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THE INTERNATIONAL CONFEDERATION OF MIDWIVES

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SUMMARIES OF REPORTS OF THE WORKING PARTIES, REGIONAL, INTRA-REGIONAL AND IN-COUNTRY SEMINARS

PREFACE

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In 1954 at an International Congress for Midwives held in London, the late Dr. Nicholson J. Eastman, an American Professor of Obstetrics and Gynaecology pointed out that more than 80 per cent of the women of the world had no professional attendance during any part of the maternity cycle. This statement made an enduring impression on the members of the International Confederation of Midwives (ICM) – an impression which has had, and continues to have, an important effect on the services provided by midwives.

In the interests of Maternal and Child Health and the reduction of Maternal and Infant Mortality Rates, the ICM at its Congress in 1963 in Madrid tried unsuccessfully to get a resolution passed to include family planning amongst the services provided by midwives. Not to be outdone, the Resolution was put forward again in 1966 at the ICM Congress in West Berlin and this time was successfully passed.

Meanwhile, the International Federation of Gynaecology and Obstetrics (FIGO) had held a World Assembly in 1960 in Vienna. Dr. Eastman's 1954 statement was still valid and FIGO set up a Study Group to investigate the training and practice of midwives and maternity nurses throughout the world under the Chairmanship of the late Professor W.C.W. Nixon, an English Obstetrician and Gynaecologist. Professor Nixon, realising that such a world survey needed the cooperation of the ICM approached Miss Marjorie Bayes, who was at that time its Executive Secretary, for help with the survey and the FIGO/ICM Joint Study Group came into existence. After four years of intensive research, the first edition of "Maternity Care in the World" was published in 1966 giving information on maternal and child care and midwifery training and practice in 1974 countries of the world. This edition did not include anything on family planning services. Following the presentation of the book and the passing of the resolution at the Congress in West Berlin in 1966 it was agreed that the second edition should include family planning. This was published in 1976 and the information contained therein covers 210 countries, and includes family planning services.

Meanwhile, the two parent bodies of the FIGO/ICM Joint Study Group (JSG) agreed that cooperation should continue and some of the recom-

mendations made in the first edition of "Maternity Care in the World" should be acted upon. The J.S.G. was not in a financial position to continue its research on a global basis but it was agreed to do so continent by continent starting in Europe.

Seventy five per cent of questionnaires sent out in the autumn of 1968 were returned by 21 European countries. After analysis of the returned questionnaires, a three day Conference was convened in March 1969 at the Royal College of Midwives in London. This Conference was attended by Obstetricians, Midwives and members of statutory bodies from 18 European countries, all of whom participated at their own expense. In implementing one of the recommendations made at the Conference, a two day Working Party was convened in September 1969 in Copenhagen under the Chairmanship of Sir John Peel, KCVO. It was composed of six obstetricians and six midwives one obstetrician and one midwife from each of the aggregate English-, French-, German-, Italian-, Scandinavian-, and Spanish-speaking countries of Europe and in addition an obstetrician from Greece and a Midwife from Eastern Europe (Czechoslovakia).

Subsequently a "Report of a Working Party on Midwifery Training in European Countries" (the Copenhagen Report) was published.

In considering the definition of the midwife as outlined in W.H.O. Technical Report series No. 331, the Working Party recommended an important alteration in the last sentence to read as follows:

"A Midwife is a person . . . . . .
Her work may extend to certain fields of gynaecology, to family planning and child care."

The Copenhagen Report was presented to the participants at the ICM Congress in September 1969 in Chile and the Latin American Midwives expressed a wish for a similar Working Party to be held in their continent but the FIGO/ICM exchequer was bare. Miss Lucille Woodville, President of the American College of Nurse-Midwives during the Congress in Chile was appointed President of ICM during the following triennial period 1969–1972. At that time also she was the midwife representative of U.S.A. on the FIGO/ICM J.S.G. Immediately after her appointment, Miss Woodville, President together with Miss Bayes, Executive Secretary of ICM became very active in preparing for the 16th International Congress for Midwives in 1972 (which was the 50th anniversary of ICM) in Washington D.C. and in interesting the United States Agency for International Development (AID) in ICM and FIGO/ICM J.S.G. activities. The J.S.G. has always cooperated with WHO, IPPF, UNICEF and the International Paediatric Association. In September 1971, AID sponsored an Executive Committee Meeting of ICM provided it was combined with a Conference on "Family Planning in Midwifery Training" and ICM in conjunction with IPPF arranged such a Conference. The full Executive Committee of ICM were present together with

representatives from FIGO, WHO, IPPF, AID, invited individuals and midwife representative from some of the ICM member countries and nonmember countries (fifteen countries were represented).

The conclusions reached at this Conference are relevant to subsequent activities under the USAID grant to ICM "with the assured cooperation of FIGO". The conclusions were as follows:

1. That the ICM is educational/promotional only, working through its national organisations. Clinical programmes must be formulated at national level.
2. That family planning should be an integral part of basic and post basic education of midwives.
3. That family planning is an integral part of maternal and child health.
4. That a major objective and effort of the ICM is the provision of family planning services to families throughout the world.
5. That the ICM recognises that the role of the midwife, while very important in improving the quality of maternal and child health services, needs the fullest support from governmental authorities, the medical profession and other health workers.

While plans were progressing for a grant from USAID to be made to the ICM, with the assured cooperation of FIGO, for the appraisal of the training and practice of midwives in developing countries and the study of their increasing influence on family planning services, a meeting of the FIGO/ICM Joint Study Group was held in September 1972 in London, supported by the Health Services and Mental Health Administration of the U.S.A. Health, Education and Welfare Department (HEW). (Part of the financial contribution made by HEW was allocated to the collection of updated material for the second edition of "Maternity Care in the World".) At this meeting, a new definition of the midwife was formulated (Appendix A) and the aim and objectives of the FIGO/ICM Joint Study Group were amended.

Summary of Conclusions of the FIGO/ICM Joint Study Group Meeting:

1. The amended definition of a Midwife should be circulated to governments, the International Federation of Obstetrics and Gynaecology, the International Confederation of Midwives, World Health Organisation and other International Organisations, the Pan-American Health Organisation and the International Planned Parenthood Federation.
2. The aim and objectives of the FIGO/ICM Joint Study Group should be adopted as amended

   A) *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.

B) *Objectives*

a) To identify the present situation in each country;

b) To suggest practical improvements for the immediate future in each country;

c) To agree to intermediate and long term guidelines suitable to the particular groups of countries under survey.

3. Copies of communications sent to governments should also be sent to Professional Organisations.

4. Family Planning is not an economic panacea but a family health measure, nor is it a panacea for maternal and child health, but only a necessary adjunct to Maternal and Child Health Services. Often Maternal and Child Health Services are the only vehicle through which Family Planning Services can be presented. The midwife's role in Family Planning should be emphasised whether it be motivation, education and/or clinical field work.

5. Recognition should be given to personnel already working in family health and to their role in the family planning service.

6. Professional midwives have a responsibility for teaching and supervising the practice of auxiliary midwives and traditional birth attendendants.

7. In studying the training and practice of midwives in developing countries, it must not be forgotten that the role of midwives in developed countries should also be examined.

8. Relevant details of the USAID/ICM project should be available to members of the Joint Study Group.

The 1972 ICM Congress in Washington was heavily subsidised by USAID and many midwives from developing countries were enabled to participate. As a contractor, it was realised that the ICM offered important advantages as follows:

1. It is the single and effective organisation for the midwifery profession, recognised for consultative status by the World Health Organization, and sharing regularly in WHO technical meetings in all parts of the world. The UN, UNESCO, and the EEC (Common Market) accord the ICM similar status. The involvement of this internationally recognised organisation can go a long way in "legitimizing" family planning as an appropriate function of professional midwives.

2. Its capacity is also recognised by the medical profession, in particular by the International Federation of Gynaecologists and Obstetricians (FIGO – the initials are from the French). In 1960, the ICM and FIGO established a Joint Study Group.

Through its member associations and through individuals the ICM has

contacts in many developing countries and the number is increased through the association with FIGO in the J.S.G.

With this in mind, AID produced a proposal document for a project relevant to the conclusions reached at the meetings in 1971 and 1972 and a substantial grant was made by AID to the ICM with the assured cooperation of FIGO.

The information contained in this book is a summary of the activities of ICM and the FIGO/ICM Joint Study Group since 1972 when the grant was made to the present time.

SYNOPSIS OF ACTIVITIES UNDER THE ICM/USAID PROJECT 1972 to June 1978

THE WORKING PARTIES

Under the ICM/USAID grant specifically given for use in developing countries, Working Parties were held as follows:

1. Anglophone West Africa, 7th–15th December 1972 in Accra, Ghana.
   Representatives were present from The Gambia, Ghana, Liberia, Nigeria and Sierra Leone.

2. Central America, 13th–21st September 1973 in San Jose, Costa Rica.
   Representatives were present from Costa Rica, El Salvador, Guatemala, Nicaragua, Honduras and Panama.

3. Francophone Central Africa, 28th September – 6th October 1973 in Yaounde, Cameroon.
   Representatives were present from Cameroon, Chad, Central African Republic, Republic of Congo, Gabon, Zaire and the Malagasy Republic. Rwanda, Burundi and Equatorial Guinea did not accept invitations to attend.

4. Anglophone East Africa, 29th November – 8th December 1973 in Nairobi, Kenya.
   Representatives were present from Kenya, Uganda, Tanzania, Zambia, Botswana, Lesotho, Mauritius, Ethiopia and Swaziland.
   Malawi and Somalia did not accept invitations to attend.

5. Caribbean, 16th–24th May 1974 in Bridgetown, Barbados.
   Representatives were present under the ICM/USAID grant from Barbados, Belize, Grenada, Guyana, Haiti, Jamaica and Trinidad/Tobago.
   With additional financial assistance from IPPF individual representatives were also present from Antigua, Dominica, Montserrat, St. Kitts-Nevis, St. Lucia and St. Vincent.

6. Francophone West Africa, 17th–23rd November 1974 in Dakar, Senegal.
   Representatives were present from Dahomey (now Benin), Ivory Coast, Mali, Mauritania, Niger, Senegal and Togo.
   Upper Volta did not accept the invitation to attend.

7. South America, 16th–25th January 1975 in Bogota, Colombia.
   Representatives were present from Argentina, Bolivia, Brazil, Chile, Colombia, Dominican Republic, Ecuador, Mexico, Paraguay, Peru, Uruguay and Venezuela.

8. East Asia, 4th–12th April 1975 in Manila, Philippines.

Representatives were present from Hong Kong, Indonesia, Laos, Philippines, South Korea, South Vietnam, and Taiwan.
Cambodia regretfully declined the invitation because of the political situation.

9. West Asia, 17th–25th April 1975 in Kuala Lumpur, Malaysia.
Representatives were present from Bangladesh, Malaysia, Nepal, Sri Lanka and Thailand.
Burma and the People's Republic of China did not accept invitations to attend.

10. All India, 5th–12th November 1976 in New Delhi, India.
Representatives were present from 24 States and Union Territories. Because of the size of India no other countries were invited.

11. 'Cento' Countries, 6th–14th December 1976 in Istanbul, Turkey.
Representatives were present from Afghanistan, Iran, Kuwait, Pakistan, and Turkey.

