Report of the ANGLOPHONE EAST AFRICAN WORKING PARTY

Nairobi, Kenya

29th November – 8th December 1973

THE INTERNATIONAL CONFEDERATION OF MIDWIVES

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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 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 held an eight day working party for senior midwives and obstetricians from nine nations in Kenya, East Africa from the 29th November to the 8th December 1973. This was the fourth 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 East African Working Party was attended by representatives from the following countries:

Kenya, Uganda, Zambia, Lesotho, Botswana, Tanzania, Ethiopia, Mauritius and Swaziland.

Also in attendance were guests from:

UNICEF, WHO, Kenya National Nurses' Association, University of North Carolina, the United States Agency for International Development, and the International Confederation of Midwives.

Two months before the Working Party, visits were made to most of the nations to explain the purpose of the meeting and to solicit official support and attendance. Of those invited only one country chose not to send representatives, Malawi. The government of Malawi expressed interest in the programme but felt it was not in their national interest to participate at this time.

Approximately one month before the Working Party, Mrs. Perpetua W. Kanyoko of Kenya was appointed as Regional Field Director.

OBJECTIVES - 2

In order to fulfil the working party aim several objectives were developed for the participants:

1. To exchange information on the present situation in relationship to Maternal and Child Health Services to include the practice and training of midwives of all categories.

2. To exchange information on the place of family planning in Maternal and Child Health services and training and practices of personnel involved.

3. To determine what are the minimum needs of mothers and babies in maternal and child care including family planning.

4. To define the role of midwives of all categories in providing for these needs.

5. To consider the training necessary for midwives of all categories in providing for these needs.

6. To consider the necessary legislative framework.

7. To consider future actions to implement recommendations.

The overall format of the eight days was to have delegates and guest speakers present papers giving background information directed at one or more of the objectives. The group of delegates were then divided into three groups to discuss the various topics and form conclusions. Following the discussions the rapporteurs and chairman of each group met to form a consensus report. This was then presented to all the delegates for their amendments and approval. The series of four approved consensus reports form the final recommendations for the Working Party.

OPENING CEREMONY

The Working Party was opened by Mrs. E. Muringo Kiereini, Chief Nursing Officer, Ministry of Health, Kenya. Following her welcome to the delegates, Mrs. Kiereini introduced the Honourable Dr. Zachary Onyonka, Minister of Health for Kenya.

Dr. Onyonka reminded the delegates that approaches to all health problems must be interdisciplinary and asked them to write their recommendations in such a manner as would be understood by governments and might, but not necessarily would, be used in formation of national policy. Dr. Onyonka in turn introduced His Excellency the Vice-President of Kenya and Minister for Home Affairs, the Honourable Daniel Arap Moi.

Vice-President Moi fittingly set the tone for the Working Party by stating that the East African nations could not afford specialists and therefore it was important that midwives expand their role to include the entire maternity cycle and care of young children. He continued by talking about the hardships created by too many children which would not happen if families were planned. This he saw as the responsibility of the midwives.

The remainder of the conference covered five main areas:

1. The present status of maternal child health/family planning in the countries attending the conference.

2. A discussion of the scope of Maternal and Child Health services.

3. How to organise maternal child health/family planning programmes.

4. How training programmes of midwives should be changed to include their expanding role.

5. An overview of current and proposed legislation effecting midwives.

Following brief reports about each country, the participants heard several papers about the scope of maternal child health/ family planning services. The discussion that followed was lively. It was generally felt that midwives were responsible for the mother during her child bearing years and that such care should include both family planning education and services. Furthermore, the midwife should be responsible for the care of young children. However, there was no consensus on how long this care should continue. The first discussion session set the general tenor of the group. Throughout the conference it was a well established fact that the role of midwives should be broad and must include education, counselling and service.

The next area to be discussed was how maternal child health/ family planning services should be organised. Again papers were presented and discussions followed. It was at this time that the participants began to look at the different types of personnel involved in maternal and child health services.

Besides the registered midwife and obstetrician and pediatrician several other types of personnel are involved including auxiliary midwives, village visitors, motivators and traditional birth attendants.

There was much disagreement on whether traditional birth attendants should be officially recognised. One group of delegates strongly advocated their identification and training. A second group felt that mass public education would be a better use of limited resources and that they should not encourage the continuation of traditional birth attendants.

Another point of discussion was the difference between registered and enrolled midwives. It was agreed that both were professional and that their duties varied little. Where there was sufficient staff to differentiate between supervision and service the registered midwife would serve in the supervisory capacity.

When discussing the training of midwives it was easily agreed that family planning should be integrated into all phases of midwifery training. To do this it would be necessary to train the midwife teacher in all phases of family planning and to help them integrate family planning content into their existing programmes. It was also recommended that family planning in-service programmes be given to all graduate midwives.

The final topic was legislation. The papers presented were informative and gave an excellent overall view of both the East African and world situation as it pertained to midwifery legislation.

At the close of the conference the delegates recommended that the work which they had started be followed by:

1. Visits by the Regional Field Director to the individual countries.

2. A newsletter should be started to help the conference participants keep abreast of activities in other countries.

3. Finally, the report and recommendations of the Working Party should be sent to the governments of each country.

DEFINITION OF MATERNAL AND CHILD HEALTH

It is the physical, emotional, spiritual and social well being of the mother during reproductive age, the unborn child and all children up to puberty.

WHAT DOES M.C.H..CARE INCLUDE?

Preventive, curative, and promotive services - good nutrition, child care up to puberty, immunisation, health education, prenatal intranatal care, post-natal, interpregnancy care, family counselling e.g. genetic counselling, sex education, marriage guidance and many other subjects.

DEFINITION OF FAMILY PLANNING

Education and counselling given to families to space their children as they wish, as well as to help the childless couple.

WHAT SHOULD FAMILY PLANNING SERVICES INCLUDE?

1. General education of the public regarding fertility and venereal diseases.

2. Counselling of Patients.

3. Provisions of family planning methods, medical check e.g. malignancy, fertility check, infertility studies, diagnosis and treatment of venereal diseases.

4. Family planning education taught to elders.

HOW DOES FAMILY PLANNING FIT INTO MATERNAL & CHILD HEALTH SERVICES (MCH)?

It fits in all through, and should be integrated right through the states of M.C.H.

DEFINITION OF A MIDWIFE

"A Midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery."

Although working in the same field, the principles and practice are the same for registered and enrolled midwives but the responsibilities differ:

1. Functions

   a. She should care for the mother and child during the maternal cycle.

b. She should care for the welfare of the family, teach the family, the community and the subordinate staff.

c. She co-ordinates and co-operates with the other services including immunisation, nutrition, health education, total family welfare, where she acts as social worker.

d. Combines preventive, promotive and curative services.

e. Keeps records and data for statistics.

2. Responsibilities

a. Administration, including job descriptions and job analysis.

b. Teaching.

c. Research - social and clinical.

d. Health education.

e. Nutrition.

f. Family planning programmes.

g. Carries out emergency measures within her capacity in the absence of a doctor.

h. Carries out functions within the policy of the Ministry.

i. Participates in social activities in the community she serves.

j. The Registered Midwife takes overall responsibility for the functions performed by an enrolled midwife.

It was agreed that Traditional Birth Attendants exist everywhere particularly in the African Communities, but in accepting their services there were two schools of thought:

1. The general public should be educated without encouraging or discouraging the activities of the Traditional Birth Attendants.

2. Traditional Birth Attendants should be:

a. Identified.

b. Trained.

c. Recorded.

FUNCTIONS OF TRADITIONAL BIRTH ATTENDANTS

To motivate the public e.g.

1. To take advantage of available health services in the country.

2. To give health education.

3. To identify easily recognizable complications and refer to the nearest health unit.

4. To give simple advice to the mother on normal child care.

5. To give basic care within her capacity to mothers during the maternal cycle.

6. To maintain hygienic standards throughout.

RECOMMENDATION

Supervision of the Traditional Birth Attendants by a trained midwife is essential.

HOW CAN FAMILY PLANNING BE INTEGRATED INTO EACH CATEGORY OF MIDWIFERY TRAINING ?

1. In anatomy and physiology subjects.

2. In Public Health.

3. In Post-partum care.

4. When teaching vaginal examinations.

5. When teaching principles of communication and motivation.

6. When teaching about drugs relating to hormones.

7. When teaching the theory and practice of M.C.H.

It was recommended that:

1. Introduction of family planning into the curriculum of the midwife should be supported by legislation.

2. Midwife tutors should be prepared to teach family planning.

3. Family planning should be integrated into the training of all categories throughout midwifery training so that the midwife is able to function as a family planning practitioner.

HOW DOES THE TRAINING PREPARE THE MIDWIFE FOR HER EXPANDING ROLE IN FAMILY HEALTH?

The training of the midwife equips her in her expanding role to:

Identify health problems, motivate, teach, counsel and provide family health services with special emphasis on maternal and child care.

IN-SERVICE TRAINING

Traditional Birth Attendants should have in-service education. The midwife is responsible for this education.

In-service training is training aimed at up-grading skills that the midwife already has, in other words, to keep up to date with the development in her field.

It was recommended that in-service courses at regular intervals should include introduction of new concepts in theory and practice of M.C.H. which includes:

1. Family Planning.

2. Teaching.

3. Paediatric practice.

POST-GRADUATE TRAINING

Training aimed at up-grading or increasing the expertise of the midwife for which she is given an added/or advanced diploma e.g.

1. Public Health Nursing.

2. Teaching.

3. Paediatric Nursing.

Recommendations:

Post-graduate courses should be made available for the midwife.

Traditional Birth Attendants should have in-service education for which the midwife is responsible.

RECOMMENDATIONS ON FUTURE ACTION

1. It was recommended that those countries who have not accepted family planning into family health service programmes, should include it in the training programme of midwives/nurse-midwives, that teachers should be motivated, and be allowed to teach it where relevant in Maternal and Child Health subjects.

2. That family planning services where existing should be incorporated into Maternal and Child Health services. All health workers should be taught family planning in Maternal and Child Health, as relevant to their sphere of practice.

3. That comprehensive clinics be provided to deal with all aspects of maternal and child care simultaneously.

4. It was agreed that as a short term solution to the existing problem of shortage of staff, training of basic maternal and child health assistants should be encouraged.

5. That mothers' waiting houses should be provided near hospitals to aid all health personnel in referring high risk cases.

6. That the terminology concerning midwives be amended because both enrolled and registered are considered as professional midwives.

7. That countries should make the registration of births and deaths compulsory.

RECOMMENDATIONS TO THE REGIONAL FIELD DIRECTOR

1. It was agreed that she acquaint herself with countries needs and progress by regular correspondence and visits.

2. A newsletter to include progress reports be circulated to all countries.

3. That follow-up should be through the Ministries of Health in co-operation with the delegates who attended the Working Party.

EAST AFRICAN ANGLOPHONE WORKING PARTY - KENYA - NAIROBI 29TH NOV. - 8TH DEC. 1973

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Appendix B

International Confederation of Midwives - Marjorie Bayes

It seems very fitting that this Working Party for Anglophone East African countries should be convened in Kenya in this beautiful city of Nairobi. Of all the countries here represented, only the Kenyan midwives are members of the International Confederation of Midwives. Through the News Letters which are regularly sent out from ICM Headquarters, the Kenyan midwives are aware of our work. I hope, however, before I leave Nairobi that I will receive enquiries regarding membership from some of the other countries here: unity is strength.

Although the ICM celebrated its Golden Jubilee at its 16th International Congress which was held in Washington D.C. in 1972, our global activities really started in 1954 when the first WORLD Congress for Midwives was held in London. At this Congress, a very eminent American Obstetrician, the late Dr. Nicholson J. Eastman, gave a wonderful and inspiring inaugural address in which he told us of the world situation with regard to maternal and child health care. This address was a challenge to all midwives and especially to our newly reformed organisation whose activities had been in abeyance since the beginning of World War Two. He said 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 whole continent of Africa, we are told that there are still approximately 70 per cent of women who are delivered of their babies in this manner.

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 of course applies not only to the Continent of Africa but to many other parts of the world.

The ICM was deeply distressed about the conditions described by Dr. Eastman and approached WHO 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 in Vienna in 1960 set up a study group.

Following the General Assembly the Secretary General approached the ICM for co-operation and the late Professor W.C.W. Nixon who had been appointed Chairman of their Study Group visited me at ICM Headquarters 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 "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 all the countries represented here is recorded in this Report. This was the first time such information had ever been collected.

The Joint Study Group is a very representative body composed of an equal number of midwives and obstetricians from all parts of the world. WHO asked for representation, also IPPF and recently the International Paediatric Association has joined us, UNICEF has also expressed interest and would like representation on the Joint Study Group.

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

The Executive Committee of the ICM had discussed the benefit of Family spacing on several occasions 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, the ICM 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 ICM, WHO and other International Organisations. This was obviously not enough and the ICM asked the Joint Study Group to take further action. Ten recommendations had been formulated by the Study Group and had been included in the Report; some of these were already being implemented by individual countries. Following the request by the ICM, 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 and in most of the papers presented Family Planning was mentioned. This conference was followed by a European Working Party in September of the same year which was held in Copenhagen. Europe was our first 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 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, Chile later that month. At this Congress, the South American midwives expressed a wish that a similar study should be undertaken in their continent. However at the General Assembly of the International

Federation of Gynaecology and Obstetrics 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 Continent by Continent.

At this time, the Joint Study Group was not in a financial position to undertake such studies. 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 International Confederation of Midwives (ICM) 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 Planning 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 should be instructed in family planning and services available. It is essential that all categories must include traditional birth attendants, a category of personnel who are likely to be an integral part of the maternal and child health team for some time to come.

TBA's could at least be motivators of Family Planning and they do need special consideration.

In many areas, the income of the TBA 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 renumeration. 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 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. A midwife is no longer an independent practitioner, she is a member of a team which includes

obstetricians, paediatricians, auxilliary 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.

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 and in the Cameroon for the francophone Central African countries.

