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THE INTERNATIONAL CONFEDERATION OF MIDWIVES

Report
of the
CARIBBEAN WORKING PARTY

Bridgetown, Barbados

16th MAY - 24th MAY 1974

USAID Grant Number CSD 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. 476).

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 methods of fertility control 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 mothers, babies and the family, 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 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 help couples and individuals to acquire 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 health team and as such has considerable influence, whether she works in urban or rural areas.

BACKGROUND - AIM - 1

The Joint Study Group of the International Confederation of Midwives/International Federation of Gynaecology and Obstetrics (ICM/FIGO) held an eight day Working Party from 16th - 24th May, 1974 for senior midwives and obstetricians from the islands and territories of the Caribbean. This was the fifth of a series of such Working Parties being held around the world in order to assist nations in the formation of plans to achieve the ICM/FIGO Aim:

"To continue the improvement of Maternal and Child Care and the quality of Maternal and Child Life through the inclusion of family planning among the services provided by midwives of all categories in their expanding role".

The Caribbean Working Party was attended by representatives from the following countries:

Barbados, Belize, Dominica, Guyana, Haiti, Jamaica, Trinidad and Tobago.

Through the generosity of the International Planned Parenthood Federation (IPPF), representatives from the following territories were also able to participate:

Antigua, Grenada, French Guyana, Monteserrat, St. Kitts-Nevis, St. Lucia and St. Vincent.

Also in attendance were consultants, observers and guests from:

Jamaica Paediatric Association, University of Barbados, Downstate Medical Centre, New York Family Planning International Assistance, Pan American Health Organisation, Agency for International Development and ICM staff.

A Barbados Local Committee was set up under the chairmanship of Mrs. Perlita Hinds.

Approximately two months prior to the Working Party visits were made to the islands and Belize by Miss Barbara Patterson, the Regional Field Director accompanied in most instances by Miss Kate Lorig, Professional Co-ordinator ICM. The purpose of these visits was to explain the purpose of the Working Party and to solicit official support and attendance.

OBJECTIVES - 2

In order to identify common problems and possible solutions the following procedures were followed:

1. The exchange of ideas and information on:

   a. The present situation of maternal and child health services in their countries.

   b. The practice and training of all categories of midwives.

   c. The place of family planning in maternal and child health programmes.

   d. The training of all categories of midwives in family planning and their participation in family planning programmes.

2. Definition of the priorities for maternal and child health/family planning services for the Working Party countries.

3. Consideration of the legislative framework necessary for maternal and child health/family planning services.

4. Consideration of future plans and suggested actions of implementing the Working Party recommendations.

THE WORKING PARTY - 3

The Working Party was opened by Mrs. Gertrude Eastmond, the Parliamentary Secretary for Health in Barbados. She stressed the important role of the participants in Family Planning services and set an excellent standard for the rest of the week.

Dr. I. Gogan, PAHO Medical Officer in Barbados then presented the Key Note address. He reviewed the background of the Ministers' of Health Ten Year Plan for the Americas, written in 1972 and spoke specifically about the Ministers' recommendations for Maternal and Child Health and population. He further outlined ways in which midwives and obstetricians could participate in fulfilling the objectives of the plan.

Another important speaker was Dr. G.T. Cummins, Medical Director of the International Planned Parenthood Federation, Western Hemisphere who emphasised the priorities for Maternal and Child Health/Family Planning in the Caribbean.

During their eight days of deliberations the delegates heard several other papers on various topics in the Maternal and Child Health/Family Planning field. These were followed by discussions and a final adoption of recommendations for the Caribbean.

Several themes emerged during the discussions. First, education plays a vital part in Maternal and Chile Health/Family Planning. It was generally felt that family life education should be incorporated in all education programmes in a country.

Secondly, a strong emphasis was placed on education for all midwives. It was felt that if midwives were to assume expanded roles in family planning, nutrition, child care, and management services, the basic curriculum must be expanded to include these topics and also it could be necessary to have extensive in-service programmes for practising midwives.

A third strong theme dealt with the status of midwives. The majority of participants felt that the fully trained midwive and nurse-midwife should have the same status, salary and opportunities for promotion. A minority of the participants felt that there should be a differentiation between these two groups.

A unifying theme of the conference was the need for midwives to promote family planning actively. This was highlighted by Dr. Willard Boynton, Deputy Director of the Population Office of the Agency of International Development. Mrs. Thelma Grant, Clinical Co-ordinator and instructor from Downstate Medical Centre, added emphasis to this theme in her discussion of the Downstate family planning training programme for midwives.

Everyone at the Working Party agreed that family planning was necessary for improved family health. Most participants also recognised the need for family planning as a means of preserving the limited resources and quality of life in the Caribbean.

The general format for this Working Party attended by about 30 obstetricians, paediatricians and midwives was to have delegates and guest speakers present papers giving background information directed at one or more of the objectives. To allow for increased opportunity for delegates to participate the group was divided into three to discuss the various topics and form conclusions. Following the discussions, the rapporteurs and chairmen of the groups met to draw up resolutions and recommendations. These were then presented to all the delegates for their amendments and approval.

CONSENSUS REPORTS ON THE FOUR MAIN TOPICS FOR DISCUSSION - 4

1. PRIORITIES OF MATERNAL AND CHILD HEALTH IN THE CARIBBEAN

EDUCATION. Family life education including nutrition, breast feeding, sex education and family planning.

a. Primary and Secondary Schools.

b. Social Groups - Youth Clubs, Guides, Scouts, Sea Cadets.

c. Professional Groups - Medical, Nursing, Teachers.

d. Military, Para-military and Police.

e. Expectant parents.

f. Government Social Agencies.

CHILD CARE

a. Prevention and treatment of malnutrition:-

(1) Breast Feeding.

(2) Use of indigenous feeds.

(3) Knowledge of foods.

(4) Balanced diet.

b. Prevention of gastro-enteritis and infection of the newborn.

c. Family Planning - Child spacing with special emphasis on high risk mothers.

d. Maintenance of Statistics.

e. Immunization.

THE IDENTIFICATION, TRAINING AND UTILIZATION OF ALL AVAILABLE MANPOWER FOR MATERNAL AND CHILD HEALTH

More use of:

a. Influential community members.

b. Specially trained community health aids such as St. Vincent and Jamaica.

c. Traditional Birth Attendants.

d. Professional Midwives and Doctors.

IMPROVED COMMUNICATION AT ALL LEVELS

a. Professional to patient and vice versa.

b. Professional to professional.

c. Involvement of all grades in decision making.

IMPROVEMENT OF INTRAPARTUM CARE (in labour and immediately after delivery.

THE NEED TO HAVE TRAINING AND FACILITIES FOR RESUSCITATION AND MANAGEMENT OF PREMATURE BABIES

IMPROVED MANAGERIAL SKILLS IN RUNNING DELIVERY SUITES

TO REVIEW SCHEDULES OF ANTENATAL CLINICS WITH THE VIEW OF ELIMINATING UNNECESSARY VISITS

Hours of clinics should be reviewed to accommodate both working and non-working mothers.

2. THE EXPANDED ROLES AND FUNCTIONS OF ALL CATEGORIES OF MIDWIVES

Assuming that the midwifery curriculum and in-service education includes MCH, Family Planning, Family Life Education, Nutrition, Child Care, Care of the Non Pregnant Woman, the roles and functions should be as follows:

CATEGORIES	MATERNAL CHILD HEALTH	FAMILY PLANNING	FAMILY LIFE EDUCATION
Nurse Midwife Midwife	Planning Programming Implementing Evaluating Training and Supervision	1. Educator Motivator Case Finder 2. Provider & dispenser of all contraceptive services. 3. Follow up in order to detect problems and keep supplies. 4. Co-ordinator of family planning team (managerial skills) 5. Referral Service for all health problems.	Interpersonal/Intra-family. Health and Hygine. Sex eduation (generic). Contraception Nutrition
Auxiliary Midwife	Implementing depending on training received.	Up to the level of her training: 1. Educator, Motivator, and Case Finder.	Up to the level of her training.

CATEGORIES	MATERNAL CHILD HEALTH	FAMILY PLANNING	FAMILY LIFE EDUCATION
Auxiliary Midwife		2. Distributor of pills, condoms and conventional methods. 3. Referral.	
Traditional Birth Attendant	Implementing	Up to the level of her training: 1. Educator, Motivator, and Case Finder. 2. Distributor of pills, condoms and conventional methods. 3. Referral.	Can be useful depending upon her personal qualities.

CATEGORIES	NUTRITION	CHILD CARE	CARE OF THE NON PREGNANT WOMAN
Nurse Midwife Midwife	Teach Demonstrate Follow-up care: especially pregnant women and puerperal women in breast feeding.	1. Notification & Registration of birth. 2. Care of the newborn, Weaning. 3. Advise, demonstrate, follow up on nutrition in homes, schools, clinics. 4. Referral and follow-up to immunization programme. 5. Advise and recommend in the care of the under-privileged child. 6. Knowledge of available services and planning of all child care services.	PRE-PREGNANCY Advise on family life education, family planning and nutrition and the expanding role of women. IMMEDIATELY POST PREGNANCY Continuing health education. INTERPREGNANCIES Continuing education - using formal and informal opportunities. INFERTILE WOMEN Advise with referral to appropriate agencies. POST MENOPAUSAL General health advise.

CATEGORIES	NUTRITION	CHILD CARE	CARE OF THE NON PREGNANT WOMAN
Auxiliary Midwife	Useful in every way depending on training.	Depending on training	Depending on training.
Traditional Birth Attendant	Can be useful depending upon her personal qualities.	Could be utilised in: 1. Notification & Registration of birth. 2. Care of the newborn, weaning. 3. Advise, demonstrate, follow-up on nutrition in homes, schools, clinics. 4. Referral and follow-up immunization programme.	

3. CURRICULUM CONTENT FOR TRAINING ALL CATEGORIES OF MIDWIVES FOR THEIR EXPANDED ROLES

TRADITIONAL BIRTH ATTENDANTS

They should be instructed in:

a. Family Planning

(1) Methods of communication.

(2) History of contraception.

(3) Methods of contraception.

(4) Side effects of contraceptives.

(5) Knowledge of referral agencies.

b. Child Care

(1) Nofication of Births and Deaths.

(2) Detection of abnormalities in newborn.

(3) Resuscitation of the newborn:

(a) Disposable mucus extractor.

(b) Mouth to mouth.

(4) Knowledge of immunizations.

(5) Safety measures and prevention of home accidents.

(6) Methods of recording and reporting information.

c. Nutrition

(1) Knowledge of use of local foods, preparation/combinations/tasting.

(2) Reinforce breast feeding.

PROFESSIONAL MIDWIFE - BASIC TRAINING

The following should be added to the basic curriculum if it is not already included:

a. Family Planning

(1) History of contraception.

(2) Methods of contraception:

(a) Traditional.

(b) Modern.

(3) Side effects and complications of contraception.

(4) Theory and clinical practice:

(a) Antenatal and postnatal clinics.

(b) IUD and Diaphram insertion.

(5) Communication - interviewing - counselling of the entire family.

(6) Sexuality:

(a) Anatomy.

(b) Physiology.

(c) Function.

(d) Responses:

i. Physical.

ii. Psychological.

(7) Demography.

(8) Genetics.

(9) Family Economics.

(10) Infertility.

(11) Problems of teenage pregnancy and high parity.

b. Child Care

Teach the importance of:

(1) Normal growth and development of the embryo and foetus.

(2) All aspects of prenatal examinations including:

(a) Serology.

(b) Haemoglobin.

(c) Blood Grouping (ABO/RH).

(d) Sickling.

(e) Urine.

(f) Clinical examinations for tubella.

(g) Cervical and urethral swab.

(3) Nutrition of pregnant woman - emphasis on preparation for breast feeding.

(4) Resuscitation of newborn including intubation care of the umbilicus.

(5) Examination and recognition of abnormalities in the newborn.

(6) Growth and development:

(a) Physical)
) noting progress
(b) Mental)
)
(c) Emotional)

(7) Comprehensive immunization programme.

(8) Weaning and the establishment of independent feeding.

(9) Continued nutrition of the mother.

(10) Preventive aspects of common childhood disorders:

(a) Malnutrition.

(b) Gastroenteritis.

(c) Helminthiasis.

(d) Skin infections.

(e) Detection of allergic disorders.

(11) Notification and registration of births and deaths.

(12) Care of handicapped and retarded children and their families including information on referral.

(13) Safety measures and the prevention of accidents. (Home visits should consider the whole family).

c. Nutrition

(1) Introduction of basic principles.

(2) Food - cost, value, and content of local foods.

(3) Composition and structure of foods.

(4) Menu planning.

(5) Understanding of balanced diet.

(6) Dietary factors for various age groups - metabolism and calorie content.

(7) Malnutrition.

(8) Allergies.

(9) Infant feeding:

(a) Breast Feeding.

(b) Supplementary feeding when necessary.

(10) Nutrition in illness:

(a) Child.

(b) Adult.

(11) Handling and preparation of food.

(12) Technique of teaching nutrition.

(13) Protection of food from contamination.

(14) Disposal of waste.

PROFESSIONAL MIDWIFE - POST BASIC TRAINING

The content is the same as in the basic programme; objectives are as follows:

a. Family Planning

The midwife will be able to advise on the control of human fertility and provide Family Planning services in order to:

(1) Improve the health of the population.

(2) Protect the environment.

Child Care

(1) The midwife will have knowledge of the normal healthy infant and its development into a healthy child.

(2) The midwife will know and carry out services for recording/and reporting births and deaths.

(3) The midwife will have knowledge of community facilities for children.

(4) The midwife will function to improve the quality of life for all children in the community in order to lower the incidence of child morbidity and mortality.

c. Nutrition

(1) The midwife will have correct concepts of a balanced diet and be able to impart them meaningfully.

(2) The midwife will be able to teach and demonstrate the use of locally available foods.

d. Family Life Education

(1) The midwife will be able to prepare individuals for responsible parenthood.

(2) The midwife will understand and encourage harmonious relationships within the family.

4. IDEAL MATERNAL AND CHILD HEALTH/FAMILY PLANNING PROGRAMME FOR A CARIBBEAN COUNTRY

OBJECTIVES

a. To promote the improvement of maternal and child care in order to achieve optimum health for the entire family.

b. To provide a programme for the training of personnel to enable them to give good quality care.

The ideal Maternal and Child Health/Family Planning (MCH/FP) Programme should start before pregnancy with family life education, in order to secure and inform target population. This should help to avoid too early pregnancy and ensure adequate management whenever pregnancy does occur. The future mother would therefore be well nourished and would attend prenatal services early in pregnancy. The incidence and the complications of social diseases would also be reduced. Another result would be to encourage a responsible and co-operative attitude amongst the future fathers - thereby leading to responsible parenthood at all stages.

EDUCATION PROGRAMME

Planned curriculum for schools which will include:

a. Health Education.

b. Sex Education.

c. Family Life.

Education of expectant parents in the following:

a. Personal hygiene.

b. Nutrition.

c. Breast care and feeding.

d. Weaning.

e. Family Planning.

f. Preparation for labour and confinement.

g. Recognition of abnormalities.

h. Benefit.

PRENATAL CARE PROGRAMME

Prenatal services should be designed to encourage regular attendances. They should be flexible enough to take account of all the circumstances of the mother's life. Screening should include:

a. Blood investigations such as Haemmoglobin, VDRL and Group, investigation for sickling etc. Random blood sugar should be done in the presence of glycosuria.

b. Complete physical examination including a review of breast anatomy.

c. A thorough family, medical, surgical, obstetric and social history.

d. Routine urinalysis.

e. Routine inspection of the vulva and a vaginal swab/smear, where indicated.

f. Blood Pressure, weight, height should be recorded.

The process of communication and education should go forward and rapport is therefore established. This may be supplemented by informative pamphlets which may have to be the main means of communication and education.

The patient is then screened for risk and allocated to the appropriate available programme for antenatal care and delivery.

HIGH RISK PATIENTS

These include:

a. Primigravidae at the extremes of the child-bearing period.

b. Parity greater than five.

c. Multiple pregnancy.

d. Previous Ceasarean section or a history of previous gynaecologic surgery.

e. Bad obstetric history:

(1) Habitual abortion.

(2) Stillborn or perinatal death.

f. Medical complications of pregnancy including diseases of the central nervous system and psychological disorders.

g. Previous history of hypertensive complications of pregnancy including pre-eclampsia.

h. A primigravid breech or any form of unstable lie of presentation.

i. Previous obstetric haemorrhage and complications of the third stage.

j. The syndrome of prediabetes.

k. Any suspicion of foetal abnormality.

PREPARATION FOR DELIVERY

The patient should be instructed in:

a. Nutrition including dental hygiene.

b. Preparation for breast feeding.

c. Parentcraft.

d. Relaxation and exercises which profitably may include the father.

d. The phenomena and sensations of the actual delivery. For domiciliary delivery, preparations will include visits of the health team to the home to assess and become acquainted with the home and the family.

f. All antenatal patients should have care by midwife, obstetrician, physician and social/medical worker as indicated.

DELIVERY

The essential task of the obstetrician/midwife team is to ensure a safe delivery under optimum circumstances. The birth should be notified and registered in order to secure statistics and to guarantee a continuation of supervision.

In the puerperium, supervision and education ensure adequate postpartum care including:

a. The establishment of breast feeding.

b. The avoidance of puerperal sepsis.

c. Maintenance of good nutrition.

This is the optimum time to educate the patients and recruit them for family planning. Suitable arrangements should be made for follow-up. Appointments for routine postnatal care including family planning and a Papanicolau smear should be made. Arrangements should be made to follow-up defaulters.

PUERPERAL CARE PROGRAMME

a. Sterilization

If desired this is best done in the immediate postpartum period. If this is impossible, suitable arrangements should be commenced at this time and may include plans for interim contraception.

b. Child Welfare Appointment

These should be scheduled at this time.

c. Preparation of the Family

The family must be prepared for the arrival of the mother and the newborn child so that the child is accepted into the environment.

Family Planning Education is advocated in the postnatal period:

a. From a health point of view.

b. As a responsibility to parents.

c. As a means of population control.

TRAINING OF PERSONNEL

Training of:

a. Midwives.

b. Nurses.

c. Doctors

d. Social Workers.

e. Teachers.

f. Others including medical secretaries in:

(1) Prenatal care and education.

(2) Intranatal care.

(3) Postnatal care, follow up and family planning.

(4) Immunization procedures.

(5) Child Care.

IMPLEMENTATION

a. Proper utilization of well trained personnel.

b. Provision of adequate facilities.

c. Create ideal environment.

d. Adequate remuneration.

PLAN FOR ACTION

Committee

a. The Government should be the driving force in such a programme which would have involvement of the Private Sector as well as organisations previously involved in MCH/FP programmes.

b. A committee should first be set up in the country involved.

c. Members of such a committee be drawn from:

(1) Health Services personnel.

(2) Nutritionists - Government and Private.

(3) Mothers and Fathers.

(4) Social and community workers not involved in Health Services.

(5) MCH/FP Officer or officers selected by committee should be Ministry of Health personnel.

d. Funding of such a committee and programme should initially be by the Government.

e. The Government has control of salary structure as well as setting up of standards to be maintained.

PROGRAMME

The programme guidelines to evolve from the priorities set out by Consensus Report on MCH/FP in the Caribbean by the Caribbean Working Party. These priorities should be under constant review.

FUNCTIONS OF COMMITTEE

a. Planning of programme.

b. Identification of specific priorities for particular territory.

c. Advise Government as to the approach and methodology to achieve aims of the programme.

d. Budgeting.

e. Evaluation.

FACILITIES

a. Utilisation of all available facilities for efficient functioning of programme.

b. The Domiciliary service or facility be maintained or expanded when necessary.

WORKING PARTY RECOMMENDATIONS - 5

OVERALL

1. The series of four concensus reports are approved and form the major recommendation of the Working Party in relation to priorities, midwife function, midwife training and ideal Maternal and Child Health/Family Planning Programme for the Caribbean countries.

2. All Governments in the Caribbean area should introduce family planning as an integral part of all health services. N.B. (one delegate from Belize voted against this recommendation).

TRADITIONAL BIRTH ATTENDANTS

1. Since Traditional Birth Attendants already exist in some communities - it is recommended that they be identified, recruited and trained.

2. Where necessary midwives should be prepared to teach and supervise Traditional Birth Attendants in all aspects of Maternal and Child Health.

3. In the basic course midwives should be taught about the presence, purpose and usefulness of Traditional Birth Attendants and the role Traditional Birth Attendants play in communities where midwives do not exist. Traditional Birth Attendants should be brought in for discussions.

MIDWIFERY AS A PROFESSION

1. The professional advancement for midwives should be regularised in view of the fact that they will be acquiring expanded roles and functions.

2. Personnel following specialized training should be allocated in such a way as to make use of their newly acquired skills.

3. Practicing midwives should be included in planning and policy making at the highest levels.

4. Midwives should be invited to participate in all medical meetings dealing with Maternal and Child Health/Family Planning.

5. Midwives should promote their profession by every means available especially through their organizations, mass media - e.g. radio, television, newspapers.

6. Stimulation should be given to the organization of a professional body for midwives in each territory. These should be so consituted as to be able to seek recognition and affiliation with International Confederation of M dwives.

MIDWIFERY TRAINING

1. Schools of midwifery should have adequate libraries and students taught how to use them.

2. Research should be included as part of the midwives' expanding role.

HEALTH SERVICES

1. Governments should make sure that the programme of immunization of children be completed before entrance to primary school.

2. Governments should introduce the "co-operative" antenatal cards containing essential clinical information for each pregnant mother. These should be a type which could safely be carried by the mother herself.

RECOMMENDATIONS FOR FOLLOW-UP OF WORKING PARTY

1. As soon as possible delegates should report on the Working Party deliberations and recommendations to:

   a. Their immediate staff.

   b. Their Ministers of Health.

   c. Midwifery Tutors.

   d. Pupil Midwives.

   e. Staff Senior to themselves.

   f. Local Midwifery and Nursing Associations and Councils.

2. Regular meetings of this nature should be held on a regional basis at intervals between one and two years.

3. The Regional Field Director of the Caribbean Working Party should visit the countries periodically to discuss the implementation of the recommendations with all members of the Health Team involved in Maternal and Child Health/ Family Planning Services.

4. The Regional Field Director should keep in close touch with all participants through correspondence.

5. A report should be sent by each country and territory advising the International Confederation of Midwives how they are progressing towards implementation of the recommendations.

6. The possibility of members of the Maternal and Child Health Team making inter-territorial visits should be explored.

7. Representatives of the Caribbean Working Party should attend Working Parties in other parts of the world and vice-versa.

8. At future Working Parties, field visits should be included in the programme.

RESOLUTIONS - 6

RESOLUTION I

THE CAREER OF MIDWIFERY

The participants of this Working Party

Recognising

that expanded roles in the areas of Maternal and Child Health, Family Planning, Family Life Education, Nutrition and Child Care have emerged as an urgent need for our community

and recognising

that the performance of these roles in addition to her professional role as birth attendant will require a much greater commitment in training and in the performance of her duties

and further

recognising that the need for such professionals in the health team is extremely urgent and widespread

do resolve

that the recruitment, training, career development and remuneration of the midwife be reviewed in keeping with the above and as a professional in her own right

and do further resolve

that where there are auxiliary midwives, these should be upgraded by extended training, giving due recognition to the WHO Technical Report Series No. 428 that - ".. Each country must define the general educational background and technical training of its auxiliary midwives."

RESOLUTION II

WHEREAS we recognise that early discharge of postnatal patients from hospital is inevitable and that Domiciliary Midwifery Service is absent or inadequate in most of the countries represented

BE IT RESOLVED

that the participants of this Working Party view with concern the gap in coverage which at present exists from two days to six weeks postnatally as an area for improvement and recommend that urgent implementation of a programme to effect the results of this deficiency be considered as a priority by all governments in the area.

RESOLUTION III

BE IT RESOLVED that:

in order to maintain and improve on the standard of Midwifery Practice in the Caribbean Area and to enhance the role of the Midwife as a professional person - a Caribbean Midwives Association be formed.

Two examples of the objectives of such an association would be:

1. To initiate research.

2. To provide means of publication.

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ADDRESS BY MRS. GERTRUDE EASTMOND
ACTING MINISTER OF HEALTH AND WELFARE

Madam Chairman, Dr. Gogan, Dr. Cummins, Miss Patterson, Miss Lorig, Distinguished Guests, Ladies and Gentlemen.

It is indeed a great pleasure for me to be here this morning to extend a hearty welcome to the participants in this Caribbean Working Party on the Training and Practice of Midwives in Maternal and Child Health and Family Planning.

I am particularly happy that the Joint Study Group of the International Federation of Gynaecology and Obstetrics and the International Confederation of Midwives has chosen Barbados as the venue for the Caribbean Working Party, at a time when activities are being held to mark Child Month 1974 and World Population Year.

I have noted with great interest the Aim of the Joint Study Group, which is:

"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."

I have also noted with great interest the objectives of the group, which are:

1. To identify common problems and possible solutions, through the exchange of ideas and information on the present situation of Maternal and Child Health Services in their countries; the practice and training of all categories of midwives; the place of Family Planning in Maternal and Child Health Programmes, and the training of all categories of midwives in Family Planning and their participation in Family Planning Programmes.

2. To define the priorities for Maternal and Child Health and Family Planning Services for the working party countries.

3. To consider the legislative framework necessary for Maternal and Child Health and Family Planning Services.

4. To consider future plans and suggested actions for implementing the Working Party recommendations.

In Barbados, the majority of babies are born in institutions. The greatest number of confinements occur in the Obstetric Department of the Queen Elizabeth Hospital, which has a capacity of 58 beds. There are two District Maternity Hospitals with 20 beds each and it is expected that construction of another unit will commence later this year. In addition, there are three private institutions where confinements also occur.

During 1973 the total number of births recorded was 5,140. The figure of 1972 was 5,454. Of that number of births in 1973, some 4,980 or 96.9 per cent took place in institutions.

I would like to say a few words about our Maternal and Child Health Services. Prior to confinement, expectant mothers receive ante-natal care at 11 centres throughout the island. The number of first attendances at these centres during 1973 was 4,446 and total attendances were 28,026.

Post-natal care is also provided at 12 centres, where total attendances during last year were 2,835.

We recognize that the children of today are the mothers and fathers of tomorrow and that the appropriate measures should be taken to ensure that they grow up to become normal, healthy adults.

There are 10 centres where Child Health Clinics are conducted; and during 1973 first attendances were 3,754, while the total attendances were 33,844. The largest clinics are held at the three main Health Centres in St. Michael, St. Philip and St. Peter, while other clinics are conducted at centres strategically located in various areas of the country.

In addition to those clinics I have just mentioned, there are other clinics conducted at 16 centres by the Child Health Committee, which is a Voluntary Organisation. There were 4,454 first attendances at these clinics during 1973; and there was a total of 13,757 attendances. At these clinics, immunizations are administered, instructions in child care and nutrition are given, and milk, cereal and vitamins are supplied.

The main purpose of all Child Health Clinics is to continue the advice on child care which was started during the ante-natal period; emphasis being placed on infant feeding, general care and immunizations. Mothers are encouraged to attend the clinics nearest to their homes as soon as possible after confinement.

At the age of three months, children are given the routine doses of oral polio vaccine as well as triple vaccine against Diphtheria, Tetanus and Whooping Cough.

In order to solve the problem of malnutrition among our children, a National Nutrition Centre has been established. Some of its functions are:

1. To be responsible for community education in nutrition.

2. To follow up all ex-malnutrition cases discharged from the Queen Elizabeth Hospital or any other institution.

3. To provide appropriate training for medical and paramedical personnel connected with child care and nutrition.

The effect of careful and informed mothering on the health of a family, and the relation of family health to community health are important factors in individual and national development. The object of maternity care should therefore be to ensure that every mother maintains good health, learns of the art of child care, has a normal delivery, and bears healthy children.

