village life for many future decades. To utilise her services effectively, a suitable, more adequate training programme must be devised. Few countries give any form of recognition or status to the TBA: in some states the authorities refuse to admit her existence and in others they are actively persecuted - yet these are women who are providing maternity care to nearly half of the world's mothers and babies.

Working in a world of scientific ignorance with skills developed through trial and error, the TBAs are very deeply rooted in the cultural practices of some countries, and there is evidence to show that people want to utilise their services as well as modern facilities. The least we can do under these circumstances is to encourage these handy women, give them a modicum of training and the recognition which is long overdue.

In a recent survey in an MCH demonstration zone in an African country, it was discovered that over 200 TBAs in the area with a population of about 36,000 conducted 75 per cent of the deliveries. About 40 per cent of these TBAs were male and the majority were elderly, the average age being 60-65 years. It should not be too difficult to replace them with trained personnel in the foreseeable future.

WHO Expert Committees have recommended that TBAs be given training and supervision to make them more effective in the health care system. The recommendations include the following:-

- a) Training should be given either by a qualified midwife or an auxiliary midwife.
- b) The major part of the training should be given in the domiciliary field, but some orientation should be given to existing health and medical care services.
- c) The main emphasis in training should be placed on:-
  - principles of cleanliness;
  - recognition of symptoms of abnormality during pregnancy;
  - refraining from interference during labour;
  - care of the woman during confinement;
  - care of the mother and the newborn during the early postnatal period;
  - "preventive medicine";
  - keeping simple records;
- d) On completion of training, the TBA be:-
  - given a simple midwifery kit;
  - required to bring her clients to the health centre;
  - afforded a regular programme of supervision.
- e) A register of traditional birth attendants should be kept.

This training has already been implemented in certain countries but if the TBA could be taught to wash her hands BEFORE conducting a delivery and to refrain from interference during labour, some progress would be made.

Procedures carried out and advice given by TBAs in some countries are incorrect and may be harmful. In view of their special relationship with the community they should be given orientation to undertake health education of mothers particularly with regard to infant feeding, nutrition and family planning activities. In certain Asian countries they have proved effective agents in persuading couples to attend family planning clinics.

#### Family Planning Activities

Doubts have been raised about the beneficial effects of health programmes because of their obvious effects on population growth and positive contribution to economic development.

It is accepted that there is need for the inclusion of family planning activities in the health services of any country although certain countries have reservations or even refuse to accept this.

High pregnancy rates and high fetal wastage result in maternal depletion. High pregnancy rates are primarily intended that children should survive to ensure some comforts for aged parents and thus a vicious circle is created. Unless couples are convinced their children will survive they will not opt for fewer children.

Several Knowledge, Attitudes and Practice studies have shown:-

- a) Husbands objected to family planning practice by wives on account of fear of infidelity.
- b) There is a current false impression that contraceptive jellies and pessaries induce impotency or reduced virility in men.
- c) Women find excessive or irregular bleeding associated with IUD particularly distressing.
- d) The larger the family, the greater prestige of the male in the community.
- e) With increasing education women are becoming more family planning conscious. Some economically independent women divorce their husbands to prevent further childbearing. With increased knowledge of contraception this reason for divorce or separation is no longer valid and greater marital harmony is secured.

The attitude of a health worker influences any family planning programme. It is therefore of increasing importance to determine the type of service a community needs and to plan training curricula for health personnel accordingly. Ideas about the development of health care systems must be revised. Effective essential services must be within the reach of those who need them.

### Conclusion

The developing Third World must make greater use of auxiliary health personnel. The role of professional midwife must be adapted and she must assume greater training and supervisory responsibilities for the formation of auxiliaries.

Professional health personnel must have training in supervision as distinct from inspection and adequately prepared teachers should have experience and knowledge in the art of teaching to enable them to teach auxiliaries who have a lower level of education. Family planning activities are an integral part of basic health services, particularly in connection with maternal and child health and should form part of training programmes. Practical field training should be provided for every auxiliary.

In the words of the Director-General of WHO -  
"Innovation is what we need in all countries. Innovation depends on knowledge. Knowledge is the bridge to achievement, but education is the bridge to knowledge".

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**(i) MIDWIFERY PRACTICE BY THE TRADITIONAL BIRTH ATTENDANT****(ii) THE TRAINING OF THE PROFESSIONAL MIDWIFE IN NIGERIA**

by

R. O. Sosanya, S. R. N., S. C. M., M. T. D.

The Federal Republic of Nigeria is situated in the West Coast of Africa. It has an area of 356,669 square miles which is approximately four times the size of the United Kingdom. Nigeria is the most populous single country in Africa with a population of approximately 66,000,000 inhabitants. Shortage of doctors and midwives is great. Accurate record of the number of practising midwives is unavailable but 800 midwives are trained in the country yearly. The auxiliary midwife is non-existent in Nigeria. The native doctors or Ifa priests or babalawo or Agbebis could be regarded as traditional birth attendants. They continue to attend a large proportion of the population in sickness, pregnancy, labour and puerperium.

**The Traditional Birth Attendant and Midwifery Practice**

Traditional preparation for motherhood is practised in many communities all over Africa. The little girl shares fully in the family life and her behaviour is generally governed by fairly strict rules. Almost as soon as she can walk she shares the responsibilities of looking after her juniors and performing the household chores. At the age of puberty in some areas, female circumcision is carried out in an attempt to prepare her for future child bearing although it has been found time and time again that this procedure leads to stenosis of the vaginal introitus with consequent complications in labour.

In all parts of Nigeria especially among the Yorubas, the birth of a new baby into a family is an occasion of extreme joy and happiness. Congratulatory messages and presents are sent by all members of the extended family to the parents. In the evening of the day of birth, there is the usual "Idawo" (which means, literally, cutting of the cord) when the father buys drinks and food for his friends and they make merriment in his house.

The naming ceremony of the new born baby is performed on the eighth day. Everyone that goes to the house to congratulate the parents is expected to give the baby some gifts, usually money, which is usually collected by the mother.

Infertility is a ground for divorce in marriages contracted under the Native law and custom. This explains the reason why gods, oracles and the native doctors are consulted and offerings are made by the infertile couple.

Women have been known to encourage marriage of younger wives for their husbands, so that the family may be blessed with children. Sometimes the barren woman becomes pregnant soon after the marriage and pregnancy of the younger wife. The barren woman is never isolated unless it is proved that she was frivolous before marriage. Treatment in the form of herbs, concoctions, native soap and caustic pessaries is given to treat various obstetric and gynaecological conditions, such as uterine fibroid, effluvrien seminis, vesico-vaginal fistula etc.

**Traditional Pre and Postpartum Care of Patient**

Religion characterises quite a number of the habits of our people and the traditional method of healing the sick and the treatment of women during pregnancy, labour and puerperium. Two cadre of people carry out traditional care of women during labour. The Native Doctor or herbalist or Ifa priest has supernatural powers. His training is by apprenticeship. He

learns to treat all kinds of affections including psychosis. It is believed generally that pregnancy lasts for a period of ten months. Although there have been cases of post-maturity of 11 months to 3 years. These babies called Omope demand special sacrifices. Babies born with one or a couple of teeth at birth are believed to be supernatural beings whose forecasts come true. The Ifa priest through his oracle foretells whether the foetus in utero would be delivered as a male or a female child. He can diagnose twin pregnancy on palpation.

#### Management of Labour

Labour in the primigravida is generally believed to last longer than in the multipara. Juju rings, amulets and knots are sometimes tied to treat habitual abortion and sustain pregnancy. These are removed at term otherwise labour may be prolonged or obstructed.

#### Conduct of Labour by the Traditional Attendant

Ogun Adera, liquid soap, preparation is sometimes used (by the patient) to bath right from the seventh month of her pregnancy to facilitate easy delivery. The native doctors make use of incantations to bring easy delivery or to stop postpartum haemorrhage. Onset of labour is diagnosed by the presence of liquor amnii and lower abdominal pain. Antepartum haemorrhage is believed to be the work of evil and the enemy should be appeased.

No special place is prepared for the delivery of the baby. In an emergency any active or elderly woman or anyone who has witnessed childbirth before can be called to assist at delivery. The native doctor or agbebi is called when difficulties arise in labour. In labour the patient is made to assume any posture from squatting to kneeling but she must bend low in order to prevent injury to the baby's head. The baby is not picked up until the placenta "ibi omo" is delivered (the devil of the baby). It is obvious from its name that the danger of the 3rd stage of labour is recognised.

In some areas paternity is decided in favour of the man who can produce the placenta of the child. The placenta is collected by the father and after certain religious rites it is buried. It is believed that when an adult dies he goes to remove his placenta before his spirit can travel away. In the case of "Abiku" (a child believed to have died several times) the placenta is burnt, and used in the preparation of "etu", medicine which the mother uses to take with pap (staple food of cornflour which contains 75% water, 24% of carbon-hydrate and 1% protein). This ensures that the baby will not die if he comes back again. The Yorubas recognise abnormal labour and have special names for them e.g. a Breech is Ige, Oke is the name given to the baby born in the "caul", a baby born with the cord round his neck is known as Aina.

As with the delivery mentioned in the Holy Bible, Genesis Chapter 38 verses 27 and 28, when the first twin was marked with a red string and the second twin was named Pharez: the Yoruba name for the first twin is Taiwo and the second twin Kehinde. Infant mortality is high probably due to bad treatment of the cord at birth and a number of other factors like poor feeding.

It must however, be mentioned that there are some medicine men who specialise in midwifery and apart from using "alligator pepper" and a few words or incantations to sustain the observer in their belief for efficiency of his art or science, he uses some of the methods practised by the trained modern midwife. At present the competition between the trained midwives and the agbebis is keen. In small towns and villages, a great percentage of pregnant women are attended to by the agbebis. The agbebi sees his patients more regularly than the midwives and doctors in medical institutions see their patients. He gives several herbs and medicine, although it can be argued that these are given in far too large quantity and often prepared under very unhygienic conditions. Until there are enough trained midwives

and doctors to serve the need of the population perhaps a programme aimed at improving the skill of the agbebis should be formulated. Stress should be laid on prevention of infection, recognition of abnormalities and reference of patients for medical care. Incidentally all agbebis are male, women are not trained by them.