Our plans for next year include a Caribbean Working Party, two in South America, one in South East Asia, one in Oceania and probably 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, 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 the Right Honourable, the Minister of Health for Kenya. May I now on behalf of the ICM 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 ICM and the Joint Study Group will always be readily available to you.

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.

UNICEF - Mr. Jones, Regional Director

Miss Bayes, in her remarkably able presentation this morning, mentioned UNICEF's interest in the Joint Study Group. I am happy to confirm that this interest is a very real one. UNICEF's main interest during its twenty-seven years of existence have been in the child and its mother, and of course in the mother-to-be. Our interests have been expressed through the assistance UNICEF has given to maternal and child health and welfare programmes throughout the developing world, including mainland China from 1948 to 1950 or 1951. The largest single proportion of our total assistance has always been directed to MCH activities, and a growing share of this MCH proportion has been for the support of family planning activities within the context of MCH during the past six or seven years.

Our Executive Board (a 30-nation board elected by the Economic and Social Council) had its first serious discussion about family planning in 1965 when a delegate raised the issue. I should say, however, that several Asian govenments had made unofficial approaches to UNICEF field staff during the early 1960's. Our Board agreed to have further discussions the next year (1966) when the Executive Director presented the subject along with two project proposals. But the Board wasn't ready to take a favourable decision right then and the matter was referred to the UNICEF/WHO JCHP and WHO's secretariat for further consideration. Their recommendations were considered by the UNICEF Board in 1967 and a policy was then adopted which is still effective today in 1973, although it has been enlarged and extended to include types of aid which we were not permitted to supply in 1967. Broadly, the new policy permitted UNICEF to assist family planning activities for which governments requested aid and which were technically approved by WHO; the assistance would be of the following kinds: training of health personnel in MCH care, including family planning, and supplies, equipment and vehicles to help in the rapid expansion of the basic health services including MCH services. It was recognised that the health services in most countries would have to be greatly expanded to provide scope for family planning as an integral part of health.

I think you will be interested in hearing some of the observations made by the eminent panel which made up the JCHP in 1967: (quote from paper).

In 1970, our Board agreed that UNICEF could include contraceptives, and equipment for making them, in our assistance to MCH/FP programmes, if requested by governments and approved by WHO. The Board also agreed that we might not only assist in the training of health personnel in matters of Family Planning but also the training of other categories of personnel such as teachers, community workers, etc., who work with people and are thus in a position to educate and motivate them.

1970 was a landmark for UNICEF in that the UNFPA (U.N. Fund for Population Activities) channeled their first aid through UNICEF - $350,000. During the years since 1970, UNFPA have greatly increased the resources channeled through UNICEF.

In 1972, and again this year - 1973, the UNICEF Executive Board has gone on record to reaffirm earlier policy decisions and to note that MCH services of which Family Planning must be an integral part were expanding much too slowly to meet the needs of the community, especially in the more remote rural areas which usually have the poorest elements of the community-at-large. Well, that brings us up to date, and you will realise from what I have said that UNICEF is firmly committed to assisting in the development of MCH services, including family planning. But before I end my little talk, I would like to say a few words about the traditional birth attendant - the village midwife - about whom Miss Bayes spoke so eloquently and sensibly this morning. Miss Bayes knowledge is worldwide - mine, except for the last four years, has been almost entirely in Asia where I spent 28 years in international service. I was surprised when I came to Africa to find so little was heard or said about the traditional midwife, although I knew that the vast majority of deliveries were not conducted by qualified personnel. My mind went back to Asian countries where the traditional midwife's work is well known and respected even by qualified midwives, and where the two work together harmoniously and for the benefit of their mutual concern - the pregnant woman and the mother and child.

Mind you, the situation as it is in most African countries was exactly the same in Asia twenty - twenty-five years ago. The traditional midwife was usually one of the more elderly ladies in the village (in Thailand, especially in the northeast, quite a few of them were elderly men!), none too clean in her habits (a bamboo knife for cutting the cord) or person, but available at any time of the day or night and willing to help with the cooking and looking after the mother's other children and perhaps even her husband if he was in dire need! There weren't enough trained midwives to take care of all pregnant women anyway. Some time in the early 1950's, the government of Thailand accepted WHO advice and agreed to a pilot project in which selected traditional midwives (moh-tam-yaes) were induced to come to the nearest MCH centre for training during a period of two weeks by senior midwives (supervised midwives). The TBAs were paid UNICEF stipends to persuade them to enrol in this training programme and I doubt that any of them would have participated if it had not been for the payment. But they came, they heard, they saw, and they were convinced!

Basically, they were taught to be clean and not to do anything that was not absolutely necessary. They were also taught to bring their clients to the MCH centre at least once or twice during early pregnancy for a thorough check-up by the qualified midwife, and to bring the mother in at once if any complications developed. As a badge of merit, the traditional midwife who passed through the training course successfully, and who also agreed to co-operate with the MCH centre thereafter, was awarded a UNICEF modified midwifery kit which she was taught to use properly. She was also taught to bring it to the MCH centre at regular intervals for checking and re-stocking.

When the Thai experiment proved successful, other countries followed their example, and in the next few years tens of thousands of traditional midwives were trained and brought under the qualified personnel's supervision in the Phillippines, Indonesia, and elsewhere. In this case, what was good for Asia would, I am sure, be good for Africa.

There is another bonus from this training of traditional midwives in Asia - since they are closest to the village woman, they are in the best position to motivate women in favour of child spacing. In Pakistan in 1968 or 1969 at least 40,000 dais were participating in the MCH/FP programme, bringing in to the health centres and MCH clinics hundreds of thousands of anxious women, willing customers for family planning. Here again is an opportunity which AFRICA should not miss. But a start has to be made by making contact with the traditional midwife, of gaining her confidence and respect, and of showing her that she can be helped and, more important, that she has a role to play in MCH/FP that in turn will help in national development.

Appendix D

MATERNAL AND CHILD HEALTH

By Dr. J.L. Molapo
M.B. CH.B. Dip. Mid. C.O. & G (S.A.) F.C.O.G. (S.A.)

MINIMUM NEEDS OF THE MOTHER

In considering minimum needs of the mother it is impossible not to consider the whole individual in toto, her physical and mental well being; her interreaction with society, her family set up and her religious beliefs. In these days of super specialisation and boundary disputes it happens only too frequently that the midwife or the obstetrician is obliged to leave certain responsibilities to others.

Historical Background

Over the centuries the medical profession regarded women merely as containers of a uterus and ovaries. What could be regarded as the beginning of care for mother and child was a social service around 1788 in Paris for women who had been sufficiently indiscreet as to be both pregnant and destitute (femmes abandonees). The real motive seemed to have been that of disposal rather than care. There was no appreciation of the peculiarities attending women of childbearing age.

The real scientific interest in mother and child was only shown in 1902 by Ballantyne. He was of course more concerned about stillbirths and foetal abnormality, but this idea soon came to embrace the wider concept of maternal well-being. But to a large extent the medical profession still remained complacent until in 1941, Norman Gregg, an eye specialist, drew attention to the association in early pregnancy between maternal rubella and cataract. And to drive the nail home, recently in 1961, came the terrible tragedy of thalidomide deformed babies. This has to be seen against the background of numerous pharmaceutical preparations which are given to a pregnant woman by the well meaning midwife or obstetrician.

In the light of the aforegoing, what are the minimum needs of the mother?

1. General Good Health

It is believed that during the childbearing age, roughly 15 to 45 years, the first respondents in the medical care of women in and outside of pregnancy should be the obstetrician and midwife. This may be regarded as an extreme view by others.

a. General State of Nutrition. In order to ensure good health the nutrition of the mother must be attended to. A concerted effort must be made to motivate and educate the mothers on good eating habits using locally produced foods.

b. Eradication of Parasitism. Although my own country is lucky because of its geographical situation to be free of parasites, I know that the rest of Africa is bedevilled by hookworm infestation, malaria etc. All of which make the woman dangerously anaemic so as to render her unsuitable for child bearing and child rearing. Aside from parasites, anaemia of the iron deficiency type can creep in surreptitiously from repeated childbearing.

c. Preventive and Promotive Health. The common infective diseases should be prevented and generally good health should be promoted. Chronic infections such as tuberculosis, for example, should be vigorously treated or better still the spread of the disease should be contained. If all the public health measures are instituted, individual health will automatically gain.

2. Supervision During Pregnancy.

Every pregnant woman should be seen by a skilled attendant at the first opportunity as soon as it is known that she is pregnant. Enough has been said by many experts on the value of antenatal care and it would certainly be outside the scope of this background paper to extol the merits of antenatal care except just to bring them into relief. Every woman who starts her pregnancy healthy should end her pregnancy healthy if not healthier.

3. Supervision During Labour

Proper and adequate supervision of mothers during labour can go a long way towards ensuring maximal health of all women throughout their reproductive career. It is unfortunately too true that many women suffer injury to their health during unskilled management of labour; and the sins of commission or omission dog them for the rest of their lives. Again it is outside our scope this morning to discuss the management of labour.

Suffice it to say that high risk mothers should be identified for hospital delivery where all facilities to cope with emergencies exist.

4. Supervision in the Pueperium and between Pregnancies.

The same principles apply during this period as well, but the point to stress here is the detection of cancer by Papanicolaou smear. Mothers will have to be motivated and educated on the importance of early detection of cancer. And here might be mentioned the importance of breast examination.

5. Child Spacing

There is no doubt in the speakers mind that unplanned pregnancies do not confer any benefit to the good health of the mother. Child spacing is a must in the interests of the health of the mother and the already born children. A woman who goes through repeated pregnancies is tired, slovenly and overworked and is most probably anaemic. She loses interest in the other

children and in herself. There are people more qualified to talk about Family Planning - all I can do is to emphasise it as one of the minimum needs of the mother.

One would have wished for a lengthy tabulation of all the points but in the time available one hopes participants in the workshop will read more between the lines.

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Appendix E

WHAT CONSTITUTES MINIMUM NEEDS OF THE CHILD

By Professor N.O. Bwibo
M.B., Ch.B. (E.A.), M.P.H. (Berkeley), F.A.A.P.,
Professor of Paediatrics, University of Nairobi

For my talk on "Minimum needs of Children" I will limit my discussion to the health needs in the care of the newborn children since this is the area that will interest the midwives, members of this Conference.

Many lives are lost among the newborn children and it is essential that we provide health care in this period to save these lives. Many transitional events occur to the children during and after birth which lead into high mortality. These should be anticipated and prevented if we have to end up with healthy children.

Since we cannot afford all the required care for these children certain minimum health needs must be provided using the most limited facilities and personnel available in the health services of our countries. The provision of these minimum needs will vary from country to country according to their financial resources.

There are three levels at which minimum health needs can be provided namely:

1. Provision of a proper place and adequate facilities for the delivery of the children.

2. Provision of facilities and staff for the immediate care of the newborn children.

3. Provision of preventive and curative facilities for the newborn children.

I will now briefly discuss each topic in turn.

PROPER PLACE AND ADEQUATE FACILITIES FOR DELIVERY

To ensure that a child is going to be born normally, there should be a section of the hospital or health centre designated as a maternity unit where mothers should be delivered. This unit should be staffed by midwives who are trained to handle normal deliveries and able to recognise the difficult ones for referral. There should be a doctor in charge in case of a hospital maternity unit.

PROPER FACILITIES FOR CARE OF NEWBORN CHILDREN

There should be facilities for the care of full term and premature (low birth weight) babies. This should include a room with baby cots for the children designated a nursery but better still the baby cots should be placed besides the mother's beds. For the premature children there should be a special nursery kept warm and with high humidity for nursing them. Premature babies do quite well in these

warm and humidified rooms. A few incubators should be available for the very small prematures for administration of oxygen. But oxygen can be administered from cylinders using nasal catheters.

There should be facilities for isolating infected children so as to avoid the spread of infection in the nursery.

The staff to man the maternity units should be midwives supervised, where possible, by doctor with special training in Paediatrics. There should be a doctor for the bigger hospital maternity units.

The staff should be knowledgeable in the routine care of the newborn, and the special care of the premature children. These routine procedures should be written for the Junior Midwives by the Senior Midwives or the Doctors. The midwives should have adequate knowledge to be flexible in individual cases that may have problems. All the attendants should know the simple methods of resuscitating asphyxiated children. Simple methods of coping with this situation must be available in writing to all the staff. The equipment needed for resuscitation should be readily available and checked frequently to ensure that they are in a working condition.

The staff should also know where to refer the problem cases such as the child with congenital defects.

While in maternity units the newborn child should have a source of adequate supply of milk. Breast feeding is ideal and should be provided. Where there is need for alternative, then artificial preparations should be available with adequate facilities for reconstitution. There should be a milk room in the maternity unit for this purpose.

FACILITIES FOR PREVENTITIVE AND CURATIVE SERVICES

The newborn children should have preventive services such as immunisations available to them in maternity units and in health centres. As the children are taken to the health centres for immunisation, their general health, including weights, should be assessed by a nurse or a health visitor or a midwife. Each child should have a record card where all his records are kept.

Since the newborn children are prone to infection, facilities should be available for diagnosing and treating infection as well as dealing with other newborn problems such as birth trauma. Those requiring more facilities should be referred to bigger centres.

This then, Ladies and Gentlemen, is what I have to say about minimum needs of children.

Appendix F

MATERNAL AND CHILD CARE SERVICES IN A RURAL AREA

By Sister Lydia M. M'muthara KRN, KRM, KRMN
IPPF Mobile Unit, Meru, Kenya

INTRODUCTION

We believe, as midwives, the maternal and child care services which include antenatal care, child welfare and family planning are one of the most valuable services given to the people living in rural areas of Kenya.

All these services have taken a long time to be accepted. Even now the antenatal care and child welfare are more accepted than family planning. Although family planning is not a new idea, the use of artificial methods never existed. This has been resented by various groups in the community due to various reasons such as customs. A man having two wives, each of them want to have a good number of children, mother-in-laws like looking after their son's infants and are pleased when surrounded by many grand-children. Common belief that there is a lot of land and the saying in the Bible that man should produce and fill the earth, are a few of the reasons given in opposing family planning.