The modern midwife has been aptly defined as "a person specifically 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."

Our nurse/midwives are fulfilling these duties admirably, and I would like to compliment them at this point for the important role they are playing in this delivery of Maternal and Child Health Services.

Since 1960, there has been a reduction in the birth rate from 33.5 per 1,000 population to 22.5 per 1,000 population in 1972. Despite these decreases, there can be no doubt that a population of over 240,000 in an island of 166 square miles, and with very limited resources, is a matter for great concern.

The planned and orderly expansion of our population in the face of such limited resources and job opportunities will therefore continue to be a necessary goal of development policy in the future.

There is abundant evidence of problems of unwanted children and unnecessary pregnancies, particularly among teenagers. Our community is, therefore, faced with an urgent need to enlighten these unfortunate women as to how they can improve their well-being by controlling their pregnancies in relation to their ability to provide useful and healthy lives for themselves and for their children.

The world food crisis, and the high cost of living make it imperative that a serious attempt be made to control the sizes of our families. The nurse/midwife is in an ideal position to help with this problem. The most practical place for the institution of family planning would, therefore, seem to be in the post-natal clinic. If the nurse/midwife can give such advice, and provide the patient with one of the currently available methods of family planning as a part of post-natal care, she may well become the key person in our population control. Properly trained, she above all others, has the time and sympathy to win the confidence of the patient, and therefore make such information effective.

I realize, however, that to equip nurse/midwives with the necessary knowledge and technical skills concerning family planning methods would not be enough. They must be educated to appreciate the need for family planning as a health measure and then to accept that they have a duty, not only to teach those who express the need, but to seek out those who may be in need and guide them to the services for care.

One can readily appreciate that there is great benefit to be derived from the linking of Maternal and Child Health and Family Planning Services. Greater spacing of children and reasonable limits to family size are important for improving the health of mothers and existing children. Family Planning should therefore be viewed as an important component of basic health services - particularly Maternal and Child Health - and in the promotion of family health. It also plays a role in social and economic development. Every family should, therefore, have the opportunity of obtaining information and advice on problems connected with family planning.

For the past 20 years family planning services have been available in Barbados to those who desired them. Since 1965 our programmes have included the use of midwives in the delivery of such services in recognition of the effectiveness of the contribution which they can make and of the fact that the most economical usage of health manpower can thereby be achieved.

Madam Chairman, I take this opportunity to express appreciation on behalf of my Ministry and the Government of Barbados of the decision of the Joint Study Group on the Training and Practice of Midwives and Maternity Nurses to hold their Caribbean Working Party in our island. I hope that our visitors will have a happy and enjoyable stay in our midst.

I now have much pleasure in declaring this Working Party open and in wishing you every success in your deliberations.

I thank you.

THE TEN YEAR HEALTH PLAN OF THE AMERICAS

By Dr. Irial Gogan
Country Representative, PAHO/WHO, Barbados

It was with pleasure that I accepted the kind invitation of your Organisation to deliver the opening address on the subject of Maternal and Child Health Goals in the Ten Year Plan for the Americas. However, I felt some apprehension because I have become somewhat out of practice in public speaking, to large groups of ladies. Also, as a relatively new officer in the World Health Organisation, it is difficult to summarize succintly the many documents which have been published by our Organisation and a number of governments on the subject, "The Ten Year Health Plan", or the goals of the Ministers of Health of the Americas for the decade.

The Ten Year Plan for the Americas is actually the Final Report of the third special meeting of the Ministers of Health of the Americas which was held in Santiago, Chile, in October of 1972. It sets forth the task which the countries of the Hemisphere have accepted for themselves in the field of health. Through the signatures of the various Ministries of Health of the Americas, they committed themselves solidly to carrying out a specific Health programme for this decade.

The plan is a composite of the historical experiences of the Governments, of the expertise of their own specialised technical personnel, and the scientific support of the experts of our own Organisation. It is the product of an in-depth analysis of health problems which was carried out in each of the countries for a period of over three months preceding the meeting of the Ministers. The basic reference document which was prepared is a synthesis of all of the information which could be gathered on the most common health as well as economic and social problems having the greatest significance throughout the Region.

The deliberations of the Ministers showed that progress has been made on the reduction of the volume of illness and in the reduction in numbers of deaths. Unfortunately, these two factors have not produced as significant an improvement as desired on the well-being, either collectively or individually, of the population at risk.

Approximately 40 per cent of the population of our Region is without access even to the most minimum of Health Services. This means that over 100 million people are without even the most elementary health care. In the light of your own deliberations this statistic is significantly highlighted by the fact that approximately 60 per cent of that population is composed of women and of children under the age of 15.

The problem of delivery of health care to this underprivileged percentage of the population has not resulted entirely from a lack of resources, but rather to two other factors. The first factor is that:

> Modern methods and solutions have, to a large extent, scorned the use of traditional and folkloric methods for the prevention and cure of disease.

And the second factor is that:

> It is a characteristic of many of the cities of the Latin American Continent and the Caribbean, to have a concentration of its human resource, in terms of physicians, nurses and midwives while the rural areas are grossly undermanned.

Primarily, the Ten Year Health Plan, from the operational standpoint, focuses attention on the control of communicable disease, on maternal and child health, on nutrition, and on matters related to the physical, biological and social environment. The achievement of the goals that were established for the Region at the meeting will be through the rational utilisation of all categories of human resource, trained to realistic levels, rather than by personnel trained to unrealistic and highly sophisticated levels, and their support by material which is both adequate and properly maintained, by financial resources, and management systems.

The Ministers recognised that for many years it will be necessary to orient and use previously existing resources in the rural strategy, and then in accord with rational planning gradually reinforce those resources with more advanced personnel and techniques. This demands the development of the health auxiliary who preferably would be a resident of the locality where he or she works, with tasks and responsibilities carefully delineated and assigned to the level of his or her competence. The auxiliary worker is to become the focal point of prevention and care. The health auxiliary would be expected to supervise the empirical health worker, as well as to encourage and guide individuals, families and groups to accept more responsibility for their own health. Thus, the training of the auxiliary health worker would be directed to a specific level of competence, of which community health education would be a most important component.

This level of auxiliary personnel would, in turn, be supervised by professional nurses. The structure would be complemented by a rural internship, where graduates from the health sciences would spend one or two years working in rural areas as a prerequisite to practice. The challenge of health coverage - especially to mothers and children and even more, to

those living in rural areas is enormous. It is complicated by the increase of the population, which is expected to be 33 per cent in the decade, or an increase of one hundred million new inhabitants in Latin America and the Caribbean countries.

Through the implementation of the health goals, governments will be either initiating or strengthening their health planning. The planning will have to include the assessment of the situation, improved information gethering processes, and continuing assessment of the validity of current actions in the light of new developments and techniques.

The Ten Year Health Plan for the Americas was incorporated in the policy of PAHO/WHO, by resolution of the Directing Council. Thus, in effect, the plan became the guide for co-operative activities of our Organisation with the member governments. Hopefully, it will form the basis for the planning and activities of other International Agencies, and lead to the recognition and solution of high priority health problems which are so closely related to soio-economic development.

Time will not permit me to go into a great deal of detail. However, a simple listing of some of the deliberations of the Ministers may be useful. They include:

1. Population growth - as related to the availability of resources.

2. The environment as it affects individual and collective health.

3. Malnutrition - either from inadequate or improper diets.

4. The role of the community, both as the creator of the demand for health services, and the beneficiary of the health resources.

5. Preparation of manpower resources, ranging from empirical health workers to university-trained specialists.

6. The upgrading of infrastructure, including the organisation and the administration of services.

7. The development of an epidemiologic surveillance as part of an improved health information system.

The Ten Year Health Plan states that health care coverage to expectant mothers reaches only 30 per cent; fewer than 50 per cent receive adequate care during delivery; and less than five per cent receive care during the puerperium. Mortality in children under five years of age accounts for 37 per cent of all

deaths. When we consider that most of these deaths are preventable, the inferences are clear.

The Ministers of Health at their Third Special Meeting recommended "within the framework of this programme, that every family should have the opportunity of obtaining information and adequate services for problems relating to fertility and sterility, providing it does not conflict with the policy of each country". Their resolution emphasises the necessity for the education of couples, hopefully to prevent the consequences of excessively frequent pregnancy.

The goals also recognise the fact, that the quality of life is determined by the continuous interchange and interaction of human beings with their environment, in a process which might properly be termed social metabolism. This involves the interplay of every conceivable variable induced or produced by man and nature. It is essential that the countries follow through with policies and national goals that define what they propose to do during the decade, state the facts underlying the purpose, and prescribe the ways of achieving them.

A useful objective for all of us is to assist Governments in developing standards. This would make it possible for the Governments to identify the problems of greatest priority in accordance with social parameters, including health and economic parameters. Without this process of identification, it is impossible to formulate a national plan for the benefit of the population. A national plan or policy should include projects for the installation of basic services - water supply, sewage, solid waste disposal, housing - all closely related to the physical environment and all with impact on social well-being. It has been quite obvious from the experience of the last decade, when for example 151 million people joined the ranks of those who had the benefits of piped water supply, that these programmes require large capital investments.

The Ten Year Health Plan also recognises the impact of chronic malnutrition and frequent infection. It has been established that maternal malnutrition and illness during pregnancy have serious repercussions for the child. It has also been established that malnutrition is a frequent underlying cause of child morbidity and mortality. A great deal more research is necessary to determine the social and health effects of malnutrition and gastroenteritis..

It has been clearly established that low weight at birth increases the risk of disease and death during the first year of life. Improvement of the mother's diet has a definite effect on babies condition at birth and on death rates. Improved maternal nutrition leads to increased resistance to disease and

enhances the chances of survival of the baby. These findings suggest that maternal and child care policy and programmes should be revised so as to place full emphasis on maternal nutrition, the spacing of pregnancies and family planning - not necessarily to reduce populations but to improve the general well being of this vulnerable sector. The incidence of the advanced types of malnutrition, such as marasmus and kwashiorkor, are on the decrease, yet what has been called "dietary sub-nutrition" probably affects the equivalent of five million children in the Region.

As a result of this we need to know:

1. How the structure and functions of their brains are altered.

2. How the behaviour of the undernourished child is affected.

3. What are the effects of the social and environmental conditions upon the child.

There is obviously very good reason for the Ministers of Health to establish very definite goals for the reduction of protein calorie malnutrition and for the elimination of nutritional anemias in pregnancy.

To conclude, you will note that I have endeavoured to avoid loading you with numbers and statistics. Perhaps the most important thing I have said is that the plan offers to all of us engaged in international service, a document which has sufficient challenges to occupy every resource available. Working within the Ten Year Health Plan, assures us of a reasonable chance that our endeavours will be within the goals of national parameters. In the words of the Ministers themselves, "co-ordination of all health services, regardless of who provides them is given priority in the institutional realm. And the participation of every human being capable of contributing to the common good is given prime importance."

FROM THE BEGINNING

By Miss Marjorie Bayes, M.B.E.,
Executive Secretary

This morning I am hoping to tell you quite briefly how and why these Working Parties are being held. You may think the title "From the Beginning" is a rather strange one, but so few of you know about the International Confederation of Midwives and I hope what I have to say will give you a better understanding of our aim and objectives.

I feel it is very fitting that this Working Party for the Caribbean countries and territories should be convened in this beautiful island of Barbados, definitely an Island in the Sun. Of all the countries here represented, only the Jamaican midwives are members of the International Confederation of Midwives. Through the News Letters which are regularly sent out from I.C.M. Headquarters, the Jamaican midwives are aware of our work. I hope, however, before I leave Barbados that I will receive many enquiries regarding membership from some of the other midwives represented here and also from the obstetricians; unity is strength.

The I.C.M. celebrated its Golden Jubilee at its 16th International Congress which was held in Washington D.C. in 1972. It really was a Golden Jubilee. Our global activities however, really started in 1954 when the first WORLD Congress for Midwives was held in London. It was at this Congress that a very eminent American Obstetrician, the late Dr. Nicholson J. Eastman, gave a wonderful and inspiring inaugural address in which he told us of the world situation with regard to maternal and child health care. This address was a challenge to all midwives who were present and especially to our newly reformed organisation whose activities had been in abeyance since the beginning of World War Two. He told us that in some countries 90 per cent of women had no professional attendance during the maternity cycle and were delivered by traditional birth attendants, relatives or just old women of the village.

In looking at the continent of Africa, we are told that there are still approximately 65 to 70 per cent of women who are delivered of their babies in this manner. In some areas of the world this figure reaches 80 to 90 per cent. This particularly applies to the Phillipines.

Dr. Eastman said that professional midwives must be prepared to do everything in their power to improve midwifery training and practice in the interest of mother and babies, and in the same interests they should accept and help to instruct their less fortunate colleagues who have little or no training. This

applies to almost every part of the world. I must say the I.C.M. was deeply distressed about the conditions described by Dr. Eastman and we eventually approached W.H.O. about doing something to improve the lot of expectant mothers and maternal and child care.

Fortunately, the International Federation of Gynaecology and Obstetrics was thinking on the same lines and at their General Assembly held in Vienna in 1960 they set up a study group on Midwifery Training and Practice.

Following the General Assembly the Secretary General of F.I.G.O. approached the I.C.M. for co-operation and the late Professor W.C.W. Nixon, who had been appointed Chairman of this Study Group, visited me at I.C.M. Headquarters in London to discuss the formation of the Joint Study Group which has continued to operate ever since.

To start a world project with the object of improving maternal and child care was no easy matter.

Our first joint effort was on the Training and Practice of Midwives and Maternity Nurses throughout the world and after intensive research the Report "Maternity Care in the World" was published in 1966 giving information on 174 countries of the world and on 75 per cent of the world's population and I am pleased to say that information on many of the countries represented here is recorded in this Report. This was the first time an international survey of midwifery training and practice had ever been done.

The Joint Study Group is a very representative body composed of an equal number of midwives and obstetricians from all parts of the world, indeed every continent is well represented. In the very beginning - in 1960, World Health Organisation asked for representation, later International Planned Parenthood Federation and recently the International Paediatric Association have joined us, UNICEF has also expressed interest and would like representation on the Joint Study Group and I am glad to report that we have agreed to invite their co-operation.

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

I feel I must tell you that since 1957 the Executive Committee of the I.C.M. has on several occasions discussed the benefit of smaller families in the interest of improving maternal and child health but it was not until the Congress in West Berlin in 1966 that a resolution was passed that Family Planning should be included in the training of midwives as a means of improving

maternal and child health. It may interest you to know that in spite of our many discussions over the years the I.C.M. was, in fact, the first professional organisation to recommend that family planning in its broadest sense be included in the training and practice of midwives.

This resolution was sent to the governments and members of all member countries of the I.C.M., W.H.O., and their Regional Offices and other International Organisations. This was obviously not enough and the I.C.M. asked the Joint Study Group to assist in taking further action. Ten recommendations had been formulated by the Study Group and had been included in the Report "Maternity Care in the World".

Some of these were already being implemented by individual countries. Following the request by the I.C.M., the Joint Study Group agreed to act on the recommendation which states that there should be established basic midwifery training requirements which would set a common minimum standard. In furtherance of this, a European Conference was held in London in March 1969; twenty-one countries were represented by obstetricians, midwives, members of Statutory Bodies, paediatricians etc. Although this was not a family planning conference, in almost all the papers presented, Family Planning was mentioned and there was no doubt in our minds that we were going on the right lines to have family planning included in the training and practice of the midwife. This conference was followed by a European Working Party in September of the same year which was held in Copenhagen. We held our first working party in Europe - Europe was our field of activity because we realised that we were unable to cope with a further world survey at this time. The "Report of the Working Party on Midwifery Training in the European countries" in which it was reiterated that family planning should be included in midwifery training and practice was published and presented to the 15th International Congress of Midwives held in Santiago, the capital city of Chile later that month. It was at this Congress that the South American midwives expressed a wish that a similar study should be undertaken in their continent. However at the General Assembly of F.I.G.O. held in New York in April 1970, the Obstetricians after consideration of this report decided that such studies should continue on a global basis but taken Continent by Continent. Owing to circumstances beyond our control, we have not yet held a Working Party in South America but we hope to remedy this later this year when we hope the midwives of that Continent will at last achieve their wish.

Every representative attending the European meeting and working party had been responsible for his own expenses, but we realised that other continents could not do this; the Joint Study Group was not in a financial position to undertake such studies and bear expenses. It was therefore necessary to appeal

for monetary assistance in order to proceed further. After considerable negotiation the United States Agency for International Development made a generous grant to the I.C.M. to enable us to pursue our studies in different parts of the world. We are now able to do this through Working Parties such as the one we are now attending.

Our Aim - although you all have it printed on your programmes - bears repetition. It is:

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

I think here I should place emphasis on "the services provided by midwives of ALL categories" which brings me again to the point I made previously of the availability and provision of Family Planning in its broadest sense.

It is this aspect of family planning which is most important to obstetricians, paediatricians, midwives and nurses, indeed the whole maternity team and it is of supreme importance that all categories of birth attendants should be instructed in family planning and services available. It is essential that all categories must include traditional birth attendants, a category of personnel which in many parts of the world are likely to be an integral part of the maternal and child health team for some time to come.

T.B.A.'s could at least be motivators of Family Planning and they do need special consideration and organised supervision.

In many areas, the income of the T.B.A. depends on the number of babies she delivers and she cannot be expected to participate in a programme which, without providing an alternative source of income, can only mean financial loss to her. If we are to recognise this category of personnel, then they must be identified, encouraged to register and given some training to ensure that their practice is more hygenic and safer, they then may be afforded some status and basic financial remuneration. By so doing their income would not be lowered and they would help in the motivation of rural couples to seek information and advice about child spacing.

Traditional Birth Attendants in many areas especially in Africa and many parts of Asia are highly esteemed in the communities they serve and have considerable influence on the inhabitants. This regard can only be enhanced by official recognition. The work they do is of extreme importance in their own locality and to the nation as a whole. Professional personnel, in the

interests of maternal and child care and the quality of maternal and child life must accept, help and instruct those with little or no training in normal midwifery practice until such time as they can be replaced by professional personnel. In many parts of the world a midwife is no longer an independent practitioner, she is a member of a team which includes obstetricians, paediatricians, auxiliary midwives, nurses and traditional birth attendants, parents themselves and their families.

Let us therefore, until such time in the future when professional care is available to all, use such personnel as already exists to give the best possible maternal and child health service, including family spacing.

This is Population Year - we must play our role in this. Over population brings social unhappiness, unemployment and food shortages. These conditions apply in every country and territory of the world and it is the mothers of the world who suffer most as a result of them. Unmarried mothers have additional problems in that they do not have the support of a husband. One parent families are not ideal for mother or child.

Since the European Working Party other Working Parties have been held - in Ghana for the anglophone West African countries; in Costa Rica for the Central American countries, in the Cameroon for the francophone Central African countries, and in Kenya for the anglophone East African countries.

Our plans for this year will we hope include this Working Party, South America, South East Asia, possibly one in Oceania as some of the Islands and territories are very over-populated and we may also arrange a second Working Party in francophone Africa. Meanwhile, the programme for this particular Working Party must continue.

There is much to be done - you are here to do it and to make personal contributions and arrive at conclusions in order to make recommendations which, with the goodwill of all concerned particularly your governments, will be implemented to improve maternal and child care and the quality of maternal and child life within your own countries.

We have been so warmly welcomed by Mrs. Gertrude Eastmond, may I now on behalf of the I.C.M. and the Joint Study Group add our welcome and assure each of you that should you require support for the advancement in your own countries within the field of Maternal and Child Care and Family Planning, the accrued knowledge of the I.C.M. and the Joint Study Group will always be readily available to you.

In Washington at the 16th World Congress for Midwives, our theme was "New Horizons in Midwifery" and Family Planning was indeed a New Horizon. Our next International Congress of Midwives will be held from 21st - 28th June 1975 in Lausanne, Switzerland. The theme will be "The Midwife and the Family in the World Today". All aspects of this theme will be covered and this will give us every opportunity also to discuss the improvement of family life through family planning.

1975 is also the International Year of the Woman and I hope we can put special emphasis on the woman as "A Mother" as I feel she is the most important woman in the world. In a world which grows daily smaller the survival of healthy happy families is essential for the increased status of all countries and only by sharing our knowledge can we achieve our AIM.

I hope this will be a happy and successful Working Party and that your final recommendations will be acceptable to all your Governments and bring improvement into your maternal and child care services which I know is so necessary everywhere.

WHAT CONSTITUTES MATERNAL AND CHILD CARE IN THE CARIBBEAN

By Dr. G.T.M. Cummins

Ladies and gentlemen, in addressing myself to the topic of Maternal and Child Care in the Caribbean, I have naturally employed some restrictions. It is essential that these should be identified for our mutual understanding, and I would now like to do so.

First of all, I think it should be clear that the basic principles and ultimate aim of Maternal and Child Care are universal. But I would like to reiterate them at this time. I would submit for your approval that the ultimate aim of Maternal and Child care is to guide and to help the pregnant woman at all stages of her childbearing career so that she bears her child in perfect health, is herself restored to perfect health and then cares for the child through its growing stages until it is physically and emotionally independent. In other words what we are depicting is a Utopia in the cycle of reproduction of the species.

I am myself ignorant of what standards have been laid down for international professional usage in order to attain these aims. Perhaps I am fortunate in my ignorance. Because it allows me to depict freely what seems to me desirable. I am quite certain that at the time when the words Maternal and Child Health were first used, the ultimate aims might have been the same as today; but that the immediate aims were much more limited - I have no doubt. In the absence of authoritative information, I would hazard that the immediate aims were routine antenatal and post-natal care for the mother, and routine immunization and mother-craft directed to the welfare of the infant. In other words, one cared about the pregnant woman and her child. One accepted the fact of pregnancy and acted only after it was diagnosed.

Whatsoever the original specifications were, the passage of time has been accompanied by a progressive expansion of the concepts of life, of the acceptable risks to life, of reasonable and optimal expectations of life and of the quality of life. There have also been redefinitions of what we would call health. There has been an identification of the significance of nutrition in terms of health and there has been an awakening consciousness of the depth and persistence throughout a lifetime- indeed over a generation - of the ill effects of malnutrition. Today we fear the possibility that a malnourished child may become an unhealthy adult, may have a precarious prospect for reproduction and may produce - years later - another unhealthy child. In today's concept we include the whole reproductive cycle and would like to ameliorate every step in the chain. Our scientific know-how is just beginning to identify the parameters of malnutrition.

Mental ill-health is now being interpreted in terms of specifically identifiable chemical imbalances in the central nervous system. Diseases, until recently considered congenital and in some cases even hereditary are responding to chemical supplements.

All these discoveries have been reflected in rapidly expanding horizons, of what may be possible through sophisticated preventive medicine. In terms of what we are saying, maternal and child health in 1974, today, is a far cry from maternal and child health as first conceived.

Now, ladies and gentlemen, the main thrust of this meeting is to review the above and to consider what part family planning can and should play. The key lies in the phrases: quality of life and expectation of life. These two phrases, coupled with the rapid sequence of events in the fields of demography, agriculture, industry, education and housing have made it plain that the quality of life and the accompanying expectations divide the world into have's and havenot's. This is true whether we speak of countries and divide them into ceveloped and under-developed or of families and divide them into Social Classes 1, 2, 3, 4 and 5 or even within the family. For within the family it has become clear that children born into large families and to mothers with a reduced birth interval have a demonstrably poorer expectation for life and health than if the family unit were not overcrowded. Other experimenters have shown that the interpersonal relationships between siblings degenerate in inverse proportion to number of siblings whether they are humans or rats.

Time does not permit me to continue without focussing on our particular situation in the Caribbean. In the Caribbean we have been blessed by an equable climate, a fortunate agricultural situation, and good sea-food. Thus with a minimum of housing and food many have survived. We have also had cultural and sociological norms which have led to large families or perhaps one should say frequent pregnancies. We have accepted teenage pregnancy, childbirth outside wedlock, multiple sex-partners and inexpensable patterns of parenthood. The controlling factors of industrialisation, urbanisation and the emancipation of women have not had the effects seen in the developing nations of enshrining the two-child family as the norm. On the other hand we have until recently enjoyed the demographic and economic safety valves of colonial or at least charitable relationships with metropolitan countries. These have allowed us migration and protected markets for our products.

Let us face the facts, ladies and gentlemen, our safety valves have been removed. We are face to face today with the full effects of our natural increase of population. We are proud that our death rates are falling. Now we must decide to control

our birth rates. If we do not, as economically improverished ministates, we shall be running faster and faster - in housing, in education, in development and in productivity. But possibly we shall not merely be standing still. Possibly our quality of life will be deteriorating. This is currently and visibly happening in other countries. Can it be that it is happening under our very eyes in the Caribbean? Finally, our responsibilities as doctors and midwives. As practitioners in the field of reproductive medicine we are face to face with these problems and with the responsibility for helping our patients to know, to decide and to act as responsible humans aiming at improving the quality of life for themselves and for their children.

I shall not go into the details - that is the purpose of this meeting - but I would like most sincerely to assure you that obstetricians and paediatricians all over the world have recognised and given due respect to the need for controlling human over-fertility - alongside all the other things that we must do to ensure healthier mothers and children. Obstetricians and Paediatricians and other doctors have also accepted the need for the help of their nursing colleagues in this task. This collaboration in aims, in training and in actions is the justification, the very reason for the existence, of this joint working party.

I would therefore propose that we cannot define maternal and child care in the Caribbean today without including the following:

1. We must research and identify the locally applicable real truths of preventive health care for ourselves. We must elucidate the interplay of genetic, environmental, parasitic and nutrional patterns true to ourselves and our area which bear upon healthy mankind.

2. We must consider the unhealthy child of today as the suboptimal parent of tomorrow.

3. We must take every step to ensure that women in the child-bearing period of life are conscious of their responsibilities to the children they may bear. They should not embark upon pregnancy by chance or without the greatest of self-reverence. They should aim to be proud, loving, mature and healthy mothers.

4. In pregnancy we must cherish them, socially, professionally and with humanity. They should be suitably educated and nourished during pregnancy to the ultimate well-being of the children in their wombs.

5. They should not be overburdened by pregnancy, neither too early nor too frequent nor unwanted pregnancy. Suitable measures of sex education, social norms, legal protection and contraception to avoid these must be available. Where these measures fail, the modern and aesthetically acceptable methods of termination should be legally and openly at their disposal. Measures to relieve under-fertility should be available. All steps should be take to control over-fertility as defined by the potential parent.

6. We must educate and use all available manpower. The most effective and economical methods must be made available. This clearly must employ not only doctors but midwives and indeed all grades of health professionals and assistants. The sympathetic opinion of community based leadership and avenues of distribution must be mobilised to this all important measure of national survival.

WHAT ARE THE PRIORITIES FOR MATERNAL CARE?

By Mrs. G. Omphroy-Spencer, Jamaica

INTRODUCTION

I would like to think of the subject which I have the honour to present as a form of national analysis - a time for stock-taking as to how far we have progressed and to what extent we have fallen short in our priorities for Maternal Care.

BACKGROUND TO "POPULATION GROWTH" IN JAMAICA

If you will bear with me I would like to give a picture of population growth in Jamaica dating back as far as the year 1655.

Period		Population	
1655	-	1,500	
1658	-	5,900	Influx of slaves
1787	-	236,000	
1881	-	581,000	
1930	-	1-million	
1974	-	2-millions	

Period	Crude Death Rate	Crude Birth Rate	Rate of Natural Increase
1920	24.2	37.6	13.4 per 10,000
1945	11.5	31 (Relates to the War Years 1939 1945)	16.7 per 10,000
1960-64	37.12	40.3	
1973	7	31	

The above may be associated with:

Related Problems, viz.

a. Illiteracy.

b. Unemployment.

c. Social Problems:

(1) Crimes.

(2) Drugs.