## THE TRAINING OF THE PROFESSIONAL MIDWIFE IN NIGERIA

### Early Modern Midwifery and Nursing Services

There have been great strides and improvement in training and production of midwives and nurses in Nigeria. The early missionaries were first to start midwifery and nursing service. A few notable ones are Mary Slessor of Calabar who saved twins and preached against the killing of twins as it was then believed that twin delivery was a bad omen. At the late Rev. Father Coquard's Hospital at Itesi in Abeokuta, General Nursing and Midwifery training was boldly embarked upon. The Wesley Guild Hospital at Ilesha has withstood the test of time. The introduction of village maternity centres where a sort of on-the-job-training in midwifery was carried out in Ijebu was one of the achievements of the Church Missionaries brought about through the enthusiasms and fortitude of the Reverend W. F. Mellor now a retired Methodist Missionary living in Nigeria. Most of these midwifery centres have now either been taken over or are being sponsored through grant-in-aid by local government of each area.

### Midwifery Legislation

#### The Midwives Board of Nigeria

The first midwives ordinance was published on the first of April 1931. A statutory body known as the Midwives Board of Nigeria was appointed by the government. The first meeting of the Board took place on 11th of June, 1931. Among its many duties, the Midwives Board of Nigeria is charged with the following responsibilities:

1. To prescribe training for midwives.
2. To inspect and give approval for the opening of training schools and to conduct qualifying examinations.
3. The Board maintains a roll of all midwives and lays down rules and regulations which govern the practice of midwifery.
4. It is also responsible for the maintenance of discipline in midwifery practice.

For those trained outside Nigeria, the Midwives Board examines the syllabus of the countries concerned in order to decide on the type of recognition to give to the training.

#### Membership of the Midwives Board of Nigeria

The Federal Chief Medical Adviser is the Chairman of the Midwives Board. Other members are:

- The Federal Chief Medical Adviser.
- The Federal Chief Nursing Officer.
- The Principal Nursing Officer of each state (12).
- Professional representative of Midwifery Schools of each state.
- A representative of the Ministry of Education.
- Two representatives of Mission Hospitals, and
- One member of the Armed Forces of Nigeria.

The Midwives Board carries out its functions through various committees such as education examination, discipline and finance. A district Midwifery Committee is established in each of the twelve states of the Federation of Nigeria. The Committee is empowered to carry out some of the functions of the board, to make enquiry on behalf of the board, submit recommendations and advise the Board.

## Midwifery Education in Nigeria.

For forty years (1927-1967) there were two classes of training for Nigerian midwives. These were grade II and grade I Midwives. The recognition since 1968 of only one class of training for midwives is most welcome. The Nigerian midwife is trained to cope with the normal pregnancy, labour and puerperium. She should be competent to work in rural areas where transport facilities are limited. She must therefore be able to perform and repair episiotomy. She should be competent to deliver breeches and multiple births, prevent and treat post-partum haemorrhage. She is expected to screen all her antenatal patients carefully so that the potentially complicated cases are referred to the obstetricians. Infant welfare clinics and post-natal clinics are conducted by the midwives.

### Registration of Midwives

The graduate midwife is registered as N. C. M. (Nigeria Certified Midwife). Fourteen thousand midwives are registered on the roll of Midwifery Board of Nigeria although the data of practising midwives is not easily available. Midwifery training affords the Nigerian qualified nurse the opportunity for promotion. Eighty per cent therefore of female nurses are also qualified midwives although many of them do not practise midwifery. The exercise to obtain the statistic of practising midwives is at the moment being carried out by the Midwives Board through the supervising authority of each state.

### Midwifery Training Schools

There are 32 Midwifery Training Schools in Nigeria. A training School must be equipped with a minimum staff of one Midwifery Tutor and a specialist in obstetrics and gynaecology. Lectures are given in other fields of medicine by specialist doctors and para-medical staff. Examples are the paediatricians, dieticians, social workers, and family planning workers. Other conditions stipulated by the midwives Board of Nigeria such as building requirements, adequate practical experience for student midwives, required number of beds and establishment of trained midwives must be fulfilled before approval of a school by the Midwives Board.

### Entry Requirement into Training Schools

A two and a half years course of training is available for School leavers who wish to be midwives. The minimum basic educational qualification as laid down by the Midwives Board is Standard VI or Middle II (8 years of primary education). In practice, the number of applicants far exceed the vacancies in the training schools and the majority of the applicants possess the West African School Certificate or General Certificate of Education, (a qualification usually obtained after five years of study in the secondary Grammar School). The qualified nurse undergoes a post basic midwifery training in one year. In addition to lectures in obstetrics, preventive medicine, social welfare, dietetics and paediatrics, the direct entry pupil midwife must have delivered and nursed not less than 50 patients and the qualified nurse must deliver and nurse not less than 30 patients. The national qualifying examination for midwives is conducted by Midwife and Medical Examiners appointed by the Midwifery Board of Nigeria.

### Post-Graduate Midwife Tutors Course

There is an acute shortage of midwifery tutors in Nigeria. Two years ago the government of the Federation introduced a crash programme for training of Midwifery Tutors. The course which lasts for one academic year takes place at the College of Technology, Yaba and Two Midwifery Training Schools are used for Teaching practice and hospital field work by the student teachers. They are the Island Maternity Hospital, Lagos and the University College Hospital, Ibadan. Graduates of this programme are expected to serve in areas where there is a dearth of Midwifery Tutors. It is hoped that the post-basic

programme at the Department of Nursing University of Ibadan which leads to the Bachelor of Science in Nursing degree would in future be widened to produce tutors of Midwifery.

### Problems of Midwifery Practice

The commonest cause of maternal mortality and morbidity is dystocia e.c. cephalo pelvic disproportion and its sequelae of ruptured uterus.

### Anaemia in Pregnancy

Severe anaemia is very common. It has been established through research at the University College Hospital, Ibadan, that iron deficiency anaemia is rare in the Western State. Malaria heads the list of causes of anaemia. Folic acid deficiency anaemia is rampant due to prolonged cooking method used in the preparation of many Nigerian dishes.

Taboos which are usually associated with traditional treatment of all illness cause anaemia and malnutrition. For example the pregnant woman is forbidden to eat snails and eggs which are very good sources of protein. The baby when delivered, it is believed, will salivate all his life if the mother eats snails and would turn to be a thief in the case of the mother who eats eggs. Beverages are forbidden for fear of the foetus becoming too big resulting in obstructed labour. Fortunately the majority of mothers who seek modern medical care no longer believe in the taboos.

### Problems of Training Schools

Only a few Midwifery Schools are adequately equipped and fewer still can boast of a good library for the use of students and practising midwives. Midwifery textbooks to serve the local needs should be produced as symptoms of some conditions in patients in the African community do not conform to the pattern described in the present textbooks used in our training schools, e.g. many of our patients have been known to have eclamptic fits with blood pressure as low as 120/80. Books quote 140/90 as sign of moderate pre-eclampsia.

### Communication and Transport Difficulties

Although there have been great advances in medical services, the need for more facilities is great. The slow communication system in the country and in hospitals in particular is a hindrance. Roads and transport facilities are rather poor in most places so that time is wasted and lives are lost owing to delay in the transfer of patients to hospital. When these are improved, midwives in rural maternity centres can make their problems known to the hospitals in time.

### Under-Developed Health Programme

Preventive Health is under-developed. The rate of infant mortality (50 per thousand live births), maternal mortality and morbidity is high often due to lack of care. Poverty is responsible for a large proportion of pregnant women not seeking medical care or going to the quack doctors.

### Looking to the Future

Basic educational requirement for entry to midwifery schools needs to be raised. Syllabus of Midwifery training needs to be constantly reviewed and adapted to the local needs.

### Facilities for Research by Midwives

Midwives should be trained to be interested and carry out research on their own e.g. the midwife should find out the various traditional methods of the treatment of the umbilical cord. Hot body fomentation in the puerperium or the use of brandy are other fields which

offer scope of investigation as many of our patients believe that these two methods aid involution of the uterus. Dangers of the traditional methods, superstitions, beliefs and taboos attached to the methods employed by the Agbebis (traditional birth attendants) should be studied. We should ask questions and find answers all the time.

### Conclusion

An improved Midwifery standard is the goal to which the government of Nigeria and the Midwives should work. The professional Association of Midwives of Nigeria has a noble role to play in this regard. The Association should, among other things, give government suggestions towards improving the standard of Midwifery Training, organise regular Midwifery seminars and part-time Midwifery education programmes for the Midwives.

Precis of paper given by Mrs. Comfort Akrofi

Family Planning Programmes in Ghana

Each census in Ghana had revealed that as the number of children surviving increased due to improved medical care, the population growth was becoming alarming.

In 1961, the Committee on Christian Marriage and Family Life (CCMFL) of the Christian Council of Ghana opened a centre in Accra. It found that the chief problems were either too many children in a family or childless homes, and CCMFL therefore became a family planning clinic dealing with contraception and infertility. The CCMFL met no opposition and soon opened more centres. It organises a Christian Home Week every year to educate the public in family life.

The Planned Parenthood Association of Ghana

In 1967, the Planned Parenthood Association of Ghana (PPAG) was inaugurated by a group of Obstetrician/Gynaecologists who had attended a meeting in Denmark. Midwives, lawyers, housewives, educationists etc were all asked to assist their endeavours. There was no opposition from the Government and they were permitted to operate clinics in Government institutions.

The PPAG believed that family planning had four functional parts:-

- 1) Premarital or family life education
- 2) Birth Control
- 3) Infertility and Subfertility
- 4) Problems in Marriage

Both the PPAG and the CCMFL continued their family planning efforts with the help of the International Planned Parenthood Federation (IPPF) prior to the establishment of the National Family Planning Programme (NFPP). In 1968, under the Ministry of Economic Planning, the Manpower Board was formed to study the vital link between the economy and rapid population growth.

Ghana Population Policy

In March 1969, the Board published "Population Planning for National Progress and Prosperity, Ghana Population Policy". From this it was shown that the two to three per cent annual population growth exceeded the economic growth considerably. About 50 per cent of the 8,500,000 population at this time were young and the majority of these were not employed. The overall mortality rate had declined but the fertility rate remained high and was increasing.

On the recommendation of the Committee, the National Family Planning Programme (NFPP) was officially launched by the Minister of Economic Planning in May 1970. The slogan adopted is "Family Planning, Better Life". The National Family Planning Secretariat is the co-ordinating and planning body under the Ministry of Economic Planning and uses all existing facilities.

The Secretariat has an Executive Director and it has Units for Services, Information and Education, Training, Research and Evaluation and Administration.