12. Middle East Regional Seminar, 12th–18th November 1977 in Khartoum, Sudan.
Representatives were present from Egypt, Lebanon, Sudan and Syria. Jordan accepted an invitation to attend, but the delegates were unable to travel when the time came.

Aims and Objectives of the Working Parties.

These were basically the same on each occasion, but the statement of aims and objectives was amplified and clarified as time went on. The following – from the West Asia Working Party – is a representative example:

1. To exchange information on the countries' present situation of Maternal and Child Health/Family Planning Services.

2. To exchange information on the training and functions of all categories of midwives and traditional birth attendants (TBAs).

3. To identify:
   (a) Common problems in Maternal and Child Health Services especially in the rural communities, such as obstetric and paediatric emergencies.
   (b) Unmet needs in Maternal and Child Care such as family planning, health education and nutrition particularly in the rural communities.

4. To consider how functions of the midwives of all categories can be expanded so as to assist in solving the problems and in contributing towards the unmet needs.

5. To suggest actions which are necessary to promote an expanded role for midwifery personnel and their motivation, e.g.
   (a) Changes in government policy and regulations governing the practice of registered midwives and TBAs.

(b) Training: – Regulations; Curriculum Modification; Define the broad areas of the new curriculum content which should be incorporated in the training of each category of midwifery personnel; Postbasic Training/Continuing Education; Seminars/Workshops.

(c) Services – Working with TBAs; Working with Professional Organizations.

6. To plan appropriate follow-up action programmes for each country in order to ensure implementation of the recommendations.

Preliminary Procedures and Organization

1. The participating countries were selected by ICM and from these the host country was determined. All invitations were sent out from ICM/HQ.

2. All correspondence was sent in the first instance to the Minister of Health in the countries concerned. Information was sent on:
   (a) The history of the FIGO/ICM Joint Study Group, and
   (b) Aim and objectives and general guidelines for the Working Party.

3. Information about the Working Party was also sent to the Obstetrical Societies and Midwifery Associations (where they existed); to IPPF, Family Planning Associations (national and otherwise), WHO, UNICEF, IPA, and other voluntary agencies.

4. The Minister of Health of the host country was invited to nominate a midwife as Regional Field Director.

5. Each participating country was invited to send two midwives and one obstetrician as delegates; all their expenses were paid by ICM/USAID.

6. In addition, each Working Party was attended (at their own expense) by representatives of WHO Regional Offices, IPPF, IPA, UNICEF, USAID, National Family Planning Associations and by Government representatives.

7. Selection of participants was made through the Ministry of Health and (if they existed) through the local Midwifery Association and Obstetrical and Gynaecological Association. If no Associations existed, the Ministry of Health was asked to select all the participants.

8. A Local Committee was formed to advise the Regional Field Director on local customs and culture, to work with her in the general preparations for the Working Party and to assist in its management.

9. Governments and delegates were asked to update their country reports on Maternal and Child Health and Family Planning, or to prepare a report if none existed. These reports enabled the delegates to review the situation in their own countries, helped the project staff in planning the Working Party, and provided valuable information on the complexities of the problems facing each country. They were also useful in the revision of the book *Maternity Care in the World.*

10. Educational materials – books, posters, films and other literature relating to Maternal and Child Health and Family Planning and Nutrition were sent from ICM HQ so as to set up a library at the Working Party, and delegates were invited to take whatever materials they wanted. The delegates were asked to bring with them relevant educational material for exhibition at the Working Party.

11. An evaluation questionnaire was prepared for use at the end of the Working Party.

Field Visits

Following the initial approaches by correspondence, members of the ICM/USAID Project Field Staff paid preliminary visits to the host country and (where possible) to all the countries which had been invited to participate. Discussions were held with officials of the Ministry of Health, Obstetrical and Gynaecological Associations, Midwifery and/or Nurses Associations, Family Planning Associations and with individuals to ensure that the representatives chosen to attend the Working Party would be able to make some impact in their own country when they returned. The USAID mission in each country was visited.

Follow-up visits – as required, but at least one – were made by ICM/USAID staff to all the participating countries to ascertain if and how the recommendations made by the Working Parties were being carried out, and to give assistance if required.

INTRA-REGIONAL TRAINING SEMINARS

Two Seminars were held on aspects of Family Planning:

1. Anglophone West Africa Family Planning Training Seminar, Freetown, Sierra Leone, 7th – 25th June 1976.
   This evolved from requests by midwives from Sierra Leone following the Anglophone West Africa Working Party for theoretical and practical training in family planning. At the request of other countries in the region invitations were issued to senior midwives and other health personnel. There were 15 participants from Sierra Leone, 3 from The Gambia, 2 from Ghana (plus one whose expenses were paid by the Ghana Medical School), 2 from Liberia and 2 from Nigeria.

2. Family Planning Information, Education and Communication Seminar, Dacca, Bangladesh, 20th – 30th November 1976.
   This arose from requests following the West Asia Working Party. Midwives and other health personnel from Bangladesh, Nepal and Sri Lanka attended. There were present 14 participants, 3 observers, and members of the local organizing committee.

IN-COUNTRY TRAINING SEMINARS

The ICM/USAID Project now adopted for its Seminars the umbrella title of 'Expanded Role of the Midwife in Reproductive Health'. Their aim was to train the trainers of traditional birth attendants in the hope that the needs of women in rural communities in developing countries would be better met. National Field Directors replaced Regional Field Directors and worked for a three month period – one month before, one month during and one month after the Seminar.

Letters of invitation were sent at this time to 72 countries to ask if ICM could assist them by means of this new project. Eighteen countries did not reply; five gave verbal expressions of interest to ICM Field Representatives during follow-up visits made after Working Parties. Of the 49 countries who responded directly, 22 were positive, 10 were doubtful and 17 were negative.

Two meetings have been held:

1. Workshop on Training of Trainers/Supervisors of Traditional Birth Attendants, Comilla, Bangladesh, 9th May – 4th June 1977.
   This Seminar was attended by 24 nurse-midwives, public health nurses, lady health visitors and doctors involved in the training of dais. The Deputy Director and Secretary of the Population Control/Family Planning Division requested the preparation of a Manual to be used as a guideline for the trainers of dais. The ICM/USAID Field Director made a draft manual which impressed the PC/FP staff. It was to be studied by members of the Training Committee before being translated into Bengali.
2. Workshop on Training of Trainers and Supervisors of Rural Health Workers, Kabul, Afghanistan, 7th January – 2nd February 1978.
   This Seminar was attended by 19 Afghani midwives and nurses. Its aim was broadened to cover the training of trainers and supervisors of all categories of paramedical personnel in maternal and child health and family planning services, especially in rural areas.

OTHER ACTIVITIES

Haiti, 26th–30th January 1976

Arising from the follow-up visits after the Caribbean Working Party visits were made by representatives in connection with a request for assistance for curriculum development in midwifery training. Due to a change of government the representatives were advised to return home, but in January 1978 a new request was received from the Secretary of Public Health for the representatives to return. This matter is still under consideration.

Morocco and Tunisia, 23rd–28th May 1976
Preliminary visits were made in preparation for a Francophone North Africa Working Party, but this proposal was dropped because of the political situation.

Taiwan, July 1976
Initiation of a series of workshops for the instruction of MCH midwives and nurse-midwives in family planning. This request was a result of the East Asia Working Party.

Chad, 25th November – 2nd December 1977
A consultation visit was made and preliminary arrangements put in hand for a workshop on the Training of Trainers of Traditional Birth Attendants, but the actual dates were not decided upon.

Belize, 9th–16th January 1978
Consultation visit in connection with preparations for the convening of an in-country training seminar for Training of Trainers/Supervisors of Traditional Birth Attendants and other rural health personnel.

Togo, 20th–25th February 1978
Consultation visit. It became apparent that the needs of Togo differ somewhat from what is offered under the ICM/USAID Project. Togo's need will be reviewed at a later date.

Yaounde, Cameroon, 27th Feburary – 4th March 1978
Consultation visit to discuss the possibility of convening a workshop on the Training of Trainers/Supervisors of Traditional Birth Attendants from 3rd–19th July 1978.

Dominican Republic, 5th–10th March 1978
Consultation visit for discussions with government appointed personnel. Suggested dates (2nd 27th October 1978) for workshop on Training of Trainers/Supervisors of Traditional Birth Attendants clashed with those suggested for Costa Rica. Alternative dates were awaited from the Ministry of Health.

Costa Rica, 11th–26th March 1978
Consultation visit for the Seminar on Training of Trainers/Supervisors of Traditional Birth Attendants tentatively scheduled to take place from 18th September–4th October 1978 in San Jose.

Nicaragua, 27th March–5th April 1978
Consultation visit in connection with an in-country training seminar on Training of Trainers/Supervisors of Traditional Birth Attendants scheduled to be convened from 26th June – 22nd July 1978 in Managua.

Turkey, 29th March – 2nd April 1978
Consultation visit made at the invitation of the Ministry of Health. Following discussions it became evident that no training seminar will be convened in Turkey because the government does not consider it to be necessary.

Bangladesh, 15th–20th May 1978
A follow-up visit was made in connection with the Workshop on the Training of Trainers/Supervisors of Traditional Birth Attendants held twelve months previously in Comilla.

ANGLOPHONE WEST AFRICAN WORKING PARTY, ACCRA, GHANA, 7th – 16th DECEMBER, 1972.

Participating countries: The Gambia, Ghana, Liberia, Nigeria, Sierra Leone.

I. Preliminary visits.

No record of these visits is now available.

II. Preparations.

To facilitate discussion and exchange of information a questionnaire was prepared which is reproduced as Appendix I of this section.

III. The Working Party

1. ***Attendance.*** Those attending comprised:
   (a) 16 representatives from The Gambia (2); Ghana (4, including 1 from IPA); Liberia (3); Nigeria (3); Sierra Leone (3); WHO (1).
   (b) 6 observers from USAID (3 – 1 from Washington and 2 from Regional Office, Ghana); WHO (2 – 1 from Regional Office, Brazzaville, 1 from Regional Office, Nigeria); IPPF, London (1).
   (c) Project Director, Field Director and Deputy Field Director, ICM.

2. ***Organization***
   (a) Dr. P. H. O. Bannerman, a member of the ICM/FIGO Joint Study Group, and Chief Medical Officer, Education in Family Health, WHO, was unanimously elected Chairman of the Working Party.
   (b) Dr. Belmont Williams, obstetrician and gynaecologist from Sierra Leone, and Miss Olga Roberts, midwifery tutor from The Gambia, were elected rapporteurs.

3. ***Summary of Proceedings***

   The Opening Ceremony was performed by the Commissioner for Health, Ghana, Col. J. C. Adjeitey, who welcomed all the participants and observers. This session was also attended by representatives from the Ministry of Health, obstetricians, paediatricians, nursing, midwifery and public health tutors, midwives, student nurses and pupil midwives, and representatives of Family Planning Associations, WHO, IPPF, and USAID. The Chairman at this opening session was Dr. M. A. Baddoo, Director of Medical Services, Ghana.

   In his opening remarks Col. Adjeitey said that the Working Party was being held at an opportune time when consideration was being given to the role and practice of the traditional birth attendant (TBA) as well as to that of the professional midwife. He hoped that action would be taken to see that the best possible use was made of the services of the TBA.