2. Basic Problems.

The age structure of the population has to be considered in any attempt to define the fundamental problems in the Caribbean areas. In 1968 in Jamaica:

41.3 per cent of the population was under 15 years
4.2 per cent " " " " over 65 "

This made a total of 45.5 per cent of the population dependent on 54.5 per cent for their upkeep, but of this figure approximately 20 per cent are unemployed, so in actual fact it is 65.5 per cent that is dependent on 34.5 per cent of the population for upkeep. Thus this situation has been affecting our social development adversely.

MATERNAL MORTALITY

Dating back to the year 1938 maternal mortality showed the following figures:

Period		Rate
1938	-	6.0 per 1,000 live births
1960	-	2.1 " " " "
1964	-	1.8 " " " "

This is a reduction of 60 per cent in 23 to 25 years. While this reduction is gratifying it leaves no room for complacency.

It is thought that improvement in medical facilities and those provided by the State, the introduction of antibiotics and the control of Puerperal Sepsis, use of blood transfusion played a big part in the reduction of Maternal Mortality.

PRIORITIES FOR MATERNAL CARE

1. Ante-natal Care

a. The Need for Education

The importance of early booking and regular attendance at the clinics, in the home or to the doctor must be emphasized on all pregnant women. Statistics have shown that over 50 per cent of the maternal deaths in (Victoria Jubilee Hospital) Jamaica occurred in patients who had no ante-natal preparation. The maternal mortality among patients with no ante-natal care is higher than those who had limited ante-natal preparation. This is a tragic witness to this need.

2. Nutrition

Attention to the nutrition of the pregnant woman should not of course just start during the pregnancy, but attention should have been directed to this from childhood. It has now been proven fairly conclusively that malnutrition in childhood affects the capacity of the child to learn, who will of course become the future fathers and mothers of the society. In the child-bearing woman adequate nutrition is necessary for the preparation of lactation and so the promotion of breast feeding. The fact that breast milk is the most desirable food for the baby aiding in the development of the child's brain, that it established the psychological link between herself and her child, is that it is of course the cheapest and most hygienic form of infant food must be brought home forcibly to the mother.

3. Family Planning Aims

a. The importance of the family as a unit.

b. The proper spacing of children.

c. The importance of family planning of the State.

Not only must the programme be introduced, but people must be educated to recognise the following:

a. The benefits to them as a family unit.

b. The benefits to each child's future.

c. The effect on their personal economy.

d. The effect it has on the State as a whole.

When people are educated to recognise personal attributes they will undoubtedly co-operate.

4. Dissemination of Education and Information

a. The professional midwife who is a key person in the community as she is both an educator and clinician. Her role is to:

(1) Observe and advise in maternal nutrition.

(2) She examines and detects any deviation from the normal and refers such cases to the obstetrician for his diagnosis.

(3) She arranges schedules of pre-natal visits.

(4) Makes selection of cases for hospital and home confinement.

(5) Stresses the importance of the advantages of breast-feeding to mother and child; teaches the care of the breasts at this period and during the post-natal period as well, thus preparing the mother for the establishment of lactation.

(6) She advises on contraceptives, the limitation or family spacing on size of the family; she gives instructions in the preparation for parenthood.

(7) She has the greatest opportunity of motivating both partners towards family planning; she holds dialogue with individuals from the entire community and so is a valuable liaison within the ambit of the health team.

b. The Assistant Nurses' role may be extended from the bedside to the field to assist the Public Health Nurse. She has a contribution towards educating the people in the importance of health and Family Planning.

c. The Community Health Aid

The philosophy of Community Health Aid in the health programme is based on the concept that much can be accomplished at the grassroots level by training this cadre of people drawn from within the community to teach and advise people the basic health care, nutrition and family planning on a very personal level.

d. Family Life Education In School which in a way prepares the child for responsible parenthood.

Emphasis being laid on nutrition and the protection of health. It has been found that some parents voice objection because of ignorance. The academic teacher may not be able to put the subject over effectively because of limited knowledge. The School Nurse could play a major role here, because of her close association with the students and her professional status should place her in a position of confidence with the parents. She should strive towards the co-operation of parents by

gaining their confidence and educating them to hold frequent and free dialogue with their children.

5. <u>Objectives for the future suggest that among our Priorities are:</u>

a. The need for Education among the people so as to reduce the presence of illiteracy and obliterate it, if possible.

b. <u>The Need for Improved Standards of Ante-Natal Care</u>

We cannot provide an adequate pre-natal service through clinics that operate once a week as is the case in rural areas. There is no reason why pre-natal clinics should not be run by the professional midwife working in conjunction with the doctor instead of being an assistant to the Public Health Nurse. The Domiciliary Midwife (Jamaica) <u>must</u> be upgraded to become a "full time", "salaried" personnel under the umbrella of Central Government. The system of retainer and collection of small fees is degrading to the professional midwife. There should be uniform conditions of service. Opportunities for promotion within her field and into administration must be created by the provision of further education and post-graduate courses. In the area of Family Planning the professional midwife must be educated to select and introduce contraceptive devices, to recognise side effects and educated to advise on these.

c. <u>The Traditional Birth Attendant</u>

We need to revise our attitude towards the unqualified Attendant. A programme (Jamaica) is being worked out for their training to help them to recognise dangers, to practise methods of asepsis and so prevent maternal death.

d. The need for more obstetric beds.

e. The need for expanding our Laboratory Services.

f. The need for expanding Blood Bank facilities.

g. The need for improvement in our Home Delivery Services.

h. The need to expand our Family Planning Services. The programme must be accelerated and become

integrated with all other areas of health so that the time factor of the woman may be more economically utilized.

i. The need for a National Maternal Survey.

CONCLUSION

Death is a tragedy and that of the child-bearing woman, especially so. Whether it be slow or sudden it affects the very foundation of any country's family unit as the stability of the family unit is guided by the presence of a good mother and wife. Many of our juvenile delinquents today, even criminals, may be children who were deprived of a mother at a very early stage of life.

These priorities are offered that a clearer picture may eventually emerge to enable us to tackle the problem in maternal priorities and the reduction in maternal mortality especially in our Island of Jamaica.

STATISTICS OF EXAMPLE FOR VICTORIA JUBILEE HOSPITAL

ATTENDANT AT DELIVERY - JAMAICA (1960 - 64)

YEAR	PHYSICIAN	MIDWIFE	UNQUALIFIED
1960	3,177	40,187	25,039
1961	3,384	39,569	23,175
1962	3,302	40,228	21,383
1963	3,294	42,963	19,932
1964	3,388	46,612	18,359

TABLE I - MATERNAL MORTALITY BY PARISH (1950- 1964)

PARISH	1950-54	1955-59	1960-64
KINGSTON & ST. ANDREW	2.7	1.6	1.0
ST. THOMAS	4.6	3.0	2.3
PORTLAND	3.4	3.2	2.8
ST. MARY	4.1	2.0	2.2
ST. ANN	3.0	2.5	2.4
TRELAWNY	2.1	2.8	1.6

PARISH	1950-54	1955-59	1960-64
ST. JAMES	4.4	2.5	1.3
HANOVER	3.3	2.9	2.8
WESTMORELAND	2.5	2.7	1.5
ST. ELIZABETH	2.2	3.5	1.6
MANCHESTER	3.0	1.7	1.8
CLARENDON	3.1	2.4	2.3
ST. CATHERINE	3.0	2.5	1.8

TABLE II - MATERNAL MORTALITY - LATIN AMERICA AND JAMAICA (1964)

COUNTRY	RATE
PUERTO RICO	0.5
EL SALVADOR	0.6
URUQUAY	0.8
VENEZUELA	0.9
NICARAGUA	1.2
PANAMA	1.6
MEXICO	1.7
JAMAICA	1.8
GUATEMALA	2.0
CHILE	2.6

TABLE III - MATERNAL MORTALITY IN THE WEST INDIES (1964)
(Rates are for 1964 unless otherwise stated)

COUNTRY	MATERNAL MORTALITY
GRENADA	4.1
ANTIGUA	3.2
DOMINICA	2.8
MONTSERRAT	2.7
ST. KITTS - NEVIS - ANGUILLA	1.9 (1962)
JAMAICA	1.8
ST. VINCENT	1.8 (1961)
BARBADOS	1.4
TRINIDAD & TOBAGO	1.0
BRITISH HONDURAS	1.0

COUNTRY	MATERNAL MORTALITY
ST. LUCIA	0.8 (1963)

PRIORITIES FOR CHILD CARE

by Dr. Keith McKenzie

I am speaking to you with the background of ten years hospital experience in Paediatrics in Jamaica. While this paper inevitably quotes many statistics from Jamaica, my experience of previous Caribbean Medical Conferences indicates their general applicability to the other Caribbean countries.

STATISTICS

1. Population

   a. In 1970, Jamaica had a population of 1,869,100 as compared to 1,402,900 in 1950. In January 1974, the population passed the 2 million mark. (1)

   b. 46% of the 1970 total was below 15 years of age. (2)

2. Birth Rate

In 1950,	birth	rate	was	33	per	1000	population	
1960	"	"	"	42	"	"	"	
1970	"	"	"	35	"	"	"	
1973	"	"	"	31-3	"	"	"	(3)

3. Death Rate

In 1950,	death	rate	was	12	per	1000	population	
1960	"	"	"	9	"	"	"	
1970	"	"	"	7.7	"	"	"	
1973	"	"	"	7.2	"	"	"	(4)

4. Child Mortality

And what of child mortality? Abraham Horwitz, Director, Pan American Sanitary Bureau in the foreward to the book Patterns of Mortality in Childhood - Report of the Inter-American Investigation of Mortality in Childhood (Scientific Publication PAHO No. 262, 1973) has described child mortality as the most important health problem in the Americas today. (5)

Is this also true of the West Indies? I suspect that it is, but the statistics have not been collected to prove or disprove this.

Most child deaths occur in the age group below five years. Figures from the Registrar General's Department show that in 1971, the four principal causes of death below five years of age were: (6)

a. Enteritis and othe diarrhoeal disorders 20.5 per cent

b. Perinatal causes 20.0 " "

c. Pneumonia (non viral) 14.9 " "

d. Malnutrition and avitaminosis 12.3 " "

5. Infant Mortality Rate

In 1950, the infant mortality rate was 78 per 1000 live births

1960, the infant mortality rate was 51 per 1000 live births

1970, the infant mortality rate was 32 per 1000 live births

1973, the infant mortality rate was 26.2 per 1000 live births (7)

In 1971 deaths in infants i.e. below age one year accounted for 63.8 per cent of the total deaths below age five years. The four principal causes of death below one year of age were:

a. Perinatal causes 31.2 per cent

b. Enteritis and other diarrhoeal disorders 22.5 per cent

c. Pneumonia (non-viral) 14.0 per cent

d. Malnutrition and avitaminosis 12.2 per cent (8)

6. Perinatal Causes of Death

a. Unfortunately, it was not possible to obtain really accurate data on the specific perinatal causes of death although a high proportion were of low birth weight. The report of the Inter-American Investigation of Mortality in Childhood showed great variation in the specificity of causes from what was written on Death Certificates.

b. Dr. Robert Cook, Director of the Caribbean Food and Nutrition Institute has pointed out the very important fact that the peak mortality in the Caribbean below five years of age is between six months and twenty three months. (9)

c. He has also shown that the highest incidence of malnutrition is in the six month to four years age group, and that the malnutrition rate is fairly constant during that time. He arrived at these conclusions from analysis of data collected from various national Food and Nutrition surveys in Caribbean territories in 1969 to 1971. (10)

7. Malnutrition

a. In a study in 1963 by McKenzie et al in Jamaica, Protein-Calorie Malnutrition was the largest single cause of death (31.3 per cent) in children in the one year age group. (11)

b. In 1968 to 1970 in Kingston and St. Andrew (population of over 400,000) malnutrition was directly responsible for or associated with 51.4 per cent of the deaths in the same age group. (12)

c. In 1967-68 at University Hospital of the West Indies malnutrition was the most common cause of death (34 per cent) in children below two years of age while during the same period at the Children's Hospital, Kingston, Jamaica it was responsible for or associated with 35 per cent of the deaths in the same age group. (13)

8. Gastro-Enteritis

a. In the 1963 survey by McKenzie et al in Jamaica, gastro enteritis was the principal cause of death (37.4 per cent) in the age group six to eleven months. (14)

b. In 1968 to 1970 in urban Kingston, gastro-enteritis was the most common single cause of death in the age group one to twenty three months. (15)

c. At the University Hospital of the West Indies in 1967-68 it was responsible for 18 per cent of the deaths below two years. (16)

9. Morbidity

a. At the University Hospital of the West Indies from 1955 to 1968, malnutrition was the primary or secondary diagnosis in 50 per cent of the admissions below two years. (17)

b. At the University Hospital of the West Indies from 1959 to 1968, gastro-enteritis was the most common cause of admission below two years. (18)

c. The University Hospital of the West Indies' records show that malnutrition, gastro-enteritis and respiratory diseases account for approximately 75 per cent of all admissions below two years. This consideration of some of the main health problems helps us to arrive at the priorities for child care. (19)

PRIORITIES

1. Prevention and Treatment of Malnutrition

Malnutrition is the major contributor to child mortality and morbidity below the age of two years in Jamaica and indeed in the majority of the Caribbean countries as represented at the St. Vincent conference in January 1974. Apart from its considerable physical effects, increasing concern is being expressed as to its possible long term mental effects. Prevention of malnutrition is therefore of paramount importance.

2. Prevention and Treatment of Gastro-Enteritis

The interlinkage between malnutrition and gastro-enteritis is striking. The fact is well recognised by Caribbean Health Ministers, who were the motive force behind the Technical Group Meeting including representatives from eleven Caribbean countries which met in St. Vincent in Janauary 1974 and formulated a Strategy and Plan of Action to combat gastro-enteritis and malnutrition in children under two years of age.

3. Promotion of Breast Feeding

This is of such vital importance in the prevention of both malnutrition and gastro-enteritis that it deserves a heading by itself. I do not have to labour this point to this gathering. Nevertheless, the fact is that at present bottle feeding has so displaced breast feeding in many parts of the Caribbean that in some of the largest cities as little as 5 per cent of babies are solely breast fed up to age four months. (20)

4. Investigation of Perinatal Morbidity and Mortality

The various aetiological factors need much more precise analysis in order to improve the standard of care in this age group.

5. Immunization

Prevention of certain infectious diseases by widespread immunization is a priority in countries where the interlinkage between malnutrition and infection is so common. Comprehensive immunization before school entry is recommended against diptheria, tetanus, whooping cough, poliomyelitis, tuberculosis, measles and smallpox.

6. Family Planning

No discussion on priorities for child care can be complete without emphasizing the growing dangers of overpopulation in many of our countries. Unlimited population growth will only compound the problems of providing adequate child care in our countries. Effective family planning measures are needed now in order to arrest the population growth and so help to ensure for the young child a better chance for a better life.

ACKNOWLEDGEMENTS

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I am indebted to the International Confederation of Midwives through their Regional Field Director for the Caribbean, Miss Barbara Patterson, for the kind invitation to be present at this Working Party.

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THE PLACE OF NUTRITION IN THE PRIORITIES OF MATERNAL AND CHILD HEALTH

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INTRODUCTION

The title of my assignment is such that I feel it is important to define my terms of reference. Since mothers and children comprise about two-thirds of the population of developing territories, their health care delivery needs no further justification. For the purposes of this discussion I shall define nutrition as the science of food, the nutrients and other substances therein, their action, interaction, and balance in relation to health and disease, and the processes by which the organism ingests, digests, absorbs, transports, utilizes and excretes food substances. In addition, nutrition must be concerned with certain social, economic, cultural and psychological implications of food and eating. The term priority implies precedence in time and/or rank. Whereas it is possible to give nutrition or a priority rating in Maternal and Child Health (M.C.H.) Services, nevertheless it is my contention that nutrition is an integral part of all the components of M.C.H. Services.

The PROBLEM which the providers of M.C.H. Services in the Caribbean must face is the relatively high risk of morbidity and mortality to which mothers and children are currently exposed and the need to extend the coverage of Maternal and Child Health Services.

Our GOAL therefore, should be to improve the quality of health care in M.C.H. Services so that the outcome of a pregnancy will be a healthy infant of normal birth weight born to a mother who will be alive, healthy and motivated to breast feed fully for at least four months. This should be the foundation for children to become healthy adults and enjoy a normal family life in an enlightened community.

In the absence of such a high quality M.C.H. Service, high risk mothers often go undetected and contribute to the relatively high infant mortality rate in some Caribbean territories as well as the high rate of low birthweight babies. It is important therefore to identify, isolate and, where feasible, provide special clinics for high-risk mothers as well as for low birthweight babies, bearing in mind that the risk factors will vary in priority in different Caribbean territories.

After outlining some factors contributing to high-risk mothers and low birthweight babies, I propose to summarize the findings of the National Food and Nutrition Survey conducted in Barbados in 1969 and so demonstrate that Nutrition should be an integral part of all the components of an adaptive M.C.H. Service.

HIGH RISK PATIENTS

1. History

   Unwanted pregnancies, poor reproductive history, sub-fertility, too long spacing, too rapid child bearing, excessive numbers of pregnancies (five and over), history of long obstructed labour, abnormal presentations, mental illness or instability, overwork, rubella or other infections, syphilis.

2. Examination

   Short stature (under five feet), hypertension (B.F. 140/90 +), oedema, albuminuria, overweight, diabetes, rapid weight gain, malnutrition, anaemia, sickling, haemorrhages, uterine abnormalities (fibroids), tuberculosis, pyelitis, vaginitis, heart disease, asthma, chronic bronchitis, Rh. sensitization, disproportion, pelvic abnormalities, multiple pregnancies, poor vaginal outlet, anxiety.

SOME POSSIBLE AETIOLOGICAL FACTORS OF LOW BIRTHWEIGHT BABIES IN THE CARIBBEAN

1. Underweight due to Gestational Prematurity

   a. Maternal ill-health:

      Heart disease, hypertension, chronic nephritis, syphilis, viral infections, pneumonia, acute intestinal infections, chronic malnutrition, anaemia, physical overwork.

   b. Obstetric:

      Antepartum haemorrhage, preeclamptic toxaemia, hydramnios, multiple pregnancy, gross foetal abnormality.

2. Underweight at Full Term

   a. Small maternal stature:

      malnutrition, genetic factors.

b. Possible adaptation of the newborn to geographico-climatic factors:

hot, humid environment (possibly requiring less subcutaneous fat).

c. Maternal malnutrition or anaemia during pregnancy including folic acid deficiency.

d. Placental disease:

insufficiency due to chronic vascular and renal disease.

e. Multiple pregnancy.

SUMMARY OF THE MAIN FINDINGS OF THE NATIONAL FOOD AND NUTRITION SURVEY (BARBADOS, 1969).

Of 248 preschool children, 16.5 per cent were suffering from malnutrition, the criterion being under 80 per cent of the internationally accepted standard of weight for age. The majority of these cases occured between six and twenty four months of age.

There was moderate growth impairment in school children. 20 per cent of women, as contrasted with only four per cent of men were obese, i.e. more than 30 per cent over the standard weight for their height.

Of preschool children, 33 per cent were anaemic, half being due to iron and the other to folate deficiency. 19 per cent of women were anaemic.

There was a very high degree of decayed, missing and filled teeth as well as periodental disease. The mean number of decayed, missing and filled teeth (D.M.F.) at fifteen years was 23 per cent, at twenty five years 50 per cent, and at fifty five years 75 per cent.

There was a significant association between low income levels and malnutrition in the children of these families.

The enquiry into child care and feeding practices demonstrated a need for more health education and training in nutrition.

The survey showed that the amount of food produced in home gardens was relatively small.

The 1966 Food Balance Sheet yielded marginal figures in terms of need of 2,476 calories per day per person (including alcoholic beverages) and 64.6 grams of protein. Not infrequently, therefore, vulnerable groups such as mothers and children, suffered from

unequal distribution of certain essential food items.

Additional evidence has shown that the death rate from diabetes mellitus is very high in Trinidad and Tobago, Jamaica and Barbados.

In order to cope with the problem, adaptive M.C.H. Services are needed to meet the health needs of mother and child.

M.C.H. SERVICE

1. Maternal

   Antenatal midwifery, postnatal, family spacing, referral, gynaecological, nutritional, dental, immunization, health education, (directed especially to breast feeding and the weaning process), social and community services especially for the teenage mother.

2. Child Health

   Surveillance, immunization, nutrition, dental, health education, paediatric out-patient and in-patient services.

A consideration of the aetiological factors of high risk mothers and low birthweight babies above demonstrates that nutrition should be an integral part of all the components of a M.C.H. Service. In order to meet the health needs of mother and child, the idea of M.C.H. Services should be accepted at the level of the Ministry of Health and where feasible, an M.C.H. Officer should be appointed in the Ministry to implement and evaluate these services at regular intervals. Furthermore, it is imperative to have a National Food and Nutrition Policy to meet the nutritional needs of the child and adolescent so as to withstand the stress of pregnancy and lactation in later life.

To achieve this requires co-ordinated action between M.C.H. Services and those agencies providing the services of midwives, obstetricians, gynaecologists, paediatricians, public health officers, nutritionists, family planning officers, health educators, social workers and community development officers. Such integrated action can best be served by a Co-ordinating Committee for M.C.H. Services.

The quality and coverage of such a M.C.H. Service will depend on the available resources in terms of people, money, materials and time. Our priorities will inevitably arise out of matching these resources with the stated health needs above.

PRIORITIES

In providing M.C.H. Services in the Caribbean we must face the problems of inadequate antenatal and obstetrical care, large and poorly spaced families, malnutrition, specific diseases and dental problems. In setting priorities for M.C.H. Services consideration should be given to such criteria as community concern, prevalence, seriousness and susceptibility to management. Weightings can be applied intuitively to these criteria and a score arrived at by multiplying the weightings. Although I would give equal weighting to family planning and nutrition it should be borne in mind that a reduction in infant mortality has been demonstrated to be a pre-requisite for successful family spacing.

ADAPTION OF M.C.H. SERVICES

There is no room for imported "potted plant" systems in M.C.H. Services in the Caribbean. Instead of searching for a blueprint we must address ourselves to building our priorities and adapting our M.C.H. Service to meet the health needs of our people. The selection of priority activities in a M.C.H. Service must be adapted culturally, technically, logistically and financially to the epidemiology and ecology of the territory as well as to the staff and resources.

Within budgetary limitations, health manpower and especially health aides must be trained to provide this Adaptive M.C.H. Service. In the content of this training it is not so much the "what" as the "how" which is needed. Consequently, training in managerial skills is needed especially at the central and middle levels of management.

RECOMMENDATIONS

Arising out of the above exposition, it is recommended that:

1. A M.C.H. Co-ordinating Committee should be established in the Ministry of Health with the Chief Medical Officer as Chairman.

2. A M.C.H. Officer or professional with a special interest in M.C.H. should be responsible to the Ministry of Health for the planning and implementation of M.C.H. Services.

3. Training in managerial skills and of health aides should be stressed in a M.C.H. Service.

4. Consideration should be given to a National Food and Nutrition Policy.

5. A Medical Nutritionist or person with a special interest in nutrition should be responsible for up-dating the teaching of nutrition and motivating his or her colleagues to include nutrition education in all areas of M.C.H. activities.

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MATERNAL & CHILD HEALTH & FAMILY PLANNING

By Dr. A. Wynante Patterson, M.R.C.O.G.

In 1973 a decision was taken to integrate the delivery services of Maternal and Child Health, Family Planning and Nutrition. For the first time a post of a Principal Medical Officer for Maternal and Child Health, Nutrition and Family Planning was created. No other Officers have as yet been assigned to this division at the Ministry level.

The Maternal and Child Health programmes have traditionally been operated as part of the public health services and account for some 50 per cent of public health nurses time. With the present staff shortage, school work - with the exception of the K.S.A.C. where there is a team of School Nurses - is seriously affected, home visits are at a minimum and supervision of health centre nurses is inadequate. It would seem that more efficient use of categories of staff other than public health nurses is essential.

The Family Planning programme was until April 1974 administered through a Statutory Board which has been in existence for three years. This programme was prior to 1971 administered by a provisional board for one year and prior to that by a voluntary organisation - the Jamaica Family Planning Association, an affiliate of International Planned Parenthood Federation which operated in selected parishes of the island. From April 1974 the delivery of services was integrated into the Maternal and Child Health system. The process of integration, has, therefore only just begun.

The rationale for integration as expressed in the Ministry Paper on Family Planning is that "the delivery of services takes place to a large extent within the Government hospitals and Health Centres and is therefore necessary for those services to be properly orchestrated." The aim is that Family Planning Services will be offered on an on-going basis in all health centres and that centres which under the previous regime offered only family planning services will be equipped to offer other Maternal and Child Health Services.

The population of Jamaica in 1971 was 1,953,472 and some 60 per cent of this figure falls within the age and sex groups served by the Maternal and Child Health Programme. 45 per cent of the population is under 14 years; 55 per cent of the population is under 18 years.

Who provides the services? In 1972 there were six senior Medical Officers of Health and 21 Medical Officers of Health. The Medical Officer of Health is a doctor with specialised public

health training who has responsibility for the public health services in a Parish. He is also the Regional Family Planning Officer. In the large parishes such as Kingston & St. Andrew there is one Senior Medical Officer of Health and four Medical Officers of Health. There are 14 Parishes in the island, Kingston and St. Andrew Corporation being counted as one. There are presently two parishes without a Medical Officer of Health. When a vacancy exists the Medical Officer of Health from an adjoining parish is asked to oversee the vacant parish until the vacancy is filled.

There are 22 Senior Public Health Nurses and 125 Public Health Nursing Posts. The Public Health Nurses' posts are divided between the parishes on a population basis. At present there are approximately thirty vacancies in this category so at this level too the parishes are understaffed.

Also on the field are 312 district midwives and in the parishes of St. James, Hanover, St. Elizabeth and Central Kingston, there are 330 Community Health Aides. A figure for paediatric nurses was not possible as in all hospitals except the Children's Hospital, nursing staff is inter-changeable between wards. A breakdown between urban/rural population emphasises the fact that 58.6 per cent of our population is rural and 56.9 per cent of women live in the country. Bearing in mind the rural terrain and the distances between homes, the need for adaquate staff in the rural areas is evident. However, all our obstetricians and paediatricians are located in urban areas and the rural woman and child has little access to their services.

The Ministry of Health & Environmental Control's "Green Paper" on the Health of the Nation recognises this fact and states that "there is urgent need to institutionalize the system under which a medical graduate is required to devote a period of time to rural service before receiving his degree. This measure should be supplemented by organising the services in such a way that the largest possible number of persons are within the reach of trained auxillaries working under adequate supervision.

Where are the services offered?

The majority of the clinic services are offered on the field by the Public Health Nurses. There are 300 prenatal and 300 child welfare clinics per month held in some 154 health centres and dispensaries. For the most part one prenatal and one child welfare clinic is held in rural areas per month, and in urban areas one per week. In addition daily pre-natal clinics are held at the Victoria Jubilee Hospital and weekly post-natal clinics The University operates three pre-natal and two post-natal clinics per week. Daily paediatric clinics are held at the Children's

Hospital and University Hospital. Except in the capital, in Montego Bay, in Mandeville and in Spanish Town, post-natal services have not yet been developed extensively. A first step towards the establishment of this service has been made by incorporating a post-natal service into the services offered by the Daily Family Planning Clinic. There is (subject to imminent change) a daily Family Planning clinic in each parish offering family planning services 1.30 a.m. to 4.30 p.m. each day as well as 150 sessional clinics operating weekly, fortnightly or monthly.

There was a drop in birth rate of 7.6/1,000 population between 1960 and 1970 and a drop of 3/1,000 population 1972-73. Births take place either in hospital or in the home. It is estimated that 40-45 per cent of deliveries take place in the home and the remainder in hospital. Deliveries in homes are conducted by district midwives, an estimate of 20-25 per cent or by Nanas an estimate of 20 to 25 per cent. In hospitals 70 to 95 per cent deliveries are conducted by Nurse/Midwives or single trained midwives. Maternal mortality is approximately 33/1,000. Maternal death with haemorrhage was in No. 1 position in 1971.