Family Planning Services

Midwives are involved in the delivery of family planning services. In using existing facilities the NFPP uses:-

1. Services provided at Ministry of Health Institutions as part of Maternal and Child Health (MCH) Services.
2. The Planned Parenthood Association of Ghana (PPAG).
3. The Christian Council of Ghana (Committee on Christian Marriage and Family Life (CCMFL) ).
4. All others engaged in health services -
  - a) Government linked institutions not under the Ministry of Health.
  - b) Church Related Hospitals and Clinics
  - c) Mines Hospitals and Clinics
  - d) Private Hospitals and Clinics

Thus the administration of family planning services is divided into three groups -

1. Hospitals and Clinics which combine Family Planning and MCH Services.
2. Freestanding clinics
3. Commercial distribution of non-prescription contraceptives through the Ghana National Trading Company (GNTC).

Although the country is not yet completely covered by family planning clinics, by the end of September 1972, there were 138 clinics registered in urban and rural areas.

Cases of infertility are always given the serious attention they deserve.

#### Personnel Offering Services

The successful implementation of the NFPP depends on the participation of trained personnel and in order to support the increasing demand on the services of Medical Officers, para-medical personnel are being trained e.g.

1. Medical Officers without previous Family Planning Service training receive instruction over three to five days.
2. Selected professional nurse midwives including Public Health Nurses are given intensive training for a period of eight weeks to give services up to the insertion and removal of intra-uterine contraceptive devices.
3. Selected professional midwives without previous nurse training receive intensive training over a period of three weeks to deliver services up to the administration of the pill. They are then designated Family Planning Auxiliaries.

Because the midwives are already known to the mothers, they avail themselves of the services provided by midwives and this has contributed to the good attendance at clinics.

Prices of contraceptives are at a standard low rate to enable everyone to make use of the services at a token fee. Those who cannot afford the token fee are given services free.

#### Motivation Work for the Services

Motivation for family planning through Education and Information and especially through face to face communications is essential. An eight weeks training course is available to Middle School leavers to equip them to be full time Family Planning Field Workers. A ten day training course is available to people with experience in field work to enable them to use this type of motivation as an integral part of their work. Such people include Social Welfare and Community Development Officers, Agriculture Extension Officers etc.

In May every year a family planning week is organised and this increases clinics attendances.

#### Family Life Education

Family Planning to be properly appreciated and understood should come within the context of family life education and the CCMFL has planned an elaborate programme. Family

Advisers and Family Counsellors are being trained annually from all walks of life e.g. Ministers of Religion, Teachers, Social Welfare Workers, Housewives etc. They are employed in a part-time capacity in some of the family planning clinics, in secondary schools, teacher training colleges, church groups and voluntary organisations. The first Counselling Centre was opened in Accra in October 1972 and others are planned in the Regional Capitals, then in the districts and finally in all the hamlets in the country. A composite committee of representatives from the Council of PPAG, CCMFL, Ministers of Religion, Educationists, Social Workers etc. has submitted a report, draft syllabus and the following proposals to the NFPP.

1. A comprehensive Family Life Education Programme should be established in Ghana with the full support and participation of the Ministry of Education, the Educational Institutions and the Churches.
2. A Pilot project should be started in selected Schools to pre-test and evaluate proposals for the family life Education programme before an extensive national programme is launched.
3. The Ministry of Education should be asked to institute, as soon as possible, a crash programme for the training of a group of teachers who will initiate Family Life Education Programmes in schools.
4. The Ministry of Health and the Ghana Medical School should be asked to include anatomy and physiology; Human Reproduction; fertility and infertility; Sexual Behaviour; Methods of Contraception; Moral and Social Aspects of Family Planning as part of their basic training courses for Doctors and para-medical personnel.
5. The West African Examinations Council should be invited to consider incorporating aspects of Family Life Education into the Health Science or other appropriate examination papers for the General Certificate of Education.
6. Parent-teacher Associations should be encouraged to discuss the teaching of Family Life Education in Schools.
7. The existing Marriage Guidance and Counselling programmes of the Christian Council should be expanded, and given wide publicity throughout the country.
8. In due course, serious consideration should be given to the establishment of a Marriage Guidance Council on a national scale, with government support.

From these proposals it is hoped that the Ministry of Education will in due course, establish a National Family Life Education programme.

#### Family Planning in Midwifery Training

The present family planning training for midwives is post certificate but plans are afoot to incorporate it into the basic training of midwives and nurses and into the postbasic tutor's course. Thus eventually all midwives will receive training in family planning. It is encouraging for midwives to know that family planning is increasingly being considered as an acceptable life style and it is hoped that all midwives including Traditional Birth Attendants will in incorporating family planning services in their practice continue to help to improve maternal and child health thus ultimately improving the health of the nation.

**INCORPORATION OF FAMILY PLANNING  
IN THE TRAINING OF MIDWIVES**

by  
Miss Winifred Evans (USAID, Liberia)

In the basic curriculum of nurses and midwives, an orientation to Family Planning has been provided as part of the component of obstetric nursing since 1969. This orientation until now has been mainly theoretical.

Family Planning often referred to as Family Health in training documents, has been developing recently in Liberia since 1956 when the Midwives Council of Liberia in collaboration with Family Association organized to assist mothers who were bearing their children in rapid succession. However, the first regular Family Planning clinic, supported by Pathfinder and IPPF, did not open until 1966. The first full time administrator of FPAL was appointed in 1967.

In June 1969 under an agreement signed by the Government of Liberia and by U. S. AID, an in-service course was initiated in collaboration with FPAL within the Division of Maternal and Child Health, Division of Preventive Services, of the National Public Health Service (now known as the Ministry of Health and Social Welfare). The course is entitled Maternal and Child Health/Family Health In-Service Course. Its purpose is to train government employed nurses, midwives and other para-medical personnel, particularly those assigned to remote clinics throughout Liberia, to improve the existing Maternal and Child Health and Midwifery Services. This project was co-ordinated with existing training programmes of the MCH Division, assisted by UNICEF. The project's main aims are to expand the numbers of MCH clinics operating throughout Liberia and to initiate county training programmes for other para-medical personnel serving in remote areas.

The In-Service Course is four months in length and is conducted twice yearly; 140 hours is devoted to theory. Theory is given in the initial block of 4 or 5 weeks followed by intensive practice in hospital, clinics and schools during the remaining weeks.

The topical outline of the course is as follows:-

1. Introduction to MCH Service.
2. Communication and Teaching Methods.
3. Health Education.
4. Environmental Sanitation.
5. Vital Statistics.
6. Maternal Health.
7. Child Health.
8. School Health.
9. Organization and Management of Clinics.
10. Training and Supervision of Empirical midwives.
11. Family Health.
12. Nutrition

Over a five year period, this project is to produce a cadre of 100 qualified personnel. As of December 4, 1972, 57 trainees have completed the course. Graduates of the course are stationed in all nine of the counties of the Republic of Liberia.

Family Health in the In-service Curriculum

Initially the Family Health component was assigned 5 hours of theory with one week of practice in the Family Planning clinic at FPAL headquarters in Monrovia. As of 1972,

Family Health has been increased to 10 hours of theory integrated with a two-week practice period in family planning clinics.

The content of the Family Health component is as follows:-

1. History of Family Planning.
2. Sociological cultural and economic aspects of family life in Liberia.
3. Identification of high risk mothers.
4. Statistics are related to Family Planning.
5. Motivation and counselling.
6. Sex education.
7. Contraceptive methods.

At FPAL trainees are indoctrinated in family health and welfare principles as the contraceptive component is but one phase of the programme, for FPAL provides other needed services as well - Gyn and infertility, post-partum, nutrition and well-baby.

This two week period in Family Health was not designed to develop technical skills in the area of IUD insertion, for example, but to help the trainee develop a broader concept of comprehensive Maternal and Child Health services, to try to bring about attitudinal changes, and to help them become more effective counselling and referral agents.

Upon completion of this component, trainees are able to give information concerning available methods, explaining the advantages and disadvantages of each; to be able to identify couples needing assistance and to be aware of services available, public and private, and to refer and to follow up when indicated.

Each is given an instruction folder with pamphlets and samples for use in their respective clinics.

#### Empirical Midwives in Family Health

Empirical Midwives during their four month training course in Monrovia, are also being orientated to Family Planning. They have an opportunity to observe the FPAL educators in pre-natal clinics and on post-partum services of Maternity Hospital. They spend one morning session at the FPAL headquarters where they are orientated to family planning methods. They leave the course, it is hoped, with a stronger awareness of their unique role as counselling and referral agents within village communities.

Every year a workshop is held in Monrovia for licensed empirical midwives from all over Liberia. The topic for this year's workshop will be the Empirical Midwife's Role in Maternal and Child Health/Family Health.

#### Training of Midwives and Nurses in Family Planning at FPAL

FPAL employs a number of nurses and midwives who have been trained abroad in collaboration with USAID or who have been given on-the-job training at the FPAL headquarters in Monrovia. These technically trained personnel constitute a cadre of health workers who, under the new integrated programme, MCH and FPAL, organize and conduct Family Planning clinics in several government MCH clinics in Montserrado County.

It is anticipated as clinics begin to operate under the new integrated plan, that the graduates of the MCH/FH In-Service Course will become involved in the aspects of child spacing service for which they have been trained.

WEvans/18 Dec. 1972

ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA,  
8th-16th December, 1972.

THE ORGANISATION OF A FAMILY PLANNING SERVICE .  
Precis of Paper given by Dr. Ampofo (Ghana)

Because family planning is a new activity in the traditional divisions of the Health Care system, it is necessary to discuss the organisation of a service which will promote and enhance it.

Although family planning is a private concern between individual couples, it has acquired such an important status in the last decade as to become a major health phenomenon. Throughout the world, it is now generally realised that there is a direct relationship between high fertility rates and high incidences of infant and childhood diseases and high mortality. Family Planning is now considered to be part of Maternal and Child Health (MCH) and the two together are referred to as Family Health, i.e. the health of father, mother and children.

Initially, the physicians felt that the provision of a large scale family planning service was in their domain, but it quickly became evident that particularly in the developing countries, they would need the assistance of other personnel. The doctor/population ratio in Africa is about one to 12,000 - it is more in other countries - and unfortunately, it is in the high doctor/population ratio areas where family planning is most needed. It is therefore logical that the doctor's "mates" - nurse/midwives and the auxiliaries should be made to provide the service after being properly trained, and refer complicated cases to the doctor.

Before formulating a family planning training programme for nurse-midwives, training materials for similar courses in other countries should be examined. Educational standards and local circumstances must be considered and the material should be adapted to the particular course. If this is not possible, a preliminary orientation course should be given.

The structure and duration of the course depends on the job description, the background of the candidates and the provision of adequate time for practical sessions. Doctors are trained to provide family planning services in three to five days, but in order to provide a similar type of service proficiently, nurse-midwives would require eight weeks. The course should comprise theory, practical and field training. Theoretical instruction may be by lectures with diagrams and visual aids or by programmed learning (usually using written manuals) and both followed by group discussions.