Mr. R. J. Fenney, the Field Director, enlarged on the theme of the meeting and discussed possible ways of achieving its aims. Miss M. Bayes, the Project Director and Executive Secretary of ICM, also spoke of the aims and objectives of the meeting and referred to the recommendations published in *Maternity Care in the World.* She went on to describe how the ICM/USAID project had come into being and was operating.

There followed background papers by Dr. R. H. O. Bannerman on *Maternity Care in the Developing Countries* and by Mrs. R. O. Sosanya (President of the Nigerian Midwives Association) on *Midwifery Practice by the Traditional Birth Attendant and the Training of the Professional Midwife in Nigeria.*

Dr. Bannerman began by quoting the WHO definition of Maternity Care and went on to outline the scarcity of resources, both financial and of manpower, in the developing countries as a whole and in their rural areas in particular. Health professionals were largely Western trained and preferred to practise in urban areas where facilities were greatest.

Education and training should be matched to local community needs, and traditional customs and practices respected. He stressed the importance of the midwife's role because of her access to families both in the home and in institutions, which gave her special advantages in the field of family planning. The development of family planning would largely depend on the activities of the nurse-midwife, both as educator and as trainer of more and more field workers.

Midwifery training needed to be adapted to provide shorter and less academic courses in view of the great needs in the fields of nutrition, health education, paediatrics and family planning. The role of the auxiliary midwife should be made clear, and her training redesigned to that end. Professional health personnel must play a greater part in supervision and training.

The TBA still had a vital part to play in maternal and child health care and a recommended programme for their training had been laid down by WHO. It was important that they should be trained in asepsis and to refrain from interference, if nothing else.

Family planning was suspect in some countries because of its effects on population growth and of local cultural objections. Programmes should be planned to take account of these objections and to stress the positive benefits to health of family limitation.

Mrs. Sosanya described rural midwifery practice in Nigeria, where a large part of the population were attended in pregnancy and child-birth (as well as in illness) by male native doctors, who could be

considered the equivalent of TBAs. Many normal deliveries were supervised by experienced women of the family or the community. Infant morbidity and mortality were probably largely due to bad treatment of the cord at birth and to poor feeding. Training of the native doctors was desirable, particularly in prevention of infection, recognition of abnormalities and reference to professional medical care.

Turning to the training of the professional midwife in Nigeria, she described the origins of midwifery work in Christian missions, and the subsequent setting up of the Midwives Board with its legal responsibilities for training and registration. Up to 1967 there had been two categories of midwife, but in 1968 one class of training had been established, and qualified midwives were now competent to undertake normal and many types of abnormal delivery as well as conduct pre- and postnatal clinics. They must be able to recognize potential complications and refer them to an obstetrician. There was a great shortage of midwifery tutors and a one-year course for their training had been instituted.

She outlined the problems of health care in Nigeria — communications, poverty and lack of preventive care. The main medical problems in practice were anaemia in pregnancy, and cephalopelvic disproportion in labour, leading to ruptured uterus. Future needs included the constant review of the training curriculum, facilities for research by midwives and activity by the Midwives Association in promoting standards of education, training and practice.

These two papers were followed by a lively discussion.

The whole of the next day was devoted to problems of family planning.

Mrs. Comfort Akrofi, Deputy Field Director of the Working Party, gave a comprehensive paper describing the *Family Planning Services in Ghana*, the personnel involved, and their plans for the future, including the introduction of family planning into basic midwifery training and giving post-basic training to senior midwives. By the end of 1972 there were 138 clinics in urban and rural areas. Training in family planning was being given to medical officers, to selected professional nurse-midwives to give services up to the insertion and and removal of IUDs, and to selected midwives to give services up to the administration of the pill. This latter category was known as Family Planning Auxiliaries. It was hoped eventually to involve all midwives (including TBAs) in family planning activities. Contraceptives were made available free of charge or at a token fee. Field workers were being trained and an elaborate programme for family life education had been devised which, it was hoped, would be taken up by the Minister of Education.

Miss Winifred Evans, representative of USAID in Liberia, described the *MCH/Family Health In-service Course* which had been set up in Liberia. It was held twice yearly and lasted for four months. Between 1969 and 1972 57 trainees had completed the course, and it was hoped to have trained 100 over a period of five years. Family planning now occupied a two-week period of this course, and trainees were instructed in education and motivation and in methods and services available. TBAs were also receiving instruction in family planning as part of their four-month training course and a workshop for licensed TBAs was held annually. The Family Planning Association of Liberia employed a number of nurses and midwives who had been trained abroad in collaboration with USAID. They organized and conducted clinics in several Government MCH centres.

Dr. D. A. Ampofo (Ghana) discussed the *Organization of a Family Planning Service*. He dealt with training requirements, national population policies, and the utilization of available trained personnel, including TBAs.

This presentation was followed by papers by Dr. Belmont Williams and Dr. D. S. Collins, who described the *Organization of the Family Planning Service* in Sierra Leone and Liberia respectively. In the discussion which followed it was unanimously agreed that family planning should be an integral part of MCH services, and should be included in the syllabus of midwifery training for all categories of midwife, including TBAs.

Developments in the Training of Midwives and the *Organization of a National Service to include all Categories of Midwives* was the subject of papers by Dr. A. Akinkugbe (Nigeria) and Dr. K. K. Korsah (Ghana). Dr. Akinkugbe reiterated many of the points made earlier by Mrs. Sosanya, in particular the need for more midwife tutors. He also described two other categories of midwife:

(a) Community Nurses. Most were former Grade II midwives with much experience, who were given 18 months' training in public health, hygiene, maternal and infant welfare and related subjects. A few had been admitted directly to a 3½-year training course after passing the school leaving certificate, and their training included general nursing, midwifery and public health. Community nurses were employed in prenatal and infant welfare clinics, the school health service, district nursing, domiciliary midwifery, etc.

(b) Public Health Nurses. These were experienced nurse-midwives who had had one year's additional training in public health. They were employed first as supervisors of Community Nurses and after further experience were promoted to health sisters.

Dr. Korsah spoke of the gradual development of the midwifery training programme in Ghana since its beginnings in 1928 and gave

details of the courses available. Maternity services were offered in three main central hospitals, regional hospitals and some district hospitals, as well as in Mission Hospitals up and down the country. In some areas there were maternity clinics staffed by trained midwives. Family planning services were offered in some places.

Although not officially recognized, TBAs still conducted most domiciliary deliveries (75% of all deliveries in 1971) and the majority of the rural population would continue to rely on them. They would benefit from some elementary training. Untrained and unrecognized auxiliary midwives practised in some places and were sometimes officially employed in a temporary capacity. They had learned their practice by observation. There was urgent need to train more midwives and to provide more training schools.

It would be desirable to (i) increase the number of urban clinics to take the load off central hospitals; (ii) integrate Government and private services; and (iii) establish population densities so as to site clinics in areas of greatest need.

Both of these papers were again followed by lively discussion.

The afternoon of that day was taken up with a paper by Dr. Carl Reindorf on the *Role of the Paediatrician in Midwifery Training* and the discussion which followed.

Dr. Reindorf spoke of the topics he included in his lecture-tutorials to midwives. His view was that the prime duty of the midwife was to the mother, and any treatment given to the neonate was of an emergency nature until other help could be summoned. He thought there was need for a Special Paediatric Nurse who would assume total responsibility for the child from birth to adolescence, thus allowing the Paediatrician to concentrate on more obscure problems.

Wednesday, 13th, began with a talk by Mr. Fenney on *Licensure and Control of Midwives of all Categories,* and this was followed by a paper by Mrs. Joanna Samarasinghe of Ghana on *The Role of the Midwife as a Family Health Worker.*

She stressed the role of the midwife in the family context and the opportunities this gave for advice on family planning, the need for supervision and advice in the prenatal period, especially in matters of nutrition and general health; and her need to establish good relationships with other members of the MCH team, including TBAs. Good supervision would have enabled potential complications to be recognized and referred for specialist care, and would prevent illnesses and complications in the postnatal period. Health education of the family could be undertaken at the same time. There was need for midwives to keep accurate records and statistics.

In Ghana prematurity, infections, poor environment and nutrition,

and local customs and beliefs were factors affecting infant morbidity and mortality, as well as poor MCH services, lack of trained personnel and the ignorance and low standards of practice of TBAs. Good health education of the whole family was needed, auxiliaries should be better trained, and the midwife must promote this.

The final papers discussed the *Training and Practice of Midwives of all Categories, including Curricula.*

Mrs. P. Acolatse dealt with the *Training and Practice of the Professional Midwife in Ghana.* She said there were 1730 professional midwives working in 279 MCH clinics with about 1470 maternity beds. If every mother had the services of a midwife, midwives in urban areas would conduct four deliveries daily and those in rural areas 30. Since the decree of 1972 auxiliary midwives and TBAs were not legally entitled to practise. She thought that all qualified nurses ought to be enrolled as auxiliary midwives and legal recognition given to TBAs because of the shortage of trained staff. She discussed the membership and work of the Nurses and Midwives Council. She gave details of training courses and of the factors regulating the practice of midwives. The midwife, she said, was now more involved in total health and in education of the family.

Mrs. K. G. A. Betts, Sierra Leone, spoke on the *Training and Practice of the Auxiliary Midwife in Sierra Leone.*

The first auxiliary midwives were the Village Maternity Assistants, who were mainly illiterate and learned by rote and by repeated practical instruction. Emphasis in their training was on prenatal care, safe aseptic delivery, and recognition and referral of abnormalities. Successful students were registered and in 1956 were issued with UNICEF kits. They worked mostly in domestic midwifery in the villages. Periodic refresher courses were held every one to three years.

This training was superseded in 1970 by the MCH Aide programme, the intention being to provide one aide for every village. They received 18 months' training in midwifery, basic nursing, child care and community health. There were four training centres, each taking 12 pupils. The successful ones were registered and licensed by the Sierra Leone Midwives Board; they then worked for three months under supervision before returning to their own village, where they were supervised monthly. Many chiefdoms were providing the working facilities needed.

The State Enrolled Multipurpose Nurse received two years' general nursing and six months' midwifery training. They acted as midwives in areas which were short of professional personnel.

A scheme for professional midwifery training had been drawn up and submitted to the Ministry of Health.

Mrs. Beatrice Barmadia, Liberia, dealt with the *Training and Practice of the TBA.*

There were three schools in Liberia giving midwifery training to TBAs. The course lasted for 16 weeks, 10 of which were practical training. Family planning was included in the curriculum. Final evaluation was by the Director of the MCH Division, and successful students received a certificate and a midwifery kit. The licence was renewable annually by the Liberian Midwives Council.

The trained TBAs had to register all births, live and still; use prophylactic penicillin eye ointment; and care for mother and baby for 14 days. They were supervised monthly. TBAs played an important role because they lived in the country among the people.

A period of discussion followed these three papers, and there was general discussion of the matters raised at the Working Party. Eventually certain recommendations were arrived at and a plan for future action prepared. A preliminary draft report was compiled.

The Closing Session was conducted by the Director of Medical Services, Dr. Baddoo. The President of the Ghana Midwives Association was unfortunately ill and unable to attend. In the address she had prepared she mentioned her own experiences in a rural area of Ghana and suggested that governments should create opportunities for midwifery training of girls who had full primary education, so as to fill the many vacancies in villages and rural areas. Midwives would render all possible assistance in the education of men and women to accept family planning.