The stillbirth rate is estimated at 16.1/1,000 in 1971 and 8.2/1,000 in 1972. These two figures represent a flaw in our registration figures. The statistics are derived from a survey on Childhood Mortality done in 1968-70 by Puffer and Serrano. During the process of the survey it was found that the International definitions of live and stillbirths were not being adherred to nor was the definition of a "foetus" as against a "stillbirth". Tightening up on these procedures produced a figure of 7.9 per cent for deaths under one day from 0 per cent and the stillbirth figures quoted above 8.2/1,000 live births in 1971 as against 16.1/1,000 live births in 1972.

Evaluation is conducted through regular monthly reports made by the Public Health Nurse to the Medical Officer of Health and monthly and yearly reports from the Medical Officers of Health to the Ministry.

Sub-Committees at Ministry level in conjunction with the Medical Officers of Health use these reports in planning.

Vital Statistics are provided by the Registrar General at quarterly intervals. Every ten years a national census is taken. At intervals special surveys, e.g. Child Mortality Survey, Nutrition in Jamaica, Fertility Trends in Jamaica are undertaken by expert teams. From these data, evaluation of the programmes is made.

UNIQUE FEATURES

1. 173 special trained Family Planning Workers.

2. Ten Rural Maternity Centres.

3. Community Health Aides.

4. Post Partum Programme.

MATERNAL CHILD HEALTH/FAMILY PLANNING IN BARBADOS

By Miss Elayne Scantlebury, Barbados

Barbados is the most easterly of the Caribbean Islands and is situated 134° north and longitude 59°, 37° west in the Atlantic. It is approximately 166 Sq. miles, and in 1972 a population of approximately 241,600. It is generally flat except for the north-eastern parishes, where the land rises over 1,100 ft. The temperature varies from 75°F - 85°F.

The Ministry of Health in Barbados is responsible for the Maternal and Child Health care in Barbados. The child Health Committee is a voluntary agency which gives invaluable assistance with child health care.

There are three main Health Centres in the island one in the north, one in the city and one in the south, with trained Public Health Nurses and Medical Officers. The first of such centres was opened in the parish of St. Peter in 1953, Enmore in 1955 and St. Philip in 1957, there are several sub-centres throughout the island which provide the same medical services for pregnant mothers and their infants from Ante-Natal period to pre-school age.

All mothers who attend the Ante-natal Clinic are given routine blood test for V.D.R.L., H.B. Blood group and type; those who require treatment are kept under constant supervision to see that the appropriate treatment is carried out prior to delivery. Mothers whose blood groups are Rh negative have serology tests done during the last four weeks of pregnancy to check for the presence of antibodies. If there are signs of antibodies the mothers are referred to Queen Elizabeth Hospital for delivery so that the necessary blood exchange transfusion can be carried out.

Home visits are made by the Nurses from the Health Centres to ensure that mothers are attending regularly, so as to produce healthy infants and to preserve the good health of the mother.

If for any reason on the home visits conditions are not satisfactory, then this mother will be reported to the appropriate agency for investigation.

DISTRICT MATERNITY HOSPITALS

In addition to Queen Elizabeth Hospital with 56 Maternity beds, there are two Maternity Hospitals in the island which have an accommodation of 20 beds each, and a trained nursing staff with a part time Medical Officer. These Hospitals cater for normal cases only, so as to increase the bed allocation at the Queen Elizabeth Hospital for emergency cases; mothers who are delivered at the District Maternity Hospitals are patients from the Ante-

natal clinics and private Doctors from any part of the island; after confinement, a notification form is sent to the Medical Officer of Health for the area, so that mother is notified of the date and time she should take her infant to clinic for advice and commencement of vaccination and immunisations.

When the patient is discharged, the District Nurse for the area is notified, so that mother and infant are given follow up visits until she returns for her six weeks post-natal check, or supervise any instructions which are given by the Medical Officer in charge. Mothers are discharged from Hospital on the fifth post delivery day.

POST-NATAL VISITS

Mother and infant are examined by the Medical Officer in charge and should she wish to plan her family she starts on the contraceptive of her choice.

The husbands of the grand multipare are also given advice on family planning which is most important in a growing population.

LEGISLATION

Legislation: An act to repeal the Midwives and Nurses registration act 1932 and make provision for registration of Nurses and Midwives and enrolment of Nursing Assistants, and for correction purposes was enacted by the Parliament of Barbados in 1973.

Selected areas of the act which were relevant to Midwives are as follows:

1. Where it is reasonable to believe that a case of emergency involving a patient exists, a Midwife shall:

   a. Call a Medical Practitioner to her assistance.

   b. Cause the patient to be conveyed to a hospital. If the patient is certified by a Welfare Officer to be able to pay any fee involved, such fee shall be paid out of monies voted for the purpose of Parliament.

2. The Midwife shall immediately report to the Chief Medical Officer each case of emergency, furnishing such information as the Chief Medical Officer requires.

MID-WIFERY TRAINING

There is one training school for professional Midwives - The Tercentenary School of Nursing.

STATISTICS 1972

Birth Rate	22.5	per thousand population
Infant Mortality Rate	33.9	per thousand live births
Maternal Mortality Rate	0.8	" " " "
Neo-natal Mortality Rate	27.0	" " " "
Perinatal Mortality Rate	28.5	" " " "

re were 5,303 live births and 4 maternal deaths.

Evaluation or Benefit from Maternal and Child Health Service

a. Nutrition Centre

To follow up all exmalnourished cases discharged from the Queen Elizabeth Hospital or any other institution.

b. Health Education

To teach the population more about the control and prevention of contagious diseases.

c. Hospital Facilities

Two District Maternity Hospitals for patients in the rural areas.

d. School Health Services

Free Dental and opthalmic treatment for children between the ages of 5-15 years.

e. Trained Staff

To maintain the standard which is required by the Health Service in Barbados.

f. Ambulance Service

For transporting emergencies to Hospitals.

g. Family Planning

Advice is given in various types of contraceptives which are essential in a growing population.

h. Day Nurseries

There are 15 day nurseries in the island with a trained staff for the care of pre-school children.

i. Growing Security

For meternal benefits 6 weeks before the date of confinement and 6 weeks after delivery.

j. School Meals Service

There are 7 Centres, which supply 86 of the 126 Primary Schools with daily meals at a small fee of 50 cents per week, approximately 22,000 children receive these meals.

MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAMME - TRINIDIAD AND TOBAGO

By Dr. Andrew Bhagwansingh - Trinidad

WHAT EXISTS

1. Services

Maternal and Child Health Services are being provided by Government throughout the country. These Services are supervised by Regional Directors and local supervisory staff in the districts and in hospitals. Broad policy is determined by the Chief Medical Officer and his medical and nursing administrative staff at the central level in collaboration with field staff.

A family planning programme is also being implemented. Urgent family planning needs in the country called for a great deal of supervision in family planning to be provided through the recently established Family Planning Unit guided by the Population Council. Although family planning is less accepted as the responsibility of local supervisory staff, persistent efforts are being made to correct this. These efforts are succeeding. Family planning is being brought more and more under local supervision and is already being integrated with maternal and child health services in the following ways:

a. By provision of combined services in clinics. Twelve clinics are now integrated.

b. By utilization of the same staff and facilities for Maternal and Child Health and Family Planning services in most centres. (This includes utilisation of sessional staff recruited for the family planning programme in the broader Maternal and Child Health Services).

c. By providing, in family planning clinics, special services which relate to the broader area of Maternal and Child Health. A large proportion of the population needing such services i.e. cancer screening and VD surveillance is easily reached because of the family planning programme.

d. By orienting all staff reached in training programmes to the concept and conduct of an integrated service.

e. By including family planning in routine training programmes for all nurses.

2. Ante-Natal Services:

Ante-natal services are provided at Port-of-Spain and San Fernando Hospitals and in 90 Health Centres.

The Ante-Natal clinic is combined with the child welfare clinic and/or family planning clinic in some areas.

Expectant mothers are followed routinely by nurses and cases referred for medical attention where indicated.

It is estimated that over 80 per cent of expectant mothers receive attention at these centres.

3. Delivery Services

These services are provided at Port-of-Spain and San Fernando Hospitals, at nine Country and district hospitals, at a delivery unit in Cedros and through home deliveries by public health nurses and panel midwives.

Delivery services are supervised by Obstetrician - Gynaecologists at the major hospitals and by District Medical Officers in smaller hospitals and in the home service. Supervisory functions are not clearly defined for the maternity unit at Cedros.

In government institutions, 289 maternity beds are available. Admission to hospital for delivery is easier if the patient shows proof of having attended for ante-natal care in the hospital clinic. Many p. nts who are under the care of private practitioners attend the hospital clinics to ensure easy admission for delivery.

It is estimated that Government Services take care of approximately 74 per cent of all deliveries (in institutions and in the home). Approximately 16 per cent are handled by untrained midwives.

4. Child Welfare Services

Child Welfare Services are provided at 88 Health Centres and at Port-of-Spain and San Fernando Hospitals.

These services are combined with ante-natal and/or family planning service in some areas as already indicated.

Emphasis is on well-baby care but in many important areas the programme has not been succeeding, e.g. routine immunization.

In many areas these services are either not adequately utilised by the target population or there is great duplication of service and clinics are kept busy following the same population with too frequent visits for well baby care.

5. Post-Partum Services

Available at Port-of-Spain and San Fernando Hospitals and two Health Centres. However, it must be appreciated that with the provision of family planning services, large numbers of women are, in fact getting post-partum assessment in family planning clinics.

A programme for post-partum, post-abortal education and referral to family planning clinics is being implemented at Port-of-Spain and San Fernando Hospitals.

6. Family Planning Service

These services are now provided in 39 centres in the Government programme, including the two major hospitals. In twelve centres the service is combined with ante-natal care and/or child welfare services.

Though clinics are not specifically designated as post-partum clinics, a fair amount of post-partum evaluation is now being done through the family planning service.

Services are provided through mixed sessions where a Medical Officer is in attendance and through supply sessions conducted by nurses.

Special attention is being given to client education in clinics, in the community and through a post-partum, post-abortal education programme carried out at Port-of-Spain and San Fernando Hospitals.

Full time staff are assisted by sessional doctors, nurses and clerks. Where clinics are combined, sessional nurses and clerks are being trained to assist with the total service.

In addition, cancer screening services and VD surveillance are being introduced in some clinics. The family planning service ensures that a large proportion of the target population is easily reached with these preventive

and curative services which contribute to maternal and child health.

It is estimated that there are approximately 20,000 current users in the government programme.

6. Training

All medical graduates are trained for maternal and child health, but all do not get special training in family planning.

Medical seminars have been conducted over the past three years to give orientation and refresher training in different areas of MCH & FP. Doctors working in family planning clinics are given special orientation.

Maternal child health and family planning training is now included in training programmes for all categories of nurses.

Crash courses in family planning have already been conducted for all nursing categories and training needs are now being met largely through the regular nursing education programmes, through continuous in-service training at the Port-of-Spain Hospital and through occasional sessions organized at county level.

Clerks are especially trained for family planning recording and reporting. They are available for Maternal and Child Health recording only in a few combined clinics but have had no special training in this area.

The training programmes in family planning orient all staff levels to the concept of an integrated Maternal and Child Health and Family Planning Service.

7. Community Education

Community education for maternal and child care is very largely the responsibility of nurses at clinic sessions or on maternity wards. Very limited inputs are made by the Health Education Unit. There are indications that this aspect of care is neglected or not properly handled in areas.

The programme for community education in family planning is more vigorous and better implemented. All media are used; training and supervision try to ensure that education is done in clinics; Nurse Educators are employed

to reach post-partum, post-abortal clients in the two major hospitals; clinic drop outs are followed up in limited areas in the north and south by two Field Interviewers; attempts are being made in the Canaan/ Bon Accord area to have family planning clients followed up in the District Health Visitors' home visiting rogramme.

MATERNAL AND CHILD HEALTH/FAMILY PLANNING PROGRAMME IN GRENADA, CARRIACOU AND PETIT MARTINIQUE

By Dr. Desmond Noel - Grenada

The People of this newly independent nation have always placed health high up on the list of their priorities and we obstetricians and midwives are in an excellent position to ensure that improvement shall take place in an atmosphere of trust and affection.

71 per cent of our mothers attended the Government Pre-Natal Clinics throughout the islands in 1972.

We know that a certain percentage only go to private doctors for prenatal care and to nursing homes for delivery. We believe that the Traditional Birth Attendant is no longer in existence but I have my doubts for "BBAs" (Birth Before Arrival) of mothers delivered in their own homes is actually 42 per cent. Prenatal attendance is good the average number of attendances per patient being six.

A co-operative card is filled out by the midwife and orthodox standard prenatal procedure is carried out including blood tests, blood pressure and testing of urine.

The Co-operative Card is an important "passport" for the mother. This card gives all the particulars of her history, physical signs and prenatal care, including her blood tests, advice and treatment. This card she keeps and takes with her at each prenatal visit whether it be to the midwife or doctor. When labour commences whether she is to be delivered in the home, in the maternity unit or the General Hospital, the mother brings it along with her, and it is obvious that this is of great help.

At the clinic a decision is made concerning the place of delivery. All high risk cases are advised to have their babies in the General Hospital in St. George's and are sent to the specialist obstetrician for assessment at the prescribed time during the prenatal period.

The low risk cases can have their babies at home or in the other three Government Units in the island.

In 1972,	1356 babies	(46 per cent)	were delivered in the General Hospital
	673 babies	(22 per cent)	were delivered at home
	909 "	(32 per cent)	were delivered in other units.

In the General Hospital there were 29 still births and 24 neonatal deaths giving a perinatal mortality of 39/1000 for hospital deliveries.

In the home there were eight still-births and two neonatal deaths which gives a perinatal mortality rate for those delivered at home of 14/1000 deliveries.

Because of the high incidence of "BBAs" a small maternity unit was built in the western side of the island to enable the low risk mothers in that area to be delivered there instead of at home. Thus enabling the midwife to concentrate her efforts on delivering low risk cases in conditions which would be similar to an ideal home. It was also felt that the reason for the "BBA's" was due to the too late calls by the mother or due to poor communication to the homes. The Unit delivered 156 mothers with no perinatal loss for the year.

The percentage of "BBAs" in that area, I am sorry to say, did not however, change. A survey has to be done to account for and overcome the reason for the "BBAs". Indeed not a few of these cases had been advised to have their babies in the main hospital because they were "high risk" cases.

1972 was a bad year for maternal mortality - five cases being lost all in the General Hospital giving a figure of 1.7/1000 (Two Eclampsias, one Weils Disease, one Pulmonary Embolus, one Gastro-Enteritis due to Klebsella). In 1973 there was one death Ø6/1000.

The maternity ward in the General Hospital has only 13 beds and approximately four deliveries per day. Hence with pressure for beds 24 to 28 hours discharge system is the rule of the day.

In 1972 only 10 per cent of the mothers were actually delivered by the doctor. He however, maintained supervision of the patient and midwives and on most occasions was readily available, for all. The doctor's practice has so far been conducted in the General Hospital.

Two points of interest can be noted in the deliveries in the hospital. The greatest number of deliveries takes place in the age group 15 to 20 which shows good selection of the high risk case.

Secondly, the greatest number of five and a half pounds, and under babies were delivered in the 15 - 20 age group and more significant, the majority of these were in the "small for dates" categories with no clinically obvious cause. This we believe could well be due to poor nutrition on the part of adolescent mothers.

POST-NATAL VISITS

Post natal visits to the home by the midwife is standard procedure but there is a tendancy for care to fall down especially in the mothers that are transferred from hospital back to the home. The use of the Co-operative Card taken by the patient on her transfer home and to the midwife immediately will we hope, bring about a closer liaison between her treatment in hospital and what areas to concentrate on in the regular post-natal visits to the home and the subsequent post-natal clinic visit.

Expectant mothers who are attending doctors privately prenatally should be told of the importance of bringing a midwife into the picture even before birth to ensure the continuity of care postnatally.

POST-NATAL CLINIC

In 1972 the Sister Tutor carried out a Workshop on postnatal care and this was well attended by district and hospital midwives. The purpose of this Workshop was to bring about an awareness of the health benefits of post-natal care and to establish methods of improving such care to the community. Post-natal clinics are conducted weekly at the St. George's Health Centre but not at other medical stations and health centres. Arrangements were made to have midwives come in to such clinics in the city to become conversant with techniques relevant to post-natal care. In the meantime an attempt is being made in some districts to give post-natal care to mothers who are instructed to report for examination on prenatal clinic days.

CHILD HEALTH CLINICS

These clinics were conducted on a weekly basis. There was marked reduction in attendances - 50 per cent. This decrease was thought to be due to the cessation of skimmed milk distribution at clinics.

Despite this there was a marked reduction of Gastro-Enteritis and malnutrition of over 50 per cent.

Immunization service is good and has good coverage.

D.P.T. and Polio vaccine were given with emphasis on Polio Vaccine in view of an outbreak of Polio in a neighbouring island.

The Infant Mortality Rate was reported as 15.99/1000 live births (47 deaths under one year of age) and only 20 deaths one to four years of age.

This low infant mortality figure is so respectable that if it is true and there is every reason to believe that it is, then the delivery care service should be complimented.

Steps however must be taken to ensure that collection of statistical information does not leave any room for error.

M.C.H. PERSONNEL

Twenty four doctors and eighty two midwives. All except five are registered nurses. A Registered Nursing certificate is at present a pre-requisite for entering midwifery training programme. Midwifery in Grenada has been mainly the province of the midwife as it should be.

FAMILY PLANNING

For 1972 Grenada, Carriacou and Petit Martinique had a population of 107,000. The Birth Rate was 28.26/1000 population (2939 births). The Death Rate 6.35/1000 population giving a rate of natural increase of 21.91/1000 population (2279). This natural increase incidentally was balanced off by emigration (2263).

POPULATION POLICY

On the 23rd April 1974 Government made the following statement:

"...An official government population policy recognises the implication of uncontrolled population increase on employment, housing, nutrition, health, education and social and economic development, and sees the need for appropriate measures to alleviate the adverse effects upon the State. Government therefore recognises the right of the individual to access to knowledge and means of regulating his family size and supports educational and motivational programming directed towards this end. At the same time Government supports the principle that the size of the family shall be the free choice of every individual family.

Government further supports participation in knowledge, education and assistance available outside of the State."

Bearing in mind the rate of natural increase 21/1000 population and the limited resources at our disposal in the island's size (135 sq. mls), the statement above is most welcome, for it gives scope to the introduction of family planning into all aspects of maternal and child health delivery service.

Indeed since 1964 the Grenada Planned Parenthood Association supported by I.P.P.F. has been serving the people of Grenada.

Government has always been permissive to the Association and allowed the use of public health facilities and personnel on a voluntary basis.

On behalf of the Government and people of Grenada our delegates would like to thank I.C.M. and F.I.G.O. for sponsoring this workshop. The exchange of ideas between the countries of the Caribbean especially in health matters can only lead to the betterment of our people and that of the world at large.

OVERVIEW OF THE PROGRAM OF MATERNAL & CHILD HEALTH AND FAMILY PLANNING OF THE DIVISION OF FAMILY HYGIENE IN HAITI

By Dr. Jn. N. Cadet, Haiti

COUNTRY BACKGROUND

As you probably already know the Republic of Haiti occupies the western third of the island formerly called Hispanola, the eastern two thirds being occupied by the Dominican Republic. Its area covers around 10,714 square miles. The country is mountainous in its major part and poorly suitable for cultivation. Approximately 2.2. millions acres of land are arable. The Haiti Gross National product was $352 mil. in 1970 and the per capital annual income is about $78.00. The principal exports are coffee, sugar, aluminium ore (bauxite), aromatics. Tourism has recently increased as a source of foreign currency.

The population of the Republic of Haiti is nearly five millions according to the last estimate (1970). The gross rate of natality (G.R.N.) is about 37.8 per cent and the gross mortality rate (G.M.R.) 16.7 per cent. Thus with a rate of Natural Increase of 2 per cent the population will double in 28 years. The Republic of Haiti is densely populated (about 467 people per square mile), surpassed in the Western Hemisphere only by some of the smaller islands in the Caribbean Area.

The age structure of the Haitian population reflects the high fertility pattern; the pyramid shape with 45 per cent of the population represented by the age group: 15 years and under.

In 1971, the total number of women in the reproductive age (15 - 44) was estimated to be one million and is probably higher because women have a high fertility rate until late (49). Due to lack of information on legal marriages and prevalence of Common Law or Consensual Union, the total number of women at risk of pregnancy is not known, but may be estimated between 700,000 and 800,000,

FAMILY PLANNING BACKGROUND

From 1962 to 1970 most of the Family Planning Programs were private and several attempts are made to support a Program of Integrating Family Planning into the activities of the "CENTRE MATERNO INFANTIL" at the University Hospital in Port-au-Prince and Maternity "ISAIE JEANTY" but Family Planning Programs were organized in an anarchic and scattered manner until August 1971 when the Government of Haiti passed a law reorganizing the Department of Public Health and Population with a new Section:

THE DIVISION OF FAMILY HYGIENE RESPONSIBLE FOR NATIONAL PROGRAM OF SUPERVISION AND CO-ORDINATION - of all activities, public and private, related to maternal and child health and family planning - its ultimate goal is:

Social and Economic improvement through a decrease of human and economic wastage caused by illnesses, ignorance and over-population.

PRESENT STATUS OF FAMILY PLANNING

We have already mentioned the ultimate goal of the Division of Family Hygiene. The immediate objective that will be carried out over a five year period is a decrease of maternal and infant mortality by 10 per cent a year.

The national program is considering the opening of 40 clinics that will provide maternal and child health and family planning services throughout the country. But at the beginning, two clinics sponsored by the United National Fund for Population Activities have been organized to test the ability of the division to run a national program. Both clinics have been situated in connection with obstetrical and paediatric centres so that they will be able to offer maternal, child care and family planning services at one site. They have been active since March 1973. "U" so called because it is settled in the "CENTRE MATERNO - INFANTILE" of the University Hospital, and Clinic "M" which is located at Maternity Hospital "ISAIE JEANTY."

ADMINISTRATIVE STRUCTURE

The administration of the program will be conducted under the supervision of the chief of the FHD (Family Hygiene Division) with the assistance of a Deputy Chief. The Direction will be assisted by a team of Haitian technicians in the field of MCH (Maternal, Child Health) and F.P. (Family Planning), two Haitian administrators and an international business manager. An international council of all agencies involved will insure harmonious external assistance and protection of mutual interest.

Moreover, a Planning Committee and a Committee for establishment of norms have been created as well as a "TASK FORCE" for inspection and supervision of all Private and Governmental Clinics. An international Chief Consultant has been assigned for advising the programme:

1. Staffing Pattern

The Staff to provide services in one clinic, serving a population of around 25,000 is:

1 Physician (Obstetrician or Paediatrician)

1 Registered Nurse

2 Practical Nurses

1 Supervisor

5 Community Workers

1 Clerk

1 Part-time Administrator

1 Janitor

1 Driver

1 Part-time Maid - Optional (for clinic settled within maternity centre or hospital)

1 Registered Midwife

1 Practical Midwife

2. Recruitment of the Clientele

The recruitment of the patients is mainly through the Maternity Centre or Hospital where the women can be contacted at any time and for any reason they come, and outside, in town by the Community Workers who will give them a coupon (according to the well known coupon system). The recruitment will also be referral from doctors, nurses and other patients.

3. Data Collection and Record Keeping System

Every client coming into the program is registered on an Index Card, which contains the Identification Number of the client and her Socio-Demographic characteristics. The identification number is intended to be a number of nine digits. The first two digits will identify the clinic, the third and fourth, the location (city, town etc.), and the last five, the client. The Index Card will be kept in the clinic.

The recording system with Index Card, appointment card, follow-up card, medical record, vaccination card, reminder sheet, every-day report, etc. is somewhat complicated for a clerk who might resent filling out all these forms because it is too time consuming. We are in the process of finding a simpler method of data collection with only the Index Card and a medical record on which will figure all variables to be analyzed for evaluation purposes.

With the information taken from the medical chart and the every day report, the statistician prepares monthly

reports, trimester and annual reports.

4. Services

The fact that the program has been integrated within the Department of Public Health and Population reflects the major concern of the Government for the high maternal and infant mortality and the increasing morbidity.

Let us look at some vital statistics .....

....Therefore the program will focus its efforts to improve the health of mothers and children.

Its immediate objectives that will be carried out over a five year period are:

a. A decrease of maternal mortality of 10 per cent a year during five years.

b. A decrease of infant mortality (age group 0-4) of 10 per cent a year during five years.

c. A decrease of fertility of 20 per cent of couples in the reproductive age.

Therefore the services in the clinics are:

a. Prenatal and postnatal care with objectives to:

(1) Aim at 75 per cent of all pregnant women receiving prenatal care.

(2) Increase the utilisation of the maternity centre beds up to 80 per cent within five years.

(3) Improve the conditions in which the home deliveries are performed.

(4) Aim at 50 per cent of all women who give birth to receive postpartum check-up within six weeks of delivery.

b. Family planning services to ensure that 20 per cent of couples in the reproductive age group adopt a contraceptive method either feminine - 15 per cent, or masculine - 5 per cent.

N.B. There will be cancer detection in the clinics affiliated to Hospitals.

Paediatric clinics, with purpose:

(1) To offer paediatric services to 80 per cent of all children from birth to four years.

(2) A program of vaccination of pre-school children.

(3) Increase the number of children seen in well baby clinics.

Evaluation

It is important at this time to conduct an evaluation of this work, so called the first phase, with the following objectives in mind:

a. To assess the achievements and non-achievements of the project goals and targets and the reasons for both. It is important to identify the role of the specific project inputs.

b. To assess the possible inputs of the first phase.

c. To learn from the experiences of the first phase with a view to supplying these to the implementation of the large scale project.

d. To establish a baseline for the second phase of the project which would serve as a benchmark for future evaluations.

Since evaluation of 1974 has not yet been done, but by looking at the histograms prepared by the statisticians during the last six months of 1973 we came out with some remarks and the most striking to us are:

a. The direct acceptors at clinic 'M' at the beginning was less than 20 per cent and has increased to stabilize around 40 per cent. This is in contradiction to what usually happens in clinic 'U' where the percentage of direct acceptors are higher at the beginning and decreased after - the reason is lack of integration and education.

b. The percentage of newly delivered women at Maternity Hospital Isaie Jeanty who chose a contraceptive method is very low. The same is true for Clinic 'U'. That would be for the same reason mentioned earlier.

c. There is a sensible difference between clinic 'U' and clinic 'M' when the methods chosen are considered.

In clinic 'U' 30 per cent chose the Pill compared to 12 per cent in clinic 'M'. 40% chose the condom in clinic 'U' against 18 per cent in clinic 'M'. 12 per cent chose IUD in clinic 'U' against 20 per cent in clinic 'M'. In brief, after the evaluation unit has established the attrition and retention rate for both IUD and Pill, we will know which is a better method for the women enrolled in the programs. In this program it is important to note that a good percentage of clients had chosen the condom at clinic 'U'.

This program was reaching in higher proportion (30 per cent) the age group 20 - 29 and omitting a great number of fertile women who in our culture have a high fertility until very late in their reproductive life. So in every age group fertile women are integrated in the actual programme and we are expecting the data and results for a better appreciation and evaluation.