People have started experiencing the problems facing them especially on education and nutrition, and family planning is being accepted voluntarily in rural areas just as antenatal and child welfare.

Maternal and child health services in rural areas of Kenya include:

1. Antenatal care.

2. Child welfare.

3. Family Planning.

In Eastern Province all the three clinics are held on a daily basis in district hospitals and, in health centres efforts are made to see at least child welfare clinics are held on the same day as family planning clinics.

Clinics held on a daily basis make it easy for mothers to attend at their own convenient time, while holding child welfare clinics on the same day as family planning clinics makes it easy for educators to talk to mothers and motivate them while at the same time, it saves time for those mothers who are already members of the family planning clinic.

ANTENATAL CARE

Enrolled midwives are stationed in most health centres to look after maternity cases. These midwives and other staff, the health visitors and nutritionist, are responsible for the supervision of

expectant mothers throughout their pregnancies and confinements if the cases are not complicated.

When the mother goes to the clinic she has her past and present history taken, a general examination is done to exclude any abnormalities, blood pressure is estimated, urine tested, haemoglobin done, weight and height recorded. After doing all that is necessary at the first visit the midwife then determines whether she should continue looking after the patient or whether she should refer her to a hospital to be seen by a doctor who advises accordingly. As there is no electricity or oxygen, and sometimes no vehicle attached to the health centre, any emergency (premature labour) can be a problem so if the mother is likely to deliver before time she is advised to go to a big hospital when labour begins if she has not gone the full term.

Although antenatal clinics are well attended, not all the mothers have their babies in the hospital. This is due to lack of money, poor transportation and tribal customs. Hospitals charge Shs.40/- and the health centres charge Shs.20/- for admission fees. This is a lot of money for the poor people in rural areas, some live very far from the nearest health centre and if a mother cannot walk all the way, the family have to hire a vehicle. If they have no money she has to deliver at home or on the way, walking to the hospital or the health centre. Those who are near the centre often hire the health centre vehicle.

In some rural areas traditional midwives (untrained) are still trusted. They are not encouraged by the health workers but are very welcome when they bring their difficult cases to the hospital.

Recently, in a remote area of Meru, a man operated on his wife to remove the dead foetus. Their custom does not allow a mother to be buried while carrying the baby in the womb. As he was performing his operation the wife gasped and realising that she was not dead, he sutured her quickly and rushed her to the nearest hospital where she was properly treated. Mothers still die before, during and after birth, but in most areas people understand the importance of antenatal care and hospital confinement and, whenever possible, they follow the instructions given them by experienced staff.

CHILD WELFARE

These clinics are mainly for children under 5 years of age. The aim of them is to supervise the child from birth up to the age of 5 years. During this period mothers are advised on general hygiene, nutrition and immunization.

GENERAL HYGIENE

Cleanliness is the most important part of general hygiene advice. It prevents diseases such as diarrhoea and vomiting, conjunctivitis, tropical ulcers, etc. Advice is also given to people living around Mount Kenya on the type of clothing to wear. Children suffer from bronchitis and pneumonia and those living in the lower areas are advised on how to prevent malaria and other parasitic diseases.

NUTRITION

Malnutrition is the most common disease in early childhood in the rural areas. Mothers have everything that is required by their children but sometimes they are unable to give them the right kind of food so kwashiorkor can be found in homes where home-grown produce chickens, eggs, milk, etc. are sold to buy bear necessities.and clothes. Health visitors and nutritionists work very hard trying to educate the family, Where malnutrition is caused by poverty, dried milk is supplied and other kinds of food such as rice.

Education and demonstrations are helping mothers to improve their own methods of feeding.

IMMUNIZATION

At first people did not accept any kind of immunization but nowadays vaccines against whooping cough, diptheria and tetanus are most popular even if children are not born in hospital, mothers bring them to the clinic for immunization. Those which are available and used in rural areas are measles vaccine, smallpox vaccine, B.C.G. and (Sabin) Polio vaccine.

Mothers get a bit worried when children get fever after vaccination but this they are told to expect and a dose of aspirin is given to take home and give to the child to prevent fever.

Health visitors and nutritionists also do home visiting to assess the condition of the homes the mothers and children are living in and offer the appropriate advice.

FAMILY PLANNING

There are three groups involved with family planning:-

1. The Kenya Government's Ministry of Health.

2. The Family Planning Association of Kenya.

3. The International Planned Parenthood Federation (IPPF).

The Ministry of Health is leading the National Family Planning Programme. It provides us with materials (premises and drugs) used in family planning and education of registered and enrolled midwives while the Family Planning Association of Kenya is dealing with education and motivation of clients.

The International Planned Parenthood Federation has eight mobile teams in various rural parts of the country, all the teams are supervised by one medical officer while 3 teams are headed by a doctor, and five by a registered nurse/midwife.

In Meru, such a team is formed by a registered nurse/midwife, an enrolled nurse/midwife, two field educators and a driver. The Sister-in-Charge took over in January 1972 from a Doctor who was previously running the unit. So the present team has been working for two years now.

We go on safaris from Monday to Friday holding clinics in health centres, while midwives do the clinical work, that is, insertions of IUDs, prescription of pills, fitting of diaphragms and supplying of condoms, the field educators are busy doing on the spot motivation and also interviewing new clients and explaining each method carefully.

We start from the office in town at 8 a.m. and travel in our jeep for one to two hours to reach the rural clinic.

The family planning sessions are normally run in health centres the same days as Child Welfare Clinics so that we can have an opportunity to talk to mothers who bring their children to the child welfare clinic.

The Family Planning sessions are held in the same premises. When we arrive at the Centre there are already a number of people waiting. The midwives start organizing the examination rooms, boiling instruments, preparing antiseptic solutions, etc., while the Field Educators gather mothers and talk to them. Then they interview clients. Midwives are responsible for general examination (including pelvic examinations, blood pressure, etc.) and check up to make sure the method chosen is suitable for every single client.

There are 10 to 15 new clients and 40 to 50 revisits. New acceptors are given an appointment to return in a month's time and the pill users seen thereafter every three months. IUD acceptors are seen again after three months, six months and then yearly.

As an example, these are the average figures for 1972:

14 clinics, 20 family planning sessions per month.
Clinics are visited weekly, fortnightly or monthly according to attendances.

In 1972	120	new IUDs per month
	132	new pills per month
	252	new acceptors
and	384	revisits IUD
	400	revisits Pill
	784	revisits

besides condoms which are not recorded.

i.e. 1036 visits per month, that is to say about 50 clients to see each session. Most of these clients just come back for more supplies or simple advice. However, sometimes we get a few clients with problems, especially with IUDs (e.g. expulsion, pregnancy, infection etc.) some have to be referred to the Medical Officer and some change

their method. Although the idea of family planning is accepted, a bad rumour, like a loop travelling to the heart, on any method quickly discourages clients.

So two or three times a year you find pill users who want to change for IUDs giving all sorts of explanation. And next time it will be IUD users asking for removal for the same unsubstantiated reasons.

Our main concern is to try and stamp out the rumours and reassure our clients. For this purpose we have to identify the real medical problems in relation or not, to family planning methods and good co-operation between preventive and curative services is needed.

In rural areas people are reluctant to accept anything new like artificial family planning methods, and it will take some time for people to realize the benefit of family planning services.

We are all concerned in education on family planning, giving lectures and showing films, attending family planning seminars and giving talks to the audiences.

We are also very concerned with the training of enrolled midwives in the health centres. In co-operation with the Ministry of Health we train them on IUD insertions and pill prescriptions so all the time we are sure the clinic can run if the team is unable to get to a particular health centre, due to the breakdown of the vehicle, or because of getting stuck in the mud during the rainy season. But, for the future, the purpose of this training is to have local staff prepared to deal with all aspects of Maternal and Child Health including family planning.

These midwives are often very interested in family planning, in most centres they feel responsible for the whole maternal and child health service.

Everybody concerned with rural development is putting special emphasis on family planning as they realize no development can be done if people continue to produce so many children which they cannot feed, clothe or educate. The agriculturalists, home economists, community social workers and health workers are all working together to try and improve the life of mothers and babies in the rural areas thus creating a healthy nation.

Appendix G

FAMILY PLANNING AS PART OF MATERNAL AND CHILD CARE SERVICES

By Mrs. Perpetua W. Kanyoko

We are all aware of many benefits the mothers get in maternal and child care clinics. I feel, however, Ladies and Gentlemen, that if we fail to give family planning advice and services to these mothers, the advice and services we have given are incomplete.

In my opinion, to offer family planning advice and services as part of maternal and child care is a generally accepted idea. There are many things, however, that hinder the actual implementation of this ideal. The main hindrance, as I see it, is lack of trained midwives in the field of family planning, and this has been confirmed in our exchange of Country Situation Reports.

I am convinced that the surest way and the most effective one of ensuring the midwives will play this very important role of carrying out family planning as part of maternal and child care services, is to give them proper training in family planning. By proper training I mean training that will enable them not only to give advice, but services as well.

This now brings me to the point of training our midwives in family planning. I know we shall be discussing this subject of training midwives of all categories next week, but I would like to touch on this very briefly.

We are all, I have no doubt, in agreement that training our midwives in family planning is the only way to equip them with the full knowledge of offering the services needed by the mothers in MCH/FP clinics. By training, Ladies and Gentlemen, I mean a training that will produce midwives who are able to run family planning clinics. There are, as you know, two major issues to consider in carrying out this training, namely:

1. Pre-service training.

2. In-service training.

In almost all developing countries, and I think I am right in saying in some developed ones too, pre-service training has not yet been established. I know it is included in the curriculum as a theoretical subject, but I have no doubt in my mind that we all agree this is only educational on the part of the midwife and not training.

I would like to emphasise that family planning as part of maternal and child care will work extremely well as soon as a way is worked out where family planning is integrated in all allied subjects - from the beginning of midwifery training and over this shall we say - a period of approximately three to four weeks devoted exclusively to family planning. Let me say here that the duration of time is an issue to be discussed. But the goal to be achieved is one - a properly trained midwife who has been sufficiently prepared to carry out family planning as part of maternal and child care services.

To turn to this issue of in-service training, this is to give family planning training to that midwife who is running MCH clinic so that she can carry out these two roles together.

As I see it, the way to go about this is to compile a course that is accepted by the Ministry of Health or health agent which determines the nature and extent of their participation in this field.

I strongly feel that midwives are in such a unique position where they are able to carry out family planning as part of MCH. This is so because the midwife attends to the mother all the way, during the A/N period, labour, post natal period and child welfare. One big advantage the midwife has, in playing a part of MCH is, not only does she see the mother that many times, but the mother gets to know the midwife well, so well that she has so much confidence in her.

To finish my short talk, I would like to say how very interested I was to hear what is happening in other countries. Having heard what each individual country is doing, particularly in the field of family planning, I would like to ask you, Laides and Gentlemen, when we join in our discussion groups this morning, to discuss fully and exchange views on this important subject, namely family planning as part of maternal and child care.

Appendix H

INTEGRATION OF FAMILY PLANNING INTO TRAINING PROGRAMMES

By G. Mtawali - Tanzania

INTRODUCTION

Family Planning in the context of this paper mainly means child spacing or voluntarily limiting the number of one's family and also assisting childless couples to have children. Therefore, it becomes evident that family planning can be integrated into many subjects which are taught to nurse midwives.

Integration of various skills in each worker is imperative at the present stage of developing health services. That is why the basic training in our countries is nurse midwifery and recently nurse/ midwifery with psychiatric and public health nursing. Such integration allows workers to cope with health problems comprehensively in our rural areas and under staffed hospitals. At the same time such multipurpose staff are able to realise when health problems should be referred to specialists nurses or doctors. As family planning is an aspect of Maternal and Child Health Services (M.C.H.) and preventive health there is a great need to emphasise its integration in general medical, public health or M.C.H. training programmes. Statistics support this fact by showing that high morbidity or mortality in developing countries are caused by preventable diseases and conditions e.g. Kwashiorkor, prematurity and complications of pregnancy, childbirth and puerperium.

PROGRAMMES TO WHICH FAMILY PLANNING COULD BE INTEGRATED

Opinion or country policy varies about where family planning should be integrated. Some of the training programmes for this integration are:-

1. Maternal and Child Nursing.

2. Obstetrics and Gynaecology.

3. Public Health.

4. Venereology, Pharmacology, Medico-Surgical nursing, medical ethics, human development, and contemporary nursing problems.

Apart from policy of the country or government regarding family planning services the following points should be borne in mind when planning a teaching programme.

1. Availability of resources such as teaching staff, equipment, facilities and budget.

2. Objective of the family planning programme in relation to those of the overall content.

3. Expected functions of those who complete the programme.

4. Level of the prospective students' general and, where relevant, professional education including the type of teaching to which they have been previously exposed.

5. The cultural and social environments from which the students come especially in relation to family life matters.

6. Possibility for relevant and meaningful field experiences and the way they can be correlated to theory.

7. Expected average rate of teaching and learning as a basis for determining the duration of the programme.

8. Sequence of introducing family planning so that learning could be thoroughly comprehended, analysed and applied in practice.

9. The types of information and methods needed both for evaluating and re-organising the programme in terms of student performance teaching methods, content, facilities equipment etc.

Although the above points regarding the teaching programme seem difficult to implement where family planning training programme is the result of one individual's plan, a co-operative and co-ordinated effort of various people may lead to a successful decision regarding the training.

For example a planning committee composed of teachers from relevant disciplines of nursing, medicine, and sociology; students; registered nurse midwives; and clients.

As each institution starting a family planning training programme has had to start from nowhere I shall give examples of how we have integrated family planning in pre-service training and in-service courses. The courses are for student nurses during their four year integrated course of general nursing, midwifery/health public and psychiatric nursing, medical students, or registered nurse midwives as a post basic course. These courses are conducted according to the belief that family planning is part of preventive medicine, especially M.C.H., and that every family has a right to good health including getting information of the indications for family planning.