On behalf of the Working Party Mrs. K. G. A. Betts (Sierra Leone) expressed appreciation to the host government for the facilities provided and for their co-operation; to observers and speakers; to other governments for releasing their participants; to WHO for their support and personnel; and to the Ghana Registered Midwives Association and to individuals for support and hospitality. Special appreciation was offered to USAID for personnel and financial support, without which the Working Party could not have taken place.

4. ***Educational Visits***

During the week visits were paid to polyclinics, the homes of private practising midwives, and to the Danfor Rural Project where, in each of four areas, research in MCH and family planning was being carried out in more than 60 villages. The health personnel in the villages were identifying the TBAs and giving them some training in basic hygiene. There was appreciation of the work being done by midwives of all categories, and recognition that the suitably trained TBA had much to contribute towards improved maternal and child health.

IV. Recommendations

As the Working Party was a small one, it was agreed not to divide into small discussion groups. However, discussions took place after every session; the Field Director and the Rapporteurs had several discussions among themselves; and there was much exchange of information and ideas outside the formal sessions. As a result, the following recommendations were made at the final session, which was chaired by Dr. Bannerman.

1. It was desirable that family planning should be an integral part of MCH services and that it should be included in the syllabus for midwifery training of all categories including the traditional birth attendant. Refresher courses should be organized for qualified midwives to include family planning. It was stated that training facilities for midwives in family planning were available in some of the countries and these should be reviewed as early as possible with a view to further development and expansion.

2. (a) Immediate consideration should be given to the traditional birth attendant, who still provided care for most births in the area. Where appropriate the TBA should be identified, supervised and trained to help continue the improvement of maternal and child care and the quality of family life. As more midwives are trained to cover the whole country, the TBAs should be replaced by such trained personnel.

   (b) It was important that a well designed study of the methods used by the TBAs, and the strengths and defects of such methods, should be undertaken by a group including obstetricians, sociologists, midwives and health administrators. It was hoped that this would enable some legal and social recognition to be given to the TBA, or strengthen their replacement if the study showed this to be possible and desirable.

3. In the West African context the midwife (including the TBA) was an appropriate person to act as a motivator, educator and counsellor for family planning; she was also in a unique position as a family health worker, especially in the fields of nutrition and postnatal care. Her training therefore should be designed to reflect all these aspects of the practice, e.g. it should not be hospital based only, but should provide greater emphasis on her community role and the child health content.

4. The definition of the proper sphere of practice of the midwife in each country would determine the type of training she should have. There was need therefore for flexibility of training programmes to suit different circumstances of practice and the conditions in the part of the country where the trainee was to work, e.g. manual

removal of placenta and other emergency procedures in the absence of medical help.

5. Appropriate measures should be considered by Health Authorities for the services of private midwives to be fully utilized and for them to be regarded as part of the entire maternity service. Already there was acute shortage of midwives in all countries and the few available should be fully utilized to effect better maternity care for the mothers and babies.

6. It was desirable to consider common standards for midwives in neighbouring countries to permit reciprocity in licensure and common practices.

7. It was recommended that for efficient discharge of the duties of the midwife, in the interests of the public, accommodation, good communication and other social amenities should be provided for the midwives and some form of incentive worked out for the midwife in rural areas.

8. In the interests of a country, consideration should be given to the feasibility of including education for family life in the general education system at all levels; thus the majority of both sexes would readily accept the concept of family planning and practise it.

9. At the present time pressure of work and shortage of midwives result in the midwives being pre-occupied almost exclusively with deliveries. It was therefore difficult for them to undertake their very important responsibilities as health educators and supportive counsellors. There was an urgent need for a large increase in the number of training institutions for midwives, and measures should be taken to effect this.

10. It would be an advantage if family planning programmes were supported by Government in each country.

V. Country Follow-up Action Plan

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

VI. Evaluation

Each participant completed an evaluation form and was asked to make suggestions for future Working Parties. Comments were:

1. The Working Party had covered all aspects of the subjects coming under its terms of reference.

2. The majority felt that some of the problems of the individual Anglophone West African countries were on the way to being solved.
3. It was hoped that the recommendations would be implemented by the appropriate Ministries.
4. One of the most substantial contributions was the recognition that family planning was a most important factor in any comprehensive Maternal and Child Health Service.
5. There was need to identify and train traditional birth attendants as they would for many decades have a substantial contribution to make in the Maternal and Child Health Services and in family planning within that service.

VII. Follow-up Visits

Ghana, March 1974

1. ***Training***

   A sub-committee of the Central Midwives Board was considering the registration and training of TBAs and were likely to recommend that this be done; it was hoped that this would eventually become national policy. The only training at that time was under the Danfor Project; 19 had recently completed training and a second group were under training.

2. ***Family planning***

   Pupil midwives received some lectures in family planning but little or no practical teaching, although clinical work was available to nursing students. The hospital where family planning training was given to midwives was phasing out its family planning services. The funds provided by the Population Council were no longer available; the government, through the Finance Department, were now responsible, but internal departmental rivalry was hindering progress. A midwifery tutor was training in the USA and on her return it was hoped to increase the amount of family planning in the curriculum.

   There was an eight-week postgraduate course for nurse-midwives in which all methods, up to the insertion of IUDs were taught; there was also a course for field workers. Liberia, Sierra Leone and The Gambia would like to send midwives to Ghana for family planning training, and The Gambia had made a formal request. Ghana would agree if funds could be obtained, or if delegates were self-supporting.

3. ***Midwives Association***

   The nurses and midwives were being formed into one Association, but would retain their own subgroups and their individual membership of ICM and ICN.

4. ***Further Evaluation of Working Party***

   Field Directors should be notified in writing at the beginning of their

assignment how the money at their disposal could be spent. After the Working Party the Field Director and a member of ICM should meet to decide on future programmes of work, itineraries of visits, etc., so that early clearance could be obtained from HQ.

Planning had been rushed and fewer delegates than expected had attended; a larger group would have been better. Papers were too long and repetitive and had left too little time for discussion. The formulation of resolutions had been tedious, and some matters had been agreed to because delegates were tired. There should have been allowance for minority reports.

The Gambia, first follow-up, March 1974

1. ***Training and Practice***

   There were about 100 midwives in The Gambia, mostly nurse-midwives, one MTD, and six pupil midwives in training. Refresher courses were asked for and it was suggested that they co-operate with Sierra Leone over this and present proposals to their respective governments. They also needed another Midwifery Tutor and it was thought that ICM might be able to assist with the training if a suitable candidate were forthcoming. They were hoping for reciprocal arrangements for training and practice with Ghana, Nigeria and Sierra Leone, and possibly also with Great Britain.

   The midwife tutor had given three months' training to two groups of 20 TBAs in provincial centres. Supervision of their practice had been minimal and no evaluation of their training was possible. There was a small amount of family planning in the curriculum. The workers from University of California were hoping to write a MCH curriculum for the use of community health aides or auxiliary midwives.

2. ***Family Planning***

   There was no Government programme, but some contraceptives were given out at Government clinics. Student nurses and midwives received some training under the University of California MCH/FP programme and field workers had been trained by an IPPF affiliate in Banjul.

3. ***Association etc.***

   The midwives were attempting to form an organization with a view to joining ICM at the 1975 Congress, but there was a split between British trained and locally trained members. Midwives and nurses wished to see a combined midwifery-nursing officer in the Ministry of Health, and the government was considering this.

The Gambia, second follow-up, March 1975

1. The government's open policy on family planning was not a hindrance, and by sponsoring the development of MCH services as an

integral part of health services they were in fact promoting the development of family planning. Midwives were being involved more and more in parentcraft training.

2. There were 11 midwifery students under training. Their interest in MCH/FP was now much greater since they had begun to attend the FPA's clinical sessions. A one-year training course for auxiliary midwives, with a high family planning content, was due to begin in July 1975. Training of TBAs appeared to have ceased because, it was said, the midwife tutor was no longer available. It was pointed out that midwives in the provinces could undertake this training.

3. Meetings were held between staff from FPA, MCH, the midwifery school and the hospital obstetrician to co-ordinate family planning activities. Three nurse-midwives were attending family planning courses outside the country and two others would follow. There was client acceptance to the offer of IUDs, but the pill was popular.

4. The Midwifery Association needed to be stimulated by the election of officers and by persuading younger members to join.

Liberia, first follow-up, March 1974

1. ***Training***

The situation was very confused. There was no syllabus but the Midwifery Council wished to develop one to be submitted for legislation. The one Government school was closed, probably due to lack of students. There were differences of view as to whether training should be of a high standard with stiff entry qualifications (which resulted in few recruits) or of lower standards designed to meet rural needs. One of the few schools run by a Mission had already adopted the latter course.

The Government was identifying TBAs and offering a four-month training course at three centres. On return to their own areas the TBAs were supervised by nurses and midwives. The course included lectures on family planning and observation sessions at family planning clinics, but in practice they referred patients to the clinics. There were two training sessions a year at each centre, with about 15 students on each course; more than 200 had been trained to date; entry was restricted to those who had already attended deliveries.

2. ***Family Planning***

Family planning was not officially recognised, but the government was considering an integrated MCH/FP programme for rural areas and was already allowing the Family Planning Association of Liberia to run clinics in conjunction with government MCH centres in the larger centres of population. Most midwives strongly supported family planning, and numbers of nurses, nurse-midwives and midwives

had been trained in the USA and by postgraduate courses in Liberia, but they were not able to practise their skills because of lack of a proper programme and of supplies. The government were investigating the possibility of obtaining supplies through international agencies in order to set up a rural programme. FPAL were training field workers who talked to mothers in the centres and in their homes after the birth of their babies.

Liberia, second follow-up, March 1975

1. ***Training***

Midwifery training was still being undertaken only by Missions, although the government gave subsidies. A training course for nurse-midwives was still unlikely to be established for the same reasons as before. Additional problems were opposition to midwives from nurse-midwives and nurses and inequalities in salary scales between nurses and midwives.

About 450 TBAs had been trained at four centres, but there were still many to be trained. They were licensed by the Midwives Council and placed on a register. TBAs represented about 50% of all midwives.

A refresher course for professional midwives, probably of two weeks' duration was to be started in July 1975, and an in-service course at J. F. Kennedy Hospital in April 1975. Both would include family planning.

2. ***Family Planning***

Although there was no official policy to support family planning there were no hindrances, and the subject was included in all training curricula, with clinical instruction given at FPA clinics. Most midwives were encouraging mothers to be interested.

The government had given some money to FPA, but less than expected.

Two new FPA clinics had been opened, integrated into MCH centres and more field workers were being trained. It was proposed that FPA staff should give talks to children in secondary schools, and there had been a marked growth of attendance of young people for advice and contraception.

3. ***Recommendations implemented***

(a) The inclusion of family planning in the training of all categories of midwife, with instruction given by medical nursing and FP staff.

(b) Greater employment of TBAs, especially in family planning.

4. ***Recommendations not implemented***

(a) Failure to visit rural areas adequately to see that available resources were being fully used.

(b) Failure to retain professional midwives in the Service.
(c) Failure of obstetricians and paediatricians to work as closely with midwives as they might.

ICM/USAID Staff could help by:

1. Keeping in constant touch with delegates and Government personnel.
2. Visiting the region periodically.
3. Sending ideas for curriculum review.

Nigeria, April-June 1973

1. ***Training***

Discussion of the existence of TBAs and possibilities for their training was not encouraged, but it was felt that the matter should be raised constantly and not allowed to rest.