MATERNAL AND CHILD HEALTH/FAMILY PLANNING PROGRAMME IN BELIZE

By Dr. Lionel A. Clare
Registrar Obstetrics & Gynaecology
Belize City Hospital

I am grateful for the opportunity to address you on behalf of Belize - the new emerging Central American country in the heart of the Caribbean Basin. It is very satisfying to see the International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics coming together in a Joint Study Group in the Caribbean area to consider the situation of maternal and child health services in the area. The coming together of these two bodies (Midwives and Obstetricians) is desirable because of the very nature of their work - too often we see the nurse and doctor working side by side, and hand in hand in the hospitals, clinics or homes but never coming together afterwards to make an assessment or evaluation of the health situation. We in the Caribbean area are noted for the coming together of various races and nationalities to produce a colourful and harmonious society, and I feel certain that our mixture will be richly enhanced by the product or products of this union of Midwives and Obstetricians.

The fields of midwifery and obstetrics bring the nurses and doctors closer to patients than in most other fields in medicine and are the only ones that take an active part in human production, and quite often lead to a lifelong interdependence of those involved. This Joint Study Group will deal mainly with the training and practice of Midwives in Maternal and Child Health and the place of Family Planning in maternal and child health programmes, and I am sure we are moving in the right direction in ensuring that mothers remain healthy so that their products may in turn arrive and develop into healthy children while at the same time being given assistance as to future planning if requested. However, it seems as if there is a missing link in this chain of events - namely the father, and in this era of comprehensive medical care it might be expected that future study groups will also consider paternal health and well being, because he too quite often needs assistance.

The aims of the Joint Study Group is 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. These are admirable and necessary aims in an area like the Caribbean which consists of a large number of young developing nations each with their peculiar economic and social problems which make it difficult for blanket proposals to satisfy the entire area. Therefore to begin to achieve our aims and objectives we must

have first hand factual information of the situation in each territory and it is with this in mind that I will now give you a brief synopsis of maternal and child care and family planning situation in my country, Belize.

MATERNAL CARE

Maternal health service is offered throughout the country by:

1. Hospitals.

2. Public Health Department.

The Hospital prenatal clinics are supervised by the Obstetrician or Medical Officer and midwives, while those through the Public Health Department are supervised by the Medical Officers of Health and Public and Rural Health nurses. There are eight hospitals throughout the country and I will use the Belize City Hospital prenatal clinic as the model.

1. Selection of mothers:

   a. All primigravid patients.

   b. All grand multiparous.

   c. Complicated pregnancies referred from:

      (1) Health Centres.

      (2) District Hospitals.

      (3) General or Private Medical Practitioners.

2. Booking Clinic - held weekly on Tuesday mornings.

   a. Compilation of basic statistics on special antenatal forms.

   b. Blood taken for Hb, Grouping and VDRL.

3. Antenatal clinic attendance for uncomplicated pregnancies; monthly up to 30 weeks of pregnancy, then fortnightly up to the 36th week followed thereafter by weekly visits.

   a. Procedure:

      (1) Maternal weight.

      (2) Blood pressure.

(3) Urine testing for sugar and albumin.

(4) General examination.

(5) Education of mother in child care and hygiene.

The activities of Public Health Antenatal clinics are performed by two M.O.H.s along with Public and Rural Health Nurses of which there are:

1. One supervisor.

2. One Senior Public Health Nurse.

3. Fourteen Public Health Nurses.

4. Sixteen Rural Health Nurses.

These nurses work out of Health Centres of which there are two in Belize City, one in each of six urban areas and sixteen in rural areas. Other rural communities are covered by Mobile Units which make monthly visits. The activities of these clinics are similar to those of the Hospital clinics with the addition of immunization against tetanus to prevent tetanus in the newborn.

In 1972, 65 per cent of expectant mothers benefited from these prenatal clinics. The number of live births for the past three years were:

1. 1971 - 5,052

2. 1972 - 4,954

3. 1973 - 4,845 - of which 62 per cent were delivered in Government Hospitals by professional attendants.

In hospitals and centres a professional midwife was always present at delivery and in the domiciliary midwifery service in Belize City. Domiciliary confinements in the rural areas are largely supervised by traditional birth attendants, who usually refer complicated cases to the area professional midwife who may in turn refer to the nearest District Hospital or clinic.

In 1973 the average length of stay in Hospital, following uncomplicated delivery, for a multiparous mother was 24 hours, while for a primiparous mother it was 48 hours.

Maternal deaths in:

1. 1971 were two - causes not known.

2. 1972 were four - causes:

   a. Two from septis.

   b. One from haemorrhage.

   c. One - unspecified.

Maternal mortality rate/1000 live births in:

1. 1971 was 0.39.

2. 1972 was 0.80

The Domiciliary delivery service in Belize City is carried out by an Inspector of Midwives and two Domiciliary Nurses/Midwives whose functions include:

1. Field training of student midwives of the Belize Hospital School of Nursing.

2. Supervision of qualified midwives in private practice.

3. Supervision and training of unqualified midwives allowed to practise in rural areas.

4. Home delivery of women from second through fifth pregnancies.

5. Assistance in antenatal clinics.

6. Postnatal visits to patients discharged from the Belize City Hospital maternity ward.

CHILD CARE

1. Hospital

   Following discharge from hospital the mother and baby report to the hospital on alternate days until the umbilicus is healed. In 1974 a postnatal clinic was established at Belize City Hospital, where in 1973 32 per cent of all births occurred. At this clinic all babies delivered at that hospital along with their mothers are seen two weeks after discharge, followed by monthly visits in uncomplicated cases up to three months. The procedure here is as follows:

a. Baby

(1) Age and birth weight.

(2) Weight.

(3) Type of feeding.

(4) General physical examination.

(5) Advice on childcare.

Mother

(1) Blood pressure.

(2) General physical examination.

This clinic is supervised by the Registrar in Obstetrics and Gynaecology with the assistance of a general trained nurse and student midwives. There is, in addition, a children's clinic supervised by a Paediatrician at the Belize City Hospital.

2. Public Health

In private practice, professional midwives make twice daily visits to mother and baby for five days. In the domiciliary service where the professional midwives are in attendance, visits were made twice daily for three days, once daily until the umbilicus healed, and then weekly up to one month.

3. Well-Baby or Welfare Clinics

Well-baby or Welfare Clinics supervised by the Medical Officers of Health and Public Health Nurses are held in both urban and rural Health Centres. These are attended by babies one month through five years. Here the services offered include:

a. Immunization against several communicable diseases.

b. Medical supervision to ascertain normal development and early detection of defects and/or abnormalities.

c. Dispensing of supplementary foods and vitamins when necessary.

d. Education of parents in child nutrition, child care and hygiene.

The Public Health Nurses also give B.C.G. vaccination to the new born.

Some statistics:	1971	1972
Live Births	5,052	4,954
Live Birth Rate /1000 population	39.7	38.77
Infant deaths	148	167
Infant death rate /1000 live births	29.29	33.71
Neonatal deaths (less than 28 days)	75	52
Neonatal death rate /1000 live births	14.84	10.49

FAMILY PLANNING

Belize is a young developing country with an area of 22,949 square kilometres and in 1973 had a population estimated at 131,477 of whom about 42,860 lived in the former capital Belize City. The population is relatively young, with 48.8 per cent under five years; only 4.2 per cent of the population is 65 years or over. Census data 1960 and 1970 indicate an annual population growth of approximately 2.89.

With these figures in mind, coupled with the fact that the economy is basically agricultural, it is not difficult to see why Belize has no organised programme leading to a limitation of the population in the immediate future. Where as most of the Caribbean islands suffer from a high density population, we in Belize have a very low density and if we are to develop our resources, mainly agricultural, we will need a higher density of population. Our outlook on Family Planning is not rigid, but we feel that in our country it must be a voluntary process whereby the necessary advices and services will be available to those who request them. It must be remembered that Family Planning does not necessarily mean family limitation, but must be considered in the total context of the economic and social aspects and aspirations of a country. We are fully prepared to take part in conferences, discussions and working groups so that we will be equipped to give the necessary assistance to our people when requested. On behalf of the young developing nation of Belize I thank you for your kind invitation to participate in the Joint Study Group, also for your hospitality, and we trust that we will continue to work together in the same spirit of friendship and unity displayed at this conference so far - for the betterment of the Caribbean area and the world as a whole.

THE ROLE OF THE DISTRICT MIDWIFE IN FAMILY PLANNING

By Mrs. Hazel Sinclair, Jamaica

Nestling under the tropical sun in the Caribbean Sea is the beautiful island of Jamaica. She lies approximately one thousand miles away from her sister island Barbados and with an area of four thousand four hundred and eleven square miles she has a population of two million people.

With an ever increasing birth rate of 38.85 per thousand population it became necessary to do family planning on a national basis. In 1967 the National Family Planning Board was instituted and the setting up of many daily and sessional clinics across the island came into being. As family planning is an important component of basic health services dealing primarily with the planning of one's family with respect to one's social, mental and economic situation and with the aim of giving each member of the family an opportunity to achieve his or her goal in life the District Midwife now finds herself in a dual role as "deliverer" and "postponer".

The need for controlling the population in the wider context of global and national aspirations does not adequately penetrate the attitudinal barrier at the local community level to reach the majority of the population for whom some form of family planning is a necessary pre-requisite for fulfilling the national aspirations.

It is at the vital community level the "nerve centre" of the nation that the district midwife operates and is therefore ideally placed to play an important part in the success of the family planning programme.

As she always resides in the community she invariably has an intimate and personal knowledge of both the individuals in the community and the community itself. This implies that she either conscinusly or unconsciously understands the attitudinal problem (and although she may possibly be a victim of it herself) she can with proper guidance use this advantageously. Her knowledge of the individuals in the community their social and economical circumstances and their "philosophy of life" can be invaluable in advising as to the method of family planning most likely to meet with some degree of success in a particular client. Further, because she is present at the critical moment of the last pregnancy, the delivery, her rapport with the patient or client is likely to be much better. She is more advantageously placed to reinforce (in a humane way) the need for family planning.

The district midwife can also use her influence in removing a wide range of socio-cultural traditions that are obstacles to

family planning e.g. a woman must have out her lot, or that a woman must prove herself. There is also a belief that children are a form of social security in old age so the more the better. For the males it is an expression of manhood. In situations where there is resistance to the use of family planning she is often the best person to pin-point the sources of the problem i.e. the husband, consort or the woman herself - the "fears" of using a method or any method. She may not be able to overcome this resistance but her knowledge may be invaluable to allied workers in the same field in approaching a particular client.

The District Midwife can also help to stimulate and encourage those drop outs who for one reason or another fail to continue the practice of family planning. Two thirds of the District Midwives are now actively engaged in the family planning clinics throughout the island.

In the post-natal clinic the use of the first post-partum visit as a family planning advisory session provided it incorporates the district midwife further enhances the reinforcement.

The informality of her contact with her patients in no way encroaches on her professional integrity or respect of her patients and is a familiarity which breeds no contempt in overcoming attitudinal problems. With her knowledge, the district midwife holds a unique position within the health team in that she has access to the home at a time when the family is emotionally concerned about the well-being of the family.

A look at the age distribution of female population by age at first conception would suggest that there is a critical need to reduce the frequent number of pregnancies occurring in relatively young women (under eighteen) years of age. Traditional morality may be against advocating the use of family planning in the adolescent population but, when confronted with the evidence that the sexual act starts at a relatively early age and frequently results in an unwanted pregnancy the need to minimise this trend is urgent - and family planning should be made available to this sector of the population.

Where the long arm of Government may be ineffective in bringing about the desired result, the short arm of the district midwife operating at the community level with the advantages outlined before can in the role of a family friend and advisor identify potential problems before the tragedy occurs. Her rapport with the parental figures or the adolescents themselves would be advantageous for suggesting the use of family planning methods to postpone the early age of the first conception.

It may seem at first glance that the district midwife may be functioning in two opposing situations of conflicting interest.

This is not necessarily so, for the pregnancies which are delayed or postponed by use of family planning are those which frequently cause most concern to the midwife in Ante-natal Clinic, during delivery e.g. the grand multi-parous woman.

The birth rate of 31.3 per thousand population is still not good enough and if family planning in Jamaica is to be effective in its ultimate aim a drastic reduction in the birth rate must overcome some of the obstacles related to the adverse social and economic conditions which it seeks to improve. The ills of poverty, illiteracy, inadequate housing, and others with which we are all familiar.

In essence the success of family planning will depend largely on the incorporation of the district midwife in the entire programme as her unique position within the health team cannot be overemphasized.

THE ROLE OF THE HOSPITAL MIDWIFE IN FAMILY PLANNING PROGRAMMES

By Mrs. P. Hinds, Barbados

BACKGROUND OF THE ISLAND

Barbados is a small island - 21 miles long, 14 miles in width, having an area of 166 square miles.

The population is estimated at 241,600.

Education is free up to University Standard. It is not compulsory, but in spite of this Barbados is said to have the highest literacy rate in the world.

MATERNITY HOSPITALS

The Obstetric Department of the Queen Elizabeth Hospital has 58 beds. There are two other Government owned Maternity Hospitals, each with a complement of 20 beds. There is one Private Hospital and two known Private Clinics, each with a smal number of beds catering to midwifery patients.

ANTE-NATAL CLINICS

Four Ante-natal Clinic Sessions per week are held at the Queen Elizabeth Hospital, with an average of 130 patients per clinic. There are nine other clinic locations, scattered in such a way as to provide for easy access throughout the island, making a total of 11 sessions per week at these clinics.

FATHERCRAFT

Introduced with very good reception from a few fathers. Had to be shelved due to work pressures.

ANTE-NATAL VISITS

1. 1972 - Queen Elizabeth Hospital - 21,295
2. 1973 - Queen Elizabeth Hospital - 16,538

The drop in attendance is due to the fact that it was necessary to refer patients to other clinics, because of our heavy workload at the Queen Elizabeth Hospital.

Due to lack of time at my disposal figures from other clinics are not available.

MIDWIFERY TRAINING

Two types of programmes are conducted in our training school:

1. The one year programme - a post-graduate course for the general trained nurse.

2. The two year programme for the non-nurse student.

Examinations for the Register are written yearly for the General Nursing Council of Barbados which is the legal authority responsible for setting standards of training and practice for Midwives and Nurses.

LEGISLATION

In Barbados midwives were permitted to practise by an act of Parliament in 1932.

In 1949, the rules for regulating, supervising and restricting within limits, the practice of midwives, were enacted.

In 1973 the Midwives Act and Rules were revised and up-dated. The midwife was given much wider scope in her duties:

1. May do episiotomies.

2. Remove a placenta manually.

3. In multiple births perform external version.

4. Artificially rupture membranes.

More severe disciplinary measures were adopted for malpractice or negligence.

STATISTICS

1.	1972	-	Island's deliveries estimated at 5,454
			Of these O.B. - Department, Q.E.H. 4,064
			Other Government Institutions 734
2.	1973	-	Island's total deliveries estimated 5,051
			O.B. - Department - Q.E.H. 3,952
			Other Government Institutions 692

3. Average Patient's Stay

Three to five days, Queen Elizabeth Hospital.

4. Average Age Group

The 12 - 16 age group has been the cause for much concern. Our statistics show:

a. 1971 - 267

b. 1972 - 343

c. 1973 - 312

Midwives attend all normal deliveries.

Paediatricians are present at deliveries if his presence is indicated or he is called following delivery, if necessary. All newborn infants are seen by the paediatrician before discharge.

"Rooming in" has been practised very successfully in the department from the time it was opened.. During visiting, babies are removed to the nurseries.

FACILITIES FOR PREMATURE BABIES.

There are:

1. 24 cots.

2. Six incubators.

3. One portable incubator, battery operated, which can be used to transport an infant from the district smaller hospitals or private clinics, on request.

4. The Premature Unit

The premature unit is divided into three sections:

a. The premature section.

b. Sick Nursery.

c. Graduate Nursery.

Infants are admitted to the unit depending on the Apgar Scoring Rate, Maturity or any indication of special care.

It is not possible to make a comparative study, but the number of infants admitted and the number discharged home, indicates that the unit is making a significant contribution to the island's Neonatal Death Rate per thousand live births which was:

1. 1970 - 30.7

2. 1971 - 21.8

3. 1972 - 27

Perhaps I could mention here that the island's Maternity Mortality Rate, per thousand live births, for:

1. 1970 - 1.4

2. 1971 - 1.4

3. 1972 - 0.8

LIAISON WITH THE HOSPITAL AND FAMILY PLANNING

Very close relationships with Family Planning Personnel and the Department of Obstetrics, Queen Elizabeth Hospital was established from 1964 - 1965, when our department opened. In the early days Family Planning Personnel visited our wards three times weekly in an effort to reach patients before they left hospital.

They were also available at Post-natal Clinics. Now Family Planning is included in the curriculum for pupil-midwives.

Midwives give Family Planning advice in their Planned Teaching Programmes in the Ante and Post-natal Clinics, on the wards and in our "Outreach Programme", of which you will hear later.

There is one nurse/midwife with Post-Basic training in Family Planning, working in the department.

PATIENT EDUCATION PROGRAMME (P.E.P.)

This is simply what it says, and was introduced into the Hospital this year by the Nursing Service Department. It is a 10 - 15 minute talk to patients Monday - Friday over our call-system. Through this media we are able to reach a number of persons advising them on matters of health in general and we in Obstetrics have taken the opportunity to reach the entire hospital population.

OUR OUTREACH PROGRAMME

Because of the rapid turn-over and heavy work-load on the department of Obstetrics the in-patient stay had to be shortened considerably from our original plan.

As a result of this the Nursing Service Department became concerned - (because of the absence of a Domiciliary Midwifery

Service) about:

1. The after-care of the mother and infant.

2. The education of the pupil-midwife.

An outreach-Programme in Continuity of Care was therefore initiated in March 1973. The objectives of the programme were to:

1. Continue the education of the mother in her home atmosphere as regards:

   a. Breast Feeding.

   b. Care of the Infant.

   c. Nutrition.

   d. Family Planning Advice.

   e. General family health education including fathers when at home.

2. Our target population was:

   a. The young primigravida.

   b. The grand multi-para and associated problems.

METHODOLOGY USED FOR SELECTION OF PATIENTS

1. Asked by the midwives in our ante-natal clinics as suitable persons for follow-up.

2. Or by the Ward Sister making an assessment on her ward.

During the year 140 patients were seen. Visits made were approximately 1,000.

STAFF

1. Midwife)
) at each visit
2. Pupil - midwives)

ACCEPTANCE BY THE PATIENT COMMUNITY

1. Midwives are warmly welcomed into the homes.

2. The receptiveness to teaching and advice is very marked - and fathers participate more readily.

3. The patients confide their doubts and fears more readily in the security of their homes.

CONTACTS AVAILABLE FOR IMMEDIATE ADVICE

1. General problems - Administrative Sister, Obstetric Department.

2. Urgent obstetrical problems - Medical Officer on duty Obstetrics.

3. Non-urgent obstetrical problems - referred to next clinic of appropriate consultant.

4. Urgent neo-natal problems - paediatrician on duty.

5. Non-urgent neo-natal problems - neonatal clinic.

6. Family Planning Clinics.

7. Health Centres - for immunization of other siblings.

8. Social problems - referred to Medical Social Worker.

ASSESSMENT OF THE PROGRAMME

We consider that the programme has been a decided success. This success is due in large measure to the midwives who received the idea, were keenly interested and are filled with enthusiasm for the project.

Requests are now being received from:

1. Obstetricians.

2. Paediatricians.

3. Hospital Social Workers.

The Nursing Service Department and midwives see this project as a means of improving our M.C.H. - programme as we believe it to be an excellent forum for educating the family in all aspects of health, including Family Planning.

We anticipate the extension of this programme, but will need the support of our Government to facilitate its expansion.

TRADITIONAL BIRTH ATTENDANT - HAITI

by Mrs. Antoine Cesar Stenschke

It is a very great honour and pleasure for me to be here and I wish to express my thanks to all of those who made it possible.

After hearing of the activities of midwifery services all over the other territories, I am under the impression that I am doing the wrong thing by exposing what my country does not have. However, it is too late for me to withdraw so I will have to continue.

In Haiti we have the following personnel attending to this:

1.	Registered Nurse Midwife	-	7 per cent
2.	Registered Midwives	-	3 per cent
3.	Registered Auxiliary Midwife	-	8 per cent
4.	Aid Midwife	-	2 per cent
5.	Traditional Birth Attendant (called "Matrones")	-	80 per cent

a. The Registered Nurse Midwife is someone who went to the nursing school for three years then went to the medical school of one year and became a midwife.

b. Registered midwives are not nurses, they just went to the midwifery school but there are not too many of them anymore because of the opening of the registered auxiliary school.

c. Registered Auxiliary Midwives can do a normal delivery as they have had one year's training at school.

d. Aid Midwives are girls who have been sent from some centres in the country and have been trained at the Midwifery Hospital in the capital. We try to discourage them because they wish to have a certificate which we do not like to give after only three to four months training.

e. According to the geographic and economic condition of Haiti and the shortage of personnel in the Public Health programme, the Matrones assume responsibility for a large percentage of deliveries. In 1958 the Health Department started an Educational programme for the Matrones to:

(1) Decrease the rate of mortality and morbidity of mothers and infants caused by traditional practices.

(2) Decrease the rate of infant mortality caused by umbilical tetanus by teaching simple hygiene rules.

(3) Promote contact between matrones (leaders of the feminine community) with the new Health Centres.

(4) Promote by teaching the health rules to prevent sickness.

The matrones have acquired an unconscious and unreasoning experience by mere observation of daily occurrences.

g. They put into practice some empirical knowledge transmitted by tradition and they do not even care for understanding the techniques of the processes employed by them.

In Haiti, in the backward and the suburban regions the midwife or matrone is held in high regard by the majority of our masses. There is an emotional tie between the matrone and her client. By establishing a psychological affinity with her patient, she is able to get some positive results - she is a social entity.

Of a sample of 43 matrones interviewed in the different zones, it has to be noted that they average 25 to 80 years of age. 35.2 per cent are Protestant and the rest 64.8 per cent Catholic. Besides these two religions, a big percentage is composed of Vodou adepts. 97.3 per cent are illiterate and it is impossible for them to state exactly the number of years experience without referring to certain government or political events. So they do not have any notions concerning dates and months and are therefore unable to calculate the exact time for the delivery of the pregnant woman. The number of deliveries made by them does not exceed on an average four per month and the average fee for one delivery is $0.70. This amount shows that this sole activity is not sufficient to assure their subsistance.

Almost all of them use the same tools for the delivery (razor blades, scissors, etc.) and the cleaning methods are all the same.

In spite of their empirical knowledge, the matrones do not seem to be able to get a correct idea about the physiology of pregnant women, the position of the foetus in the uterus or the way it is nourished. Besides, they are always called when the parturient

woman presents some difficulties and particularly when they are about to give birth.

Generally they do not have any adequate facilities at home allowing them to receive their patient.

Concerning preparatory methods they are also all the same; for all of them this consists in the utilization of numerous articles for the baby and the mother before and after the birth. The presence of the matrones has without a doubt a considerable influence on pregnant women. The techniques employed by them for the protection of the mother and eventually the baby are numerous and may be divided in two categories - the more or less hygienic proceedings (6.9 per cent) and the rather non-hygienic proceedings (93.1 per cent).

In Haiti we have a saying - "God is good and God will provide".

Some examples of how they use their methods:

1. To make sure that a woman is at the beginning of her pregnancy if the latter did not have her periods for two or three months, the matrone will notice at the base of her client's neck two racing beats and a deeper colouration of the nipples.

2. In the case of haemorrhage, what she calls "Perdition" the matrone treats the so-called pregnant woman by massaging her client's back, starting from the two sides of the lower part of her abdomen towards the middle of her back as if she would fasten up her waist. Sometimes she applies on the lumbar region until the delivery, a cataplasm prepared with leaves and vinegar or a plaster bought in a pharmacy.

3. When the woman starts having pain, which means that as she is having contractions and labour pains, the matrone gives her (to facilitate the dilation) two spoonfuls of "liane-molle" (lissus sicyonides) mixed with one spoonful of olive oil. In case of abnormal presentation of the foetus a smart matrone can easily come off. In some cases really very difficult presentations, called "vini mal", the matron only intervenes with prayers and orisons.

4. After the delivery, the abdominal pain is called "tranchee caban" (bed pain) she gives to the woman in childbed some wine boiled with salt and she massages her abdomen and then puts a very tight abdominal bandage on her. Sometimes they also give her a ginger concoction or a "toff-toff" concoction without sugar.

5. The women are in the matrones hands for three months after delivery because it is traditional for them to give steam baths every day for three months and some women have to be sent to the hospital because of first degree burns in the vaginal and buttock areas.

TRAINING

Since 1955 training courses of matrones are organised at Albert Schweitzer Hospital at Deschapelles situated a few kilometers from Port-au-Prince.

The meetings are scheduled every week on Mondays. Approximately 70 to 80 matrones participate at these meetings regularly. After four classes they are given a test after which they obtain the privilege to carry a box containing the necessary equipment for five deliveries. All of them are already matrones. They average 25 to 80 years.

There are also a few men practising midwifery, they are called mid-men and the women called midwives.

During the first class they get a course on the physiology of the pregnant woman and on the importance of the prenatal consultation.

The second course deals with tetanus and is prevention by immunization. It is also a revision of the first course.

The third class deals with the delivery; diseases caused by gonococcus and affecting the mother and the baby; the prevention of tuberculosis by vaccination (BCG).

The fourth course deals with lactation, kwashiorkor prevention and the delivery of the pregnant woman at home.

Any matrone who brings 50 babies to the hospital right after the childbirth gets a radio set. (We have a control system by means of number cards in three parts. Part 1 stays at the clinic, Parts 2 and 3 are given to the Matrone who gives Part 3 to the mother she has delivered. The mother then brings Part 3 into the clinic with the new baby as soon as she can so that the baby can get immunization care, etc.).

Generally the matrones understand the importance of Family Planning as soon as one deals with the question. They are leaders bringing women to family planning clinics.

We only have two pilot clinics in the National Programme, but there will be other centres in the different regions of the country.

Many women contacted by the matrones expect to be able to get Family Planning and Maternal and Child Health clinic services in their locality, especially in the regions far distant from the F.P./M.C.H. centre.

FAMILY PLANNING

Family Planning is making its way in Haiti. Of the 43 matrones questioned, 83.7 per cent are well informed and willing to co-operate with the program. 95.7 per cent of the well informed matrones have decided to collaborate with a view to start the Family Planning Program.

From the data collected and analysed, the education of the matrones may require:

1. The formation of a flying team which will be able to open a positive way of approach to the matrones.

2. The diffusion of some necessary data; enumeration, the 12 months of the year, the number of weeks, number of days in a week, etc....

3. The popularisation of personal hygiene and then of hygienic principles at home through interrogatory methods.

4. Extension courses concerning the methods to be employed to get a happy childbirth.

5. An adequate attitude. A particular way to approach the pregnant women with a view to inciting them to adapt their methods to the principles recommended within the Family Planning Program of the Division.

MIDWIVES' EXAMINATION (FOLLOWING BASIC COURSE)

1. Show the picture of the foetus in utero.

   Can you show me the baby? .....

   the cord? .....

   the placenta? .....

2. How is the baby nourished during pregnancy? .....

3. Which foods should the mother eat during pregnancy? .....

   .....

   .....

4. What are the symptoms of tetanus? .....

5.* What causes tetanus? .....

6.* How can tetanus be prevented? .....

   Note: The answer to question 6 should be:

   Vaccination of mother during pregnancy, and the performance of a sterile technique for cutting the cord on the part of the midwife.

   The following are sub-questions to make sure that these two points have been thoroughly understood:

   a. How many vaccines does a mother need during pregnancy?

   .....

   b. Where can the mother obtain the three vaccines?

   .....

   c. Which months during pregnancy should the mother receive the vaccines?

   .....

   d. When you arrive to deliver a baby what is the first thing you ask the mother?

   .....

   e. What must you do if the mother has not received three vaccines during pregnancy?

   .....

Sterile Technique

a. Using the H.A.S. Box the midwife must demonstrate how to cut the cord.

Satisfactory: .....