Practical sessions should be given in close proximity to the training centre to enable instructors and demonstrators to maintain rapport with the trainees. After a particular technique has been demonstrated, the trainee will perform the procedure under close supervision. Nurse-midwives should be taught how to recognise high risk clients, the examination of pelvic organs, the insertion of intra-uterine contraceptive devices (IUCD) and methods of dispensing of other contraceptives.

Motivational training may be given by demonstrators at clinics or family planning centres and trainees then proceed to demonstrate how to educate clients under the supervision of an instructor who assesses and, if necessary, corrects their performance.

Field training should include visits to the health institutions, such as health posts, centres or district hospitals, in order to gain experience in rural and community settings and to see the potential of their training.

Some private clinics staffed by professional midwives and some indigenous midwives outside the Government Health system operate the MCH services in the district field and the trainee would benefit if she visited one of these, recording what she has gained.

In Ghana, since 1969, three family planning training programmes have been available. The Course for Family Planning Nurses is of eight weeks duration and is open to professional nurse-midwives who have already three to five years clinical experience. The Family Planning Auxiliary Course is of three weeks duration and is open to nurse-midwives, interested in family planning, who have had less than five years clinical experience. This category of personnel is used in motivation and in dispensing all contraceptives, except the IUCD. There is also a five day training programme, meant to cover all midwives working in Health institutions to train them to provide a motivational service only.

The comprehensiveness of a family planning service depends on national population policy, the structure of the national Family Planning Programme if it exists, the emphasis a particular country attaches to family planning as an ingredient of sound socio-economic planning and the availability of personnel for training.

In countries with population policies and family planning programmes and where the Health Ministry is responsible for their implementation, the utilisation of nurse-midwives for family planning may become part of the Nursing Service Structure. Major clinics (where clients exceed 50 per month) should be staffed by full time family planning nurses as in Ghana, Nigeria, Kerya and Uganda. Clinics should be held thrice weekly, but nurses should be available at all times. Contraceptive complications should always be dealt with immediately. The clinic nurses should keep good records, maintain hygiene, replenish supplies and motivate patients at ante and postnatal clinics, in the lying-in wards and the post-natal clinics, in post-abortal wards.

The family planning auxiliary nurse-midwife should be employed in Welfare Clinics, polyclinics, health centres or health posts where the pressure for family planning is not so great and the insertion of IUCDs is not required.

There is a place for field workers in extramural and community motivation. Previous nurse training is not necessary but they must have a basic qualification in order to train them in techniques of canvassing, motivating and explaining family planning to people in their own homes, public places etc.

In the initial stages, it may be necessary to give special incentives to nurses who opt to do family planning, but when there are sufficient trained midwives, this would become unnecessary. During family planning training, the nurse is exempted from the nursing time schedule and night duty, and the training should therefore be regarded as in-service and designed to improve her proficiency.

The service conditions for family planning field workers could be similar to that of Medical Field Units, under the Ministry of Health. The salary differential for field worker supervisors should be sufficient to give them incentive to do a good job.

In Pakistan and India, Departments of Family Planning were set up to execute and promote family planning. A civil service structure was established with the usual hierarchy down to the lady health visitor (field workers in other countries). Salary structure was high and large numbers joined the family planning service. In time it is hoped that the Family Planning Department will be abolished and the service introduced into the general health care system.

Family planning services can also be supplied by private agencies using nurse-midwives employed on a personal basis with the salary being negotiated between the employed and employee. The disadvantages are that promotion prospects are non-existent and permanent

employment cannot be guaranteed. However, more and more agencies are ensuring that funds will always be available from somewhere to finance a good family planning programme.

The role of traditional birth attendants (TBAs) in rural communities should be examined because in the developing world, nine tenths of deliveries are conducted by them. The TBA could be trained and then utilised in MCH and family planning services. Many positive approaches to this can be made at the present time, as follows:-

- 1) Enumerate the number of TBAs in a given area.
- 2) Find out how they practise.
- 3) Devise a training programme to make their practice safer.
- 4) Introduce family planning as a means of enhancing their livelihood rather than detracting from it.
- 5) Encourage them to refer women who need the family planning services, to use the clinic located in their area.

Can selected TBAs act as motivators for family planning ? Careful plans can be devised and tried, but it must be remembered that most TBAs are elderly and how far this fact will facilitate their use as motivators, remains to be seen.

ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA,  
7th-15th December 1972.

Precis: THE ORGANISATION OF A FAMILY PLANNING SERVICE IN SIERRA LEONE  
Paper given by: Dr. Belmont Williams (Sierra Leone)

One of the customs in some societies is for a newly delivered woman to return to the home of her parents or other relatives, until after the child has been weaned from the breast, a matter of about 18 months or so. After this time, she once again cohabits with her husband, so that by the time she produces a second child, there has been natural child spacing of about two and a half to three years. This custom arises from the belief that sexual intercourse is harmful to a breast fed baby. It is possible to practise this type of "family planning" in polygamous societies where each wife will have fewer children than the one wife of a monogamous marriage.

Cultural patterns are changing and monogamous unions are increasing, but the one wife produces more children than the individual wives of a polygamous marriage, because she does not return to the home of her parents, and therefore resumes sexual relationships with her husband much sooner after delivery. Infant and neonatal mortality and morbidity rates are high and stillbirths and maternal mortality rates have reached alarming figures. Women with babies only a few months old are asking for family planning advice and services.

The infant mortality rate increases as the interval between births decreases. When it can be proved to a family that children will survive and the foetal and infant mortality rates are reduced by using the family planning services, then family planning will be acceptable to the community.

Child spacing may help to decrease the maternal depletion syndrome and provide greater opportunities for the healthy development of the individual child. It is frequently the child who has to be weaned early, because of its mother's pregnancy who develops malnutrition, gastro-intestinal infection and/or deficiency diseases such as kwashiorkor. It is therefore important for the mother, the infant and in fact the whole family to have recovered from one pregnancy before embarking on another. There is an obvious need for family planning advice and services to be made available to all men and women and a general improvement in the health services is a prerequisite for this, as family planning cannot be separated from the health services to mothers and children.

In Sierra Leone, more ante-natal and under-fives Clinics - static and mobile - are being set up to reach a greater number of mothers and children. Doctors, nurses, midwives and maternal and child health aides must have tuition in family planning included in their training in order to equip them to provide a service to the patients concerned.

The targets for family planning counselling in Sierra Leone include men as well as women, because it is only with the co-operation of both that family planning can be effective.

There is a direct relationship between maternal mortality, parity and maternal age, so that family planning services should be directed towards certain priority groups e.g., older women, grand multipara and indeed the younger mother who may have a less favourable outcome of a pregnancy. Education in family planning should be included in services for adolescents and in school health and college health programmes. In Sierra Leone, an increasing number of girls in these categories are becoming pregnant, which means that either their chances of higher education are reduced or they have the pregnancy terminated. One of the major causes of infertility in the country is post-abortal salpingitis.

Abortion is a negative method of family planning and may be resorted to when family planning is not available or it fails. There is an increasing number of unwanted pregnancies, not only in these young people, but also in older women who already have as many children to cope with as they can manage. Is sex education enough or should family planning services be made available to our girls at school and college?

There is no official Government policy on family planning in Sierra Leone, although sympathy is increasing towards the Planned Parenthood Association (PPA), a voluntary organisation assisted by the International Planned Parenthood Federation (IPPF), and previously by the Pathfinder Fund. There is no population problem as such and vast areas of the country are still uncultivated, but it is hoped that with improved education on the subject, the health needs of family planning will soon be recognised.

PPA is now able to import contraceptive drugs free of duty and Papanikolau smears are carried out by a consultant pathologist at the clinic in Freetown - the only place in the country where this is done. There are other family planning clinics operating in Bo, Makeni, Kenema, Kamaquie, Gbendembu and Lunsar.

PPA holds a Public Annual General Meeting every year during the annual Family Planning Week, when all types of mass media are used as demonstrations. The President of PPA is Dr. E.O. Pratt and there is also a Consultant Obstetrician on the committee, representing IPPF, an Executive Secretary and a Nursing Sister. The Freetown Clinic operates on Tuesdays and Thursdays, most of the work being done by the Nursing Sister, although intra-uterine devices (IUD) are inserted by the doctors.

Field Supervisors and Social Welfare Workers talk to mothers in maternity wards and at ante-natal and under-five Clinics, sometimes accompanied by the Nursing Sister who will distribute contraceptive pills as necessary, but most patients are requested to attend the nearest clinic. The field and social workers hold demonstrations and give talks in some centres or villages and sometimes they and the PPA workers accompany Catholic Relief Services teams who do most of the under-five mobile clinic work. Usual methods of contraception are advocated and the association's workers can distribute dried skimmed milk, bulyor and sesame supplied to the clinics by CARE. The registration fee of two Leones is waived in some cases.

Infertile patients are referred to a specialist gynaecologist at the family planning clinics and thorough investigations and treatment are carried out. In Family Planning counselling it is important that the average husband should be informed about the optimum age when his wife should commence childbearing, the advantages of her using preventive health measures wherever possible, the importance of antenatal care and of institutional confinement or professional assistance during domiciliary confinement. Breast feeding of the infant should be encouraged and weaning on to protein containing food mixtures should be gradual. The infant should be taken to the under-five clinic, from the age of six weeks, at regular intervals for supervision and immunisation against communicable diseases of childhood. Under such conditions, the number of children's deaths would be reduced and the parents more ready to space the number of children they wish to have.

Family planning services are best given at post-natal clinics, and it is therefore important that doctors, midwives and all maternal and child care workers should be trained to do this. In-service training and refresher courses are very important.

In Sierra Leone, before any attempts are made to introduce a family planning service in a particular area, the Chiefs and Elders are approached and the whole problem discussed with them in order to gain their co-operation and keep them informed of what will be told to their young men and women.

**ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA,  
8th-16th December 1972.**

**THE ORGANISATION OF FAMILY PLANNING SERVICES IN LIBERIA  
Precis of Paper presented by Dr. D. S. Collins (Liberia)**

The Family Planning Association of Liberia (FPAL) has five clinics and its Headquarters in the capital, Monrovia, a clinic in Bomi Hills and one in the city of Bental. The clinics are staffed by five part-time doctors, seven full-time and three part-time nurse-midwives, and eleven field workers-motivators.