2. ***Family Planning***

Family planning was government policy, but operated more effectively in some States than in others. Nationals and personnel from other countries were being trained, and midwives had a good training programme. Family planning clinics were mainly in health centres and hospitals; Family Health Clinics to be built in each State would have family planning facilities. Cultural beliefs and male dominance had hindered the appointment of female nurse-midwives in the MCH/FP programme.

3. ***Association***

There was now a Midwives Board of Nigeria, separate from the Nursing Board.

Sierra Leone, first follow-up, March 1974

1. ***Training***

There was one midwifery training school with 34 pupils and three tutors. Only two of the students had had previous nursing training. Lectures on family planning were included in the curriculum, but no practical training. General facilities at the school were poor, although the level of the training programme was high.

The TBA training programme had been phased out in favour of training MCH aides. The aides had to have education up to 7th grade and be literate in English. After one year's training they conducted all normal MCH activities, including deliveries in rural areas. They were supervised by district nurses or midwives.

2. ***Family Planning***

There was no Government policy on family planning. It seemed likely therefore that they would continue neither to oppose nor to support any training given to midwives until other factors (e.g.

results of a pending census; the possibility of aid depending on the acceptance of family planning as part of health programmes) forced them to do so. The local FPA was running several clinics and had trained 28 field workers.

The Minister of Health promised to consider the Working Party's recommendations at the Sierra Leone Midwives Association.

3. ***Association***

The Sierra Leone Midwives Association was active, with monthly meetings, various sub-committees and a journal. They were concerned to run refresher courses but had no qualified tutor available.

There was concern that midwives going for training overseas did not receive their salaries and this was discussed with the Chief Nursing Officer.

The Association wondered if their influence would be greater if they were incorporated as a Company or joined a Trade Union, and they wanted the advice of ICM on this.

4. The delegates to the Working Party had written to the Minister of Health on 22 February 1974 as follows:

Comments on the Recommendations of the Working Party by the Delegates with the approval of The Sierra Leone Midwives Association

1. (a) The students have family planning lectures but no clinical observation or practice. Permission is now being sought from the Ministry for students to attend family planning clinics until the clinic here is completed and postnatal and family planning work can be undertaken here at the Princess Christian Maternity Hospital.

   (b) In addition to local seminars and refresher courses, provision should be made for midwives to attend overseas refresher courses similar to what school teachers have. There are organised Maternal and Child Health and Family Planning courses being held in other West African and East African states, also in the United States of America.

2. (a) We are in the process of identifying the TBAs, and a refresher course for those identified and for Village Maternity Assistants and Child Health Aides has been planned by Dr. Belmont Williams to be held in Kenema later this year.

   (b) No action has been taken yet.

3. As 2a above.

4. Being discussed with the obstetricians.

5. Has been discussed by Sierra Leone Midwives Board, but no decision taken yet. The question of subsidies will be difficult.

6. Agreed.
7. Could not agree more. Too much hardship is endured by midwives. When on transfer more expenses are incurred and there is psychological upset for those with children and also matrimonial upset; very often people leave comfortable homes and have to make do with the bare minimum. The Ministry could give much more assistance and consideration in this respect.
8. The Ministry of Education should be encouraged to introduce human biology, health, nutrition and sex education into the curriculum at upper classes of primary schools: this could be intensified to include family planning in secondary schools.
9. Consideration should be given to the setting up of a proper midwifery training school with adequate facilities, to the provision of more midwifery tutors, clinical teachers and midwifery sisters for the service area. All these suggestions have been previously recommended by the sub-committee set up by the Sierra Leone Midwives Board in 1972.
10. The delegates and Association agree with this recommendation as family planning is an important part of maternal and child health services.

Sierra Leone, second follow-up, March 1975

Substantial progress appeared to have been made in implementation of the recommendations and in dealing with existing problems:

1. A MCH Advisory Committee had been set up through the Ministry of Health to look into the training and practice of midwives of all categories.
2. Identification of TBAs had been achieved and some preliminary training given, mainly in asepsis. Later it was hoped to introduce training in motivation for family planning.
3. The ultimate aim was replacement of TBAs by MCH aides; 64 aides had already been enrolled and 34 more were in training. The course lasted 18 months and included family planning.
4. Health education, including sex education, had been introduced into the Secondary School Curriculum.
5. The Ministry of Health and the Midwives Board were arranging for a midwifery tutor to evaluate family planning courses held in the USA and in East Africa.
6. Family planning had been introduced into midwifery training by means of lectures, demonstrations and visual aids. Midwives also

attended central and rural clinics for 4-6 weeks for clinical family planning instruction, and this had stimulated more youths to attend classes.

7. The Midwives Association, IPPF and the Medical MCH Director were planning together to use midwifery personnel trained in family planning in the USA to organize training locally.

8. Despite lack of official Government policy on family planning, there has been no hindrance from this quarter. The IPPF staff, midwives, obstetricians and the Midwives Association were co-operating well.

9. Plans were made for a one-day seminar during National Midwives Week in May 1975 with a view to holding a 3-5 day seminar later in 1975 on The Training of Midwives in Family Planning. This was accomplished with good results.

   Plans were initiated to hold an ICM/USAID Inter-Regional Seminar in collaboration with IPPF during 1976.

VIII. Outcome, Proposals for Future Activities, Achievements

Outcome

1. Recommendations for presentation to each respective country's government, midwifery and other health personnel, for implementation where practicable.

2. Midwife delegates' reappraisal of their professional assets.

3. Midwives' professional status established.

Proposals for Future Activities

1. To persuade Governments to recognize the work of TBAs and to provide training and supervision.

2. To review existing TBAs' training programme.

3. To promote the integration of family planning into midwifery curricula (theory and practice), and to promote continuing MCH/FP education.

4. To promote the integration of family planning into MCH services.

5. To work towards the formation of Midwives' Associations.

6. To review midwifery legislation.

7. To organize an Inter-Regional Seminar on Family Health Training.

Achievements

1. The inclusion of family planning as an integral part of health services.

2. Midwifery students given practical family planning training in some of the countries, e.g. Ghana, Sierra Leone.
3. Family planning now included in midwifery curricula, e.g. The Gambia, Ghana, Nigeria, Sierra Leone.
4. The Inter-Regional Seminar on Family Health Training was held in Sierra Leone.

APPENDIX I

Preparatory Questionnaire sent to each country

A. General

1. Are there training programmes controlled by public or professional bodies for appropriate grades – professional midwives, auxiliary midwives and traditional birth attendants?
2. (a) Who provides the maternity service at present, including support and care as well as delivery?
   (b) Who provides care of the infant during the first 28 days of life?
3. Is there any public or professional control of these people (cf. question 2)?
4. Is there a family planning programme in existence?
5. Are the individuals who provide the maternity service at present, including support and care during delivery, all known or recorded by public or professional bodies?
6. If a family planning programme is in existence, are the individuals who operate the programme regularly all known and recorded by public or professional bodies?
7. If the answer to 5 and 6 is no, is some licensure procedure envisaged to give the present practitioners some status and control over the entry of future practitioners?

B. Midwifery Training and Practice

1. Are Midwives of all categories trained in the following:	Professional Midwife	Auxiliary Midwife	Others
Pre-natal care			
Intra-natal care			

Post-natal care

Infant care
(a) In the first month only
(b) After the first month

Health Education in relation to
(a) the mother
(b) the infant
(c) the family

Preparation for Parenthood

Family Planning:
(a) Motivation
(b) Techniques

2. Are midwives of all categories required to register the following:	Professional Midwife	Auxiliary Midwife	Others
Births			
Peri-natal deaths*			
Neonatal deaths**			
Infant deaths***			
Maternal deaths****			

* Peri-natal mortality includes all still births and deaths within the first seven days.

** Neonatal deaths include all deaths of children born alive who die within 28 days of birth.

*** Infant deaths include all deaths during the first year of life.

**** Maternal deaths include all mothers who die as a DIRECT result of pregnancy, childbirth or abortion during pregnancy, labour and forty two days after delivery.

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

C. **External Assistance**
Can any help be given from external sources and particularly FIGO/ICM on the following:

(a) Organization including licensure and control including protection of the public in the widest sense.
(b) Professional education.
(c) Family Planning.

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

APPENDIX II

List of Participants

Representatives

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

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

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

Speakers
Mrs. P. Acolatse, Ghana.
Dr. A. Akinkugbe, Nigeria.

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

APPENDIX III
List of Papers read at Working Party

Maternity Care in the Developing Countries	Dr. R. H. O. Bannerman, Chief Medical Officer, Education in Family Health, WHO
Midwifery Practice by the Traditional Birth Attendant and The Training of the Professional Midwife in Nigeria	Mrs. R. O. Sosanya, SRN, SCM, MTD, President, Professional Midwives Association of Nigeria
Family Planning in Midwifery Training	Mrs. Comfort Akrofi, Deputy Field Director
Family Planning In-service Training for Midwives of all Categories	Miss W. Evans, Nurse-midwife, USAID (Liberia)
The Organization of a Family Planning Service	1. Dr. A. A. Ampofo (Ghana) 2. Dr. B. Williams (Sierra Leone) 3. Dr. D. Collins (Liberia)
Developments in the Training of Midwives and Organization of a National Maternity Service to include all categories of Midwives	1. Dr. A. Akinkugbe (Nigeria) 2. Dr. K. K. Korsah (Ghana)
The Role of the Paediatrician in Midwifery Training	Dr. Carl Reindorf, Senior Lecturer in Paediatrics, University of Ghana Medical School
Licensure and Control of Practice of Midwives of all Categories	Mr. R. J. Fenney, Field Director
The Role of the Midwife as a Family Health Worker	Mrs. Joana Samarasinghe, Senior Public Health Nurse Tutor, Ghana

Training and Practice of Midwives of all Categories including Curricula	1. Mrs. Peace Acolatse, SRN, SCM, MTD (Ghana) 2. Mrs. K. G. A. Betts, SRN, SCM, MTD (Sierra Leone) 3. Mrs. B. Barmadia, SRN, SCM (Liberia)

CENTRAL AMERICAN WORKING PARTY, SAN JOSE, COSTA RICA, 13th – 21st SEPTEMBER, 1973.

Participating countries: Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama.

I. Preliminary visits

No record of preliminary visits is now available.

II. Organization

An Organizing Committee was formed with the following members:
Dr. Miguel Asis Beirute, Representative from the Ministry of Health and the Demographic Association of Costa Rica.
Miss Elena Quesada S., Director of Nursing Department, Ministry of Health, Costa Rica.
Mrs. Dora Valdes de Royo, Chief, Hospital Nursing Section.
Mrs. Miriam C. de Taylor, Representative from the National Association of Nurses and Midwives, Costa Rica.
Miss Estelia Marin, Representative from the College of Nurses, Costa Rica.
Mrs. Liliana P. de Corrales, Representative from the School of Nurses, Costa Rica.
Mrs. Miriam Esquivel de Fernandez, Representative from Postgraduate Mother and Child Training Programme, School of Nurses, Costa Rica.

This Committee was in charge of the arrangements for the Working Party. During the Working Party a representative of the Committee was always available to guide and help the participants.

III. The Working Party

1. ***Attendance***: Those attending comprised:
   (a) 17 delegates from Costa Rica (3), El Salvador (3), Guatemala (4), Honduras (2), Nicaragua (3), Panama (2).
   (b) 6 observers from Costa Rica (4), Guatemala (1), USA (1).
   (c) 9 speakers from Costa Rica (6), Guatemala (1), Panama (2).
   (d) 6 Resource persons, including representatives of FIGO/ICM, WHO/PAHO, interpreter, etc.