STUDENT NURSES COURSE

Although such a course is not a formal part of the existing national curriculum circumstances have encouraged tutorial staff to plan a family planning course during the students' obstetrics/MCH experience. Students at this time have had anatomy and physiology of human reproduction some MCH clinic experience and knowledge on motivation and communication related to health care. Therefore, talks and discussions on family planning are given to re-inforce previous learning while adding minimum knowledge on methods of contraceptives and their administration students also spend two sessions observing and participation of the work of a family planning clinic.

Objectives of this course are to enable the student nurses to:

1. Explain briefly the scope of family planning services in their country.

2. Describe indication for family planning.

3. Identify high risk mothers or families, whose total health would be improved by family planning, and refer these to the nearest clinic.

4. Describe briefly mechanics of common contraceptives.

MEDICAL STUDENTS COURSE

This course is conducted for medical students in their fourth or final year. It could be conducted for trainees previously trained in general nursing and midwifery but are undergoing a course which will make them S.R.N. equivalent.

Objectives of this course are to enable medical students to:

1. Describe the Family Planning Association's (FPAT) history, objectives, activities policy and administrative structure.

2. Describe the FPATs approach in motivating the public to accept family planning.

3. Demonstrate to and guide their future junior staff and colleagues in the organisation of a family planning clinic.

4. Set up and establish a family planning clinic in district hospital's MCH programme.

Subjects of the course are similar to the student nurses' course but include FPAT's approach of motivating the public including men, clinical experience in fixed and mobile family planning clinics. In the clinics students - observe and/or participate in health education at MCH clinics which are run besides family planning ones; - assist in compiling day to day records, and in administration of methods of contraceptives including insertion of IUD's. Handouts are issued for self study on the relationship between family size and MCH, mobile units, annual clinic attendances. Discussions and questions clarify necessary points.

NURSE-MIDWIVES COURSE

With this group the course is given as an inservice one so as to give relevant new knowledge and review subjects related to family planning. This is part of continuing education and promotion of nursing. Duration of the course is two or four weeks.

Objectives of the course is to enable nurse midwives to provide family planning information and or treatment as part of the service in which they are working. This means that these family planning trained nurse midwives should:

1. Identify male and female reproductive organs and explain their functions.

2. Motivate the public to accept child spacing for promotion of family health and consequently for the whole nation.

3. Describe mechanics of common contraceptive methods, giving specific instructions relating to proper use of selected contraceptives e.g. availability, suitability to individual clients, advantages and possible side effects.

4. Participate in the clinic work including history taking, physical examination and administration of contraceptive techniques to new and follow-up clients.

5. Maintain records.

Subjects of the course are similar to those described above but include public speaking, book-keeping for child spacing services; infertility; common gynaecological problems encountered in child spacing; family planning in developing countries, and practical experience in health education at MCH and family planning clinics.

METHODS OF TEACHING

Although family planning is an interesting subject perhaps because it deals with a sentimental subject, it is also one which some students find difficult to comprehend. The following are useful points related to integrated teaching of family planning:

1. Paticipative teaching and well planned reasonably informal talks should be common practice. Objectives for the talks should be stated in writing and then evaluated at the end of the talks by use of questionnaires.

2. Correlation of family planning with other ongoing topics related to the health service should be demonstrated. Therefore, teachers must be aware of what is going on in other disciplines.

3. Demonstration, role playing, use of films following a lecture, models and wallcharts, problem solving, case and classroom discussions and programmed instructions - all these are methods which enable effective learning of family planning as part of other training programmes.

4. The programmed instruction on methods of contraception is a self-study teaching method which has proved a good reinforcement of other teaching methods used in family planning programmes. It is a useful aid where instructors are few and students can proceed at their own pace while at the same time acquiring knowledge in a logical sequence.

5. In addition reading and reviewing literature on family planning provès a good way of broadening the students understanding. It also helps to revive and develop the habit of reading.

6. Study projects and assignments should, where possible, be given to students so that they can present their work to the whole group in turns.

IMPLEMENTATION OF THE PROGRAMME

In order to implement integration of family planning into training programmes we need human and material resources. It is the people on whom I shall concentrate as they can find material resources. One of the important factors which affect effective integration of family planning into training or other programmes is resistance to adopt family planning as a preventive health aspect. So motivation and familiarisation of the people responsible for teaching in schools of nursing/midwifery and nursing service should be done. Two days to one week seminars should be arranged so that relevant tutors or administrators can participate. At the end of the seminars tutors should be able to plan and execute an appropriate family planning course as part of their usual programme. Apart from subjects related to family planning and MCH tutors seminars should include methods of teaching, educational objectives, how to evaluate students performance etc. These subjects are specially useful for untrained tutors but serve as a useful review for already trained tutors. However, tutors education should ensure that the tutors:

1. Have knowledge of constructing curricula and developing curriculum content.

2. Can co-ordinate all the components of a training programme in order to meet objectives.

3. Understand principles of learning particularly the need to listen for response to the learners obvious or implicit comments and questions.

4. Are versed in various educational methods and know how to use educational equipment.

5. Can relate relevant subjects with family planning.

6. Have technical and clinical competence needed for teaching by demonstration.

7. Are aware of their professional responsibilities towards students, professional colleagues and the public.

8. Have responsibility to keep up to date since there are rapid changes in knowledge, techniques and attitude towards family planning, or human reproduction.

9. Have opportunities to attend refresher courses; workshops or seminars about new educational developments.

10. Are confident about and believe in family planning.

In their teaching of family planning tutors could be supported by physicians, field workers, religious leaders, public health specialists etc. Where possible and after appropriate guidance, students could participate in the teaching process.

EVALUATION

The behaviour of the learner at the end of a programme is expected to match its objectives. This would result in planned change or education and training. Measurements for this change should be done and compared to a standard. The measurement should be given at the beginning of the course, and intermittently throughout and after the course. Observation, questionnaires, interviews, performance tests, and written reports - all these are methods which can be used to evaluate the course. If students are given objectives of the course at the beginning are asked to check their work in relation to the objectives, they often get stimulated towards achieving success.

A family planning programme would be successful if the students learnt the following skills:-

1. Communication skills e.g. ability to listen; interview and prepare and use various media for teaching and learning.

2. Clinical skills.

3. Educational skills.

4. Administrative and research skills if the trainee will function as a supervisor.

Besides the above skills the nurse trainee should develop understanding of individual's needs and problems related to their needs. She should know and demonstrate her role in the community as a person to whom people turn when in need.

CONCLUSION

Integration of family planning into training programmes is necessary in order to encourage effective promotion of comprehensive medical care. It can be achieved when all concerned; i.e. teachers, administrators, appreciate the need to change. It makes possible the acquisition of knowledge, skills, and understanding on a cumulative basis. For example it is necessary at our present age for students to acquire knowledge by remembering what they have been taught, read or observed regarding methods of contraception, and relation of family size or health.

In future integration of family planning into training programmes will be easier than now since students will rely mainly on acceptance of family planning for promotion of health, mass communication and other means of teaching about human sexuality and family life. At such a stage the demographic aspect of family planning and sex education should be integrated with reasonable ease.

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Appendix I

FAMILY PLANNING IN THE WORLD AND IN TANZANIA (MAINLAND)

By G. Mtawali - Tanzania

This information is on Family Planning in the World and in Tanzania. This is intended to give you a clear picture of our work in Tanzania mainland and not what other people, especially the mis-informed and mediocre critics say. In this talk I will also attempt to explain the relationship the Family Planning Association of Tanzania has with other Associations in the world through the International Planned Parenthood Federation.

FAMILY PLANNING ASSOCIATIONS IN THE WORLD

Founded in 1952 by family planning associations in six countries the federation has gradually built up its world-wide membership to the present national family planning associations in 79 countries with its headquarters in London, and regional offices in Beirut, Bombay, Kuala Lumpur, London, Nairobi, New York and Tokyo.

There are six regions represented on the Federation's Governing Body and specialist committee. These regions are: Europe and the Near East, Oceania, South East Asia, Africa, Western Hemisphere and the Western Pacific. Member countries of the Region send representatives to the Regional Council which provides a forum for the exchange of experiences and new developments.

The council takes decisions on policy matters such as the holding of regional conferences and seminars; and on recommendations and proposals to be made to the IPPF Management and Planning Committee and Governing Body. Through this system of representation member countries are kept informed of International and Regional activites; new medical and scientific findings; clinic and administration developments and programme planning analysis.

The work of the IPPF is to stimulate the formation of family planning associations in all countries of the world and to provide them with financial support, technical assistance and advisory services in the medical, educational, training and administrative aspects of their work. IPPF supported associations offer contraceptive services, recruit and train staff and seek to inform and educate all sectors of the population about the practice of family planning and the importance of child spacing for the health of the child and the mother and of course the entire family and at large the social and economic development of the community.

The IPFF is financed by voluntary contributions from private citizens, foundations, all over the world and by grants from government. To carry out its international assistance programme, the Federation established a gross budget of Shs.140 million in 1971. In response to the increasing demand for family planning services and information, local associations also seek local private and government support for their work. The IPPF also has helped to establish fund raising campaigns in several countries.

In its capacity as a non-governmental consultative organisation to the major United Nations specialised agencies the IPPF has encouraged increased United Nations activity in the field of family planning. Through the presentation of papers and reports at international and regional conferences, the IPPF has publicised the need for greater efforts in development of family planning programmes and has prompted increased co-operation among all organisations concerned with this work.

Now that we know the background of the IPPF and its work, it is important that it should be understood that the IPPF does not dictate terms of reference to the member associations which are affiliated to it. The Association's activities, in their respective countries are entirely in accordance with the needs of the particular countries. This is as it should be,obviously the needs of Tanzania are not necessarily the same as those of India or Pakistan etc. The family planning associations therefore, have laid down their aims and objectives bearing in mind the needs of their countries.

THE FAMILY PLANNING ASSOCIATION OF TANZANIA (FPAT)

Likewise the Family Planning Association of Tanzania has its own aims and objectives. Perhaps, at this stage, it is important to mention something about the history of the Association, its aims and objectives, its activities, achievements and, of course, its failures. But to be frank, we, family planning association staff, believe that we have not been in the business for long enough to start being complacent about our achievements. We are only at the threshold of the great task ahead of us which will have to be continued by generations to come. But we think that the success of this work will very much depend on the foundation which we are trying to lay now.

The FPAT was founded in 1959. It was started by a few people who recognised the importance of curbing maternal and child mortality and to eradicate the ill-health of families in different homes in the country. When the Association started it laid down the following aims:

1. To encourage the production of healthy children and promote family happiness and stabllity by child spacing.

2. To assist couples who have involuntary sterility.

3. To promote the provision of facilities for scientific contraception so that those who wish to do so may space their families.

4. To prmote the establishment of family planning centres and integrate these as much as possible into maternal and child welfare services.

5. To plan and conduct a continuous educational programme on the importance of family planning and methods available.

6. To provide family planning training for nurses, doctors and layworkers.

7. To do all such other things as are incidental or conducive to the attainment of the foregoing objects or any of them.

Almost all the aims and objectives of the Association are in line with the health problems facing our nation.

Up to 1966 the FPAT was known as the Family Planning Association of Dar-es-Salaam. At the Annual General Meeting held the same year it was agreed that the Association should change its name to The Family Planning Association of Tanzania. It was realised that family planning services were required in many places in the country. Voluntary Agency hospitals had already started getting supplies at cost price from the Association. During almost all this time all the work which was carried out at the family planning clinics was done voluntarily by well meaning people to whom we owe our very many thanks. All this time the Association had one part-time health visitor who also worked as a clinic nurse on clinic days.

By mid 1968, it was felt by the executive committee of the Association, that it was necessary to employ a part-time paid secretary. Early 1969 more staff were employed. During the same year, the Ministry of Health and Social Welfare issued a directive to all Regional Medical Officers to get family planning supplies and advice from the Association. It was stated in the 1969/74 five year development plan that child spacing should be part of MCH services.

Since May 1971 the Executive Committee of the Association decided to give all family planning supplies to all hospitals and health centres free of charge in order to make available the services of the Family Planning of Tanzania to every one interested. Clients pay an annual membership fee of Shs.3/-. Similarly, supporting members who need not use the services, pay the same amount of membership fee. Donations are accepted.

It is evident that family planning methods enable a mother to have a say whether or not to bear another child and when. Since we know that it is only the woman who knows how tired she is when she is pregnant, how much pain she gets at delivery and how important that children should be cared for properly, the Association gives advice to parents on how to have the desired number of children and at the time they want them. The decision of how to space ones own particular family has to be made by both husband and wife, for the welfare of the family is the responsibility of the couple. The Association only advises couples to space their children from two years onwards. Thus the Association only advises couples on the methods available and does not dictate to parents as to how many children a couple must have or how long a couple should wait before getting another child. These decisions have to be made by the couple concerned, for after all, it is they alone who know, as it were, where the shoe pinches. The couple raises a family and it is therefore right and proper that they must have the right to choose the size of the family and whether they want a happy family or not.

WORK OF THE ASSOCIATION

The Association's work is to see that the public is aware of the availability of family planning services in the country. The Association has on its staff health educators and clinic nurse/health educators, in some regions, who give lectures and explain to women and groups of people the importance of child spacing. It is not the intention of the Association to employ its staff for only some of the regions in the country, but the appointments are ultimately and solely dictated by the availability of funds, good supervision of the staff and the Association's ability to provide family planning services for the public where health education is given. The Association is planning to have health educators and clinic nurse/health educators, all over the country in all the regions, with a view, in the end, to enabling every interested family to use family planning services when needed.

TRAINING PROGRAMME

The training programme now being implemented, has been organised by the Association since October 1970. The Association is conducting the training programme for doctors, tutors of nurses training schools, paramedical staff and health educators. It is hoped that rural development workers and all other personnel who are working with the public in order to improve their standards of living, will also get family planning training. So far the Association has trained, at regular intervals, nurse/midwives, health nurses, medical assistants, health educators, social workers in training and nutrition students. These staff are from government or Voluntary Agency (Mission) and private hospitals.