FPAL was founded in 1956 and was organised by midwives and philanthropists to assist women who were having pregnancies in rapid succession. The acceptance of the service is growing as part of the Maternal and Child Health (MCH) programme. Family Planning Services are also provided by physicians in some industries, mission hospitals and private clinics throughout the country.

The first regular FPAL clinic opened in 1966 when the International Planned Parenthood Federation (IPPF) began giving financial aid. Prior to this, the association's activities had been limited by lack of funds and public sympathy. A gift of 100 Dollars from Dr. Gamble of the Pathfinder Fund was used for publicity and the Fund also provided a small amount of foam contraceptives.

Family Planning motivation programmes conducted throughout the country aroused public interest and enthusiasm and by 1967, the number of women attending clinics had risen from 52 to 136. In implementing the programmes emphasis is laid on group meetings, lectures, films and distribution of literature. In the same year FPAL became an associate member of IPPF. In 1969, FPAL's constitution was drafted and approved, and it now has an Organising Secretary (appointed in 1967) engaged in growth and development of programmes, an elected Board of Directors and a full time Administrator.

FPAL services are now included in the programmes and activities of Social Welfare and Nursing and Environmental Health Education. Family Planning Services provided at the Maternity Hospital and MCH Well Baby Clinic include nutrition, contraception (spacing), infertility, counselling, health education and postpartum service. The aim and objectives of FPAL are:-

- 1) To help educate parents to have only those children for which they can provide adequate food, clothing, housing, health care and education, by using scientific methods.
- 2) To help improve the health of the population of Liberia by:-
  - a) improving the standards of MCH
  - b) reducing infant and maternal morbidity and mortality rates
  - c) helping sub-fertile and infertile men and women
- 3) To assist in training programmes for doctors, nurses, health educators, midwives, social workers and volunteers in the practical implementation of family planning services and
- 4) To help stimulate and assist in the formation and integration of Family Planning clinics throughout the Republic.

Since 1969, the Government's attitude to family planning has changed, and although there is still no official policy, FPAL has the support of the Government in such things as:-

- 1) Housing and facilities including the use of established clinics and hospitals.
- 2) Medicines and Nutritional Supplements and Well Baby Clinics
- 3) Joint use of personnel
- 4) Training of in-service para-medical staff
- 5) Joint FPAL/MCH projects now in operation in rural areas and in urban areas.

It is hoped to extend family planning services in co-operation with MCH throughout the whole of Liberia and FPAL is destined to play a vital role in Health Education generally and in Maternal and Child Health programmes.

**ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA,  
8th-18th December 1972.**

**Precis of Paper given by Dr. A. Akinkugbe (Nigeria) on:  
Developments in the Training of Midwives and the  
Organisation of a National Service to include all  
Categories of Midwives.**

The 12 States of the Federation of Nigeria are each autonomous in the provision of health care and training programmes for the State Health Service personnel, through the Ministry of Health. General considerations and standards are laid down by the Federal Ministry of Health in the capital, Lagos.

The forerunner of some of our modern Midwifery and Nurse training institutions in different parts of Nigeria, was the training started by missionaries and other voluntary agencies over a century ago. Expatriate doctors and midwives gave instruction in midwifery to women who had little basic education and who were taught on the job. With the improvement in education, more standardised midwifery training programmes were introduced and by 1927, two categories of Nigerian midwives evolved: Grade I and Grade II. In 1931, the Midwives Board of Nigeria was appointed with statutory responsibilities:-

- 1) to prescribe training for midwives
- 2) to inspect and approve the opening of training schools and to conduct qualifying examinations etc.

With the growth of medical and health institutions throughout the country, requiring the services of midwives, progress in training developed fairly rapidly. During the past 20 years, appreciable numbers of Nigerian women who have had nursing and midwifery training in the United Kingdom, have returned to Nigeria. Their knowledge and practice have had a most beneficial and stimulating effect on the training and practice of midwives in Nigeria. There was a growing demand for raising the general educational requirements, prior to commencement of midwifery training and legislation was introduced to standardise the training. In 1967, the training of Grade II midwives was discontinued.

Following the collection of information from various sources, the "Report of the Special Joint Committee on New Standards of Nursing Training in Nigeria" was compiled in 1965. Amongst the important recommendations were:-

- a) Special standards in hospital building structure
- b) Stipulation of number of beds
- c) Minimal staff requirements for the approval of Nurse Training Schools.

Many hospitals complied with these regulations during the five year period granted to make the necessary alterations and improvements. Those which did not were no longer designated training schools.

The Midwives Decree 1966 (Commencement) Order 1967 and Midwives Regulations 1967 set the standard for entry to Grade I Midwifery Training and gave guidance on theoretical and practical training, examinations, registration, etc.

Inevitably, standards vary widely between teaching Hospitals attached to Medical Schools and other training centres. Medical School training institutions attract the best quality candidates for midwifery training and offer the greatest facilities and have a high standard of staff. Often the voluntary agency hospitals have better organisations and facilities than the third group - the Government hospitals. All recruits to midwifery training must have

their school certificate (said to be standard VI of General Education). General trained nurses can take midwifery training in one year, but those students without general nurse training take two and a half years and then sit a special examination.

The first six months are spent in the Preliminary Training school, where amongst other subjects, lectures are given on anatomy and physiology. During the next two years, there is on the job training in hospitals, supplemented with lectures, tutorials and demonstrations.

Training of a category of midwives called Community Nurses (proposals have been made to call them Community Midwives), has been in progress for almost ten years. The majority of candidates are Grade II midwives with a great deal of practical midwifery experience, who are accepted for an 18 months period of training in Public Health, Hygiene, Maternal and Infant Welfare and other related subjects. The minority are girls with secondary school leaving certificate, who are admitted for direct training in Lagos, for a period of three and a half years. This training includes general nursing, midwifery and Public Health. Community Nurses are employed in antenatal and infant welfare clinics, school health, district nursing, domiciliary midwifery, etc.

Public Health Nurses are experienced nurse-midwives, who have had a further period of 12 months training in Public Health, after which they are employed as Supervisors of Community Nurses. After further experience they are promoted to Health Sisters.

Midwifery Tutors: Most Nigerian Midwife Tutors have been trained overseas. The future of the emergency midwife tutor's training school in the Yaba Technical College is uncertain, but at the moment the one year course offered should cater for the urgent needs of the country. It is however, imperative that the Midwives Board of Nigeria should encourage suitable institutions, such as the University Teaching Hospitals, to create midwife tutor training facilities.

Continuing Education for Midwives: Opportunities for post-certificate education for midwives depends on the institution in which they are employed. Specialist units offer the best facilities, but it is necessary to continue to organise seminars, tutorials and demonstrations for groups of midwives in different areas.

### Conclusion

Although the standard of midwifery training is improving there are many variations throughout the country depending on the economic and educational standard attained in each of the 12 States of the Federation of Nigeria. The Midwives Board of Nigeria, whilst continuing to maintain and improve the standard of midwifery, should also realise that the actual numbers in training are inadequate to complement the limited medical manpower. There is an unnecessary burden on the few midwives practising, which tends to lower their efficiency. The Government too, should make efforts to improve maternal and child care, so that ineffective traditional methods could be completely and permanently replaced by modern scientific methods.

**ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA,  
8th-16th December 1972.**

**Precis: DEVELOPMENTS IN THE TRAINING OF MIDWIVES & ORGANISATION OF  
A NATIONAL MATERNITY SERVICE TO INCLUDE ALL CATEGORIES OF  
MIDWIVES,**

Paper given by Dr. K. K. Korsah (Ghana).

The pioneer midwife trainees were four nurses and three health visitors, who in 1928, were taught at the Korle Bu Hospital by the medical officer, Dr. Grace Summahayes, assisted in the clinical work by one nursing sister. In 1929, at the formal opening of the hospital, there were two full-time and two part-time medical officers, two nursing sisters and nine student midwives.

After two years training in normal and abnormal pregnancy, labour and puerperium, care of premature babies and theatre work, three of the four original students took the midwifery examination.

Gradually, the number of midwifery students in training increased. Recruits were required to have had about ten years general education with a middle school leaving certificate and might or might not be general trained nurses.

The training programme includes tutorials by the midwifery tutors and lectures by doctors in anatomy, physiology and normal and abnormal pregnancy, labour and the puerperium and diseases associated with childbearing. Practical instruction is gained in hospital wards and in external clinics. Improvements are constantly being introduced.

Since 1950, the Korle Bu School has given midwifery training to general trained nurses and midwifery training for students with no previous nursing training is given at the Okomfo Hospital in Ashanti, both courses leading to the examination of the Ghana Central Midwives Board (CMB). A third Government training school was started at the Koforidua Hospital in the Eastern Region, to give midwifery training to general trained nurses. In addition, there are six private hospitals, mainly missions, which provide midwifery training recognised by the Ghana CMB.

The length of midwifery training for a State Registered Nurse (SRN), is 12 months; for Qualified Registered Nurses (QRN) and Enrolled Nurses it is 18 months and for women with no previous nurse training it is 30 months. The Midwifery Training School in Accra has adjusted its programme so that the CMB for England and Wales recognises the Ghana CMB examination as being equivalent to the examination following first period midwifery training in England and Wales. About 100 candidates present themselves at each of the two Ghana CMB examinations annually.

Between 50 and 60 per cent of professional midwives in Ghana have returned to general nursing; ten to 15 per cent are not accounted for and only a small number - 25 to 30 per cent are practising midwives.

#### Organisation of Maternity Services

Three main central hospitals at Accra, Kumasi and Sekondi-Takoradi, medium-sized regional hospitals and several 40-50 bedded district hospitals all have maternity sections, amounting to 20 per cent of the total bed capacity. The number of professional staff in the hospitals depends on the number of beds, the turn-over and availability of such staff. Health Centres, under the supervision of the medical officer in charge of the district hospital, are found in some urban areas, but mainly in rural areas in large villages. They

are staffed by a Superintendent, a Public Health Nurse and a Professional Midwife. In some areas, there are Maternity Clinics run by local councils and staffed by trained midwives. Mission hospitals reasonably well staffed by doctors, nurses and midwives, are scattered throughout the country, often in remote areas.

In addition to maternal and child care services, some of these institutions offer family planning services.

Patients delivered by private practising midwives in their own clinics, return home after a few hours, but domiciliary postnatal supervision is continued by the midwife concerned for at least 14 days. Premises and practice of a private practising midwife are supervised by regional public health nurses on behalf of the Government. Private midwives charge fees. Until recently, Government institutions offered free maternity services, but now a small charge is made for antenatal attendances, delivery and board.