2. ***Summary of Proceedings***

   At the Opening Ceremony the delegates were greeted by Mrs. Doris Henry in the name of the Costa Rica nurses and midwives, and by Miss Lucille Woodville, ex-President of ICM, in the name of the President, Miss Georgette Grossenbacker. Miss Marjorie Bayes, Executive Secretary ICM, emphasized the importance of the role of the midwife in the improvement of maternal and child health

through the services they provided, including family planning. Dr. Alvaro Mora, President of the Costa Rica Gynaecologists and Obstetricians Association spoke warmly of the work of FIGO/ICM in promoting activities in Latin America.

The PAHO/WHO Costa Rican representative, Dr. Manuel M. Villa Crespo gave a brief general description of the maternal and child health situation in Central America after which the Minister of Health, Dr. Jose Luis Orlich declared the meeting open and promised his full support for the recommendations which the group would make.

The participants were then introduced, the aims and organization of the Working Party explained and Chairmen elected.

At the first plenary session Dr. Crespo presented a paper entitled *Aims of Maternal and Child Health and Population established by the American Ministers for the next ten years and its implications for Central American Countries.*

At the next two main sessions country reports were given, prepared according to an outline sent earlier by ICM to each country asking for information on the following:

(i) Current situation of midwives' practice at different levels.
(ii) Family planning programmes provided.
(iii) Regulation of midwives' practice at different levels.
(iv) Midwives' training programme content.
(v) Type of statistical reports given out by midwives at all levels.

It appeared that the situation varied from country to country, with great differences in resources and in methods employed to improve MCH care. In most places midwives were not adequately utilized and only one country had a regular nurse-midwife training programme. In some countries the training and control of TBAs (empirica) had recently begun. Legislation on midwifery was scarce and in some countries there was none.

Costa Rica

Training of nurses and nurse-midwives was undertaken at the School of Nursing attached to the School of Medicine of the University of Costa [illegible]. TBAs were trained and supervised by a programme established by the Ministry of Public Health. Both nurses and nurse-midwives were trained to provide integrated MCH care including family planning. TBAs were trained to undertake normal midwifery and their course also included some aspects of health education and family planning motivation.

The mother and child population was 70% of the total population. 80% of the population had access to health services, about half through government services and half through the Costa Rica Social

Security Institute. Institutional deliveries had reached about 80% of the total. Nurses and midwives attended about 50% of all deliveries, doctors 25% (usually with a midwife present) and TBAs about 20% (all home deliveries). Postpartum care tended to be inadequate because of short stay in hospital. Children were cared for at health units and at home by public health nurses and auxiliary nurses.

The family planning programme was the responsibility of the Ministry of Health and was carried out at health units, the 'Carit' Maternity Hospital and at some private and Social Security institutions.

Doctors registered maternal and all infant and child deaths; births were reported by midwives only where there was no civil register office. The registration of births was normally completed before leaving hospital.

Professional practice and fees were controlled by the Organic Law of The Costa Rica College of Nurses; TBAs were controlled by the Ministry of Health. Each had its own Register.

El Salvador

Resources were limited in a country of high population and birth rate and with high maternal and infant mortality. Hospital deliveries accounted for only 22% of total deliveries, the remainder being supervised at home by TBAs.

The Ministry of Public Health had a family planning programme which was carried on cautiously in health units and health centres. The Demographic Association of El Salvador and the Salvador Institute of Social Security were more active. All modern methods were used.

There was no training of nurse-midwives or auxiliary midwives. TBAs had yearly educational programmes which included basic health education, preparation for parenthood and family planning motivation. TBAs were legally obliged to register birth and infant deaths, but this was often not done. Births were often not registered until registration was needed to ensure school entry. They would welcome help in organizing the training of nurse-midwives. As there was no training, there were no laws or regulations.

Priorities were the establishment of a more complete family planning programme and of a training course for nurse-midwives.

Guatemala

Population growth rate was 2.9% in spite of high infant mortality – 90%. Professional medical staff were few and concentrated in urban areas. The indigenous population lived in rural areas and their cultural traditions still largely influenced the health of the people.

Delivery care in rural areas was by TBAs, some of whom were trained and supervised by local health centres and the Community Development Programme. Births were registered by the father and infant and maternal deaths by the person attending, but the system was inadequate. Birth certificates were required for school entry.

Advice and assistance would be welcomed on how to promote improved MCH care so as (i) to reduce maternal mortality and morbidity, (ii) to prevent mortality and morbidity by integrated health care from doctors, midwives, paediatricians and nurses at all levels, and (iii) to pursue family well-being by counselling and educating the family group.

There were very few midwives and they needed to establish a school for training nurse-midwives and auxiliary midwives.

The present system of hospital delivery of urban patients was very impersonal and there was need for personal counselling for the mother during pregnancy and labour, which midwives could give. Most pre-, intra- and postnatal care was given by doctors assisted by midwives (trained before training ceased), and nurses. Child care was given at the hospital clinics.

A total of 428 TBAs had been trained by nurses in certain regions and this work was continuing. Refresher training of some of those already trained was planned.

Since 1971 more MCH functions had been delegated to nurses, and the MCH Division had assisted in revision of the nursing curriculum to include MCH and family planning. Further training of nurses in these areas and in administration was required.

Family planning activities had been initiated by the local Association and later incorporated into MCH care. Motivation and advice were given to mothers during the maternity cycle, and to couples and groups in the community. Refresher courses in family planning had been given to nurses and to those involved in family life education.

The Midwifery Association had a register of all its members.

Honduras

The population was mainly rural with primitive agriculture predominating. The birth rate, 45.2 per thousand population, was one of the highest in Latin America. The infant mortality rate was 128 per thousand live births reflecting severe malnutrition. There were only 25 nurse-midwives.

The Ministry of Health had a new plan to offer more and better health services, including the integration of preventive and welfare services, and the creation of a Maternal and Child Health Division which would include a family planning department. This was a progressive programme and was being developed by regions.

Nurses and auxiliary nurses were being trained but not nurse-midwives, although the 25 had been trained prior to 1962. The professional and the auxiliary nurse were trained in MCH care and obtained practical experience in deliveries. There were 20 training courses in 1972 for TBAs. Priority was being given to the training of auxiliary nurses, TBAs and health volunteers. Courses on MCH care and family planning had been given to auxiliary nurses, community leaders, health volunteers and TBAs.

It was estimated that 80% of births took place at home, mostly in rural areas and attended by TBAs with little or no training. Child care was given by nurses and auxiliary nurses in the home and by the TBAs who had attended the delivery.

Family planning was provided both through the MCH programme and the Honduras Family Planning Association. The FPA had two clinics which gave health care and contraceptive services; one of them undertook research on contraceptives used. Informational and educational programmes had been carried out.

The MCH programme was financed by USAID and aimed to reduce maternal and child morbidity and mortality and to reduce fertility, and as a consequence to space pregnancies. It had 23 clinics and 5 mobile units.

There was a register of births and of maternal and infant deaths, but no established system or control, so that many went unregistered.

The Ministry of Health had a project to legalize MCH care given by nurses, auxiliary nurses and TBAs provided that they had had some form of training. Alternatively nurses might be sent abroad for post-graduate courses in midwifery. There were no regulations governing midwifery care, but this was covered by the Organic Law of the College of Nursing. Overseas diplomas of nurse-midwives were recognized provided that they were issued by an authorized body.

Nicaragua

The birth rate was high with a population growth rate of 3.2. Infant mortality rate was 130 per 1000 live births. Of the population of 2 million 55% was rural. There were 456 nurses (including 11 nurse-midwives), 2206 auxiliary nurses and 7 midwives.

There was no training of midwives or auxiliary midwives but TBAs were being trained within the MCH programme at several health centres. Training included maternity care, care of the newborn, and health education related to mother and child and family. TBAs were asked to register births as a requisite for licensing, but there was no obligation to register infant or maternal deaths and therefore no estimate of these was possible.

A high proportion of the prenatal care offered was provided by

nurses in health institutes and health centres. In Managua, the capital, most deliveries were attended by TBAs because only one hospital offered free services. Postnatal supervision of mother and child was minimal. There was no supervision of TBAs, but efforts were being made to introduce it.

Family planning services were offered by the MCH programme (financed by USAID) which had 69 clinics, by the Family Advice Programme of the National Institute for Social Security and by 2 private associations. The government programme included training schemes.

There was no legislation or regulation of the practice of midwifery. Midwifery diplomas of other countries were recognized. Nurse-midwives could work in private practice, in government centres and hospitals, as instructors in Nursing Schools and as trainers of TBAs. They were not allowed to sign birth certificates. Their work was being more orientated towards MCH clinics.

Help from abroad, especially through FIGO/ICM, could be obtained if arrangements could be made for organization and control and professional training.

Panama

In a population of about 1½ million, the growth rate was 2.9. Nearly 30% of births took place without professional assistance. There were 143 nurse-midwives in practice, 948 nurses and 1984 auxiliary nurses.

There was no training course for nurse-midwives, but it was hoped to start one that year. Nurses and auxiliary nurses both received MCH training during their course. There was no training of TBAs but a programme existed which could be put into effect at any time. Fertility control had recently been introduced into the courses. The Centre for Education and Research on Maternal and Child Health Care trained personnel from Central America and Panama. It was run jointly by WHO, the University of Panama and the National Government.

The MCH programme was directed by the Mother and Child Department of the Ministry of Health and care during delivery was an important aspect of training. All MCH personnel, including TBAs, gave general care to both mother and child at all stages. All births and deaths had to be registered as a legal requirement.

Family planning was now part of the national MCH programme and was free for everyone.

A special law for nurses had existed since 1964. Every midwife was a graduate nurse, so that this law also applied to nurse-midwives. In addition the midwife was officially recognized by a ministerial decree

of 1967. Midwifery diplomas of other countries were recognized. A Register of practising nurses was introduced in June 1972.

At the 4th Plenary Session a paper on *Mother and Child Services Organization* was read by Dr. Gloria M. de Lopez, Obstetrician, St. Thomas's Hospital, Panama, and at the 5th a paper on *Basic Needs of Mother and Child* was read by Dr. Napoleon Diaz, Sub-Director, No. 4 Regional Health Centre, Guatemala. Both of these papers were followed by general discussion.

In session 6 a panel discussion took place on the subject *Family Planning in the Continuous Education of the Midwife.* The panel consisted of Miss M. Zapenas, WHO/PAHO Nursing and Midwifery Regional Adviser, Mrs. Hilda de Eastmond, Instructor in Mother and Child Nursing, Panama, Mrs. Ana Maria de Alfaro, El Salvador and Miss Beverly Taylor, Honduras.

Miss Zapenas spoke of the concern of PAHO/WHO that all MCH staff of whatever category should receive continuing education, and that family planning should be part of this in accord with the 10-year plan for the Americas. She listed the activities that had been and were being held for nurse-midwives, including meetings, working parties and study groups covering all grades of professional personnel and TBAs, and programmes of scholarships and technical advisory services. In addition she reported on postbasic and postgraduate courses being offered to nurses for their expanded role in MCH care.