The expenses of the training courses are paid for by the Association. Government pays travel expenses of its staff who come to our courses. The Association realises that it has a special role to play in bringing about the well-being of the present nation and of future generations.

In addition to the training programme mentioned earlier on, the Association teaches family planning skills to medical students and student nurse/midwives. This kind of training is also given to qualified doctors and nurse/midwives as in-service training. It is the intention of the Association to train as many people as possible so as to make this service available to everybody in need of family planning without distinction. We believe that the more family planning services are spread the less will be the burden in the maternal and child welfare clinics and in the general health services, for mothers and children will be healthier than they have been hitherto.

WHO CONDUCTS FAMILY PLANNING IN TANZANIA?

In Dar-es-Salaam, where the Head Office of the FPAT is, there are five clinics run by doctors employed on sessional basis (part-time) clinic nurse/midwives and health educators. Health Educators have teaching or community development training. Elsewhere in the country mission and government medical officers responsible for MCH and nurse/midwives trained by FPAT or on-the-job, conduct family

planning. Where there is a nurse/midwife or health educator employer by FPAT his/her work is supervised by the government or mission doctor.

ADMINISTRATION OF FPAT (BRIEFLY)

This is carried out by the Executive Committee whose current Chairman is a Cabinet Minister. The Vice Chairman is a doctor of medicine and Executive Secretary an ex-teacher with experience in running organisations. The Executive Committee also consists of medical staff, religious leaders, lawyers, social workers, representatives from the political party, association of parents, as well as from the National Women's Organisation. Chairmen of all the 29 branches are also members of this Committee. The Executive Secretary is also given the responsibility of directing the day to day work of the association. Subcommittees on training, finance, planning, fund-raising, medical and clinical services, information and education exist to ensure smooth running of the various departments. A Medical and Training Director who is also a consultant gynaecologist/obstetrician deals with overall matters relating to clinic services and training. Under him are medical officers trained or with previous experience in family planning, senior clinic nurse (an ex-matron of maternity hospital and MCH Services) and her staff. One Senior Training Officer and a training officer, both nurse/midwives with teaching experience, are responsible for training under the guidance of Training Committee and supervision of the Director. Personnel in charge of finance information and edcuation, are professionals in those fields.

PEOPLE ENTITLED TO GET FAMILY PLANNING HELP

Family Planning help is given to anybody who is mature and has a family irrespective of colour, creed and religion. Family Planning help is available, free of charge, in all government and voluntary agency hospitals, which give family planning help. The Association as stated earlier, gives contraceptive supplies and instruments free of charge to all hospitals and health centres. As stated earlier, a membership fee of Shs.3/- per year is charged for every client who gets family planning help. Money collected from the membership fees is used to meet some of the day to day expenses incurred for the running of the Association. As you know, this Association is voluntary and has no annual subvention from the government; salaries and other expenses are met by IPPF grant donations, from individuals and membership contributions and fund-raising campaigns. This is to say that the Association's funds are received from well wishers of its activities for the benefit of all Tanzanians. Government, however, allows all contraceptives and equipment used in child spacing to be imported duty free and through its Central Medical Stores.

There are quite a number of contraceptive methods used in family planning clinics. The methods are explained to clients so that they may be able to choose which method they should use. The doctors advise each client which method they should use. But the client has the right to choose the method she wishes. The Association is here for everyone qualified to make use of its services.

WHAT A RESPONSIBLE CITIZEN IS SUPPOSED TO DO

In his address to the TANU Conference on May 28, 1969, the President, Mwalimu Julius K. Nyerere said:-

> "The thing I want to say is this. It is very good to increase our population because our country is large and there is plenty of unused land. But it is necessary to remember that these 350,000 extra people every year will be babies in arms, not workers. They will have to be fed, clothed, given medical attention, schooling, and many other services for very many years before they will be able to contribute to the economy of the country through their work. This is right and proper and is in accordance with the teachings of the Arusha Declaration. But it is obvious that just as the number of our children is increasing, so the burden on the adults, the workers is also increasing. Giving birth is something in which mankind and animals are equal, but rearing the young, and especially educating them for many years, is something which is an unique gift and responsibility of men. It is for this reason, that it is important for human beings to put emphasis on caring for children and the ability to look after them properly, rather than thinking only that men's ability to give birth is greater than their ability to bring up the children in a proper manner."

Our duty and the duty of each and everyone of us is to translate these words into action. A true and responsible citizen is supposed to inform others on all help provided and available in our country, not only family planning help but also on other necessary services provided for the well-being and progress of our entire nation. If we inform others on what is provided and available for us all, we will not only be helping the betterment of our rural communities but also be contributing to the betterment of the whole present generation and posterity of this country.

We should teach each other and learn from each other. New ideas crop up every year in the world and for these ideas to be useful at all, they must be shared between mankind. But we must remember that we must pick and choose only those ideas that are relevant to our nation and leave what is not applicable to the needs of our country. Someone has said "Ideas have legs". Let us help in upholding the truth epitomized by these three words.

Appendix J

THE PAEDIATRIC CONTENT OF MIDWIFERY TRAINING PROGRAMMES

By Professor N.O. Bwibo
M.B., Ch.B. (E.A.), M.P.H. (Berkeley), F.A.A.P.,
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The specific roles of the midwives is stated by Stewart and Lawson, to be the "dealing with the normal obstetrics, to detect abnormalities and refer patients who have developed them to a doctor and provide for all mothers and their newborn babies the special nursing care that they require (Stewart and Lawson 1967)". To provide special nursing to these babies, the midwives should be provided with adequate training to enable them to meet their task. With the limited staff facilities in our countries, the midwives here are required to deal with more child care than their counter part in developed countries. Their training therefore should contain much practical aspects of the needs of the baby before and after birth, so as to lower perinatal and neonatal mortalities which are very high in our countries.

WHO expert Committee on Midwifery Training-Technical Report series No. 93, Geneva, 1955 classified midwives in three categories as follows:

1. Traditional birth attendants.

2. Auxilliary midwives.

3. Professional midwives.

The method of training these various midwives and the specific content of the syllabus regarding child care will vary according to their basic understanding and general education.

I will now discuss the paediatric content of the midwifery training programme for each of the category.

THE TRAINING PROGRAMME OF TRADITIONAL BIRTH ATTENDANT

The traditional birth attendants deal with the bulk of deliveries in our countries particularly in the rural areas. Most of them are illiterate and are elderly women. They may be the village herbalists, or respected women who know the art of child birth. In some cases the birth attendant must be a relative of the expectant woman; usually a mother-in-law or a sister-in-law. Thus attendants in a given village can vary in number. Their capacity to learn or accept new ideas is obviously variable too so is their willingness to be known by government officials.

The questions to be takcled then will be their selection for training, where they are trained and by whom and to what extent and what the training means to them. Such matters will come up for discussion later. Having recognised and selected these attendants

for training, then their training should be as practical as possible. We should avoid disturbing their peace and prestige as much as possible during their training. The content of their Paediatric instruction should include:

1. How babies grow in utero.

2. The food they need in utero in order to grow properly.

3. The possible bad effects on growth by herbs administered to pregnant mothers.

4. The harmful taboos during pregnancy.

5. Explanation of causes of congenital malformations.

6. The dangers to the newborn child of hurrying delivery by administration of herbs to mothers in labour.

7. Recognition of premature babies and their referral to hospital.

8. Simple resuscitation of the babies.

9. Prevention of infections by hand washing, hygienic methods of tying, cutting and dressing the umbilical cord.

10. Recognition of a sick newborn baby and referral to hospital.

11. The causes of death of newborn and how to avoid them.

12. The value to children of spacing pregnancies.

13. The immediate aim of this instruction is to lower neonatal deaths from infections and trauma that occur due to unskilled delivery. The long term effect is to lower infant mortality as well.

THE TRAINING PROGRAMME FOR AUXILLIARY MIDWIVES

These candidates should be selected for training. They should be literate but should be trained whenever possible in vernacular using simple methods of demonstration and simplified lectures. The content of their syllabus should be the same as that described for the traditional birth attendants but with little more depth. They should be given more explanation and reasons of what they are taught.

THE TRAINING PROGRAMME FOR PROFESSIONAL MIDWIVES

This category has two levels of midwives: The midwife and the nurse midwife. The nurse midwife is admitted to midwifery training with previous training in general nursing. The midwife on the other hand has no prior nursing training.

There should be minimal entry requirements for their training as their training should be detailed and what is expected of them is high degree of skills in their care of the newborn babies. Since they are highly educated, they should be instructed by detailed lectures, seminars, case studies and demonstrations. They should be able to understand the reasons of the subject matter.

The content of their Paediatric Syllabus should include:

1. Growth and development of the foetus.

2. Factors affecting growth and development such as:

   a. Nutition in pregnancy.

   b. Maternal illnesses such as diabetes and toxaemia.

   c. Maternal infections.

   d. Drugs during pregnancy.

   e. Maternal age.

   f. Irradiation in early pregnancy.

   g. Multiple pregnancies.

3. Routine care of a baby at birth.

4. Routine care of premature (low birth weight) babies.

5. Asphyxia of the newborn babies.

6. Resuscitation of the newborn.

7. Neonatal infections; manifestations treatment and prevention.

8. Neonatal jaundice.

9. Congenital malformations; causes, management and prevention.

10. Perinatal mortality (foetal and neonatal deaths).

11. Feeding of the newborn baby:

    a. Breast feeding vs bottle feeding.

    b. Preparation of breasts during pregnancy for breast feeding.

    c. Preparation of artificial feeds.

12. Malnutrition; diagnosis, treatment and prevention.

13. Diarrhoea and vomiting.

14. Immunisation of the babies.

15. The use of growth charts.

16. The role of child spacing in health needs of the children.

17. The use of under fives clinics.

18. Accidents and their preventions.

19. The role of school health programme.

This ladies and gentlemen should form a basis of our discussions on Paediatric content of the Midwifery Training Programmes.

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Appendix K

EDUCATIONAL METHODS AND CURRICULUM DEVELOPMENT

By Miss C.M. Mudie M.T.D. - Kenyatta National School of Nursing

INTRODUCTION

This is a vast subject with many diverse views and I did not feel that I was in any way an expert on the subject so I am going to speak mostly from my own experience mainly making here mention of the former and dealing with the latter.

EDUCATIONAL METHODS

Here I should deal with the methods most commonly used in any country in the world.

1. Lecture Method

Possibly the most commonly used all over, is usually formal with times made available at the end for questions.

a. Popular with students who like doing little.

b. Popular with the teachers who likes doing everything.

It has advantages:

a. Saves time - lecture 100 or 10.

b. Teacher makes the class. But:

Very often very little students participation and the needs of the individual student are just not met. This type of teaching does need a lot of other methods also used.

2. Tutorial Methods

This may be used for various reasons and usually done with the class broken up into small groups.

a. Used as coaching classes.

b. To elaborate on the lecture to try and make sure the students should really participate - question and answer etc. and have understood.

c. The Tutor needs to show how to contact this type of class.

3. Discussion

A good method to use for controversial subjects - good preparation required to make things work out - tutor and students - and must be a subject the students know something about. Can get out of hand!

4. Debate

Really just a more formal method of the above - Proper, recorder with Chairman etc.

5. Student Assignment

Much more use is being made of this method nowadays:

a. Nursing Care Studies - Reference old Casebook.

b. Written Assignment - on a departmental basis. Student responsibility must be high here - but the onus is on the student; they learn more that way!

6. Projects

a. Group Projects. The preparation is done by discussion within the group and are presented later to the whole class.

b. Presentation. Very useful indeed and does promote discussion.

c. Mother Craft Teaching. This can be done in the clinic as well as in the wards.

7. Educational Visits

These are useful but only if they are of educational value.

8. Quiz

Tutor needs to prepare well - let students do their own corrections - a good method of self evaluation.

DEVELOPMENT CURRICULUM

Again I am merely speaking here from my own experience both here at Kenyatta National Hospital - Registered Level Training as well as in the Rural Areas - enrolled Nurse Level.

The following important points need to be kept always in mind.

1. Syllabus to be Covered

a. Subjects to be covered are usually laid down by the examining body.

b. The depth or the detail of these subjects must be clearly known by the tutor.

c. Length of training with basic experience is also as a rule laid down.

2. The Person You Need

This must not only be known but must be kept to the fore all along. It does not follow that we must just rubber stamp the training given in another country.

3. Teaching Staff Available.

Here we think of various grades:

a. Tutors.

b. Clinical Tutors or Instructors. Reach for the star - every qualified member of staff a teacher!

4. Experience Available.

a. All in one centre.

b. Two or more areas.

5. Service Requirements

This is most important unless you work in a Utopia with all students being supernumary.

a. Minimum required for service load.

b. Maximum load that could be taken.

c. Night Duty Pattern.

d. Always approximate extras for LEAVE and SICKNESS etc.

6. Student Intakes

a. Educational Background required.

b. Number to be recruited.

c. Intake intervals (this needs to be geared to length of training, frequency of the examination etc.

7. Organisation - Organisation

Peruse - Use - all areas available and do not reach for the moon too soon.

8. Be Adaptable

Open to any changes required - in other words DEVELOP A CURRICULUM - do not just TRANSPLANT!

Appendix L

THE CONTRIBUTION WHICH CAN BE MADE BY THE TRADITIONAL BIRTH ATTENDANT

By Miss S. Rush - Ethiopia

As in most countries, so there exists in Ethiopia a strong group of local and traditional birth attendants who especially in the rural areas have a large influence on the local population. These women are taught by Ethiopian Womens Welfare Association with Ministry of Public Health permission and the course is included in the fourth five year plan for Ethiopia. The Association felt that these birth attendants were a good potential to reach out to masses, and they themselves once having received a basic course could go out amongst the people and be readily accepted by them in their homes, where they could give necessary assistance and teaching.

Until there are enough qualified midwives, the Ministry of Public Health and other agencies working in this field are now convinced that these local birth attendants each play an important role in the rural areas. It would therefore seem that it is essential to train and make full use of these women who through tradition have reached a certain standing and understanding amongst their own people.