Although traditional birth attendants (TBA's) are not officially recognised, they treat the majority of pregnant women of the country, throughout the maternity cycle and mainly conduct domiciliary deliveries. They are the wise women of rural communities, who have acquired experience through practice and whose advice is often sought in times of difficulty. In 1971, they were responsible for 75 per cent of all deliveries. Trained health personnel (doctors and professional midwives) were responsible for 19 per cent of all deliveries in hospitals; nine per cent in private maternity homes and three per cent in health centres.

About 60 per cent of midwifery students are general trained nurses, the majority of whom revert to nursing or become health visitors. Only about 25 per cent of these remain in midwifery and they usually work in hospitals, health centres etc. It is therefore necessary to train more midwives and provide more training schools. If each of the regional hospitals within the nine regions of the country started a midwifery training school similar to that in Accra, the number of local trainees would increase and when trained they would remain in the area to work, and thus extend the maternity services.

The majority of the rural population will depend on the services of the TBA, until sufficient professional midwives are trained. Maternity services, organised from regional hospitals could be organised so that trained midwives might be distributed to district hospitals, health centres or maternity homes. The TBA could be trained in fundamental hygiene and simple midwifery techniques by trained midwives at these peripheral centres. The midwives would gain the co-operation of the TBA's so that any difficulties they encounter would be referred to the midwife for advice and/or transfer to hospital. For smooth and effective working of such chain links, however, transportation and communications must be improved.

There are untrained and unrecognised midwifery auxiliaries, mainly in the rural areas of the country, but some in clinics in towns. These women have not reached the requisite general educational standard and may have started clinic or maternity home work in a domestic capacity. According to her performance, her duties and responsibilities gradually increase. She learns by observation and after several months, she may be able to stand in for a midwife on a labour case, while she herself is doing other things. Later, the auxiliary may acquire a blue uniform and white apron, but usually they are only temporarily employed although some develop sufficient interest in the profession to work to improve their educational standard and then take midwifery training.

The Central Hospitals in large towns and cities have become too congested to provide a wholly effective maternity service and the hospitals are often not easy to reach. Urban Health Centres (polyclinics) could be extended and more constructed to give round the clock maternity services. Sited in strategic areas, these could deal with uncomplicated cases while complicated cases would be treated at the Central Hospitals. There have been

improvements in facilities e.g., the blood transfusion service and good Government planning should yield satisfactory results.

Rather than complementing, the national maternity services and the private midwifery clinics are in competition and the fees charged are not comparable. Apart from the supervision of the place and standard of practice, the Government has very little to do with them. If they were integrated into the service, had better liaison with the hospitals and were subsidised by the Government, their function in the maternity services would be enhanced.

Population densities in towns and cities should be mapped out and clinics should be sited so that there is a fair distribution of such facilities as maternity clinics. Help could then be offered to midwives, to establish their practice in specified areas, thus avoiding over-crowding of clinics in sparsely populated or small areas.

ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA  
7th-15th December 1972.

Precis of Paper given by Dr. Rheindorf.

Because I know that student midwives have already had 63 paediatric lectures from their tutors, the eight lecture periods which I give are devoted to lecture-tutorials rather than straight lectures. The topics include the physiological and emotional characteristics of the normal newborn baby and appreciation of personality differences even at birth; the causes of prematurity, problems of premature babies, examination for congenital malformations, and the management of the premature baby in hospital and at home.

There is instruction on congenital malformations, starting with chromosomal aberrations and proceeding to skeletal and systemic malformations. Haemolytic disease of the newborn is discussed and the prenatal diagnosis and treatment of it by amniocentesis and intra-uterine blood transfusion. Other conditions leading to jaundice in the newborn are discussed including neonatal sepsis, which paves the way for other talks on infections in the newborn. We discuss pathology of the newborn and perinatal mortality, starting with genetic factors, hypoxia, resuscitation of the newborn and proceeding to infections and other causes of neonatal death.

Assessment

It is important that the midwife should be able to treat an asphyxiated baby but it is my impression that unless a paediatric question in an examination is made compulsory, the majority of student midwives would leave it unanswered. Student nurses appear to wish for more paediatric instruction than student midwives.

I only expect the midwife to recognise and initiate early first aid treatment of serious illness in the newborn until a paediatrician or someone more conversant with paediatric procedures and management can take over.

In hospitals, the Paediatrician is called to the Labour Ward by the Obstetrician and the management of ill newborn babies belongs to the Paediatrician and his Nursery Nurse. In rural areas, however, and in private clinics run by midwives, it is the responsibility of the midwife who, I imagine, as soon as the opportunity arose, would pass this responsibility to a nurse.

In my opinion, the midwife's first responsibility is to the mother, and I feel certain that anoxia in the child would still occur even if the paediatric instruction to student midwives were doubled. I feel there should be two trained people in attendance at childbirth, the midwife to devote her attention solely to the mother and a new Health Service Personnel - the Special Paediatric Nurse (SPN). We have accepted family planning and we have the big problem of reducing mortality in the newborn and in the under fives. I submit that this problem is of such severity in developing countries, like Ghana, to warrant the creation of a new corps of nurses just for paediatrics.

After graduation in general nurse training, the SPN would spend two years in various departments of Paediatric Institutions and would be trained to work both in hospitals and the domiciliary field, having total responsibility for the child, from birth to adolescence. The SPN would thus make it possible for the specialist Paediatrician to concentrate on obscure problems whose solution would open up new ways of management. I am certain the midwife would gladly hand over the care of the newborn to a competent special Paediatric Nurse.

**By adopting the SPN Programme, babies whom we have so painstakingly spaced and planned for, and for whose arrival the midwife has been trained, would be given the excellent care that it is our duty, as Health Service Workers to provide for them.**

**ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA  
7th-15th December 1972.**

**Precis: THE ROLE OF THE MIDWIFE AS A FAMILY HEALTH WORKER**  
Paper given by Joana Samarasinghe, Senior Public Health Nurse  
Tutor, Ghana.

Because the maintenance of family health includes physical, mental, emotional and social well-being, all members of the health team are involved, including the non medical personnel such as social scientists and Welfare Officers.

The Midwife is esteemed and respected both socially and as a professional person and therefore, has a special and unique role to play in the Public Health Service. In maintaining her position, great demands are made on her and, she has a great deal to offer.

The Maternal and Child Health Service (MCH) is one of the most important branches of the Public Health and Social Services of any country, and the midwife, whose work is preventive in scope, is primarily a public health worker.

At a World Health Organisation Conference on Midwifery Education and Services in 1964, held in Moscow, a definition of the modern midwife was produced as follows:-  
The Midwife is:

"a person specially instructed and qualified to provide care for women during pregnancy, delivery and the post-natal period, and for the newly born infant. This care includes preventative measures, health education, the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the absence of medical help."

It was further stressed at this Conference that "economic and staff resources, the geographical and climatic conditions and the pattern of maternity services of a country and area in which the midwife works, and her work situation, whether domiciliary or institutional, are the main factors in determining whether midwifery is her sole function or whether this should be extended to other wider public health activities."

With the above in mind, let us now consider the midwife's role.

#### Maternal & Child Health and the Midwife

Whether a pregnancy is planned or unplanned, the midwife is usually the first professional person to be told about it. If she has given adequate emotional and professional support to the parents when they were faced with marital problems, and child bearing and rearing problems, it is to her they will turn for advice on family planning. In order to contribute as much as possible to the well-being of parents and families, the midwife must be able to give advice on the most up-to-date family planning methods and techniques.

#### The Prenatal Period

Whilst taking into account the socio-cultural factors, food habits and taboos in the area, it is at this period the midwife must assess and screen the health of the mother to be and keep her under close medical supervision. It is a great opportunity for the midwife to implement her role as a health teacher, and to recognise and treat any maternal ailments and institute protective measures. The importance of good nutrition in the maintenance of good health cannot be over emphasised in developing countries, and the midwife should

enlist the help of nutrition experts in order to improve poor health practices in the family and community. Nutritional education should be intensified during pregnancy and poor nutritional conditions should be identified and advice given on the correct diet.

Professional midwives and other members of the MCH team should establish cordial relationships with the traditional birth attendant (TBA) and give her the recognition which she deserves. This acknowledgement of the TBA, (whose work cannot cease abruptly) may yield overall better results in the MCH Service.

#### The Confinement

The efficient midwife will have recognised any abnormal or potentially abnormal conditions in the mother in the antenatal period, and they, together with "high risk" mothers will be referred for specialist care and supervision, as indeed will any deviation from the normal during the actual labour. This will reduce morbidity and mortality.

#### The Postnatal Period

Although this period is of equal importance with the others, it has been somewhat neglected owing to the shortage of doctors and ignorance on the part of the mothers. The midwife should keep mother and baby under close supervision in order to prevent infection and/or other postnatal complications. She should be trained to carry out postnatal examinations and to recognise any conditions which might later produce gynaecological complications. Every opportunity should be taken by the midwife for the health education of the mother and her family and the importance of postnatal examination should be stressed, and the mothers encouraged to take advantage of the available services.

#### The Midwife & Other Members of the Health Team

No health worker can work effectively in isolation. In order to co-ordinate the services, there must be full co-operation amongst all the team members if the patient and her family are to derive full benefit. The midwife must be in a position to identify situations in her practice which need referral to other members of the team and she should act upon this to draw on the advice of any of her colleagues. Results of the action would be assessed at the follow-up.

#### Recording and Reporting

Statistics are important and reflect the development of the health and social services of a country. The midwife must notify and keep accurate records of perinatal, neonatal and infant deaths and of maternal deaths. It is known that a high percentage of these are preventable. Records should also be kept of the numbers of pregnant women receiving prenatal care, "high risk" mothers referred to hospital and the number of deliveries. In addition, maternal and infant morbidity should be recorded.

#### Some Factors affecting Morbidity & Mortality during Infancy in Ghana

Prematurity, infection, poor environmental conditions, poor nutrition, local customs and beliefs, poor MCH services, lack of trained personnel, ignorance and the standard of practice of the traditional birth attendant.

#### Health Education

The aim of this should be the improvement of factors adversely affecting infant and maternal morbidity and mortality and the health of the whole family. To do this the

midwife must co-operate with other members of the health team. Much can be achieved by skilled nursing care and by the midwife's own example and practice. Simple language should be used to ensure patient co-operation. She should observe physical and emotional situations accurately and take action to remedy them if necessary.

The auxiliary is not a substitute for the professional midwife, but she is an important complement to the MCH team. The professional midwife should assist in the training of such personnel, to equip them to perform specific assigned duties in order that the midwife may use her professional skills to best advantage.

The midwife has many roles to play - her success depends on her training, competence and proficiency, and also on socio-economic development and health legislation of the country.