Mrs. de Eastmond emphasized the need for the nurse-midwife to be highly trained in dealing with fertility control, as she was in the most favoured position to carry out this work. She needed to be able to work competently and without supervision in this area. Many of her normal duties ought to be transferred to auxiliaries.

The Saturday was a holiday to celebrate Central American Independence, and on Sunday a trip was arranged to the Irazu volcano.

Monday began with the 7th plenary session with talks by members of the staff of the School of Nursing, Costa Rica, on *Midwifery Training and Practice.* The first talk, by Sra. Lillyana Picado de Corrales, was on *The Basic Maternal and Child Health Programme,* which had developed through various stages, and then occupied one semester in the second year. Teaching was given by nursing teachers who were specialists in obstetric and paediatric care and on occasions by other clinical teachers. Theory (160 hours) included: overview of the MCH situation in Costa Rica; sexual education in family life; nursing care during pre-, intra- and postnatal periods; nursing care of complications during pregnancy, delivery and postpartum; nursing care of the newborn and of premature babies. Clinical practice took place in the hospital and included public health, labour ward, care of

premature babies and of the newborn and a stay in the postpartum room.

Sra. Miriam E. de Fernandez then described the postgraduate MCH courses. From 1954-1973 207 nurse-midwives had graduated, 37 of whom had been from other countries in the Americas. In 1968 a seminar had been held to evaluate the training programme and it was decided that there was insufficient integrated care to mother and child and that there was over-emphasis on midwifery aspects, especially the delivery itself, and insufficient teaching on socio-cultural and public health aspects and on prenatal and child care. There was no supervision of TBAs. As a result, a new philosophy was formulated on which a new curriculum was based stressing the needs of the family as a whole, including nutrition and family planning, the importance of a proper scientific approach to midwifery so as to give the best possible care at all stages, proper practice of her profession and ability to supervise and administer as required. Details of the curriculum were shown.

The third speaker, Sra. Haydee Morales de Briceno described the training programme for TBAs at the Health Unit of Santa Cruz at Guanacaste. Because of excessive maternal mortality and morbidity in patients cared for by TBAs, training courses were begun in 1967, following a census of TBAs to establish which of them would most benefit from training. Nineteen women attended the first 5-week course and 18 of them qualified and were licensed. A second 3-week course was held in July 1970 attended by 14 women and a third in December/January 1970/71 at which 8 women attended. Those who completed the courses successfully received a basic delivery kit and a manual, the regulations, a licence and a health card. The latter two items had to be renewed annually. Trained TBAs met together periodically so as to integrate them into a group. Deliveries attended by trained TBAs numbered about 150 annually. It was planned to continue this training and supervision and recommended that (i) in rural centres where a TBA programme was functioning two nurse-midwives should be appointed to improve the supervision of the programme, (ii) there should be at least one vehicle in each province where a programme existed and (iii) an adviser or supervisor should be appointed exclusively for the programme in each place where such training was carried on.

The delegates then split into groups for the first discussion topic – *The Role of the Midwife at all Levels*, and the groups reported back to the 8th plenary session. The second discussion topic was taken the next day – *Midwifery Training at Different Levels* – and after discussion the groups reported back to the 9th plenary session.

On Wednesday, at the 10th plenary session a paper, prepared by

the Costa Rican Educational Technology Center, was given on the subject *Educational Technology applied to Mother and Child Health and Family Planning.* Educational technology was an adaptation of modern communication techniques to teaching, and studied how much could be achieved by individual methods and how much by machine. Applying this theory to particular cases meant deciding on teaching objectives, selecting the content, and then devising the presentation, probably in audio-visual form.

Group discussion on the third topic then followed - *Midwifery Practice Regulations* – and the groups reported back to the 11th plenary session. On the following day the same procedure was applied to topic No. 4 – *Drawing of a short, intermediate and long-term Plan to implement the Recommendations of the Working Party.*

The final day opened with a visit to the Educational Technology Center, and this was followed by the 13th plenary session at which the Final Report was read and Conclusions and Recommendations agreed.

At the Closing Ceremony addresses were given by Miss Lucille Woodville, Vice-President ICM, Dr. Miguel Assis, B., Director of Medical Services Division, Director of Mother and Child Department, Ministry of Health, Costa Rica, and by Dr. Eliecer Valverde, General Director of Public Health, Mrs. Adela de Saballos expressed the thanks of the delegates to the organizers of the Working Party.

IV. The Discussion Groups

The importance of the expanding role of the midwife was stressed at all times, and that family planning should be part of her activities. In fact family planning had already been incorporated into the midwife's daily routine in some countries, especially in public health. Only one participant, a doctor, objected to the expanding role of midwives. The majority of participants accepted that TBAs were a valuable human resource for the improvement of the quality of mother and child life.

In discussing the topic Midwifery Practice Regulations, the group was assisted by the Costa Rican Nurses College legal adviser and by Mr. Roger Fenney, FIGO/ICM Director for the Study Group. There was unanimous agreement that legislation was necessary, not only for the protection of midwives but also for the protection of the public against irregular practices.

The discussions are dealt with under three headings: Subject; Guidelines for Discussion; Conclusions and Recommendations.

1. *The Midwife's Role at all Levels*

(a) *Guidelines for discussion*

The reports presented by the delegates to this Working Party

have shown a tendency to keep or increase the professional level of the midwife in order to face the increased needs of the mother and child population.

(i) Which levels do you consider more adequate for Central America and Panama?

(ii) To improve the quality of maternal life at every stage, i.e. pre-, intra-, and postnatal and in those stages in which the woman can space her pregnancies and also for the improvement of the infant's health, which types of functions would you assign at the present time to each level and what would be the expected expansion of the midwife's role at each level?

(b) *Conclusions and Recommendations*

(i) Considering that in Central America and Panama the term 'Enfermera Obstetrica' (which includes the midwife) is well accepted and feeling the need to establish the terminology from the beginning of this Working Party when referring to the professional midwife, *we recommend* the governments through their Ministries of Health and the Professional Associations to continue using the terms 'Enfermera Obstetrica' or 'Obstetrica'.

(ii) Considering that the nurse-midwife and the midwife are vital elements in the running of the Mother and Child Health programmes and in pursuing the aims established by the Ministers for the present ten years to meet the needs of the MCH and Family Planning of Central America and Panama, it is necessary to have a common definition of these professionals for the different countries. *We recommend* acceptance of the ICM definition of the midwife or nurse-midwife with a short attachment, as follows: 'A Midwife is a person who, having been regularly admitted to a Midwifery education programme, duly recognized 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 officially registered to practise Midwifery legally during the Mother and Child Care Cycle.'

(iii) Considering that the large number of mothers and children (63% of the total population) has the right to benefit from the services aimed at by the Health Ministers for the period 1972-1982 in a special meeting held at Santiago de Chile, and considering the necessity to identify the different personnel levels working in the solution of this problem, which is the purpose of these aims, *we recommend* that governments, through their Ministries of Health and professional organizations, acknowledge the necessity of establishing and keeping the following categories of nurse/

midwifery personnel involved in the Mother and Child Care Team and in family welfare: (a) nurse-midwife or midwife; (b) professional nurse; (c) nursing auxiliary; (d) traditional birth attendant.

The countries using any other kind of nursing personnel such as Nursing Technician and others must determine a definite role for them within the services for Mother and Child care and Family Planning.

(iv) Considering that it is necessary for each level of personnel working in the Mother and Child Care Field to have a determined function in accordance with the actual reality of our countries and with the need to expand their role in order to survive the changes, to adopt new techniques and to use their human resources reasonably, *we recommend* governments through their Ministries of Health and professional organizations to accept the following functions:

Nurse-midwife or midwife. Integral direct assistance during the maternity cycle in pregnancy, delivery, adolescence and family planning including the continuous education of the family unit. Also the detection and referral to a doctor of high risk pregnancies, deliveries and children, assuring also the continuity of nursing care to all mothers and children. Other functions include: administration, supervision, education, research and leadership in Mother and Child programmes. (Reference: *Conference on Nursing/Midwifery Education in Latin America. Nursing Report No. 14.* Washington, D.C., PAHO/WHO, 1969).

Professional nurse. Direct assistance during the maternity cycle within the limits of her competence as a nurse, in accord with the legal definition and under the regulations for services. Other functions include: administration, supervision, education and research. (Reference: *PAHO/WHO Expert Committee on Training of Mother and Child Nursing in Nursing Schools of Latin America. Scientific Publication No. 260.* Washington D.C., PAHO/WHO, 1973).

Nursing auxiliary. Direct care of Mother and Child within the limits of her competence, in accord with the legal definition and under the regulations for service.

Traditional Birth Attendant. Direct care of Mother and newborn under her own responsibility within the limits stated in its legislation and with co-operation of the Health Services, under the supervision of the Mother and Child Care Team. (Reference: *Guide for Orientation and Supervision of Traditional Birth Attendants. Reports on Nursing No. 12.* Washington D.C., PAHO/WHO, 1969).

(v) Considering that in our countries the term nurse-midwife is

accepted only when referring to the professional person as it has been defined in the second recommendation; and considering that having different categories of midwives could lead not only to confusion but to legal conflicts among the professionals and the countries, *we recommend* the international bodies ICM/FIGO to speak of different 'levels of personnel working in midwifery' when referring to people working in the field of obstetrics in Central America and Panama.

2. ***Training of the Midwife at Different Levels***

(a) *Guidelines for discussion*

The Central American Working Group has decided to recognize the following different levels of midwives: Midwife or nurse; Nurse-midwife; Auxiliary nurse; and Traditional Birth Attendant.

A pattern should be established for each level as a guide to programming their training in accordance with their functions and specific tasks.

Please describe the specific tasks at each level, specially those which are to be their own responsibility, and what should be the educational content for each level of the training programme?

Reference: Conference on Education of the Latin American Nurse-midwife. Paper, PAHO/WHO, page 63.

(b) *Conclusions and Recommendations*

In order to draw up the syllabus for the training of the different levels of personnel working in obstetrics it is necessary to know the functions attached to each of them within their expanding role in the Mother and Child Care and Family Planning. *We recommend* the professional organizations and each of their members, as well as the Institutions which employ them, to recognize the internationally approved duties of each level in order to make better use of them according to the needs of the MCH and within the framework of the countries' regulations and those of the Institutions employing them:

The Nurse-midwife and the Midwife

Her duties and degree of responsibility in the MCH services have more depth and scope than those of the general nurse because she specializes in obstetrics, which includes attendance at deliveries under her own responsibility, supported by the legislation of her country, and in collaboration with the doctor.

(i) *Direct care.* She takes responsibility, with medical advice, for the MCH care through the whole period of family life under normal conditions. This involves the diagnosis of every physical, emotional, social and mental need of the mother

and young child; the undertaking and use of a plan to meet these needs; the procurement of medical help in abnormal conditions of the maternity cycle and the application of urgent measures when needed.

(ii) *Planning.* She initiates, develops and completes plans which are within her province in the care of the patient and also educational programmes.

(iii) *Teaching.* She promotes a natural approach to pregnancy and normal childbirth through health education of every group. She provides the right environment for a happy maternity experience for both mother and father. She also acts as a technical resource, giving advice on the implications attached to the establishment of realistic aims in the daily nursing-obstetric work of health professionals and students inside or outside the clinic.

(iv) *Organization.* As a leader she is responsible for the continuity of the services provided to mother, child, family and community, and takes the necessary measures to improve the nurse-midwifery services offered in the light of the human and material resources available in the health team.