Although there are certain arguments put against these programmes, the chief being that these women are too conservative to accept new ideas, and another that they are too old to learn, the fact is that this first year of experiment has rather refuted the prevalent argument, especially if at one point the women should become the responsibility of the government.

These women are eager to learn new methods. The large percentage not only accepts them but as seen by the evaluation and follow-up programme, they put in practice what they have learned. They also have a good contact and referral centre to keep them under the supervision and in constant contact with the other government health agencies. So not only have the people accepted them but also the other hospitals and MCH centres. The EWWA feels this is a big step. There is understanding and co-operation between the two, and it is in this way the women can best contribute to the general health development programme of the country.

Again, as these women carry a certain prestige and are readily accepted in the people's homes, the Association believes that here again the women can use the homes for teaching. They can integrate with the work, other programmes, such as family planning, family guidance, public health teaching etc., not only to the mothers but to the whole family and they as a whole would be ready to understand and accept new ideas. The full extent of their influence will not only be felt at the time of delivery but will play an important part in coming months and years of the family.

All these women chosen for this programme are also recommended and interviewed both by the local elders, members of the Association in Branch Office and a local committee composed of private and government representatives. They are an integral part of the local community, so the people on the whole feel very confident and have shown much interest in this programme.

Similar programmes have been implemented in a few other countries. In Ethiopia the training of a group of 15-20 women can be done at a minimum cost, using mostly local materials and an efficient mobile team. Thus the association feels it is important that the programmes are mostly for those who would be unable to afford hospitalization for their deliveries. This seems a most important factor when we are trying to train people. These TBAs do not receive any renumeration from the government.

Therefore the E.W.W.A. feels that for countries of the third world trying to train the masses the contribution of these birth attendants is important in three factors:

1. Economically.

2. In training and upgrading of the local population.

3. In budging the tradition and modern concepts and using the local population potential for a most important programme that affects the health of the nation.

These women reach a section of the population not readily available to health centes and other teaching personnel.

Appendix M

THE ROLE OF THE MIDWIFE OF ALL CATEGORIES IN THE MATERNAL AND CHILD CARE PROGRAMME

By Mrs. K.S. Sowanyana - Uganda

In the light of scientific and social change and the goals of our social and health policy to extend health services to the population, midwifery and other health professions are faced with the need to adopt and expand their roles.

In planning to meet maternal and child care, it is important that midwives and obstetricians collaborate to promote the development and utilization of both professions.

A variety of practices may evolve in different settings including the creation of new categories of midwifery workers, although, this may require midwives of all categories to delegate some of their activities and undertake new responsibilities.

The role of their practice and the title should remain distinctly midwifery, including child care, and education programmes should be geared to prepare them for their recognised role.

The midwife is a nurse with post-registration qualifications or without nursing qualification who provides service to mothers, children and individuals in the community.

The African Universitites are trying to make a chair for the maternal and child care programme, but in actual fact it does not exist yet.

The role of the midwife is an integral part of any Maternal and Child Care programme. Without the midwife, this programme could hardly be put into operation. However, the midwife can be more or less passive in her role, or she can be a stimulating and vibrant part of the programme.

The group discussions which follow are orientated towards making a midwife really active in her sphere, and by this activity she will be instrumental in lifting the standard of health and hygiene of the nation.

The subjects for discussion are given on the programme. I would like to emphasise the need to be practical in your discussions, and not to build 'castles in the air'. You all know the restricting problems of finance, transport, lack of personnel, local customs, lack of response on the part of the people - often due to the very health problems we are attempting to solve. People who are malnourished, infested with intestinal parasites, weighed down with chronic malaria and other diseases, rarely have the energy to be responsive in health education programmes. They are too apathetic, yet if their problems are to be solved, they must try to put into practice the teaching of the health teams.

The midwife has a unique role here - she, of all members of the health team, is probably closer to the mother than the others. She will have established a relationship born with the infant she brought into the world, and she will be aware of the problems of the family. She can encourage and assist, if she herself is convinced of the need, for conviction is a necessary part of teaching.

The work of an enrolled/nurse/midwife in a rural area is invaluable. It is important that doctors are attached to the training hospitals, but the present number of doctors is not adequate to staff the rural areas as one would wish, so a great responsibility devolves on the nurse/midwife in the rural area. Perhaps the best way for her to operate for the good of the greater number, is from a central health/maternity centre, all patients coming to her from a predetermined radius. Many health workers have designed health centres, and plans for these can be seen in a number of books written on the subject, for example Professor Maurice King's book on Medical Care in the developing countries. She would have to arrange various clinics and educational programmes, as well as dealing with maternity cases and possibly sick people while awaiting transfer to hospital. In other words, she has to be an administrator as well as a nurse/midwife, and this is putting a great burden of responsibility on her shoulders. This means that the training of this cadre must be very well and thoughtfully done,

In your groups you will discuss the function that a midwife is expected to perform and her responsibilities in the Maternal and Child Care/Family Planning Programme. Remember to keep this down to practical values, and to respect the beliefs of people, even if you do not agree with them. You all know the material from which enrolled midwives are trained. Practically they may be all that is desirable, but educationally few have reached S.IV standard, so we should not plan elaborate and confusing programmes for them.

The second subject shows that the function of the professional (registered) midwife and the enrolled midwife are thought to be different. Functionally, there is little difference, but regarding responsibility, the registered midwives should be concerned with the teaching of midwives, in countries where they are comparatively few in number. This means that the registered group will probably be concentrated in the training hospitals in order to turn out enrolled midwives of the calibre previously described, so that they are fit for the responsibility they will have to assume in the rural areas. This point is important in your discussions.

The third point indicates the possibility of integrating the traditional birth attendant. This depends very much on the customs prevalent in the area in which the midwife lives or works. It is not easy to contact these birth attendants in some areas, and few would be interested in a training or integration programme, but there may be people with different and wider experience in your group, who can explain how this is possible. The traditional midwife is probably very far removed from the modern midwife, in her methods and in her beliefs, so it is up to you to discuss the possibilities of integration.

It will be very interesting to hear the fruit of your discussions, and we look forward to meeting you when they are over.

Appendix N

THE IDENTIFICATION AND TRAINING OF TRADITIONAL BIRTH ATTENDANTS INCLUDING MOTIVATION FOR FAMILY PLANNING

By Miss S. Rush - Ethiopia

There have been attempts by various groups or persons to identify the Traditional Birth Attendants. Usually there seemed to be no knowledge of any in the Community. However, when the EWWA began the training of Traditional Birth Attendants it became evident that there are many of them.

The Pilot Course in Addis Ababa had 20 women who came from the 10 areas of the city. Letters were sent to the local governors who contacted the Idirs (social community group) who chose two to three birth attendants to be interviewed to join the class. Most of these women were not literate and so needed to have the forms filled in for them after answering the questions. Let us remember that it is not lack of ability but lack of opportunity that these women are not literate.

In each of the other areas where training has taken place, the EWWA of that province has recruited the women in similar ways. In each place too, there were requests for more admissions, however, to do a demonstration adequately and have each one do return demonstrations, it was not advisable to accept more than 12 - 15 in one class.

The local MPH staff give help in providing a Community Nurse to interpret and assist the teacher. They also provide opportunity for the Traditional Birth Attendant to see at close range what is done in an ante-natal clinic. Guest lecturers are invited to participate in the teaching such as Doctors, Nurses, Health Officers and Sanitarians. Women see deliveries in clinics or hospitals where it can be arranged.

The course includes the following lectures and demonstrations:

1. The Menstrual cycle - depth of detail limited.
2. Development of Foetus.
3. Ante-natal care including nutrition.
4. Complications of pregnancy.
5. Germs.
6. After care of mother and baby.
7. Complications of labour.
8. Later care of newborn.
9. Infant diseases with immunisation.
10. Personal hygiene.

Women are given opportunity to talk about the methods they use.

Demonstrations:

Hand washing, cord tying, delivering baby on model, bathing newborn, bathing older child, use of things in Kit.

Each Birth Attendant must do one or more return demonstrations.

An oral examination is given to each woman individually after two weeks and again at the end of four weeks.

Each Birth Attendant receives a kit containing:

1 towel, 1 plastic sheet, 1 pan with lid to boil blade and cord tie, 1 pack razor blades, 1 cake of soap, 1 box matches, 1 candle, 1 tube eye ointment, 1 small bottle alcohol for cord stump, 1 apron, 2 - 6" x 6" cloths (to wipe mucus as baby is born, the other to lift baby by feet.

The Menstrual cycle is explained carefully with chart as blackboard demonstrations of what takes place during the cycle. Here Family Planning is introduced. Each woman is asked to explain the cycle and tell when a woman with a 30 day cycle or a 28 day or 26 day cycle can become pregnant. Later the reasons for planned families is discussed in connection with the health and welfare of the mother and child. The TBA will spread the knowledge that help is available for those who want children and can't have them and also for those who want to space their children.

One of the big things for these women to learn is a bit about germs and the reason why babies get tetanus and mothers get infection. For some, the idea of washing hands and using clean cloths for a messy job is a new idea. Assisting a delivery is also mostly not done unless it is long delayed then the methods used are not the best. A woman will not expose herself so they wait for the child to be born. It is a new idea for them to know that medical help is needed if a woman especially a multipara remains in active labour for more than several hours and that the baby and mother can often be saved if help is obtained.

Looking at charts to learn a bit of female anatomy helps dispel the idea that the placenta may go to the upper part of the body and kill the mother if it doesn't come quickly. It is commonly believed that the baby is upright in the mother and turns when about to be born.

The care of the mother from conception to delivery is discussed with emphasis on Ante-Natal check-ups. The greatest emphasis is placed on cleanliness for the mother and surrounding and for the birth attendant. The techniques for a normal delivery is demonstrated on a model and return demonstrations are done several times during the course. Bathing is demonstrated and the model is used for return demonstrations. Finally, role playing is used and the women are called to a delivery and live subjects are used until delivery time when they switch to the model. The women are taught nutrition for the preganant woman from local food charts.

Each woman must clean up her kit and wash the contents preparing everything for use. The kits can be locked and therefore will not be disturbed by anyone.

The traditional birth attendants programme is new and we need to evaluate it more fully to know just how useful these women will be in spreading family planning information but we have reason to feel that they will be able to interest those whom others may not have access to. She should be useful in overcoming the harmful practices such as digging out the first teeth when the gums swell, to cut the uvula, scratching the tonsils, all done by unskilled people without sterile techniques. They may well encourage women to attend baby clinics.

The EWWA has great hopes for the improvement of delivery procedures which these women carry out which should result in lives saved, better living babies, as well as happier mothers and fathers.

The Ethiopian TAB is being identified, has begun to be taught and will prove to be a great asset in improving the health of the Community in which she moves.

She will learn to practise in a sanitary way. She will teach the mother to take advantage of pre-natal care. She will learn to recognise abnormalities which need to be referred. She will become interested in the child and family and can be a teacher in the community in general health measures.

I feel Ethiopia has begun to face reality in a good way and is beginning to use a tremendous potential to get health teaching out to the multitudes.

It is good to be idealistic, but we <u>must</u> face reality and cope with things as they are at the same time helping to raise standards.

TRADITIONAL MIDWIVES T.B.A.'S COURSE OUTLINE USED IN ETHIOPIA

Growing into Womanhood

Puberty Menstruation and Ovulation Hygiene of Menstruation	Use Visual Aid to explain Menstrual Cycle Family Planning Introduced

Signs and Symptoms of Pregnancy

Early Signs	Minor Discomforts
Probable Signs	Nausea and Vomiting; Varicose Veins
Positive Signs	Frequency of Urine; Hemorrhoids; Heartburn; Backache; Constipation; Leg Cramps, Pruritis; Dyspnea; Edema.

Development of Fetus

Fertilization Development of Placenta Amniotic Sac Internal Organs and Systems	Illustrate with Pictures

Ante-Natal Care

Exam includes: urine; blood; lungs and heart; breasts; blood pressure.	Danger Signs Monthly check of: blood pressure; pulse; weight; fetal heart; hemoglobin; urine albumin sugar.
Nutrition Exercise and rest Hygiene	

Complications of Pregnancy

Haemorrhage	Causes: Abortion; Ectopic Pregnancy; Placent Previa. Signs and Symptoms of each Treatment of each
Hyperemesis Gravidarum	Signs and Symptoms Treatment
R.H. Factor	Simple Explanation - just enough to know about it.
Communicable Diseases	German measles; Hepatitis; Small Pox

Other Diseases	Diabetes; Syphilis; T.B.; G.C.: Malaria; Heart.

Germs

Types of Germs	Show Pictures
How germs enter body	
How we know when they enter	
Emphasise danger surrounding delivery and infant care	
Hand washing demonstration	Use soap only as brush can be source of contamination if not cared for.

Wash hands thoroughly with soap and water. Rinse well, Wash to elbow with soap and water. Rinse. Now do forearms again. Last do hand again with soap and water. Rinse and air dry unless you have sterile towel.

Labor and Delivery

Signs of coming labor: Lightening Contractions; Show; Ruptured Membranes	Stages of Labor 1. To complete dilation of cervix. 2. To birth of baby. 3. To delivery of placenta.
Nursing Care and Delivery	Outline what to do in each stage and drill well.
Cord Tying Demonstration	Have the ladies bring the type of cord tie they use and teach them to do square knots. Use pencil or piece of rubber tubing.
Supplies needed for Delivery	(Give demonstration of their use)

Boiled water; small pan for boiling cord tie and blade; plastic sheet (old newspapers, if available); scorched cloths; receiving blanket; clean box or carton for baby; eye ointment; towel and soap.

After Care of Mother and Baby

Mother: Bath, Perineal care, Diet, Elimination

Baby: Bath, Feeding, Sleeping, Exercise

Complications of Labor

Haemorrhage	Prolapsed Cord
Distended Bladder	Non-descent of head
Ruptured Uterus	Pre-Eclampsia and Eclampsia

Abnormal Presentations

Genital Infection - Breast Infection Phlebitis

Later Care of Newborn

Baby's Needs: Food, Warmth, Sleep, Protection from Infection, T.L.C.