Unsatisfactory: .....

Why? .....

b. When the H.A.S. sterile cord-cut sets have been used up describe how to make one at home.

.....

.....

.....

c. When the cord has been cut what do you put on the stump?

.....

.....

d. When does the stump fall off? .....

e. Does the midwife pull it off? .....

7.* How can blindness in the baby be prevented? .....

.....

Note: Midwife must demonstrate putting in silver nitrate.

Satisfactory .....

Unsatisfactory .....

8.* How is tuberculosis prevented in the baby? .....

.....

a. Show the midwife the B.C.G. tickets.

How do you use these tickets? .....

.....

9.* How can gastro-enteritis be prevented in the baby? .....

.....

Note: The following questions are to make sure that this has been understood:

(1) What causes diarrhoea and vomiting? .....

.....

(2) When does the mother first give her baby the breast? .....

.....

(3) Should the mother give her baby a bottle?

☐ Yes - Why? .....

☐ No - Why not? .....

10. How can malnutrition be prevented in a child? .....

.....

Note: The following questions are to check that this has been understood.

a. Which foods does a child need to make him grow and prevent malnutrition (ti-moune enfle)? .....

.....

b. At what age is a baby weaned? .....

c. At what age should a mother begin to add supplementary foods? .....

d. How does she introduce new foods? .....

.....

11.* If a mother is sick during pregnancy what do you advise her to do?

.....

.....

Note: If possible the midwife should accompany the mother to the hospital.

12.* How do you prepare a mother for labour? .....

.....

Note: The required answer is good hygiene as regards hand-washing, washing mother, and asking for clean linen, and NOT as regards shaving, douching or giving enemas.

13.* If the mother bleeds after giving birth what should you do?

.....

Note: The required answer is only to give uterine massage and to refer to the hospital if the bleeding does not stop.

14.* What do you do if the baby does not breathe after birth?

.....

.....

Note: The required answer is to wipe mucus away from the child's face, and to do mouth-to-mouth resuscitation.

These questions must be answered in order to qualify for a H.A.S. Box.

THE TRADITIONAL BIRTH ATTENDANT - BELIZE

By Belle Lovell

Before I present my topic, I would like you to bear with me while I give the following information on Belize.

No doubt some of you might be asking the question, where is Belize? Well, I will answer that question now.

B E L I Z E, as it is spelt, is situated on the East Coast of Central America, has an area of 8,867 square miles, and an estimated population of 131,477 inhabitants. Census data for 1960 and 1970 indicate an annual population growth of nearly 2.89.

The population of the country is relatively young, with 48.8 per cent under 15 years of age and 18.3 per cent under five years. Only 4.2 per cent of the population is 65 years or over.

The country's literacy rate is comparatively high, with an average illiteracy index of 10.5 per cent ranging from 1 per cent in the capital to 30.2 per cent in the rural areas of the southern district of Toledo.

The territory is divided into seven districts, viz: Belize City, Cayo, Corozal, Orange Walk, Stann Creek, Toledo and Belmopan, which is the capital. Population density is highest in Belize District, where Belize City, the one-time capital is located, and lowest in the Toledo district, ranging from 4.75 to 24.83 inhabitants per square mile. Each district is comprised of villages called Rural Areas.

In each district town, there is a Government hospital and Health Centre. These areas are staffed by the Ministry of Health. In the majority of Rural Areas, there are small Health Centres staffed by Rural Health Nurses, who are accountable to the Public Health Nurse in the District Town.

Living in these Rural Areas are Traditional Birth Attendants or Nannies, as they are called in Belize.

In the year 1957, Government in collaboration with UNICEF, became very concerned over these ladies and two gentlemen practising midwifery and decided to work out a programme where these people would receive some formal training in the Midwifery Unit at the City Hospital for a duration of six months.

Candidates selected for this programme must meet the following criteria:

1. Presently performing the service.

2. Live in a locality where there is no other certified Midwife or Semi-trained midwife in practice.

3. Enjoy good health and suffering no incapacity as certified by a medical examination.

4. Must be able to read and write.

VENUE AND DURATION

A clinical experience will be given in the Belize City Hospital and will be for six months duration.

COURSE CONTENT

The course consists of theory given by the Inspector of Midwives personnel of the Obstetric team and of the Public Health Service over a period of two months. Four months practical work in the Belize City Hospital Maternity Ward - 20 deliveries the minimum, under supervision of the staff, and two months Domiciliary training with at least 10 deliveries.

Trainees will work normal duty hours while with the unit and will be expected to perform one month night duty as part of her training.

ALLOWANCES & PRIVILEGES

Candidates are expected to pay their own expenses to the city, and also make their own boarding and lodging arrangements.

Trainees are paid a stipend of $75.00 per month by the Ministry of Health.

Trainees are provided with meals, and other privileges such as free medical attention, enjoyed by the nursing staff.

Trainees are expected to provide themselves with white uniforms to be used on duty. The Department provides aprons and caps. The course commences January and June.

Candidates are expected to sign an agreement in the presence of the Inspector of Midwives before the training commences.

On completion of training, these ladies are given a Kit provided by NICEF and are expected to return to their area to practise. They are not allowed to practise in the city and district towns where there is a full supply of certified midwives. These ladies receive periodic visits from the Inspector of Midwives

for the country. They are expected to have their Kits ready for inspection during these visits. If they do not meet the standard that is expected, these Kits are withdrawn and their certificate taken away.

They are also required to attend Antenatal Clinics where the Public Health and Rural Health Nurse observes whether they are maintaining standards at the same time keeping abreast with present trends.

These Nannies are under Statutory Instrument No. 23 of 1957. Regulations made by the Committee of Medical Registration under Section Nine of the Midwives Ordinance, 1929 (No. 26 of 1929), (Gazetted 30th March, 1957).

RECOMMENDATIONS

1. Programme for single trained midwives.

2. Family Planning Programme.

M E D I C A L D E P A R T M E N T

Belize City,
Belize.

Date:

This is to certify that Mrs./Miss .... has undergone six months course of training in Practical Midwifery and experience in deliveries in the Belize City Maternity Ward from ..... to ..... and has received an equipped Kit to enable her to continue efficient services in .... Village and surrounding services in the ..... District only.

On retirement, the Kit must be returned to the Medical Officer of the District or the Inspector of Midwives.

Inspector of Midwives

FAMILY LIFE EDUCATION - ITS RELEVANCE FOR HEALTH WORKERS

Written by Mrs. Carmen, B.Sc., N.P.H.
Acting Director, Bureau of Health Education,
Ministry of Health and Environmental Control - Jamaica

Read By Miss Barbara Patterson

INTRODUCTION

The purpose of this paper is to present a brief review of the development of Family Life Education in Jamaica, as a basis for recognition of the roles and responsibilities of health workers.

"I am the Public Health Nurse in charge of X school. I watched with pleasure the development of Janet Grant* as I visited her school each year. She was 14 years this year. She turned up pregnant at one of my ante-natal clinics. Janet was not a bad girl. I have had similar experience with many other girls. Isn't there something we can do to prevent this?" These were the kinds of concerns and S.O.S's that reached us in the Bureau of Health Education from as far back as the mid-fifties. These calls for help, emphasised for us the need for a programme of Family Life and Sex Education, which, as time went by, has gained in momentum and importance.

The Family, regardless of the structure, is a basic social institution which influences every human being. Many social ills, such as early teenage pregnancies, result from a breakdown in family living.

Man is a social being. People live, work and play together, and will continue to do so. Man is also a sexual being. To live a life that is full and satisfying, individuals must understand their roles as male, or female and be able to make adjustments within their society. The quality of our life long existence as male or female in a society, within which interaction with others is intrinsic and unavoidable, must not be left to chance.

BASIC POINTS OF VIEW

The ultimate goal of any health worker is directed towards improving "quality of life" - to help people to make best use of their potentialities and capabilities.

Accepting the World Health Organisation's definition of health as a "state of complete physical, mental and social well-being", the Bureau of Health Education, views Family Life Education as the

* Fictitious Name

provision to all age-groups within the society (and in particular children, adolescents, young adults and parents), of those educational opportunities which are aimed towards the development of mature and responsible persons and stable family living.

We believe that the following principles are fundamental to the development of any programme of Family Life Education, or Sex Education.

1. Man's sexuality is integrated into his total life development as a health entity and a source of creative energy.

   Human Sexuality - the quality of maleness or femaleness must be recognised, understood and used in a creative and purposeful and positive manner.

2. A programme of Family Life Education is of concern to the total community, and calls for concerted community-wide involvement. Since Family Life Education is involved with attitudinal changes, the influence and pressures from other groups within the society must be taken into consideration.

3. The home, the church, the school, community and youth groups, health and other social and welfare agencies, each has specific and important functions in relation to Family Life Education. Parents, teachers, religious and other leaders need adequate preparation to carry out these functions. In Jamaica, most social and educational agencies are now keenly alert to the urgency for implementing programmes of Family Life Education. Some of the prime movers have been the Ministries of Health and Environmental Control, Education, Youth and Community Development and the National Family Planning Board.

4. Family Life Education is not merely information giving. The Objectives of such a programme also include development of right attitudes and positive values.

5. The content of a Family Life Education programme must give recognition to the many needs of the total man along the following dimensions - Physical, Mental, Emotional, Social, Spiritual, Psychological. A Family Life Education programme should aim not only to combat negative factors such as illegitimacy, promiscuity, venereal disease and other forms of anti-social ills, but also should seek to direct itself in a positive way, towards the building of improved interpersonal relationships, self acceptance, human fulfillments.

HISTORICAL REVIEW

The highlights of the historical development of Family Life Education in Jamaica over the past two decades include:

1. 1954

   a. Concern of health workers, teachers and educators over adolescent behaviour, resulting in the development of a unit - "Growing up" for use in extra curricular courses in some schools. This unit in addition to topics related to physical development at puberty and human reproduction, included personality development, boy - girl relationships, marriage and job selection as areas of concern.

2. 1960's

   a. Appointment by Ministry of Education of a sub-committee to develop a curriculum in Family Life Education. It was through the work of this committee that the concept of a need for the broader area of Family Life Education which includes sex education was established.

   b. Conduct of a sex education study by Bureau of Health Education on the status of teacher training colleges and youth groups.

   c. Under an agreement between the Ministry of Health and the National Family Planning Board, the Bureau of Health Education was charged with a specific responsibility of accelerating the development of a comprehensive family life education programme, including sex education in schools, by assisting the Ministry of Education; and with stimulating the development of programmes in youth organisations.

   d. Inservice training courses in Family Life Education for teachers, nurses, social workers, religious and other leaders.

   e. Development of a reference library in the Bureau of Health Education of books and other educational materials. The increase in number of short courses for school leavers throughout the island.

3. 1970

a. National Family Planning Act 1970 provided that among its functions, the National Family Planning Board "may provide for sex education and encourage the development thereof". (No. 22 - 1970 4 (3) (d)).

b. Inclusion of courses of Family Life Education in teacher training institutions.

c. Seminars with leaders of youth groups.

d. Conduct of workshops for development of resource and teaching materials. The participants of these workshops represented a cross section of health, social and welfare workers, teachers and religious leaders from Jamaica and the other West Indian islands.

e. Special project at the Social Welfare Training Centre of the Extra Mural Department, University of the West Indies to train social workers to carry out their responsibilities in Family Planning and Family Life Education programmes.

4. 1973

a. Appointment in Ministry of Youth and Community Development of Family Life Education Officers, working at a regional level, and inclusion of Family Life Education in the course of training at Youth Centres.

1974

a. The Ministry of Health and Environmental Control Paper tabled in Parliament this year, gave strong support to the proposed programme of Family Life Education in the schools, and Family Life Education was accepted by Ministry of Education, for inclusion in the school curriculum.

b. Reorganisation of the curriculum of Grade 7, to include Family Life Education, by the Curriculum Development Trust of the Ministry of Education.

c. The new curriculum will be adopted in September of this year.

d. The Trade Unions, Jamaica Council of Churches, Voluntary Social Services are all launching out in programmes of Family Life Education.

e. Research into a Community approach being conducted by the University of the West Indies in collaboration with other agencies.

OBJECTIVES

All aimed towards the development of stable and responsible persons, the "Overall objectives for Education for Family Living Course for Youths", developed by the Sub-committee of the Ministry of Education, mentioned before, included statements such as:

1. To help young people develop an appreciation of and respect for the complementary roles of the different members of a family.

2. To help youths appreciate and accept their role and responsibility as members of their family now, and their responsibility for establishing stable families of their own in later years.

3. To give young people a knowledge of the biology of sex.

4. To help youths develop acceptance of and respect for their own sex as male or female, and to adjust wholesomely and successfully to others of their own sex as well as to members of the opposite sex.

5. To combat misunderstandings and lurid concepts about sex, and to help young people establish desirable attitudes regarding the part sex plays in life.

SCOPE OF FAMILY LIFE EDUCATION PROGRAMMES

Based therefore on the premise that the aim of Family Life Education is to fit individuals to live, and to meet the objectives, the scope of any Family Life Education Programme must be a wide one. Programmes must extend beyond the mere supplying of information on the biological facts of reproduction to include aspects such as:

personality development, nutrition, child care, immunization, environmental sanitation, interpersonal relationships, personal hygiene and good grooming, career guidance, manners and social graces, the search for an identity,

all of which contribute to personal growth and development as well as family and community well being.

CONCLUSION

We must be thankful for how far we have come, but that we have a far way to go, is clearly evident.

Because Family Life Education is concerned not merely with supplying factual information but with the development of attitudes and skills which will create a way of life in which individuals can grow, develop and function satisfactorily within the family and society, materials are needed which deal directly with Jamaican and West Indian needs, situations, and problems and which are written by Jamaicans or West Indians themselves.

Implicit in this is the recognition that Jamaicans and West Indians must themselves find solutions to problems which are disruptive to our family life and must determine the kind of family patterns most satisfying to individuals, families, and the society on the whole.

There is need for more programmes of training of teachers and leaders and others who have a direct role to play in the Family Life Education programme, and the commitment of these workers must be encouraged and strengthened.

New techniques for achieving the behavioural objectives must be developed.

All these re-emphasise the need for a systematic scientific and co-ordinated approach to programmes in Family Life Education.

The stage has been set, the time is ripe, the ball is in the courts of all those who work towards bettering the quality of life. And it is to these, to us, I now direct these few closing remarks.

First, every person who touches on the role of sex in life, must feel responsible for the development of appropriate attitudes as well as for the presentation of accurate factual information. Development of a "sense of responsibility" begins with us.

Lastly, Family Life Education has been defined as essentially an education in human relationships, that is learning to live with ourselves and with others. To borrow the words of Dr. Zhivago,

> "Well, what are you? What is it about you that you have always known as yourself? What are you conscious of in yourself; your kidneys, your liver, your blood vessels? No. However far back you go in your memory it is always some external manifestation of yourself where you come across your identity, in the work of your hands, in your family, in other people. And now listen carefully.

You in others - this is what you are, this is what your consciousness has breathed, and lived on, and enjoyed throughout your life, your soul, your immortality - your life in others".

FAMILY LIFE EDUCATION - A ONE WORLD CHALLENGE

WHAT DO WE MEAN BY FAMILY LIFE EDUCATION

Family Life Education is essentially an education in human relationships - that is learning to live with ourselves and with others.

It is a lifelong process and involves everyone - adults, youth, children, married, unmarried, single and celibate.

Family Life Education is concerned with formulating positive attitudes and with the development of stable and responsible individuals rather than with merely supplying information. It seeks to educate - lead forth, liberate, rather than indoctrinate.

Education in family living is positive and dynamic rather than negative and static. Hence, the primary aim is not to cure symptoms of breakdown in family living, such as teenage pregnancies, promiscuity, delinquency, illegitimacy and criminal abortions. Rather education in family living aims at going deeper than merely treating symptoms. Through the educational process, the programme seeks to build the kind of foundation which will enable our young people and our adults to become better able to live with themselves and with others, to feel more confortable about themselves, to become more competent to make decisions, to develop a greater sense of responsibility for their actions, and the likely effect of their actions on themselves and others. The ultimate aim is that all of us Jamaicans along with other peoples of the world, develop that feeling of self worth and caring for others which will enable us to enjoy life, to enjoy relationships, to achieve a better quality of life - physically, emotionally, spiritually, economically socially and healthwise.

JAMAICA AND FAMILY LIFE EDUCATION

Family Life Education in Jamaica with its broad goal of improving the quality of family living for all our citizens has for many years been the concern of various organisations, agencies and individuals.

Although the family has always been recognised as the basic unit of society and deep concern has always been expressed for the development of stable family life, there was no co-ordinated or systematic effort on the part of the various agencies and organisations concerned.

Today, we have arrived at the stage where many Agencies and Organisations have not only identified Education in Family Living as an area for priority attention but have recognised the benefits of a concerted rather than an isolated approach in which the home,

school, church and community are all involved in supporting, supplementing and reinforcing each other.

Implicit is the need for a concerted and systematic approach to Family Life Education is the belief that learning to live fully and purposefully to have positive feelings about self, others and country and to relate satisfactorily with others does not depend on chance, but demands practice, concentration, genuine insight and understanding. It is to these ends that Family Life Education addresses itself.

SEX EDUCATION

WHAT DO WE MEAN BY SEX EDUCATION

Sexuality is not only an awareness of the sex organs and the opportunity for sex relationships, but it is also an awareness of oneself as a male or female person. It includes the roles of the individual in society.

It involves respect for the opposite sex, and an understanding of the similarities and differences of both sexes and how they complement each other. It involves growing to manhood and womanhood and being able to enjoy one's role and live creatively as a male or female person.

Sex education is a part of and a very important aspect of family life education. Sex in itself is a very important aspect of our personality.

We believe that the same attitudes and values which permeate our other relationships also influence our sexual relationships. Hence if basically we care, we will approach our sexual life with a feeling of caring and responsibility. On the other hand if we have developed attitudes and behaviour patterns of exploitation these attitudes and values will influence our sexual behaviour.

AIMS OF SEX EDUCATION

Sex education should help people develop an understanding of their sex roles, accept themselves as members of their own sex, and establish their own guidelines and standards for responsible sexual behaviour.

Our concern is not only with making individuals aware of what sex is, but also to put sex in its proper context in life.

We want individuals to understand that sexual feelings and attitudes are part of normal life and to know how to handle sexual feelings to ensure a healthy and happy life for themselves and others.

We feel that learning to make choices is far more important than blind conformity and that any attempt to indoctrinate people with a set of rigid rules and ready made formulas is doomed to failure.

Rather than supplying ready made answers we feel that the objectives of an educational programme should be to equip individuals with the knowledge, attitudes and skills which will enable them to make intelligent choices and decisions. This is based on the premise that if people are to make decisions for themselves they should know where their decisions are likely to lead. As social beings individuals also need to consider the possible effects of their decisions not only on themselves but also on others.

FAMILY LIFE EDUCATION IN SCHOOLS

(EXCERPT FROM MINISTRY PAPER - 22ND JANUARY 1974)

It is invariably felt that the ideal place for sex education is the home. This pre-supposes parents who are themselves knowledgeable and sufficiently imbued with wholesome attitudes towards sex to adequately undertake this essential task. Since this is very far from being the case in Jamaica, the school must fill this gap and it certainly offers the best opportunity of reaching the next generation of parents.

Unfortunately, there are at present few teachers who feel competent to take on this task. A primary task of the organisers of the programme must therefore be the training of suitable teachers and an attempt to improve the attitudes of all teachers towards sex so that their influence will be wholesome. In view of the shortage of trained personnel, it is not feasible to start an immediate islandwide programme in the schools. The immediate focus will be on teacher training at the level of the teacher training institutions and through in-service courses.

The Ministry of Education fully recognises the present need for adequate family life education in all schools and colleges in the island. This need is all the more pressing because so many families are unable to cope with the task of rearing their children in a manner which stresses this and other aspects of personality development. Most parents are too ill-informed or too shy to deal with what has long been regarded as a very delicate subject.

Among the results of ignorance and undesirable social attitudes, not the least is the frustration and unhappiness of school girls who, through premature pregnancies, drop out of school to give birth to unwanted babies. This sets up a cycle of inadequate parenthood, neglected children, poverty, illiteracy, lack of training skills, unemployment, poor housing, unstable families, delinquency and sometimes crime.

The proposed programme for schools goes far beyond mere information about the anatomy and physiology of sex, important though that may be. The objectives stress the development of healthy attitudes, good inter-personal relationships in the family between the sexes, an adequate personality and sound moral principles. Far from encouraging promiscuity, pornography and other aberrations, the programme aims at combatting and reducing these through emphasis on the positive, wholesome aspects of sex.

The programme will be designed and carried out in such a manner as to reassure the public of the benefits to be derived and to counter any adverse criticisms that are not based on facts. It is also of the essence that the co-operation of parents and guardians be sought.

There have been consultations with the Jamaica Council of Churches and the Jamaica Teachers Association and these organisations have pledged their support.

The outline of the type of curriculum considered satisfactory is attached. This has been developed over the past 5 years by an inter-agency committee consisting of representatives of the Ministries of Education, and of Health & Environmental Control, the National Family Planning Board along with many other voluntary groups and associations and much work has already been carried out in developing individual programmes in some schools and welfare institutions.

The curriculum indicates that instruction will be integrated with the on-going health and social studies subjects already being taught in schools and will cover the span of a child's school career from the primary to the senior high stage.

SELECTED HEALTH PROBLEMS AND NEEDS ASSOCIATED WITH JAMAICA FAMILY LIFE HAVING IMPLICATIONS FOR FAMILY LIFE EDUCATION

Prepared by the Bureau of Health Education,
Ministry of Health with the assistance of
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INTRODUCTION

Family Life Education in Jamaica, with its broad goal of improving the quality of family living, is approached from many angles. This outline touches upon elements of one aspect only, namely the health aspect. Personal health problems and needs of children and youth arise as they grow and develop within the family or household. Moreover, the family in performing its various functions, creates conditions which favourably or unfavourably affect the health of its members.

Children and youth, as they live in families and anticipate families of their own, need instruction on the responsibilities inherent in family living, including health responsibilities.

This outline points to selected health problems and needs of the individual, and of the family or household as a unit which have implications for family life education in Jamaica. Since conditions vary with economic, social, and educational status, and between rural and urban settings, items included here are suggestive only of those which may need attention in a specific programme of family life education. Space is left at the end of each section for individuals, or groups, who are using the outline, to add the particular problems, and the particular problems and needs, which require attention in their situations.

SELECTED HEALTH PROBLEMS AND NEEDS OF CHILDREN AND YOUTHS AS THEY GROW AND DEVELOP WITHIN THE FAMILY OR HOUSEHOLD

1. Food and Eating

   a. Protein-calorie malnutrition - infants, young children.

   b. Full use not made of nutritious, locally grown fruits and vegetables.

   c. Maternal malnutrition during pregnancy and lactation, affecting adversely both mother and child.

d. Early weaning, as when mother works or becomes pregnant again. When intervals between pregnancies are short, mother cannot build up the nutritional reserve for herself and the developing foetus and for breast feeding the child soon to be born.

e. Patterns of sharing available foods at mealtime - for example; man of household may consume proportionately more proteins while the growing children may fall short of requirements.

f. Many school feeding programmes inadequately demonstrate desirable food selection as example for home practices.

g. Food fads; unqualified beliefs and attitudes surrounding specific foods.

h. Other.

2. <u>Alternating Periods of Activity and Inactivity</u>

a. Children keeping same late hours as adults.

b. Crowded living quarters which interferes with sleep and rest.

c. Travelling long distances by foot to and from school, thus causing excessive fatigue.

d. Other.

<u>Safety</u>

a. Frequent lack of parental supervision.

b. Unfavourable attitudes and practices of children and their social groups toward safe use of environment.

c. Other.

4. <u>Prevention and Control of Illness and Disease</u>

a. High incidence of diarrhoeal and respiratory disease, especially among malnourished children and those living in homes and neighbourhood where sanitary conditions are poor.

b. Prevalence of venereal diseases.

c. Need for parents to use more consistently the available immunization services.

d. Need for children to know the preventable diseases for which immunizations are offered by the Public Health Service in the country and the value of preventive measures.

e. Dengue fever endemic and possibilities of its becoming epidemic.

f. Other.

5. Development of Emotional Stability and Adaptability

a. From early infancy, need for love and a sense of identity. These and other basic emotional needs often not met in broken or divided homes or in large families where ways have not been found for the distribution of family responsibilities.

b. With onset of puberty, intensification of emotional stresses and urges which may become accentuated by lack of parental supervision, the "generation gap", and other factors.

c. Early sex experiences and their possible consequences in terms of physical, emotional and social problems.

d. Need for developing confidence and assurance that progress is being made in the development of the Jamaican society.

e. Other.

6. Use of Drugs

a. ("Any substance that, when taken into the living organism, may modify one or more of its functions" - Wld. Hlth. Org. Techn. Rep. Ser. 407, 1969, p.6)

b. Harmful long-term effect - physical, emotional, and mental - associated with the use of and dependence on drugs, alcohol, smoking.

HEALTH PROBLEMS AND NEEDS ASSOCIATED WITH CARRYING OUT THE FUNCTIONS OF THE FAMILY OR HOUSEHOLD AND FULFILLING THE RESPONSIBILITIES OF PARENTHOOD

1. Reproduction

a. Many pregnancies, large family, short spacing between pregnancies, and early age of mother, all interrelated factors which may effect adversely maternal health, child health and even family health.

b. Pregnant teenagers a high risk group. High incidence of complications of pregnancy, including high blood pressure and anaemia, prematurity, abortion complications, high death rate of babies, and in the young girl, not fully developed physically, serious difficulties during delivery.

c. Pregnancies outside of marriage, when rejected by parents or guardians, inhibiting some girls from seeking pre-natal care, and, in some instances, leading them to secure non-medically controlled abortions.

d. Continuum of pregnancies, starting at an early age with resulting large families which cannot be adequately fed and cared for.

e. Need for better spacing of children so that one pregnancy does not immediately follow another to the detriment of maternal and child health.

f. Need for scientific knowledge of reproduction, birth process, and early adolescence.

g. Other.

2. <u>Physical Maintenance and Protection</u>

a. Crowded housing conditions, making it difficult to carry out the necessities of life and creating emotional problems. Infectious diseases more readily spread under crowded living conditions. Lack of privacy exposes children and youth to sexual aspects of family living.

b. In some areas, water supplies may be inadequate.

c. Inadequate facilities for and careless disposal of body wastes and refuse.

d. Poor food handling practices and lack of suitable food storage facilities.

e. Personal hygiene practices sometimes poor and restricted or aggravated by above conditions.

f. Accident hazards in and about the home.

g. Other.

3. Education and Socialization

a. Family Patterning

(1) In some instances, pattern of early sex relationships perpetuated from generation to generation.

(2) A son may smoke because his father or older brother smokes.

(3) Other.

b. Status Conferring

(1) Fertility may become a status symbol proving manhood or demonstrating that a woman can produce children.

(2) Using limited funds for luxury items with high status value at the expense of less costly items of greater health value.

(3) Other.

c. Recreation

(1) Over-stimulation, over-eating and fatigue of children who are included in family recreation pursuits unsuited to their age levels.

(2) Promiscuous sex experiences becoming a form of recreation for some young people.

(3) In some areas, lack of home and community recreation outlets appropriated for physical, emotional and social development of children and youth.

(4) Other.

Defining Masculine and Feminine Roles

(1) Some evidence of differentiated treatment according to culturally accepted sex roles - boys often allowed great freedom while girls

may be burdened with household and child care duties, sometimes beyond their physical and emotional capacities.

(2) Need for encouragement and opportunities to develop within the family and community those qualities of life as boy and girl or man and woman, which contribute positively to good interpersonal relationships and strengthen the fibre of family and of Jamaican Society.

(3) Other.