### Conclusion

In Ghana, and in fact in Africa, women hold important positions in the family and community and contribute to the economy. The health and happiness of the baby, husband and the family depend on the care given by the mother. The midwife should see that the child-bearing women maintain good health and promote the health of the extended family, by giving due recognition to the health and social factors which affect midwifery practice in particular.

**ANGLOPHONE WEST AFRICAN WORKING PARTY**  
8th-16th December 1972

Precis of Paper given by Mrs. P. Acolatse (Ghana) on:

**"The Training and Practice of the Professional Midwife in Ghana"**

About 80 per cent of the 9,000,000 population of Ghana live in rural areas. There are 1,730 professional midwives in the country, working in 279 Maternal and Child Health (MCH) clinics with about 1,470 maternity beds. If every mother had the services of a midwife during childbirth, it has been estimated that midwives in urban areas would conduct four deliveries daily and those in rural areas 30. Prior to the Nurses and Midwives Decree 1972, according to the law any person registered by the Nurses and Midwives Council, formerly the Midwives Board, is entitled to practise as a midwife. Since the decree, there is no provision for auxiliary midwives or traditional birth attendants (T.B.A.), who probably were previously enrolled on the official list of Unqualified Midwives under the old Midwives Ordinance.

Auxiliary nurses are legally recognised but not auxiliary midwives. Because of the paucity of professional midwives legal recognition ought to be given to the T.B.A. and all qualified nurses enrolled as auxiliary midwives.

The Nurses and Midwives Council is the only legally constituted body responsible for the training and education of midwives and for the maintenance and promotion of standards of professional conduct and efficiency. It is also responsible for the approval of training institutions, registration, system of training and instruction, selection of students for admission to training schools, setting and conducting the examination. The problem of the adequacy of the midwifery services in Ghana does not appear to be covered specifically in the functions of the Council.

The Council consists of eleven registered nurses and five registered midwives (elected by their nurse and midwife colleagues), three medical practitioners appointed by the Ghana Medical Association, one hospital administrator and one other person presumably from the field of education. If the nurse members are also midwives, then there would be sixteen midwife members of Council from a total of 21. In the early 1930's the Midwives Board had five medical practitioner members and only one midwife.

Now there is no legal training or practice of midwifery without Government approval in consultation with the Nurses and Midwives Council. The Council has stipulated that all midwifery training schools must have a minimum student intake of fifteen; the school must be a Maternity Hospital or Unit of a general hospital with a minimum of 50 beds and a capacity for 300 deliveries annually and lecture rooms and equipment must receive the sanction of the Council.

There are four Government Midwifery Training Schools and five run by Private Organisations. Two of the Government Schools (in Accra and Koforidua) are for State Registered Nurses (SRN) and Qualified Registered Nurses (QRN) only but students with no previous nurse training may have midwifery training at all the other schools. A midwifery qualification is a pre-requisite for Public Health Nurse Training and therefore the midwifery training for nurses is in great demand.

Midwifery training in Ghana is single period as follows:

12 months for S.R.N.'s

18 months for Q.R.N.'s

24 months for Enrolled Nurses

and 30 months for students with no previous nursing training.

Perhaps consideration should be given to splitting the training into two parts to enable all nurses to take first part training and then be registered as Auxiliary Midwives. Only nurses who are subsequently to practise midwifery need take the second part. At the moment there is considerable wastage as the majority of nurse-midwives do not practise midwifery.

Recruits to midwifery training come from Government and non-Government Hospitals and from school-leavers through the Ministry of Health Recruitment Office, these latter having to pass an entrance examination conducted on behalf of the Nurses and Midwives Council by the West African Examinations Council.

During the period 1969-1971, three Government institutions produced an average of 244 midwives annually compared with 140 annually from 1964-1968 inclusive. During the same two periods, five mission hospitals produced 38 and 30 annually, respectively.

In 1971, there were 3,461 midwives on the Roll. The midwifery training curriculum includes Anatomy and Physiology of the Pelvis and Female Genital Tract; normal and abnormal pregnancy, normal and abnormal labour; normal and abnormal puerperium; paediatrics; legislation; family planning and contraceptive techniques. Responsibility for teaching is shared by qualified Midwifery Tutors, Public Health Tutors, Obstetricians and Paediatricians. Practical experience is gained in hospitals and maternity homes and each student must herself conduct a specified number of deliveries. The tutors give periodic class tests and there are house tests at six monthly intervals. The final State Examinations are held biennially in May and November and candidates may take the examination on three occasions. If a student fails to satisfy an examiner after her third attempt, she is discouraged from becoming a midwife.

Consideration should be given to the establishment of a training school for physiotherapists and the inclusion of obstetric physiotherapy training in the interests of maternal and child care.

Besides training professional personnel, the women and general public of Ghana must be educated in maternal and child care through experts at middle schools, secondary schools, vocational institutions and universities and through mass education programmes. Intensive training of mass-education staff in maternal and child care should improve the situation.

Periodic post-certificate seminars and courses are the best means of broadening the perspective of the midwife in health problems of the mother. The distribution of maternal and child care services at Government Hospitals, Urban Health Centres, Rural Health Posts, Private Hospitals and Maternity Homes is determined by the density of the population and other facilities available.

Fundamentally, midwifery practice at district and regional level in Ghana is the same as in developed countries. Ante-natal clinics are enthusiastically attended and mothercraft talks and other health education activities very much appreciated. The general health of the expectant mother is checked and her medical, surgical, obstetrical and family histories are taken. Blood is taken for Grouping, Sickling, Haemoglobin estimation and Kahn Test. Unless otherwise indicated, she is examined at monthly intervals up to 28 weeks gestation, at fortnightly intervals up to 36 weeks gestation, and then at weekly intervals until the baby is born.

Most of the ante-natal care and deliveries is the responsibility of professional midwives who refer complicated cases to doctors at district and regional hospitals. Because of the shortage of staff and beds in institutions and the resultant heavy work load, patients are sent home 12 to 24 hours after delivery after being shown how to care for themselves and their babies and they are referred to the nearest clinic for cord dressing for the baby's cord, puerperal care and in case of trouble.

The patient attends two post-natal clinics, the first 14 days after delivery and the second six weeks after. The doctor makes a general examination of the patient and particular notice is taken of her abdominal wall, lochia, perineum, cervix, vagina, uterus and appendages and whether or not she is anaemic. The midwife examines the urine for albumin, takes the mother's blood pressure and examines the baby and gives advice on feeding problems. Should any abnormalities be found in the mother, arrangements are made for her admission to hospital. The baby is referred to the Public Health Nurse at the Child Welfare Clinic.

In Private Hospitals and Maternity Homes, the patient stays four or five days by which time the baby's umbilical cord has dropped off. She is given domiciliary puerperal care until the seventh day, and attends her first post-natal clinic on the fourteenth day.

The administration of drugs by professional midwives in hospital is under the supervision of the doctor. Pethidine and other pain relieving drugs are prescribed and trilene or penthrane are used for selected cases. In Maternity Homes, the professional midwife is permitted to use aperients; antiseptic lotions; methylated spirit; ergometrine; and cord powder. In complicated cases where other drugs are required she must call medical aid or refer the patient to hospital. In Private Practice, Health Centres and Health Posts, the Ghanaian midwife uses potassium bromide with or without chloral hydrate for relief of pain in labour.

By subsidising maternity homes so that fees are the same as in hospital, pressure on them would be relieved.

There is a continuing change of concept of midwifery practice so that the midwife is now more involved with the total health and education of mothers and probably fathers in the spacing of their family. Her knowledge should include home economics, psychology, religion and the economic conditions of the country.

ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA  
7th-15th December 1972.

Precis: THE TRAINING & PRACTICE OF THE AUXILIARY MIDWIFE IN SIERRA LEONE  
Paper given by Mrs. K. G. A. Betts, Sierra Leone.

There has been auxiliary midwifery training in Sierra Leone since 1940, when it was introduced at the instigation of Sir Milton Margai. On qualifying as a doctor, he returned to his native land to serve his own people. He worked in the Southern province and gained the confidence of the people and the paramount chiefs and other traditional rulers, through whom he was able to recruit suitable candidates for training.

The women, recruited from villages, were of high social standing and influential in their community and were trained on the clear understanding that when they qualified, they must return to their respective villages to serve their people. They were paid by native administration.

Because many of the women at this time were illiterate, their training and scope of practice was limited. Sir Milton wrote a midwifery catechism which was taught in the Mende vernacular and he was assisted by professional midwives who could read the vernacular. The 12 months training was very basic emphasis being laid on antenatal care, safe and aseptic delivery, recognition of abnormal conditions and referral of these to skilled care, maintenance and care of equipment and instruments. Students learned mainly by rote and by repeated practical instructions and demonstrations, followed by practice in the wards, and in the patients' own homes.

Originally there were three training centres, at Bo, Moyamba and Makeni, but when Sir Milton was Minister of Health in the 1950's, provincial doctors were encouraged to extend the training throughout the country.

All students were assessed practically at one centre and those who were successful were put on a register of Village Maternity Assistants (VMA) and issued with a certificate. In 1956, the VMA's were issued with UNICEF kits for use in the villages where they worked mainly in domiciliary midwifery. The kits are inspected each month. The VMAs are permitted to carry a specified antiseptic solution, iron tablets and ergometrine tablets. They must attend a statutory refresher course once in three years. Record keeping presented problems because most of the VMAs were illiterate. Native Administration clerks and relatives who were literate kept some records from information supplied by the VMA, but this was far from satisfactory.

It was realised that because the Health Service was far from ideal, the use of auxiliary midwives would be necessary for a considerable time, particularly in the rural areas. In the 1960's, a more appropriate scheme of auxiliary training was planned. Until there are sufficient professional midwives, it is better to have personnel with some training, than to leave deliveries and child care in the hands of the totally untrained.

The VMA training was superseded by the Maternal and Child Health (MCH) Aide Programme in April 1970. This is scheduled to provide every village with a MCH aide. Trainees must be female and between 25 and 40 years, have had at least seven years of primary schooling and be literate in English, the official language of the country, to enable them to keep accurate records. Training takes 18 months and includes basic nursing, child care and community health in addition to midwifery.

## Definition

A MCH Aide is "a female person who has trained for a period of 18 months in an officially recognised programme under the direction and supervision of a midwifery sister and a health sister in maternal and child health activities of a normal nature, but is able to detect the abnormal and potentially abnormal and direct such patients to the nearest hospital for medical aid."