The Growing Child: After 10th day 50 mgm Vit. C and 400 I.U. Vit. D.
6 to 8 weeks diluted fruit juices.
3 months fine cooked cereals; egg yolk; banana

Formula feeding ONLY if breast feeding is impossible.
Milk - Boiled Water - Carbohydrate g.4 hrs.

Infant Diseases

Communicable and Other (Adapt to your class)

Demonstration - Bathing Babies

Newborn - Avoid chilling and wetting cord
Older - after cord has dropped off. Use basin or tub.

Teaching Mothers

How to bathe and feed baby.
How to prepare feeds and clean bottles where used.
Personal cleanliness and cleanliness of house.

Family Planning

Have Doctor or someone from Family Guidance Program lecture to class. Film, if possible.

Other Lectures By Invitation

Abnormal Deliveries
Ethics for Midwives
Harmful Customs

Film Strip used - prepared by Ethiopian Nutrition Institute showing woman cleaning house and linen - Care of Mother after delivery - Baby bath - Nursing baby - Food for mother and use of sunshine. Supplementary feeding.

Practical Demonstration

The teacher demonstrates the practical procedures. Then each student does a return demonstration in front of the class. Repeat demonstrations should be done by those who have not mastered the art. Each student also should be seen doing a home delivery as part of the course.

Field Work

This needs to be arranged according to local facility. Two or three at a time might spend a set number of days in a hospital or clinic observing and/or helping with obstetrical patients. The best time for this is probably during the last two weeks of the course. Attend ante-natal clinic.

Birth Registration

A type of birth certificate is being prepared for use where midwives assist at delivery. Some responsible person should fill out two forms - one for the mother and one for the E.W.W.A. files.

Questionnaire for Traditional Birth Attendants E.W.W.A.

Name of Applicant _____ Age _____

Address _____ Marital Status _____

Person Recommending you _____ Language _____

1. How many babies have you delivered? _____
2. How did you begin to do this work? _____
3. Describe how you take care of the umbilical cord _____

_____

4. What do you do if the placenta does not come? _____
5. What kind of difficulties have you experienced in your work? _____

_____

6. Do you receive any payment for your services? _____
7. What do you expect to learn in this course? _____
8. Can you read or write? _____
9. Do you refer patients to hospital or clinic? _____
10. How do you earn your living? _____
11. With whom do you live? _____

Remarks:

LEGISLATION

By R.J. Fenney

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:

> "A midwife is a person who is qualified to practise midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the postnatal perod, to conduct normal deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognise the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor, and to carry out emergency measures in the absence of medical help. She may practise in hospitals, health units or domciliary services. In any one of these situations she has an important task in health education within the family and the community. In some countries, her work extends into the fields of gynaecology, family planning and child care."

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 establish some system of control of the licensee. (A questionnaire is attached with a series of headings which attempt to analyse the scope of licensure).

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.

IMPORTANCE AND NECESSITY FOR LEGISLATION IN THE MEDICAL PROFESSION

By Mr. Lawrence Mungai LLB
Assistant Registrar - University of Nairobi

It is almost a natural phenomenon that a human being requires a kind of code of conduct to regulate his activities. An individual will draw up a schedule for himself to regulate his activities for the day, week or for the whole year; a group of people will form and respect a code of regulations; a profession will set rules usually known as code of ethics; and in a much wider context the state has a set of laws to be observed and obeyed by all its citizens. Among the principal purposes of any set of laws of a state is to protect the fundamental rights and freedoms of the individual.

Pursuant to this basic and fundamental principle, it is a universally accepted belief that a human being has a right to live and it is therefore the duty of the state to protect the lives of its citizens and to penalise the agents that terminate human life by means other than natural causes or those recognised by the law - for example in execution of justice like in the case of capital punishment or for self defence. The law does not only put these protective measures but also goes further to provide for various ways and means to conserve the human life for the longest possible time. These include, among others, health services. It is therefore consonant to this basic principle that the noble medical profession has lived.

Despite the clear humane purpose of the medical profession, it is necessary, like in all other cases to draw up some kind of rules and regulations, first to regulate the standards of the profession and secondly to safeguard the interests of the members of the profession against the rest of the community and vice versa.

The set of rules concerning the medical profession can be classified into two major groups - the statute or written law enforceable by the state machinery for example the Public Health Act, Cap 242 of the laws of Kenya which makes provision for securing and maintaining public health. This Act sets up the administrative machinery for running the health services and also for the prevention and suppression of infectious diseases. It also gives right for the health authorities to detain persons infected by these diseases.

Another example is the Medical Practitioners and Dentists Act, Cap 253 which makes provision for the registration of medical practitioners and dentists and more appropriately, The Nurses Midwives and Health Visitors Act, Cap 257 - an Act of Parliament making provision for the training, registration and enrolment of nurses midwives and health visitors and also to regulate their practice and education. The second group constitutes the rules that are not enacted by the State and which govern the internal administrative matters of conduct and discipline within the profession for example codes of ethics for the profession.

But whether a set of rules are enshrined in an Act of Parliament or codified as set of regulations, two characteristics are necessary if they have to carry any meaning in the eyes of its subjects. These are respectability and enforceability which inevitably go together. A law which is totally against the norms of a society or a set of rules that sets standards which a profession cannot maintain both in terms of available manpower and facilities is repugnant to these two fundamantal qualifying characteristics. Existence of both the law and regulations must not only be justified by the recipients but they must also be told why such rules are necessary. They must also understand them thoroughly.

Despite all the good intentions of the legislators and other law makers, no law can close all the gaps and loopholes. The provisions of a statute may be overtaken by new social values and tastes or by new technological inventions. The legislative machinery may be lengthy and complicated and the required changes may not be incorporated in the new law in good time. It is for this reason that most Acts of Parliament provide for the establishment of administrative bodies for example the central Board of Health set up under section 3 of the Public Health Act Cap 242 whose many functions include "advising the Minister upon all matters affecting Public Health and particularly "..... to carry out researches and investigations in connection with the prevention or treatment of human diseases....." Likewise, the Nurses Midwives and Health Visitors Council of Kenya set up under section 3 of Cap 257 (currently under revision) is enpowered, under section 23 of the Act, to make regulations for better carrying out the provisions of the Act particularly in connection with the keeping of registers and rolls and the administration of examinations and syllabuses.

The functions of these administrative bodies are identical to the principal legislation - "that is to maintain and improve the standards of the profession." Can't we do with the codes of ethics and other rules set up by the professional bodies? The answer to these questions is two fold. First the law is not meant for those members in the junior echelons of the profession only. The powers of those in authority should be checked lest the rules of justice are abused. Checks and balances on their decisions should therefore be instituted to ensure that they do not exceed powers vested upon them by the law. Secondly the ethics and rules have no statutory congnizance, and their enforceability is limited. For example, a professional body would not stop unqualified persons from practising medicine nor do they have powers to take action against those who are grossly negligent in the performance of their professional duties. Striking them off the register does not, in itself, redress the victim of their negligent mistakes nor does it deter the doctor as a person. Cancellation of his name may not prevent him from practising in a different part of the world.

Production of good work and the solution of hospital problems, be they technical or simple public relations matters will not be achieved by water tight sets of laws or codes of regulation. The most important factor is self-conscience in the maintenance of ethical values on the part of the medical staff. But on the other hand, human beings cannot run on the tramlines however smooth these may be.

Personality relationship usually mars the smooth administration of the hospital despite the existence of the law and its niceties. Discontent and strife among the junior members of the profession are not infrequently due to those in authority not taking adequate care about the rights of those under their jurisdiction. Resentment and laxness in performance of duties spring from the failure to balance responsibilities, rights and obligations - a sympton of injustice - hence, the necessity of intervention of the law to contain the situation at the legally established normative.

Personal integrity and sense of responsiblity particularly that which comes as a result of education and training and not that which develops out of fear of punishment for infringing the rules will go a long way towards the solution of the problems for which the law is meant. Members of the medical profession especially those in the junior ranks are expected to exercise independent assessment of the results of his or her actions. Those in supervisory positions should not take the advantage of the provisons of the law and should also exercise humility and respect in the execution of their duties according to the provisions of the governing regulations.

Perhaps the best companion of personal integrity is sense of duty by the nurses towards their patients and those others in need. Acceptance of duty and responsibility should be free. Rules to enforce performance of certain tasks should be avoided as much as possible. Such atmosphere will automatically plug off the typical loopholes in hospitals and offices especially involving malicious neglect of duty, careless errors of omission and attitudes tantamount obstruction in the running of the institution.

The importance and effects of legislation cannot be ascertained without looking at the practical aspects of the profession. It is only through practical application of legislative provisions that the efficacy or otherwise of those provisions can be effectively tested. A brief cross-section view of some of the more frequent legal problems in the medical profession is therefore necessary. A professional practice, particularly medicine is not always a rosy career. Mistakes in treatment may impair the good intentions of the doctors and nurses. Errors in diagnosis wreck the chances of a successful operation. Mistakes may arise as a result of unintended oversight of an important step in the treatment or through careless and deliberate disregard of professional standards. Victims of such circumstances have a right to some kind of compensation under personal law and in the case of serious negligence the state may punish the culprit under the penal code or under the provisions of other laws which set out the kind of punishment one would expect on committing a certain offence.

On the other hand the member of the profession has a legal right for criminal offences against him by the patient for example, battery and other kinds of assault and also for civil wrongs done upon him for example defamation.

On the civil side there are those matters concerning the contract of employment, the duty of care the members of the profession owes to the members of the public and vice versa.

Let's first have a brief review of these two areas which have raised considerable controversy in the legal history, namely criminal and civil liability arising in the course of doctor's duties.

Contract of employment establishes the relationship of master and servant and spells out the duties and obligations of each party arising from this relationship. The employee is expected to carry out the duties assigned to him in accordance with the standards laid down by the professional body which is recognised by the employing authority. The employer is on the other hand expected not only to pay salary and provide facilities necessary to enable the employee to carry out his professional duties but is also responsible for the wrongful acts done by the employee in the course of his or her duties - a responsibility known in law as vicarious liability. The extent and circumstances to which the employer's liability extends has been the subject of protracted legal argument but the general principle of employer's responsibility on the acts of his employee was enunciated more than one century ago.

There have been several cases on this point which have been brought before the courts of law for decision but many incidents have been left unchecked mainly due to the fact that the victims are not aware of the provisions of the law and therefore the courses of action open to them or because the authorities have deliberately chosen to obstruct justice. Written law in these areas has been amended frequently and the court's decisions have played a great role in re-modelling the statutes. For example in the case of Collins V Herts County Council (1947) 1 All E.R. 663 a student nurse acting as a house surgeon during war time took instructions from a consultant surgeon over the telephone regarding the operation list. She noted in error that the consultant surgeon required 100 ml. of 1 per cent cocaine with 1 in 20,000 adrenaline. She conveyed this information to the hospital pharmacist who, without query or even asking for the doctor's prescription, signed by a registered practitioner made up the solution and sent it to the theatre. About 80 ml. were injected into the patient resulting in his death.

When the matter was brought up in court it was held that the consultant surgeon, the acting housing surgeon and the pharmacist were all negligent. The damages due to the plaintiff were apportioned equally between the three but the hospital authority was compelled to meet the portions for the acting surgeon and the pharmacist for its vicarious liability. The court did not specially address itself on the fact that the acting house surgeon was only a nurse. The law recognises as we have seen earlier the necessity to bend the law to meet emergency cases. This principle was followed in the case of Nevelle V Cooper (1958) E.A. 594 where a doctor who was operating on an emergency case left a swab in the body of the patient to beat the time. The court decided that there was no negligence due to the special circumstances of the case. Although

in the first case the student nurse was exhonerated on the point of professional competence due to the war circumstances, personal integrity and due care is called for even if one is sure that the law would come to her rescue.

For those midwives and gynaecologists practising in Kenya there is a very recent example of the misery that midwives and hospital staff can be subjected to. This is the inquest concerning Mrs. Perez Ambala. The findings of the inquest have not been officially reported and without going deep into the facts and issues of the inquest the point at test is that of negligence. The law does not require anything unusual to proof good intentions. Negligence has been defined in many books to include "omission to do something which a reasonable man (in this case gynaecologist or midwife) would do or doing that which a prudent man would not do under normal circumstances". The law further recognises the old words of counsel that "experience is the best teacher." In the case of Roe V Minister of Health (1954) 2 QB66 the judge observed that "the doctors, like the rest of us have to learn by experience and ... experience teaches us the hard way". The law is alway vigilant to see that corrective measures are taken whenever a weakness is detected and it will not extend clemency where there is an abuse of this exception.

The powers of the professional body must, on the other hand, be checked to maintain the balance between all the parties concerned. There is a tendency among some senior officers in positions of responsibility to exceed their powers and at times to act harshly and unreasonably against their juniors - such acts may raise seriou infringement of the most fundamental principles of the law ordinarily referred to as the rules of natural justice namely

1. That no man should be condemned unheard.

2. That no man should be the judge in his case.

3. The accused must be told the nature of his or her offences.

It is not unusual to dismiss staff without hearing their case. It is not infrequent that parties to a dispute (in most cases members of the management) are participants in the disciplinary pannels. A case covering this point was brought up in the English High Court in 1953. (Palmer V Inverness Hospital Board of Management (1953) S.L.T. 124). The facts of the case were as follows:-

A house officer dismissed one of the hospital staff purporting to be acting on behalf of the hospital authority. The dismissed member of staff appealed to the Hospital Board who appointed a sub-committee to look into the case. The sub-committee found that the dismissal was unjustified. The Board sat to review the decision of the sub-committee. Among the members sitting in the Board were the house officer, his supervisor who had supported his actions all along and also the hospital lawyer. With the Chairman's casting vote the decision of the sub-committee was reversed. The dismissed staff appealed to the High Court and it was held that the board erred in its findings because, among other things, they infringed the maxims of natural justice by including the parties to the complaints in the

adjudicating pannel. The board had also failed to accord adequate hearing to the accused.