4. <u>Home Management</u>

a. Management of time - difficult to carry out the basic necessities of healthful living in households where human energies are depleted by ill health or by the numerous household tasks connected with raising a large family.

b. Distribution of responsibilities - need for assignment of tasks, including such tasks as child care, food preparation, cleanliness of premises. Often difficult to carry out in urban communities when both parents work outside the home; perhaps less difficult in rural areas where extended family can share some of the responsibilities.

c. Distribution of resources - need is especially acute in respect of competition for limited funds and determining priorities for their use including health and medical care.

d. Need for young people anticipating families of their own to consider ability to manage a household and assume responsibilties which will befall them in keeping a family in good health.

e. Planning family size in terms of health, socio-economic position, and life goals increasingly recognised as a need among all parts of society.

f. Other.

<u>Child Care</u>

a. Young people often become parents without thoughts of parental responsibilities, including their responsibilities for health care of the child.

b. Need to recognize that a child has his rights as well as parents - that he shall "enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity". "Declaration of the Rights of the Child" as proclaimed by the General Assembly of the United Nations on November 20, 1959. See U.N. Division of Human Rights 1968 Year Book for Human Rights. Human Rights. New York, United Nations, 1967 pp. 89-90.

c. Need for a child to be brought into a world where he is wanted.

d. Need for good pre-natal and post-natal care and continuing attention to the healthful development of children and youth throughout the years of dependency.

e. Need for communities to provide essential child health facilities and services and assist families in their effective use.

f. Other.

LEGISLATION

By Mr. R.J. Fenney, C.B.E., Field Director

INTRODUCTION

The W.H.O. Expert Committee in their report on The Organisation and Administration of Maternal and Child Health Services said:

"The field of maternal and child health is covered primarily by public health laws, but also by other laws related to education (school health), social affairs (adoption, institutional care, day care, care of children in foster-homes), labour (employment during pregnancy), etc."

MATERNAL AND CHILD HEALTH LEGISLATION CLASSIFICATION

1. Legislation regarding registration and reporting, e.g. the registration of births and deaths, the reporting of communicable diseases.

2. Legislation regarding licensing, e.g. licensing of personnel (physicians, nurses, midwives) or of services (hospitals, institutions, day-care centres).

3. Legislation regarding action, e.g. immunization of certain groups, such as children, examination of certain groups, such as children on admission to school, or protection of certain groups, such as pregnant working women.

   MCH administrators should inquire into the need for legislation, advocate legislation where it is necessary and assist in the drafting of laws.

   The reasons and need for legislation should be clearly explained. Before legislation is enacted it is sound practice to conduct hearings with experts in the field concerned and with interested organisations and groups. Following enactment, it is essential to make provision for consultation with the agencies, organisations and individuals concerned so that the intent and purpose of the legislation are observed. Consultative and supervisory staff are needed for this.

   In general, specific procedures required by law usually represent the necessary minimum. Manuals of recommended procedures usually set higher standards.

LICENSURE AND DEFINITION OF PRACTICE

I propose to deal with Class 2 - Licensure and Definition of Practice.

In most countries the professional recognition of a midwife implies that she is licensed to attend women in childbirth.

The system of licensure of professions is usually classified as "friendly" or "unfriendly" depending upon whether the underlying object is to protect the profession or to protect the public.

In the first category the members of the profession seek to protect themselves by establishing a system of training and examination to exclude undesirables. In the second category the state seeks to protect the public by establishing a similar system. In practice there is no reason why the two systems should be mutually exclusive, but if professionalism is going to be anything more than "a conspiracy against the laity" the control of licensure must always operate in the public interest rather than the narrow interest of the members of the profession.

Legislation to establish a profession needs first to define the profession. The World Health Organisation definition of a midwife for instance represents in a few short phrases a mass of accumulated wisdom and experience. But legislation to establish this definition in a particular country needs careful consideration and drafting.

The first objective of such legislation must be one of identification; identification of present practitioners.

In the developing countries where we understand two-thirds of births are attended by traditional birth attendants this is particularly important. The maternity service in any country depends upon the workers who are currently available.

The second objective of legislation is to establish an effective system of licensure. There are two facets to this objective; the first is to confer status and responsibility on the licensee; the second is to establish some system of control of the licensee.

It is essential that midwives like other para medical or allied health professions should practise within defined limitations, (unlike medical practitioners whose practice is only defined in general terms).

It is a function of licensure to define the limits of practice for which the licence is issued. It is a secondary function of licensure to operate controls to see that the limits on practice are observed. This is not only to protect the patient but also to protect the practitioner.

My purpose is to urge that the legislative framework of a satisfactory system of licensure is of fundamental importance. Only on such a secure foundation can improvements be built. The identification, licensure and control of all birth attendants should take priority over the training of elite cadres of midwife tutors or other educators.

It seems obvious that such legislation must be drafted to suit the circumstances of individual countries. But though no universal pattern can be applied, great advantages can accrue from comparative studies of systems in comparable countries and comparable cultures.

For fear it may be thought that I am urging a bureaucratic rigidity and uniformity as desirable I should stress that while certainty is an essential element in legislation there should also be a built-in system which allows for development.

Midwives conferences are always obsessed with future training and no legislation should be considered which does not make provision for future improvements in training and future developments in practice. This implies that training should not merely cover the training of new entrants to the profession but the retraining of existing members.

PAEDIATRIC CONTENT IN EXPANDED AREAS OF TRAINING FOR MIDWIVES

By Dr. Keith McKenzie

INTRODUCTION

The primary purpose of pregnancy is to produce a healthy normal full-term baby.

The care of the pregnant woman is designed to achieve this result.

Traditionally the midwife has been trained to care for women during pregnancy, labour and the puerperium, to conduct deliveries on her own responsibility and to care for the newborn.

ANTENATAL CARE RELATED TO PAEDIATRICS

At present then, the midwife tries to ensure regular antenatal visits from the first trimester not only for obstetric reasons but also to ensure a healthy baby at birth.

To this latter end she pays particular attention to the following:

1. Nutrition of the mother.
2. Preparation for breast feeding.
3. Blood Group and Rhesus factor.
4. Blood serology.
5. Prevention of antenatal Rubella.
6. Vaginal discharges and smears.
7. Care of the newborn.

By the end of the neonatal period she has handed over responsibility for supervision of the baby's care to her Public Health Nurse colleague or Health Visitor.

The new concept of an expanded role for the midwife seeks to extend her responsibility to include supervision of care of the infant and young child in keeping with the role of a community health worker.

Let us consider what further training will be indicated.

NORMAL DEVELOPMENT IN INFANCY AND CHILDHOOD

A knowledge of the normal course of development of a baby during the first years of life is basic in order to advise the mother of what to expect and to reassure her in the face of the many little anxieties that worry the inexperienced mother from time to time.

The fact that little Johnny next door is sitting up at four months while Richard is still trying to balance at six months does not necessarily condemn Richard as a retarded child as the mother may be quick to fear. It may simply be illustrative of the fact that there is a normal range for development and that there is no magic age at which the child must sit up or be promptly labelled as retarded.

Apart from the physical developmental milestones, mental, emotional and social development must be understood as well, as these factors play equally important roles in the growth of a healthy child.

NUTRITIONAL CARE OF THE INFANT AND YOUNG CHILD

This is of special importance in our countries where malnutrition is such a problem.

Traditionally, the midwife should be one of the most important of the health professionals promoting the necessity for breast feeding, as she has the opportunity of seeing the pregnant woman from her first antenatal visit. Furthermore she has the unrivalled opportunity of seeing her at each subsequent antenatal visit or of visiting her in her home and so can play a vital role in the mental conditioning of the pregnant woman as well as in the physical preparation for breast feeding.

Just as essential is her role in seeing to the establishment of breast feeding for the newborn as she sees much more of the mother and the baby than the Doctor.

She must continue her good work by encouraging breast feeding for four months and advise the mother on weaning practices and good mixed feeding so that by age one year, baby is feeding from the family table.

I will not dilate on this topic as it will be dealt with by the next speaker.

IMMUNIZATIONS

The midwife can play another valuable role in advising the mother on the importance of a comprehensive immunization programme for her baby.

Far too much illness in our communities and Hospitals is due to preventable disease.

The midwife should not only advise the mother but should see to it that the mother knows when and where to go to start off the immunization programme.

PUBLIC HEALTH ASPECTS OF CHILDHOOD ILLNESSES

The midwife will expand her role into public health education of the mother as regards certain illnesses and disorders that may occur in the early years of life with emphasis on prevention.

I am not drawing up an exhaustive list but conditions like congenital defects and disorders, malnutrition, gastro-enteritis, whooping cough, diphtheria, tetanus, measles, congenital heart disease, sickle cell anaemia, scabies, skin sepsis, nephritis, rheumatic fever and accidents in the home come to mind.

THE FAMILY AS A UNIT

The midwife in her community health role can help to instruct the parents of the child as to the emotional needs of the child and the importance of harmonious relations in the home between the children, mother and child, father and child and mother and father.

Anything she can do to strengthen the family unit in our countries will be for the welfare of the child.

In conclusion this new concept of the midwife as a community health worker is exciting and challenging, but requires further discussion as to integration with the other workers in community health such as the Public Health Nurse.

EXPANDED AREAS OF TRAINING FOR MIDWIVES (IMPLICATIONS FOR NUTRITION)

By Patricia M. Pena

INTRODUCTION

Adequate nutrition is unquestionably of prime importance in the health of the individual and more so in the vulnerable groups. In a survey conducted in Barbados in 1969, the vulnerable groups were identified as children six months to 59 months, pregnant and lactating women. The maternal diet is the ultimate source of nutrients supplied to the foetus and it is well known that with maternal deprivation the outcome of the pregnancy will be less than satisfactory. Carefully designed longitudinal studies have shown that maternal malnutrition during pregnancy has serious repercussions for the child. Fortification of the mothers' diets had a definite effect on the babies birthweight which in turn was associated with increased resistance and better adaption to the hazards of the environment. The synergistic effect of malnutrition and frequent infection in children is well known.

There is an increased need for certain nutrients during pregnancy - protein to meet the increasing demands for growth of new tissue (the foetus, placenta, uterus and breasts), Calcium and Phosphorus for tooth formation, Folicin and Iron for formation of haemoglobin in the increased total volume of red blood cells and proper maturation of cells. (Nutritional anemias in pregnant women throughout the region has been identified as a major health problem by the Ministers of Health in the Ten Year Health Plan 1971-1980). It is accepted that the increased requirement for Iron cannot be met by ordinary diets, therefore the use of supplemental Iron is recommended; other nutrients required in additional amounts are vitamins, especially Vit. A and C, B Group (fol cin has already been mentioned); Magnesium, Zinc, Iodine, Calories. The allowances for Calories have been established at 2,100, 2,200 and 2,300 in each of the three trimesters. The total energy requirement imposed by pregnancy may not be more than seven per cent of the mother's total energy expenditure. During lactation the requirement of Calories, Vitamin A, Niocon, Riboflavin, Iodine and Zinc are even higher than during pregnancy. Increased fluid intake is also important as well as modification of the normal diet for the complications of pregnancy.

ROLE OF THE MIDWIFE

What is the role of the midwife in dissemination of nutrition information? She is often the person who has the most frequent contact with the mother - at antenatal and postnatal clinics whether in a hospital or health centre facility, or in the home.

Nutritional counselling is not, nor should it be the exclusive domain of the nutritionist. It is in fact the nurse/midwife who assumes much responsibility in this area. To do this she does not need to be an expert in nutrition, but she must have a sound basis for much of the advice regarding nutrition which she must give. At the present time throughout the region little nutritional counselling is given and the information imported is often not uniform.

M.C.H. Services should aim at continuity of care - in the hospital, health centre and home. Because of the nurses' knowledge of the family background and because of the mutual trust founded on long contact, MCH services form ideal sites for education of direct or indirect nutritional importance. Advice on the delivery of nutritional requirements needs to be interpreted in terms of local food preferences, habits and meal patterns.

NUTRITION EDUCATION IN THE TRAINING OF MIDWIVES

Where does the midwife acquire her basic nutrition information? Often such information is limited to he basic nursing programme. Examination of some of the existing midwifery curricula reveals that there is little or no nutrition offered. What exists in some areas consists primarily of infant feeding, breast and artificial feeding.

To improve nutrition education in the training of midwives and upgrade their competency in nutritional counselling, the midwifery curriculum should contain a minimum of 20 hours of nutrition and diet therapy to include the following:

1. Introduction to the basic principles of nutrition.

2. Food nutrients, their functions and sources with emphasis on cost-nutrient values of local foods.

   Nutrients - Carbohydrate, Protein, Fat, Vitamins, Minerals (Water and Cellulose).

3. Composition, structure and selection of foods. Principles of food preparation. Menu planning. The understanding of a balanced diet.

4. Metabolism and calorie requirement.

5. Dietary factors required to meet the nutritonal needs of various age groups - infants, preschool, school-age, adolescents, pregnant and lactating women. Recommended Dietary Allowances.

6. Paediatric Nutrition.

a. Nutrition for normal growth and development.

b. Feeding handicapped children.

c. Malnutrition:

(1) Undernutrition (P.C.M.)

(2) Overnutrition (obesity)

d. Food allergies.

e. Infant feeding and emphasis on breast feeding.

f. Supplementary feeding (multimix concept).

7. Role of nutrition in obesity and cardiovascular disease (reducing diets, low sodium diets - current concepts).

8. Modifications of the normal diet for diabetes. Diabetes in pregnancy.

9. Community nutrition.

10. Nutrition in complications of pregnancy.

11. Socioeconomic or educational factors affecting adequate nutrition.

12. Good dietary practices is not current food fads and misconceptions.

The objective of the foregoing outline is to impart to the midwife knowledge of food, food habits, food economics, provide a sound background in nutrition, to indicate the part a well balanced diet plays in good health; to create an awareness of the nutritonal problems affecting mother, child and family and the role of the modified diet in nutritional rehabilitation; to create an appreciation for the place of nutrition in the midwifery curriculum.

Ideally, guided clinical and field experiences should be correlated with theoretical learning to provide opportunities for the application of learning and acquiring of new skills.

But the inclusion of nutrition education in the midwifery curriculum is not enough. The midwife must at all times impart current up-to-date nutrition and diet therapy information to mothers. Nutrition education must be a continuing process as new research brings additional knowledge. Therefore, in service training should constitute a part of the continuing education

programme for the midwife as she, and indeed all those who impart nutrition information, formally and informally, must keep abreast of changes in the field of nutrition. More misinformation is passed on by well meaning individuals who have not bothered to keep up to date. The long outdated concept of the green banana being a good source of iron (due to colour changes during cooking) is an excellent example!

M.C.H. Services must have a vital educational role. The plethora of costly prestigious highly advertised infant foods pose special problems of interference with lactation and wasting of a limited budget on convenience foods with high cost/nutrient values. How many midwives are aware of the nutritive value of local foods? Are midwives in the region fully aware of the concept of the supplementary value of proteins (amino acids) and that traditonal cereal legume mixtures like rice and peas, roti and dhall, pea soup with dumplings are good sources of protein since the limiting amino-acids in the cereals and legumes are supplemented when the two are eaten together? That greater stress is now laid on the provision of sufficient calories rather than protein in P.C.M.; the concept of the multimix for supplementary feeding.

These are but a few of the newer concepts in nutrition education of which you must be aware in order to provide effective nutrition counselling and fully achieve the goal of competence in patient care.

FAMILY PLANNING AND HOW IT COULD BE INTEGRATED INTO THE MIDWIFERY CURRICULUM

By Helen Christian - Trinidad & Tobago

The government of Trinidad and Tobago recognises the fact that Family Planning is an essential part of any health oriented curriculum. In keeping with the terms and agreement between the Government of Trinidad and Tobago and the Internationa Bank for Reconstruction and Development, The Ministry of Health has incorporated Family Planning in the Basic Nursing Curriculum and Post-Basic Nursing Programmes in the country.

The aim of the project is to give more emphasis to Family Planning in the basic training of nurses, because it is felt that nurses can be very influential in motivating a substantial proportion of the female population with whom they come into contact, during the performance of their functions in the Health Services.

The integration of Family Planning demands that the subject matter be included in all education programmes. It also demanded that Nursing Tutors be prepared for their educational role in Family Planning.

Under the direction of the Medical Officer, Population Programme, workshops were arranged in 1970-71 to give the tutors required training, and at the same time to prepare guidelines to be used in their classrooms. The result of these efforts is a Family Planning Reference Manual, which is used in all nursing education programmes in Trinidad and Tobago.

I have been asked to speak on Family Planning and how it could be integrated into the Midwifery curriculum. Prior to 1971 lectures by obstetricians and tutors consisted of a course of lectures including the following:

1. History of Family Planning.
2. Socio-economic factors.
3. Organisation of family planning clinics
4. Methods of contraception and advantages and disadvantages.
5. Knowledge of available facilities in Trinidad and Tobago.

On the advice of the Director of Nursing Education the following topics have been incorporated into the obstetric programme under the following headings:

ANATOMY AND PHYSIOLOGY

1. The Reproductive System

   a. Human reproduction

   b. Concepts and Methods of prevention of conception.

2. Ante-Natal and Post-Natal Care

   a. Health aspects of family planning in relation to the mother with emphasis on increasing incidence in venereal disease.

3. Paediatrics

   a. Health effects of family planning in relation to the child.

   b. Socio-economic effects.

4. Public Health

   a. History of family planning.

   b. Community education and motivation in family planning.

   c. Family planning clinic organisation.

5. Vital Statistics

   a. Health of family.

   b. Advantages of careful planning.

In addition to theoretical experience, all pupil midwives have eight-eight hours practical experience in the Family Planning Clinics. This is in addition to experience gained on Post-natal and gynaecological wards.

CONCLUSION

So far the midwifery school staff has found the programme to be working well. However, I shall welcome any suggestions for change.

FAMILY PLANNING MANPOWER

By Dr. Willard Boynton
Deputy Director, Office of Population USAID

Midwives should be aware of the population problem as well as the health aspects of family planning. There is a world population problem and those of us who are population workers believe that if we do not blow ourselves up with atomic bombs, the slow quiet cancer of the population explosion may destroy society just as completely unless birth control parallels death control.

Today there are nearly four billion people in the world. Each year there are 80 million more than the previous year. In 10 years we will add another billion people, whereas it took hundreds of thousands of years, until 1830, to reach a world population of one billion.

This Conference has been talking about two million people in Jamaica, nearly 250,000 in Barbados, etc. and the difficulties of providing reasonably adequate MCH services for these numbers. In our AID Population Office we talk about the 800 million fertile couples that need family planning services. If we can't provide adequate health services for our present populations, how can we provide for 80 million more people each year?

Why must we, as midwives and physicians, be interested in population and family planning? There are four good reasons:

1. To promote economic and social development - the prime interest of AID and of most developing countries.

   Plans for economic and social development in developing countries are undermined by rapid population growth rates of 2.5 to 3 per cent per year. When national productivity gains of approximately 5 - 6 per cent have to be divided among 3 per cent more people, little is left over to improve health and nutrition.

2. To protect the health of mothers and children.

   As a public health physician working in developing countries, I am convinced that the spacing and limiting of children will do more to improve public health than most any other health measure possible with limited resources.

3. To ensure a human right and therby enhance human freedom.

The United Nations has declared that access to family planning information and services is a human right; 30 heads of state have signed a declaration to that effect. Midwives are largely women and women are demanding their right to equality and freedom, including the choice of being pregnant or not being pregnant.

4. To ensure adequate world resources and to limit world pollution.

The recent petroleum shortage should make us all aware of the finite resources of our planet. We heard today that bus schedules changed from once every half hour to once every hour because of a shortage of petrol. The majority of the world's population are undernourished and malnourished. Increased agricultural productivity is offset by population increases while prospective shortages of petrol, fertilizer and insecticides make future increases in productivity uncertain. Most of the major cities of the world are developing a canopy of unhealthy smog which becomes steadily worse.

What is going on in family planning? AID is providing about 100 million dollars a year to assist family planning programs in developing countries. Private organisations and governments of other developed countries together are giving about the same amount. This assistance is available through bilateral programmes-country to country assistance; through such multilateral programmes as the United Nations Fund for Population Activities; through the International Planned Parenthood Federation; through intermediaries such as the Family Planning International Assistance, the Population Council, the Pathfinder Fund etc; through training centres such as Johns Hopkins University, Downstate Medical Centre Midwifery Programme, the University of North Carolina, etc; and through private foundations such as Ford and Rockefeller.

So you can see there are many opportunities that you can take advantage of to expand and enrich the family planning component of your MCH services. No MCH service can be considered satisfactory or complete unless it includes adequate information and services for the spacing and limiting of children.

Are we making any progress? Yes! A few years ago we could hardly discuss birth control - not at all at AID until 1965. Now we assist 36 countries bilaterally and 80 countries through intermediaries. WHO has received requests from 50 countries for assistance in family planning. There has been a rapid increase in family planning acceptors, but programmes still reach only

5 - 10 per cent of fertile couples worldwide. The more advanced programmes reach 25 - 50 per cent of fertile couples. We have done very well in a short time but we are just starting and have a long way to go in a hurry.

As health professionals we have neglected family planning as a health measure. I was able to graduate from medical school with no training in family planning and even today I am afraid most doctors, nurses, midwives and public health workers receive little or no training in family planning. Yet the outcome of pregnancy is determined more by the number of pregnancies, the interval between births and the age of the mother than by most of the routines we doctors and midwives put our patients through. If we really care for the welfare of our patients, we must focus more on those three factors.

The 'WORLD HEALTH' magazine of WHO in the January 1974 issue has an excellent article by Dr. Omran on the health benefits of family planning for the mother and child. Every midwife should read it.

Since 1865 it has been recognised that grand multiparas run greater risks of disorders of the placenta, uterine rupture, haemorrhage and abnormal presentation. They also run an increased risk of diabetes, cancer of the cervix, malnutrition, and chronic ill health. Even fathers are subject to hypertension and gastric ulcers due to worrying how to pay the bills.

Mothers who conceive before twenty or over thirty are poor obstetrical risks. Those who conceive between the ages of thirty and forty have twice the risk of dying in pregnancy or childbirth. as women between twenty and thirty. For example, in Thailand, it has been estimated that if births to mothers over thirty could be averted, approximately 1,500 women per year would be saved from death.

The interval between births is also important. Relevant data demonstrates that the period between the end of one pregnancy and the beginning of another should be no less than two and no more than five years.

In his article for WHO, Dr. Omran concludes:

"World-wide experience indicates that effective family planning can favourably influence the health, development, and well being of families and individual family members in many ways:

> By making it possible to plan family size - that is, by enabling every couple to have the number of children considered best in terms of health, socio-economic resources, and family goals. Four health objectives

should be considered in planning family size:

a. To lower levels of fetal, infant, and childhood mortality and sickness.

b. To improve the physical, mental and intellectual development of children.

c. To secure the health and life of the mother.

d. To enhance family health and adjustment.

2. By planning birth intervals, to improve maternal health and child development and well-being.

3. By making it possible for women to have children at the ages at which pregnancy carries the least risk for the mother and the best chance of successful outcome - a matter of particular significance with regard to the first and last pregnancies.

4. By making it possible to avoid unwanted births, whether legitimate or illegitimate.

5. By preventing abortions, especially high-risk (illegal) abortions.

6. By making it possible through genetic counselling for couples with hereditary diseases of handicaps to avoid passing them on to their children.

Family Planning has two principal problems, adequate coverage and continuation rates. Midwives can help solve both problems.

Most family planning programmes do not begin to provide complete coverage of the country with adequate services. We know from many studies that 90 per cent of visits to rural health clinics are made by people living within three miles of the clinic. How many family planning programmes have clinics located only five to ten miles apart?

A very important deterrent to better coverage is lack of trained manpower. Most developing countries in the world have one doctor for 5000 - 25,000 of population, and they tend to congregate in cities. The number of graduates of medical schools in most of these countries are barely adequate for the population increases. Therefore, doctors cannot provide the family planning services needed to solve the world population problem.

Midwives and nurses must come to the rescue; they must provide the bulk of the professional person power required. Every study with which I am familiar demonstrates not only that they can do the

job, but that they can do it better. Nurses and midwives will take the time to establish rapport with women patients; they can learn to insert IUDs safely; they can screen patients for the safe use of oral contraceptives; they can teach patients to use conventional contraceptives; and they can provide treatment for side effects of contraceptives.

Although midwives and nurses can provide tens of thousands of family planning staff, we need hundreds of thousands if we are to serve all 800 million fertile couples in the world. That means we must enlist the help of auxiliary nurse-midwives, indigenous medical practitioners and indigenous midwives. These auxiliary workers must be supervised by qualified midwives. Since midwives have experienced and sometimes resented the quality of doctors' supervision of their own work, I am sure you will recognise the need for gracious and sympathetic supervision of your auxiliaries.

As a physician, I would like to see every patient have the best medical care possible. As a public health worker, I know our family planning programmes must have realistic staffing patterns or we will effectively deny any service to people. Therefore, the medical service offered in family planning programs must be the best possible under existing conditions, but it must be consistent with the level of medical care possible in the country.

Family planning services have been plagued with poor continuation rates - sometimes as low as 30 per cent after one year. I am convinced that the most significant factor is an unsatisfactory experience at the clinic where services is rendered. There is often a lack of interpersonal communication - failure to explain adequately the procedure and the expected results. Further deterents to patients' continuation of family planning are excessive fees for the service and a long waiting period without adequate shelter or diversion. Supplies may be limited and equipment lacking. Patients may be required to return too frequently or clinics may be held at inconvenient times or for very limited hours. Too often potential family planning acceptors are told to return at some other time or to go to another clinic.

As midwives you know that preventive services such as prenatal care or family planning must be offered to patients in an accessible and acceptable manner if you want them to return for more services. They must be convenient as to time and place, financially affordable and acceptably presented. Midwives who understand tender loving care are needed to organize family planning services.

My conclusions are that:

1. Midwives have a duty to protect the health of mothers and children by providing family planning services for the spacing and limiting of pregnancies.

2. Midwifery training courses must include adequate instruction in family planning.

3. Midwives must participate in family planning work or it cannot succeed.

4. Midwives must co-operate willingly in family planning work both with the doctors who supervise them and with the auxiliaries whom they supervise.

5. Family Planning must become part of our accepted health culture, if we are to solve the world population problem and are to take full advantage of an important health measure.

In these ways midwives can help improve the quality of life in the world by improving health and extending personal freedom.

CONTINUING EDUCATION IN FAMILY PLANNING

By Thelma Grant - Downstate Medical Centre, New York

The topic of my discussion will be continuing education in family planning. Before I discuss this I would like to spend a few moments discussing our family planning training programme at Downstate Medical Centre.

FAMILY PLANNING TRAINING PROGRAMME AT DOWNSTATE MEDICAL CENTRE

With the financial assistance of the Population Council, the Ford Foundation, and the Rockefeller Foundation, our family planning training of three months' duration for foreign trained midwives started in October, 1966. We started originally with three trainees, four staff members, and two physicians. Since April, 1971, our programme has been supported by a grant from the Agency for International Development. With the advent of A.I.D. support, our programme was expanded. The number of our trainees gradually expanded from 10 to 15 per session. Our family planning staff increased to eleven staff nurse-midwives and four physicians, of whom two are part time, and two are full time.

1. Description of Clinic Population

   There are currently over 25,000 patients registered in our clinic of which approximately 6-7 thousand are inactive. Our patients are 80 per cent black, 15 per cent Puerto Rican, and 5 per cent Caucasian. About 80 per cent are under age 30. In general, in our clinic, patients are permitted to choose the method of contraception they desire unless there are medical contra indications. Our clinic offers all methods of contraception.

2. Training Foreign Trainees

   There are three training sessions per year, each of 12 weeks' duration. The training programme includes:

   a. General

      (1) Comprehensive instruction in all phases of family planning.

      (2) Understanding the basic concepts of the anatomy and physiology of the reproductive systems.

      (3) Complete introduction to accepted methods of family planning and exposure to the experimental methods being investigated by us and others.