In helping to provide a midwifery service, particularly at village level, in Sierra Leone, the MCH Aide also helps in health education, especially in matters of hygiene and nutrition in the family unit.

The appropriate public officials and health personnel are notified three months prior to the commencement of a training course and advertisements are inserted in the national press and radio announcements are made for a period of one month. Recruits are selected by interviews, conducted by a panel consisting of a midwifery sister, health sister and midwifery tutor. Special consideration is given to those sponsored by their local authority.

There are four training centres, one in each of the four provinces, each taking 12 trainees. The tutors to the course are one midwifery sister and one health sister at each centre. They are provided with a teacher's handbook in order to keep uniformity of teaching. During the 18 months' course, students have a weekly study day (6 hours), and the training is divided as follows:-

a) Introductory course	six weeks
b) 1st Phase Midwifery Training	12 weeks
c) Child Health Training	12 weeks
d) Communal Health Training	six weeks
e) 2nd Phase Midwifery Training	26 weeks
f) Child Health & Paediatric Nursing training	eight weeks
g) Revision and Evaluation	four weeks
h) Assessment	one week
i) Holiday	three weeks

On successful completion of training, the MCH Aide is enrolled, pays a small fee for her name to be entered in the register of auxiliary midwives and the Sierra Leone Midwives Board issues her certificate, bearing her passport sized photograph. This is her official licence to practise.

The training syllabus includes, personal hygiene and cleanliness, basic nursing, elementary first aid, deportment and ethics, human relationships, hygiene and the prevention of infection, simple anatomy and physiology with special reference to the female reproductive system and normal midwifery. There are no text books, but students are encouraged to take notes, which are scrutinised regularly. During the first phase midwifery training emphasis is laid on antenatal care and the detection of abnormal conditions in this period, care of the abnormal antenatal patient in hospital and treatment of complications. Four weeks are spent in observation of admission and care of labouring women, witnessing 20 normal deliveries and personally conducting the delivery of five mothers of their babies. The importance of keeping accurate records is stressed.

During the second phase of midwifery training, further practical knowledge of normal midwifery in hospital and in domiciliary practice is increased, including the physiology and management of labour, the care of the newborn baby and mother in the puerperium.

She gains more experience in antenatal clinics and spends one month in a health centre from where she goes out to domiciliary practice under the supervision of a midwife. She is required to make 50 antenatal palpations of the abdomen, witness 20 deliveries, personally conduct 20 deliveries (five of which must be in domiciliary practice) and care for 20 mothers and their babies in the puerperium.

Apart from the actual midwifery content of her training, the MCH Aide gains experience in child health care, especially in nutritional deficiency diseases, injections, the value of immunisation, the emergency treatment of convulsions and the importance of the weight chart. She has practical experience for two weeks in the paediatric ward of a training centre and instruction in the follow-up care of children discharged from hospital, especially those with nutritional problems. She also has some training in communal health. She is introduced to the roles of other community health personnel, social welfare workers and health inspectors in order to be able to co-operate with them on completion of her training. During this period she is taught the methods of disposal of refuse and faeces, the care of the compound, water supplies and family nutrition, etc.

The aim of the final practical assessment is to inspect the Aide's records of her practical experience and to determine whether it is safe to allow her to work at village level and making sure that she realises her own limitations.

Following qualification, the MCH Aide spends three months either at a Health Centre under the supervision of a midwife or attached to an experienced MCH Aide, for further domiciliary experience and adjustment. After this she returns to her village, to accommodations provided by native administration or rural area council, which has been inspected and approved by the MCH Aide Supervisor.

Some chiefdoms have built small health posts attached to the Aide's self-contained residence. These comprise a clinic area, a labour ward and a post-natal ward of six or eight beds. Where these exist, deliveries are conducted in the health post and after 24 hours are nursed in their own homes for a period of seven days or until the baby's cord is off. After two weeks the baby is referred to the under fives clinic.

Her practice embraces full care of her patients during the whole of the maternity cycle, but all abnormal or complicated cases must be referred to the nearest health centre or hospital immediately. She advises mothers on family nutrition, hygiene and cleanliness of her surroundings. She may give emergency or first aid treatment and clean and dress simple cuts. Her salary is paid by Central Government and therefore although it is usual for the MCH Aide to practise in her own village, she can in fact be transferred anywhere.

At regular monthly intervals, the Aide's UNICEF KIT is inspected at the nearest health centre or hospital when she replenishes her stock of supplies, dressings and drugs. The level of her performance is under constant review and her problems are discussed with a Health Sister or MCH Aide Supervisor, who inspects the Aide's Health Post, equipment and records at intervals and without previous notification of their visit.

The main problems in this service are transport difficulties for emergencies particularly at night, poor communication because of lack of telephone links between towns and villages and an inadequate supply of drugs. Teachers in provincial centres combine teaching and supervision with ward duties to the detriment of the teaching.

It is gratifying that many chiefdoms have embarked on self help programmes. The Government provides the Aide, but the chiefdoms through special taxation provide and equip the Aide's post.

The State Enrolled Multipurpose Nurse is yet another grade of auxiliary midwife, who has had two years general nursing and six months midwifery training. These personnel act as midwives in areas where there are not sufficient professional midwives.

The training of the non-nurse professional midwife was discontinued on the advice of a WHO representative in 1965, but this led to a grave shortage of professional midwives and gave rise to great concern.

A scheme for professional midwifery training has been drawn up by a sub-committee appointed by the Sierra Leone Midwives Board and has been submitted to the Minister of Health.

**ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA  
8th-16th December 1972.**

**THE TRAINING AND PRACTICE OF THE TRADITIONAL BIRTH ATTENDANT  
Precis of Paper given by Mrs. Beatrice Barmadia (Liberia)**

There are three schools in Liberia giving midwifery training to Traditional Birth Attendants (TBA). One school in Montserrado County has trained 123, one in Bong County 29 and the third in Grand Gedeh County, 25. The average output from the three schools is 60. Prior to the introduction of a national training programme for TBA's, 110 had been trained by a nurse-midwife, (Mrs. Jermina Raily), in Nimba County.

The first course of training for 'empirical midwives' was started in 1950 when Public Health was focussed on reducing maternal and infant mortality in rural areas. The course was of 12 months duration and recruits were selected women who had had considerable practical experience in the delivering of babies in their communities. On evaluation, it was decided that the practical experience gained in their three months in hospital as aides was inadequate and following discussion it was decided that by altering the emphasis, the course could be reduced to four months.

The present training is divided into six weeks theoretical and ten weeks practical instruction. Theoretical instruction is given in two weekly study periods each of four hours duration for a total of 12 sessions and includes lectures, discussions, demonstrations and class room practice. The subjects include 'Personal Hygiene, Anatomy, Fetal Development, Midwife's bag and supplies, the prenatal period, soap enema, types of mother to deliver, delivery call, normal labour and home delivery, care of the newborn, aftercare of the mother, normal puerperium and post-partum complications, care of the premature baby and the birth certificate.'

Practical instruction is given in three weekly periods each of four hours duration for a total of 30 sessions. The TBA student spends four hours daily on three days a week in the Out-Patient Department of the Maternity Centre where she makes 75-100 abdominal palpations in prenatal clinics and attends postnatal clinics. She spends four hours (from noon to four), twice weekly for two weeks in the delivery room where she must conduct 12 to 14 normal deliveries under supervision. From four to eight p.m. twice weekly for two weeks she spends in the newborn nursery caring for 75-100 babies, sometimes premature and assisting mothers with breast feeding. A further two weeks are spent in the prenatal and Well Children Clinic of the Public Health Clinics. She is given one four hour session in family planning where instruction is given verbally, if necessary in the native language. The use of films has stimulated learning.

Evaluation of the student's performance is continuous throughout the training in all departments and her progress is assessed by her instructors every two weeks during her practical training period. Each student keeps an experience record which shows whether she has received the requisite minimum experience. Final evaluation is by the Director of the Maternal and Child Health Division. Having successfully completed the course to the satisfaction of the professional personnel concerned, each student receives a certificate and a complete midwifery kit. Her licence to practise must be renewed annually through the Liberian Midwives Council. There is no upper age limit for the practice of midwifery by TBAs - only their inability to work stops them. They must:-

- 1) Register ALL births whether live or still
- 2) use prophylactic penicillin eye ointment
- 3) care for mother and baby for 14 days.

In Monrovia, the practice of the empirical midwife is supervised by the course tutor but in other areas by Government employed professional midwives. Regular monthly supervisory visits are made to the TBAs home to check the domestic environment, equipment and supplies, the types of mothers delivered and the case book. There is further inspection of kits, equipment, supplies and case books at the annual workshop at which the whole group meets to discuss a particular phase of maternity care. At this meeting all statistics are collected.

Government employed TBAs receive a salary of about 40 Dollars monthly, but the majority are self-employed and are permitted to charge a maximum fee of five Dollars per patient.

This category of midwife plays an important role in the maternal and child health service. They live in the same community and therefore are able to influence their patients. They see more patients antenatally and refer them to the clinics run by professional midwives for checking prior to delivery. All instances of communicable diseases are reported to the professional midwife. Working thus in co-operation, many abnormalities and complications can be prevented.

**ANGLOPHONE WEST AFRICAN WORKING PARTY HELD IN ACCRA, GHANA  
8th-16th December 1972.**

**Message sent by Mrs. Hermina Ayikpa, President of the Midwives Association  
of Ghana, 10th December 1972.**

Mrs. Ayikpa said she had been impressed with the material provided by the speakers so far and referred to the difficulties she had experienced in 1935 when she first went to work in the Eastern region of Ghana, at Manya and Yilo Krobo. She said she had made an impression on the villagers by her practice and example so that they quickly turned to her for consultation and care and abnegated the old customs and crude methods associated with childbirth. During the five years she had worked in the region the staff of the Krobo Girls Boarding School had come to her for advice and to discuss the midwifery profession. When she left the region, she was replaced by a native of Manya Krobo, who was a trained midwife and was joined later by others.

She suggested that governments should open more midwifery training schools to train girls who have completed elementary education in order to fill the many vacancies in villages and rural areas, where advanced methods were lacking.

Mrs. Ayikpa then thanked the Governments of many African countries who had introduced family planning services to the countries and she promised that in spite of some difficulties, which were sure to arise, the midwives would render all possible assistance in the education of men and women to accept family planning.

Finally, on behalf of the Ghana Registered Midwives Association she welcomed the visitors who through mutual love of their profession and interest in the Welfare of mankind and respect for each other, were gathered in Ghana, to make the Working Party such a success. She offered them all heartfelt congratulations and commended them to the Almighty, to conduct them safely back to their own countries and homes.