There are numerous cases in all spheres of the administrative authorities where these fundamental principles of justice are abused or ignored and the victims left uncompensated despite the existence of clear provision in the written law. However, whatever rights the law confers to the victims of law breakers it cannot help to restore harmonious personal relationship between the contesting parties. In case of the reinstated employee, for example, his performance will enevitably be affected and his master-servant relationship strained.

On the subject of doctor/nurse - patient relationship, the law has given adequate protection to the former provided that they take adequate precaution to avoid personal injury or abuse to the profession. They are for example exempted from the general rule - voluti non fit injuria meaning that to which man consents cannot be considered an injury.. It was argued at one time that the doctors/nurses, by accepting to do tasks that might result in injury could not claim redress in case they were injured by the patients during the course of their duties. A doctor consents to undertake the risky tasks for example, treatment of mentally sick persons, for the good of the patient - a duty universally recognised as beneficial to humanity. However, one should not step into a task carelessly and expect the law to come to his rescue indiscriminately. In the case of Michie V Shenley and Napsbury Hospital Management Committee:

The Times, 19/3/53 - A Trainee Nurse was attacked by a patient in course of treatment. The nurse had not taken precaution to protect herself from possible attacks by the patient. The nurse brought an action against the patient and the court dismissed the suit on the ground that the nurse though performing the duties in good faith and for the good of the patient, had not taken adequate precautions for example calling for help - though she was quite aware of possible consequences. This judgement recognises the professional declaration of a candidate's status and competence as adequate to make rational judgements for any actions she takes in the course of her duties.

To turn to the criminal aspect, there are a few instances where members of the medical profession are particularly exposed to the provisions of the criminal law. Of particular notice is the very tempting offence of termination of pregnancy. Many nations today advocate the policy of family planning. Majority of these nations advocate preventive measures and not corrective actions to achieve this goal. But with the rapid change in the values, morals and tastes of society, adherence to religious and cultural taboos that forbid abortion is loose and is no longer the order of the day. The law in this respect has remained unchanged except in a few countries. Unlawful termination of pregnancy is a criminal offence for which severe punishment is inflicted. However, the law is again bent to cover the genuine circumstances and in particular termination under the following conditions:

1. Where continuance of pregnancy would endanger the life of the expectant mother.

2. Where continued pregnancy would invoke risk to physical and mental health of the expectant mother.

3. Where the family of the pregnant woman would suffer as a result of continued pregnancy.

4. Where substantial risk is foreseen of the child suffering mentally or physically.

In all cases, qualified medical practitioner must certify the existence of at least one of the above conditions before the operation.

Doctors and nurses have time and again been accused of assualt. The general law recognises the necessity for consent before any kind of treatment is carried out on a patient. But time and again circumstances do not allow such consent to be sought especially where the patient is unconscious. Consent may be obtained from parents or guardians in the case of minors, or, in the case of a married patient, from the other spouse. In the latter case, sterilisation may for example, be a very difficult case which may arise a chain of legal remedies if carried out without proper consent. Doctors and nurses are therefore called upon to exercise caution when carrying out such an operation. In the majority of cases consent is only deduced for example when an expectant mother visits the Ante Natal Clinic voluntarily it is taken that she has consented to all the ordinary treatment that such a patient would be expected to undergo. Likewise when she takes position in the labour ward, she has given in to whatever the profession recognises as routine in the child-bearing processes unless she objects orally or otherwise, to a particular course of action.

Indecent assault is not an uncommon suit in the medical profession. The rule that a doctor or nurse should not treat a patient of the opposite sex in the absence of another member of hospital staff is a rule of perfection which is hardly applicable in countries where there is acute shortage of medical staff. In such circumstances what counts most is the personal integrity of the doctors. Complaints of indecent assault may not be proved in a court of law, but the moral image on the persons and the profession at large is at stake.

The foregoing paragraphs merely highlight the more important aspects of the law in connection with the medical practice, and in general cite the more practical instances the provisions of legislation have been brought to test in the courts of law. It is important to remember that the law is not there to show the nurse or the doctor, how to look after his or her patients. It does not tell him or her how to go about achieving registration. It simply lays down the guidelines on these matters. What legislation does is to show those members of the profession already qualified how to look after themselves in accordance with the standards set by the profession and therefore how to remain in the register.

I feel it only appropriate to conclude this brief talk by quoting two statements from learned friends which pronounce the theme of legislation and professional licensure.

Justin Miller, Dean of the Duke University Law School in his speech at the 30th Annual Congress on Medical Education in 1960 stated.

"The purpose of professional licensure is, on the one hand, to secure to society the benefits which come from the services of a highly skilled group and, on the other hand, to protect society from those who are not highly skilled, yet profess to be, or from those who being highly skilled, are nevertheless, so unprincipled as to misuse their superior knowledge to the disadvantage of the people."

Am Dugald Gillies statement on Legislative Problems in Licensure - A.J.N. Vol. 56 March, 1956:

"Regulation of a profession or a vacation must primarily protect the public health, safety, welfare or morals by prohibiting practice in a field in which incompetent practice would create a threat to the public, and it must tend to ensure competency by requiring persons who engage in those professions to qualify themselves under standards established by the state."

INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS INTERNATIONAL CONFEDERATION OF MIDWIVES JOINT STUDY GROUP ON THE TRAINING AND PRACTICE OF MIDWIVES AND MATERNITY NURSES

LEGISLATION AND LICENSURE OF MIDWIVES IN KENYA

By Mrs. Kanaiya
Registrar Nurses and Midwives Council, Kenya

In Kenya legislation of Nurses, Midwives and Health Visitors is governed by one Act under one statutory body which is the Nurses, Midwives and Health Visitors Council of Kenya. The first ordinance making provision for the training and registration of suitable persons as nurses and midwives was passed in 1949. This was repealed in 1965 to make provision for the training, registration and enrolment of nurses, midwives and health visitors and to regulate their practice and conduct. This is now the act which is under operation and was last revised in 1967. There are certain changes calling for repealing the whole act and this now is in the form of bill awaiting to be taken to Parliament.

Prior to enactment of the Nurses Ordinance, the only nurses and midwives qualified were those who had obtained their training outside Kenya mostly in Britain all non Kenyans who had come to Kenya as Missionaries or in the Colonial service. These are the people who started courses for nurses and midwives in various hospitals wherever they happened to be. One of the major problems at that time was language. For example between 1935 and 1945 only very few Kenyans had acquired general education and therefore very few could understand English language. It was therefore necessary during those days for all expatriates to learn the local languages. The first courses for nurses and midwives were given in the vernacular - Kiswahili in Nairobi and Coast Province and Kikuyu in the Central Province. There were no set standards so each hospital taught whatever was suitable for their own use in the station and they issued certificates to those who had completed the courses. The length of these courses differed but midwifery was of 2 years duration.

After these people qualified their work was mainly to assist the qualified nurses. From then on Kenya has assumed two grades of nurses and midwives and health visitors. The Council therefore maintains Registers for the professional and Rolls for the auxilliary grade.

The professional midwife is admitted to the register and is entitled to use the title "Kenya Enrolled Midwife" K.E.M. The Registered Midwife assumes supervisory role in the actual practice and the Enrolled midwife forms the backbone of midwifery practice in the country. It is necessary to mention here, however that the number of Registered Midwives in the country is not sufficient to make it possible for these to give direct supervision in all hospitals and it is usual to find that the Enrolled Midwife is left in charge in

many instances particularly in the smaller hospitals. This applies to all cadres of nurses and this is a factor the Council have in mind when designing curricula for the various Rolls so that the preparation these people are equipped for the task they are expected to carry out after qualifying. We like to think that our enrolled cadres have covered a much wider ground in theory and practice than covered by auxiliary cadres in countries where the number of professional nurses, and midwives is high compared to what it is in Kenya. One of the problems this brings is for those in practice to appreciate the difference between the professional and the auxiliary level. Today there are 1900 on the Register and 2,500 on the Roll in the Council's office. The number of Kenya Registered Midwives trained in Kenya being four hundred and the rest being those admitted to the Register by virtue of training completed outside Kenya. The number of Kenya Enrolled Midwives trained in Kenya being 2,100 and the rest being enrolled by virtue of training obtained outside Kenya.

REQUIREMENT FOR TRAINING AT REGISTERED LEVEL (MIDWIVES REGULATIONS (LEGAL NOTICE 299))

1. Training Facilities

a. Registered Level. At present there are three hospitals approved as training schools for this level - Kenyatta National Hospital approved in 1965, Mater Misericordiae Hospital approved in 1971, Nairobi and Pumwani Maternity Hospital approved in 1972. There was the Social Service League which trained during 1964 - 1966.

In these three hospitals there are 96 student midwives in training. Although the original requirements made provision for persons who are not nurses to take midwifery training, priority has always been given to those who are already registered general nurses and it has not been possible or desirable to organise courses at this level for persons who are not registered general nurses. In 1970 Council approved a recommendation that only registered general nurses can be accepted for midwifery training. The employers are also in agreement with this move for the services of one who holds both qualifications is easily utilized in whatever fields they are needed. Those who hold midwifery qualification only, have been encouraged to take up general nursing if they meet entrance requirements. In the country there are only about 50 who hold only registered midwifery qualification.

2. Condition of approval of Institutions as Training School for Admission to Register of Midwives

The length of this course is 12 months for those who did not obtain an approved obstetric course in their general nursing course and nine months for those who did receive an approved obstetric course in their general nursing course. The nine months course is only at Kenyatta Hospital. The other two hospitals give a full course of 12 months. Doubts are normally expressed as to

whether in fact, any reduction should be given by virtue of three months obstetrics in the general nurse course.

The Council conducts four examinations a year for the registration of midwives but this is becoming very difficult administratively for the Council and the Council has asked the schools if possible to have only two intakes per year so that the Council can give two examinations instead of four. The examination consists of written, practical and oral examination.

3. Training Requirement for the Roll

There are 16 hospitals approved for midwifery at enrolled level. Three of these are run by Government and the rest are run by Mission and Church hospitals. The Church and Mission hospitals are small and the number of intakes range from eight pupils to 20 pupils. As at November, 1973 there were 380 pupils, in training.

The course is two years for non nurses and one year for enrolled nurses. As is the case with the registered midwife it has been found that it is necessary to encourage the discontinuation on non nurses taking up midwifery. There are however, some hospitals who do not have facilities to train general nurses and these are still carrying on with two years midwifery courses. It is intended to phase out this training and where possible it has been suggested to group certain general Nurse training school with the midwifery schools so that arrangements can be made for one hospital to offer General Nursing only and the other one Midwifery.

The examination for admission to the Roll are conducted by Council twice a year. There being about 120 - 150 candidates each time. The examination consists of the written practical and oral and candidates are examined in their own hospitals.

4. Conditions of Approval of Hospitals as Training Schools for Admission to the Roll of Midwives

a. Men as Maternity Nurses. As from 1972 it was found necessary for men to obtain training in midwifery and two have qualified for enrolment and there are two in training for registration. This became necessary because men are posted to work in the remote areas of the country and often are faced with obstetrics emergencies and it was argued that there was no reason why male nurses should not take up this course since the doctors took it. The choice however, is left to individuals.

b. Domiciliary Practice. This is carried out in the Municipalities and this is under the charge of Local Supervision Authorities. There are a few domiciliary midwives. The majority of mothers prefer to have babies in hospitals. Lack of transport and poor roads, long distances between homes in the rural areas makes domiciliary practice very difficult. In the next

development plan the Government intends to build health centres throughout the country and these facilities will ease the problem to some extent.

To qualify for this practice a midwife must be either registered or enrolled and the Medical Officer of Health in the area must be satisfied that the midwife is capable of carrying out such duties.

c. Refresher Courses. The midwives regulation provides for midwives to receive refresher courses but these have been done by individual hospitals. When funds and personnel are available, Council will undertake to design programmes for these courses and ensure that midwives benefit from these.

d. Disciplinary Matters. Council has power under section 22 of the Nurses Act to take disciplinary action against midwives whose conduct in the opinion of the Council has dishonoured them in public estimation and may cause such names to be removed from the Roll or the Register.

e. Community Nurse Programme. Mention must be made of this scheme of training which was started in 1968. It is a three and a half year course which is designed to integrate General Nursing, Midwifery and Public Health throughout the course. On completion, the person can function as an enrolled nurse, enrolled midwife and enrolled health visitor. Other than admit these to all the three rolls it was decided to open a separate Roll. There are 200 of these enrolled at present and there are 300 undergoing training.

f. Recognition of Midwives Trained Outside Kenya. Applicants are considered on individual basis. The content of the course is studied some qualify for registration forthwith other have to complete additional training and pass Council's examination. Those registered in United Kingdom are registered forthwith. Although Kenya Registered General Nurses are registered in the United Kingdom and many other parts of the world, our registered midwifery course has not been approved by C.M.B. England and those requiring to work there have been required to complete the whole training although the enrolled midwives are allowed a reduction of six months in the S.C.M. course in England.

g. Midwifery Committee. The work related to the training of midwives and matters affecting midwifery in general are dealt with by Midwifery Standing Committee of the Council. It consists of twelve members of whom four are persons elected to represent midwives together with four ex-official members. The Committee has power to co-opt up to four additional members who not being members of Council shall have no power to vote. The act provides for the election of four Registered Midwives who are also registered nurses

practising their profession as midwives at the time of election. One of whom must be a midwifery tutor or actively engaged in teaching midwifery. Election to the membership of Council is held every three years.

The Nurses Act also provides for a nomination by the Medical Association of Kenya of three doctors one of whom shall be engaged in obstetrical practice. This doctor serves on the Midwifery Committee.

CONCLUSION

In conclusion I would like to emphasise that the task of designing rules and regulations governing the training of midwives rests upon all Nurses, Midwives and all those in the medical profession and these people through the Nursing Council are duty bound to see that the type preparation nurses and midwives receive is geared to meet the needs of the individual families and the Community as a whole in maintaining a high standard of health of the people. The outcome of this Working Party will go a long way to assist all of us in this task.