(4) Instruction in demography and the economics of family planning.

(5) Orientation into social service problems of family planning.

(6) Clinical record keeping and follow-up of patients.

b. Pelvic Examinations

All trainees must become efficient in performing pelvic examinations. In order to properly care for patients medically, and in order adequately to prescribe family planning methods, the trainee must learn to:

(1) Determine position, size and shape of the uterus and adnexa.

(2) Determine the direction of the cervical canal.

(3) Sound the uterus and recognise gross pelvic pathology.

(4) Properly take Papanicolaou and G.C. Smears.

c. Laboratory Techniques

Our trainees are taught a minimum of laboratory techniques including:

(1) Hematocrit or haemoglobin determination.

(2) Trichomonas and monilia slides.

(3) Prenostican test and urinalysis.

These tests are performed whenever indicated on her patient and are carried out under the direct supervision of her instructor.

d. Didactic Instructions

In addition to the clinic instructions, the trainees receive didactic instructions in:

(1) Demography.

(2) Psychology in family planning.

(3) Endocrinology of the ovulatory cycle and oral contraception.

(4) Disorders of menstruation.

(5) Infertility.

(6) Paediatrics.

(7) Sexuality.

(8) Venereal diseases.

(9) Abortion, tubal ligation and vasectomy.

e. Other

After the third week, the trainee begins to insert IUDs under very close supervision. After the sixth week, she is usually capable of doing this on her own. Our past 169 trainees have performed over 16,220 pelvic examinations and 13,637 breast examinations. They have fitted over 668 diaphragms and have inserted over 4,373 IUDs, without a single perforation of the uterus and have prescribed oral contraceptives for approximately 14,000 patients.

Our clinic operation is carried out primarily by our nurse- midwifery staff and our trainees. The medical staff is present for supervision and consultation. The nurse-midwifery staff is charged with the responsibility for clinical instruction of medical, diploma, Baccularate nursing, and basic nurse-midwifery students.

The New York City Maternal and Infant Care Unit has provided us with family planning counsellors who give contraceptive advice to patients on the post partum, gynaecology and abortion units. If we are to meet the unmet needs in family planning, we must get on with the job of training paramedical people to deliver these services under appropriate medical supervision.

STATEMENT ON PHILOSOPHY ON CONTINUING EDUCATION

The complexity of knowledge and skills required to safeguard recipients of family planning services makes it imperative for physicians, nurses, nurse-midwives, family planning nurse practitioners, and family planning counsellors to continue their education in family planning. Completion of a three month training programme in family planning no longer prepares for a life time of practice. Family planning as an essential social service must be concerned with meeting changing societal conditions and needs. Programmes of continuing education in family planning must be designed not only

for nurse-midwives, but also for members of other allied health professions and recipients or consumers of health care.

1. Continuing Education Includes:

   a. Training maternal and infant care family planning personnel from other nations. Each year, from 30 - 50 graduates and professional workers in maternal and infant health and family planning programmes in other countries come to the U.S. to learn more about continuing education in family planning. These professional workers are interested in clinical techniques, especially in administration, statistical evaluation methods of family planning, and studies in behavioural and cultural acceptance of birth control.

      They are eager to share our experience in training professionals and non-professionals, and techniques for obviating the manpower shortage. Participants want to know how to use practically illiterate assistants in health programmes.

      The controversial topics of vasectomy, tubal ligation, and abortion are reviewed eagerly and the particular hazards encountered with family planning for adolescents are increasingly relevant.

      The training in such programmes are usually conducted by a public health officer (MPH) and an assistant who handles secretarial and administrative duties.

      The 56 maternity and infant care projects give physicians and nurses and social workers from less developed countries an opportunity to see family planning at all phases. In these projects, teaching good nutritional patterns to patients is emphasised. Community participation in the management of clinic programmes is demonstrated in many of these projects.

      Downstate Medical Centre has helped in the continuing education of foreign visitors. The special interests of physicians are usually:

      Family Planning, Paediatrics, Obstetrics, Ultra-Sound, Infertility, Laparoscopy, Coloposcopy and Abortion.

      I believe these graduate training programmes have been of value largely because they either supplement or tie in with the efforts to improve the health of

mothers and children in the participants' home countries. For example, the multi-disciplinary approach to MCH and family planning programmes, the extended role of the nurse and the use of auxiliary personnel are relevant to participants or students from developing countries, where manpower cannot keep abreast of the population's medical needs.

The students and participants who come to the U.S. for continuing education have benefited from scientific studies and research which would not have been available to them, in most instances, in their own countries.

In regard to these considerations, the MCH training programme has relied on the students apparent awareness that the practices they observe in the U.S. need to be evaluated in terms of their applicability in their respective countries.

2. <u>The Nurse Practitioner in Family Planning</u>

I feel that the development and utilization of family planning nurse practitioners is a logical extension of the role of the nurse as a provider of primary health care for women. Most of our large cities in the U.S.A. are faced with major problems relative to family planning; for example:

a. Inadequate services for the low income person.

b. Lack of awareness and difficulty of entry into a health care system.

c. Poor continuity of services to women during their years of potential child bearing.

d. A large number of potentially high risk non-pregnant women in low income population.

As part of a project program to attack the above problems, Planned Parenthood Association of N.Y.C., and Hartford Hospital, University of Connecticut, (funded by OEO) are training nurses so they might assume more responsibility in family planning clinics.

Instituting this programme required initial acceptance and approval by hospital administration, physicians and nursing services.

What should be the criteria of a family planning practitioner programme?

Nurses selected for programme:

a. Are registered professional nurses.

b. Have a broad knowledge of maternity nursing.

c. Demonstrate manual dexterity generally related to obstetrics experience.

d. Demonstrate ability in teaching family planning.

These criteria assure the selection of nurses with good judgement, maturity, solid background, and interest in the goals of a family planning programme.

The curriculum is almost the same as our three month family planning training programme at Downstate. More emphasis is placed on pelvic examination and evaluation. Unlike nurse-midwives, most nurses have never performed pelvic examinations.

One family planning nurse practitioner at Hartford comments, "determination of the size, shape, consistency and location of the uterus is not a simple procedure; a fact willingly attested to, by the doctors, agrees that the evaluation of the adnexa remains the greatest concern in the physical exam".

As one can see there is a great need for the extended role for nurses, but continution and general approval of this programme is yet to be seen.

3. Community Health Services and Family Planning

This is education on the part of the public to relate to the community. In 1969, the N.Y.C. MIC started a programme in the training of lay persons as family planning counsellors. The trainees were of various ethnic background, selected from the community where Maternal and Infant Care clinics are located.

Duration of the training programme is six to eight weeks. The curriculum includes:

a. Pregnancy and birth.

b. Methods of contraception.

c. Sexuality.

d. Patient/Counsellor relationship.

e. Evaluation of the programme.

f. Structure of the hospital.

g. On the job training.

h. A total view of M.I.C.

At the completion of their training, these family planning counsellors are assigned to hospital and community MIC family planning clinics. Their primary role is instruction of contraception to patients on Post Partum, Gyn., and Abortion Units. Currently there are five counsellors employed at our institution (KCH). They are doing a tremendous job of counselling our patients and we do hope we will be able to continue their employment.

4. <u>In Service Education</u>

Implementation of staff educational programmes in family planning for nurses and other hospital personnel should include one to three days workshops depending on the hospital and nursing service. This includes education on all methods of contraception. This involves encouraging health personnel to learn about birth control methods and to be aware of when and where services are available and of other matters relevant to inform patients and to help them start and continue birth control.

The staff should be instructed in providing the individual or couple with advice on the health implications of child bearing especially as influenced by the mother's age at first and last pregnancy, intervals between pregnancies and the number of pregnancies.

The staff should also be informed about the various referral agencies, e.g., Child Health Stations, Social Services, Social Hygiene, Marriage Counselling and other family planning services available.

At the Downstate Medical Centre, in service education is given to all nursing personnel at least once a year. At these sessions, organized lectures, classes and distribution of audio visual material are given in various aspects of family planning. There is usually a Question and Answer period. This is usually a worthwhile session and is considered by the staff to be of substantial professional importance, contributing to their own individual professional growth and providing structure and information to help maintain a dynamic quality of service to the patients.

5. Education in Schools

a. United States

In the U.S., programmes for population education are in various stages of development at such Universities as Columbia, Harvard and Florida State. The need for family planning education in schools, colleges, mental institutions and prisons is vital. The N.Y.C. Board of Education has established a School for pregnant girls, providing prenatal, post partum and contraceptive services. The Woman's House of Detention has expressed a desire for contraceptive services. If the State's purpose of prison detention is rehabilitation, this goal can only be achieved if education in contraceptive methodology and contraceptive services is made available to women who desire such services. Establishment of a "team approch" to family planning services, utilizing a nurse, nurse-midwife, on a visiting basis to existing colleges, schools, prisons and other facilities should be on an "on call" basis. On several occasions, our family planning staff at Downstate has visited colleges and schools giving lectures on contraception.

b. Sweden.

Sweden's sex education programme in the schools is the most unique in the world. It was introduced in the curriculum in 1944 and made compulsory in 1946. Instruction in sex education begins with the first grade and is given throughout the compulsory nine year school. Topics include contraception, venereal disease, explanation of the reproductive process and social, psychological and moral aspects of sexual relations.

c. India.

In India, publications of a handbook called, Population Education, for secondary teachers, demonstrates the importance of bringing about changes of such channels of education.

d. Nepal

In Nepal, papers by the Ministry of Education recommended inclusion of population education in secondary schools, science courses, rewriting of curriculum and in service training of teachers.

6. Video Education in Family Planning

The New York State Coalition for Family Planning is embarking on a pilot project using the newest techniques of video for family planning. The Coalition has developed a series of programmes on contraception and family planning techniques on video cassettes. These cassettes and video equipment are now placed in 15 clinics throughout the state for a six month period on an experimental basis. One of the aims of this video education is to minimize the hours of teaching time by family planning personnel. At Downstate Medical Centre, this programme is in its initial stages, therefore any evaluation at this time would be premature.

7. Family Planning Training for Social Service

The family planning training for staff in public assistance departments is the project of many creative minds and hands working in common cause. Family planning is recognised as a basic human right and information, education and services are encouraged on the basis that they permit couples to exercise their rights, knowledgeable and in accordance with conscience.

In 1967, a congressional amendment was passed that the state and local welfare agencies must offer and provide family planning information, including the availability of medical contraceptive services, as well as social and educational services. Such training programmes provide case workers in public service departments with a frame work within which they can carry out the intent and purpose of the 1967 amendment.

a. Purpose of Family Planning Social Service

The overall purpose of such a training programme in family planning is to equip the public welfare caseworker with the knowledge and skill necessary to provide adequate information of services to all families who are receiving assistance. They can then make their own decisions about the number of children they feel they should have as well as about the spacing of these children; a decision which will be in the best interest of the physical and emotional health of every member of each family.

b. Educational Objectives of this Programme

(1) Acquire the rationale for the involvement of case workers in family planning counselling.

(2) Acquire an understanding of family planning as an important preventative health measure and of the philosophy and goals of family planning.

(3) Identify and understand the contraceptive methods and techniques currently available and their relative effectiveness, acceptability, advantages and disadvantages of each method, to enable the case worker to answer client's questions.

(4) Acquire knowledge and understanding of methods and techniques for initiating services in relation to family planning.

(5) Acquire information about referral procedures, recording and follow-up procedures, in relation to case work activities in family planning.

The intent of this course in family planning for social workers is to help case workers acquire the necessary information and counselling skills to enable them to provide family planning advice and services to clients who need and want such services.

Currently, family planning programmes for case workers are now being implemented in Michigan, Illinois, and Planned Parenthood New York.

8. Courses for Family Planning Nurse-Midwives

Courses for nurse-midwives to upgrade and improve as well as augment their knowledge of family planning should be included. Continuing education should include seminars on new trends in contraception.

a. Paediatrics

The goal of continuing education programmes in Paediatrics for family planning nurse-midwives is to provide knowledge, understanding and skills that will enable them to assume a direct and responsible professional role in ambulatory child health care. The program should build on previous nursing knowledge and skills and include some knowledge and skills that conventionally have been the province of the physician. Experimentation of such programmes is indicated.

b. Sickle Cell Anaemia

This is a hereditary disorder which is only now coming into proper focus with physicians and patients alike. Much more information is needed on contraception for the patient with Sickle Cell

Anaemia. The only methods of birth control we are dispensing to these individuals are:

diaphragms, condoms and foam, and depo-provera.

c. Sexuality

Includes male and female anatomy; normal sexual response; treatment of sexual abnormality R/O organic pathology.

How far a nurse-midwife should go depends on the cultural setting, age and religion.

From four to six hours is adequate depending upon the student's knowledge of anatomy and physiology.

Patients converse more freely with family planning nurse-midwives. The family planning nurse-midwife is especially well equipped emotionally, professionally and physiologically to adminster counselling in the area of human sexuality. (Suggest films on sexuality, Human Sexual Response and the Facts and Fallacies of Sex).

d. Nutrition

This is a very important aspect of family planning. We find many of our patients have very low vitamin and iron intakes, and most often complaints are related to poor eating habits and unrelated to the modality of family planning.

e. Ultrasound

This procedure is used at Downstate for localization of the IUD in patients with suspected ectopic or uterine pregnancies, and to confirm myomata. It is of greast assistance in Obstetrics and Gynaecology. This procedure is more advantageous than:

(1) Probing with instruments and the risk of infection, perforation and unreliable results.

(2) Radiography, which exposes a fetus if present to ionizing radiation.

Implementation of all the above courses will undoubtedly require some form of incentive from voluntary or government agencies.

9. New Trends of Contraception

a. Intrauterine Contraceptive Device

The introduction of an intrauterine contraceptive device with the progesterone are now in experimental stages in New Zealand, Mexico, U.S. and other parts of the world. Progesterone is a steroid that decreases oxygen uptake of human spermatozoa, modifying, at the same time the pattern of utilization of selectivity labelled glucose.

In New Zealand, an experiment has been done on female and male rabbits and three groups of volunteer women; one group of eight normal fertile women with regular menstrual cycles with no contraception treatment; one group consisted of seven women with six to ten months of use of a progesterone T releasing 30 ug. of steroid; another group consisting of seven women with six to ten months of use of a progesterone T releasing 50 ug. of steroid.

(1) Results

Results showed uterine secretions for the normal women had little or no effect upon the oxygen uptake and utilisation of spermatozoa. On the contrary, the uterine secretion of wearers of the progesterone T produces a significant decrease in the oxygen uptake, also the changes were made more apparent with the patients wearing the increased progesterone device. It is possible to postulate in this study that progesterone released in the uterine cavity may act primarily by interfering with spermatozoa metabolism and perhaps with capacitation.

Results from this study also showed a reduction of pregnancy rate and a significantly reduced frequency of side effects such as bleeding and expulsion. Since the direct effect upon sperm motility was not directly assessed in this study, it is not possible to state that the presence in the uterine cavity of progesterone releasing IUDs makes it hostile to the spermatozoa. However, the mechanism of action of this kind of contraceptive is not completely understood, and is still in experimental development.

We are currently using the Copper T and Copper 7 at Downstate. The Copper T is still experimental.

The Copper 7 has been approved by the Federal Food and Drug Administration and is now available for general use in the U.S.

(2) Action of the Copper IUCD

Available data indicate that dissolution of the copper from the IUD causes precipitation of albumen, which sticks to the uterine walls, preventing implantation. The copper may also interfere with intrauterine sperm transport. The exact mechanism by which metallic copper enhances the contraceptive effect of the IUD has not been conclusively demonstrated. However, metallic copper is known to dissolve from a copper IUD, therefore our patients are told that their copper 7 intrauterine device should be removed in about two years.

(3) Acceptance and Suitability

The Copper T and Copper 7 intrauterine devices are well accepted by our patients at the Downstate Medical Centre. The device can be inserted into the uterus of virtually all normal multiparous women. Cramps and bleeding are minimal. What is not clear however, is whether the decreased blood loss with the copper device is due solely to its small size or to the metallic copper encasing its stem.

It can be concluded that as far as bleeding is concerned, the Copper 7 IUD in our clinic, produces the least menstrual blodd loss as measured quantitatively, and hence is suitable in developing countries, especially since their contraceptive efficacy is highly reliable.

(4) Effectiveness

Pregnancy rate of less than two per 100 women each year.

(5) Amount of Copper

89 mg of copper wire with a surface area equivalent to approximately 200 square mms.

b. Oral Contraception

The present trend is toward the use of oral contraception with less estrogen. At Downstate Medical Centre in addition to the conventional combined pills we are now using LoEstrinyl/20 and mini pills (Nor Q D 0.35 mg, and Ovrettes 0.075 mg, Norgestrel). The U.S. Food and Drug Administration has agreed to the use of oral contraceptives which contain only progestogens. Mini pills do not block pituitary activity as do conventional combined pills. Their main mode of action appears to be the reduction in the ability of spermatozoa to penetrate the cervical mucus. This loss of motility most likely is due to agglutination of the spermatozoa.

There is reasonable evidence that the thromboembolic risks of oral contraceptives are associated with estrogens, and that these risks may be greatly reduced or eliminated with progestogen only pills, although their use is not yet sufficiently widespread to enable this theory to be tested reliably.

(1) Side Effects

Progestogen only pills are associated with menstrual cycle irregularities, but have few other side effects. Their pregnancy rate is higher than that of combined oral contraceptives but is comparable to that of the IUD or diaphragm.

At Downstate, the mini pill is utilised mostly for patients who have medical problems, such as hypertension, varicosities, and who refused other methods of contraception or other methods may not be suitable.

(2) The Morning Pills

This is a series of high dosage estrogen pills given to a woman fewer than three days after unprotected intercourse in the middle of menstrual cycle. This increased estrogen affects the uterine lining so as to make it difficult for nidation of fertilized ova.

(3) Dosage

50 mg. of diethystilbesterol taken daily for five days. This method is not widely used in the U.S. (Yale University is presently using this method), and is still in the experimental stage.

c. A New Potential Approach to Male Contraception

With the advent of the steroid contraceptives, the control of contraception has become primarily the responsibility of the women. One reason for the unavailability of a male contraceptive pill based on the same biological principles as the female pill, lies in the difficulties of achieving suppression of fertility in the male without interfering with his sexual drive and potency.

Recently, however, it has been shown in castrates and in hypogonadal men that a major endocrine function of the testes can be replaced by the use of subdermal silastic capsules containing testosterone. The capsules are designed to release slowly but continuously an amount of testosterone which is sufficient to maintain libido and potency for at least one year.

This study was conducted by E.M. Coutimho and J.F. Melo at the Federal University of Bahia, Brazil, in 1973.

(1) Result

In all subjects the drop in sperm count was found to be accompanied by a marked decrease in sperm motility. In most subjects, the spermatozoa were observed to be immotile well before the sperm count reached zero. In some subjects, the initial sperm count of 87 million/ml dropped to 50 million/ml over a period of six weeks and to one million in another six weeks.

(2) Conclusion

In conclusion, this study shows that it is possible to inhibit spermatogeneses in men for up to four months without depression of libido and potency. Libido appears to be maintained by testosterone released continuously from the subdermal silastic capsules at the rate which

replaces or supplements endogenous testosterone. The testosterone capsules are active for one year or longer. Whether the progestin capsules alone have any effect on spermatozoa or male fertility remains to be demonstrated. It takes a long time for it to become effective. Usually about three to four months.

(3) Complications

Local infection and purulent discharge occurred in one patient at implantation site.

d. Potential Types of Vaginal Contraceptives

One area of particular interest is the possible use of a vaginal preparation for the dual purpose of contraception and prophylaxis against venereal disease. The vaginal contraceptives currently used have varying degrees of activity in vitro against Nisseria, Gonorrhea, Trepoema, Pallidum and other sexually transmitted pathogens. There are few data regarding the clinical effectiveness of vaginal contraceptives in preventing the spread of infection and no single product has been approved for both purposes. This aspect of vaginal contraception requires further investigation and development with respect to whether a single compound or a mixture of agents would be more effective as a contraceptive and prophylactic and whether the preparations available are suited for this purpose.

The main disadvantage of this contraceptive method is the requirement that the user be motivated enough to utilise the preparation prior to each time she has intercourse, could be solved by the design of a better delivery system for the active agent.

CONCLUSION

Although I was invited as a consultant for this workshop, it has been a great pleasure to have been given the privilege to participate. This type of workshop, a sharing by all, is a very stimulating experience.

May I take this opportunity to express my sincere gratitude for the pleasure of being included in this continuing educational experience.

SUBJECTS FOR CLASSROOM LECTURES - DISCUSSIONS

		Hours
1.	Anatomy and physiology of the breast, technique of breast examination	2
2.	Anatomy and physiology of the female reproductive organs, technique of pelvic examination, special aspects of post partum and post abortal exams	4
3.	Vaginal discharges, laboratory methods, diagnosis and management of vaginitis and cervicitis	3
4.	Overview of all methods of contraception	3
5.	Endocrinology of female reproduction, hypothalmus-pituito-ovarian axis	3
6.	Oral contraception	2
7.	Mechanism of action of intrauterine devices and insertion techniques	3
8.	Indications for the diaphragm, instruction for fitting and patient training	3
9.*	Diagnosis and management of pelvic infection	3
10.	Menstrual disorders	2
11.*	Demography	3
12.*	Sexuality and contraception	6
13.	Motivational techniques	2
14.*	Infertility	3
15.*	Sterilisation - vasectomy and tubal ligation	3
16.*	Sickle Cell Disease as an example of genetic problems	3
17.*	Paediatrics and family planning including keeping the baby alive, growth and development of infant, nutrition, immunization, gastro-enteritis, respiratory infections	10
18.	Nurse-midwifery in the United States	3

19. Organisation and management of a family planning clinic, record keeping 4

20.* International Planned Parenthood Federation 2

* Lectures given by physicians. Other lectures may be given by nurse-midwives or physicians.

AMILY PLANNING FOR NURSE-MIDWIVES

OUTLINE OF TRAINING

	Hours	Per Cent
Classroom Lecture - Discussions	67	16.8
Weekly Obstetrics Seminar	11	2.7
Tutorials and Assigned Study	65	16.3
Clinical Work	197	49.4
Visits to Family Planning Resources	17	4.3
Special Group Activities	42	10.5
TOTAL	399	100.0

CURRICULUM DEVELOPMENT

By Kate Lorig

INTRODUCTION

Curriculum development, by its very title, is something which many believe beyond their comprehension. For too long educators have shrouded the subject in mystery. However, no subject is more important to midwives, doctors and others in the health professions. Time and time again we are told that one of our most important functions is to teach. However, nowhere in our training are we taught how to teach, except possibly in the clinical setting. This paper is to discuss some of the simple steps, which, if followed, will help anyone become a better teacher. It is not important if you are teaching one mother in a pre-natal clinic or designing a full year's course of studies for a school of midwifery. Before starting, there is one thing which we must all keep in mind and that is the purpose of teaching. This purpose is to get someone else to do something new or in a different way than they have done it in the past. With this in mind we will outline the steps to accomplish this aim.

NEEDS ASSESSMENT

First, all good curriculum development must start with a needs assessment. It is also important that we find outwhat our patients or students want to know. One of the principles of adult education is that teaching must start with the student's present knowledge and interests.

Needs assessments can be very simple or quite complex. Probably the easiest assessment is done by asking the proposed student what it is that they want to learn. However, this has its drawbacks as many people do not know exactly what it is they want to learn. In this case they must be exposed to learning and then given a choice. For example, an entering midwife can tell you she wants to learn to deliver babies but may not be able to tell you that she wants to know how to conduct a breech delivery.

With this in mind, there is a second way of doing a needs assessment: it is to observe someone who is doing the thing you are trying to teach and see what they are doing. You might also ask them to list the things they need to know to do their job. Now all this seems obvious, you may be thinking, why go to all this bother when I know what my students need to learn? In answer, let me give you a couple of examples. To begin with, if we know what our students need to learn, why aren't we teaching them how to teach in our schools of midwifery and medicine. We are generally agreed that this is one of their most important functions, but they are supposed to learn this most important skill by osmosis. On the other hand we teach quantities of

material of questionable value in the belief that it is good for the student. When I was in school I was made to learn the insertion points for all the muscles in the human body. Two weeks after the examination I had forgotten all the information and have not used the knowledge to this day.

Finally, on the level of midwife to patient. If we did needs assessments of what our patients wanted to know we might be much more successful in our teaching. How many times have midwives taught something because that was the appropriate thing to teach at six months of gestation instead of listening to the patients needs. I recently observed a midwife telling a mother all about what to bring when she went into labour. However, the mother was much more interested in breast feeding, having been unsuccessful in the past.

One last word on needs assessments: there are some quite sophisticated assessment methods which are useful in designing adult education programmes for large populations: that is, fifty to several thousand people. If any of you have need to such techniques, please contact me.

SETTING OBJECTIVES

Once a needs assessment has been done, the next step is to set objectives. These objectives need to demonstrate what we wish the student to be able to do at the end of his instruction. A simple patient objective might be that Mrs. Fulan will breast feed her baby. With student midwives an objective might be that they be able to conduct a breech delivery, or to give the names and functions of seven hormones or give the dosages, effects, and side effects for four analgesics which could be used during labour. If the objectives are vague then you will have no basis on which to judge success or failure. All too often vague objectives are used to cover the sins of instructors. If we do not know what we want the outcome to be, how can we possibly teach anything in a coherent manner and how can we expect our student to learn. If a needs assessment is done and objectives carefully written, the major job of curriculum development is over. More than half of the planning time should be spent on these two steps, unless, of course, one is interested in preaching ones own ideas rather than in seeing results.

THE TEACHING PROCESS

The third step, is planning what you are going to teach and how you are going to teach it. From the objectives and the needs assessment it should be fairly obvious what you are going to teach. However, the <u>how</u> is another matter. We have a huge variety of methods open to us. Think back to your own school experience. Did you like the ways in which you were taught?

Are you using the same methods on your students and/or patients today? Unfortunately, we tend to teach in the ways in which we have been taught and this is a hard mould to break.

A few guidelines about adult education might help. Adults learn best when they participate in their learning - this would indicate that lecture is one of the least effective methods of accomplishing change. Secondly, we learn better when more senses are utilised. Therefore, using a blackboard, movies and/or slides is better than lectures. Group discussions and active learning where the student participates, is even better. Remember you cannot make anyone learn - you can only expose them to learning and the more pleasant and beneficial this experience is, the more your chance of success.

Based on this, I think that it is easy to see that for each step of our educational programme it is necessary to think out what we are going to teach and how we are going to teach. The teaching process is as important, if not more important, than the content.

EVALUATION

The last step in curriculum development is evaluation. This is the point at which we must ask ourselves, have we accomplished what we set out to accomplish and if not why. Again let me use a few examples. With students we often give tests. It is important that these tests reflect the things which we set out in our objectives. For example, if we want students to perform a breech delivery, it does no good to give them a test asking them to describe with paper and pencil a breech delivery. Rather we must go into the delivery room and watch them perform.

INTERPRETATION

Finally, we must be able to interpret the results of our evaluation. For example, if our objective was to have eight out of ten mothers coming to the prenatal clinic to breast feed and then on delivery only two of them breast fed, I would say that something was wrong with our teaching. We should go back and try to find the error rather than continuing to tell each of the mothers to breast feed.

The same is true with examinations. If more than six per cent of the students fail an examination one of the following is wrong. First the selection process for the students may be at fault. Students were admitted who could not achieve. Secondly, the teaching may be poor, inconcise, confusing or irrelevant. Finally, the examination itself may be at fault either not testing the subject matter that you taught or being more complicated or vague than necessary. When the failure rate is high, the fault lies in the educational system and not the students.

CONCLUSION

This paper has been a brief overview of the curriculum development process from needs assessment to evaluation. Curriculum development is rather like taking a trip. If you don't know where you are going, you probably won't get there.