(v) *Co-ordination.* She communicates and works with other members of the health team, providing them with guidelines on nurse-midwifery assistance to improve mother and child care.

(vi) *Evaluation.* She has a specific part in the evaluation of nurse-midwifery care in order to determine those provinces in need of improvement.

(vii) *Administration.* Her role is perhaps the key one in the implementation of mother and child assistance in the capacity of supervisor. In areas with shortage of professional personnel or under cultural pressures, the TBA, the auxiliary midwife or even a member of the family provides care during childbirth. The supervision of this non-professional personnel is essential to reduce the possibilities of infection and accidents during the maternity cycle, particularly during delivery. As an educator she has an important position in the teaching of mother and child care through family life. She can do so in nursing schools, and in training programmes for nurse-midwives and TBAs. (Reference: *Conference on Nurse-Midwifery Education in Latin America.* Cali, Colombia, 3-12 November 1969.)

Her specific duties are as follows:

(i) *Antenatal Care.* Evaluate the health and socio-economic situation. Take measurements of uterine height. Make vaginal and rectal examinations. Determine the fetal heart

rate. Make gynaecological–obstetric examinations and evaluate findings. Make obstetric diagnosis. Give information, including family planning, to the women. Prescribe some drugs according to established regulations. Make the Papanicolaou test.

(ii) *Delivery.* Supervise the uterine mechanics and progress of labour. In normal cases supervise the high risk mother. Manage normal deliveries. Make and repair episiotomies. Attend twin and breech deliveries in low risk mothers in the absence of a doctor. Examine the uterine cervix. Repair first and second degree tears of the perineum. Prescribe and administer analgesics, certain oxytocic drugs in the third stage of labour and certain anaesthetics according to established regulations.

(iii) *Postpartum.* Evaluate the health of the mother. Make postpartum examinations. Give health education, including lactation. Prescribe and distribute oral contraceptives.

(iv) *Family Planning.* Promote responsible parenthood. Prescribe and distribute oral contraceptives. Insert IUDs. Make the Papanicolaou test.

(v) *Child.* Supervision of growth and development. Prescribe some selected drugs according to established regulations. Carry out immunizations. Detect risk conditions and refer to a doctor. Give health and sex education.

(vi) *Adolescent.* Give advice and orientation about health habits and prepare them for family life. Accomplish preventative physical and mental health measures.

The Professional Nurse

She performs some obstetric functions under a doctor's responsibility and supervision.

As a member of the health team she assumes responsibility for the planning, developing, supervision and evaluation of nursing care in the specific activities concerning the improvement of the care of the woman during pregnancy, delivery and the puerperium and of the child and the adolescent. Such care includes: identification and classification of conditions which would lead to a health risk and referral of the case; collaboration in diagnostic and treatment procedures; examination, evaluation and control of women during pregnancy and the puerperium in normal cases; management of normal delivery and evaluation and supervision of the newborn; examination, evaluation and control of the apparently healthy child and those with minor complications; evaluation and control of women using different contraceptive methods; integration of the father and family in the care of the mother and supervision of child growth and development.

She also provides continuous care to mothers and children, referring when necessary to the different community health services and personnel. (Adapted from PAHO/WHO Expert Committee on Training in MCH in Nursing Schools in Latin America, PAHO/WHO, 1973.)

The Nursing Auxiliary

She performs some obstetric functions supervised by the nurse-midwife, professional nurse or doctor.

The Traditional Birth Attendant

She performs her duties after training and under the control of the MCH care team in collaboration with the health services.

Considering that it is most important to have guidelines for the doctors and auxiliary midwives in MCH care as exist for other levels of personnel, *we recommend* that International Health Bodies promote meetings for the appropriate personnel to elaborate the duties attached to the role of a doctor and an auxiliary midwife in MCH care and family planning in the Latin American situation.

Considering that MCH care in Central America and Panama requires a health team of many professions with knowledge and enough competence to participate effectively and widely in MCH and family planning programmes, *we recommend* all educational institutions in charge of the training of personnel working in health teams to emphasize in their educational programmes the problems of MCH care, and *we recommend* the Ministries of Health and other institutions providing services for MCH care and family planning to keep updating their programmes for professional, technical and administrative personnel.

3. ***Legislation for the midwife at different levels***

(a) *Guidelines for discussion*

The work of the groups had established the need to recognize different levels of midwives, taking into account the role that corresponded to each level and the training required. Basic criteria were therefore necessary to legislate and authorize the practice of the midwife. The following criteria should be discussed so as to determine how they could be applied to Central America and Panama, bearing in mind that the main purpose of legislation is to give better protection not only to the community but also to the professional.

(i) *Identification*: Requirements for registration of professional midwives, of foreign midwives and of TBAs.

(ii) *Licensing and Control*: Definition of the expansion of the practice of both professional midwife and TBA; supervision.

(iii) *Improvement through Training*: For professional midwives – previous training to registration, regular refresher courses, special courses for their expanding role or the execution of new procedures. For TBAs – basic training and special courses.

(b) *Conclusions and recommendations*

(i) Considering that updated legislation covering the different categories of obstetric personnel does not exist in every country, *we recommend* that professional organizations of nurses, midwives and doctors should together establish regulations to control the practice of obstetrics by different levels of personnel until legislation is issued.

(ii) Considering that it is necessary to know the extent of the existing human resources in obstetrics and to control their practice, *we recommend* that professional organizations should keep a record of the professional obstetric team and that the requirement for registration should be production of their midwife or nurse-midwife diploma. Foreign nurse-midwives who wished to be registered should produce their nurse-midwife's diploma issued by the school or recognized course in order to be legally integrated according to every country's legislation.

(iii) Considering that in the present situation we need to integrate the TBA in the health team to meet the great needs of MCH care in Central America and Panama, and that it is necessary to identify, recruit, train and control her, *we recommend* that Ministries of Health should identify every TBA, establish training and supervision programmes according to the regulations, and keep an up-to-date record of those who have been trained and those without any training as soon as they have been identified.

(iv) Considering that the midwife and nurse-midwife provide services for mother and child under their own responsibility in accordance with the laws and with the doctors' collaboration, *we recommend* that professional organizations elaborate, revise and update the regulations concerning the midwife's practice, taking into consideration the expanding role of the midwife and nurse-midwife in the country's mother and child programmes.

(v) Considering that it is necessary to protect both the public and midwife's practice through control of her work, *we recommend* that the legally established professional organizations, together with the authorities in charge of mother and child programmes, should name a Committee which would supervise and improve the practice of midwifery.

(vi) Considering that, in order to assure the quality of mother

and child services provided by the different categories of personnel, it is necessary to improve and update them continually, especially that of the nurse-midwife, *we recommend* that all health institutions and professional organizations should protect and maintain updating in-service programmes for all categories of personnel, and continuous educational programmes for nurse-midwives in their own country or abroad by means of Working Parties, refresher courses, grants, etc.

(vii) Considering that a nurse specialized in midwifery, because of her role as nurse and as midwife, is a most useful resource in the team of the mother and child programme, *we recommend* that the authorities and local professional organizations in Central America and Panama should require of midwife candidates the possession of a nursing diploma.

4. ***Short and long-term plan of action to put into practice the recommendations of the Working Party***

(a) *Guidelines for discussion*

Short, intermediate and long-term plans of action should be formulated in accordance with the resources of Central America and Panama and with the present situation in each country in order to put into practice the recommendations of the Working Party.

(b) *Conclusions and Recommendations*

ACTION OUTLINES

Short term (2 years)	***Intermediate term*** (5 years)	***Long term*** (10 or more years)
USE OF PERSONNEL		
1. To use immediately the highly qualified personnel, working at the moment in different functions from those they have been trained for and resulting in an inadequate use of them.	1. Every Health Institution aiming at the Mother and Child Care should have a minimum of one Nurse/ Midwife responsible for the administration of Nurse/Midwifery Services.	1. Get as soon as possible a reasonable ratio between all categories of existing personnel and demands in rural areas as well as in urban ares.

2. To rationally distribute the existing personnel in order to decentralize and get better use of it and also to cover adequately the MCH Care.
3. To establish among the requirements to enter any of the Schools for Health personnel, an obligatory 'social service' which would help to cover all Mothers and Children in need of care.
4. To help reducing the emigration of Nurse-midwives by improving their conditions of work and also their salaries.

EDUCATIONAL

1. Immediate training of personnel working at present in all Mother and Child Services as a means to achieve better quality and to reach more people.
2. To give a new structure to all training programmes for health personnel at all levels, emphasizing the Mother and Child Care and Family Planning.

1. To revise and update periodically the programmes of Mother and Child education for every category of personnel according to the problems, health situation and needs and aims of each country.

3. To take advantage of the systems of Grants for training of Nurse-midwives in and out of the country (where there is no School for Nurse-midwives) according to the actual plans of Grants and selecting carefully the candidates.

2. To take advantage of the systems of Grants for training of Nurse-midwives in and out of the country (where there is no school for Nurse-Midwives) according to the actual plans of Grants and selecting carefully the candidates.

1. Training of the Nurse-midwife in her own country under the direction and responsibility of qualified Nurse-midwives in connection with the Universities and Health Agencies in any way concerned with Mother and Child Health problems.

This could be reached by establishing a Regional Training Centre for Nurse-midwives for the Central American and Panamian area, or if there is already one to strengthen it.

This could be reached by establishing a Regional Training Centre for Nurse-midwives for the Central American and Panamian area, or if there is already one to strengthen it.

4. To establish complementary educational programmes and the necessary facilities to give the Central American Midwives opportunities to reach the standard of Nurse-midwife and to be legally recognized as such.

MATERIAL AND EQUIPMENT

1. To provide immediately with the adequate material and equipment, increasing it by 30% to maintain it in good use in all services, to help the Health Team to better accomplish their duties in MCH Care and Family Planning.

1. To continue providing with the adequate material and equipment increasing it by 50% to maintain its proper use in every service and to help the Health Team to better accomplish their duties in MCH Care and Family Planning.

1. To continue providing with the adequate material and equipment in every service, increasing it by 100% to maintain it properly in every service; to help the Health Team to better accomplish their duties in Mother and Child Care and Family Planning.

LAWS AND REGULATIONS

1. To formulate, promulgate and adjudge the laws establishing a system of levels and hierarchies of professional personnel involved in the MCH Care Team, according to their qualifications and years of service.

2. To seek prompt the adequate means to better co-ordination between all the Health Agencies in order to ensure a relative increase in the resources and a better use of them in the MCH.

1. To revise and update periodically the system of levels of professional personnel working in the MCH Care.

1. To revise and update periodically the system of levels of professional personnel working in the MCH Care.

CARE AND FAMILY PLANNING SERVICES

1. To establish common Standards of MCH Care Services and Family Planning and to implement them at National level throughout all Health Agencies.

1. To keep updated standards of MCH Care Services according to necessities.

1. To keep updated standards of MCH Care Services according to necessities.

V. Analysis of Evaluation Questionnaires

All participants completed the questionnaire. General concl.

1. The objectives of the Working Party had been achieved.
2. Topics were interesting and useful for every country.
3. Some said that the Working Party had given them the necessary background to introduce family planning into midwifery training courses. Others thought that they needed more information and experience.
4. There was need for more full courses on family planning for nurse-midwives at local level.

VI. Follow-up Visits

First follow-up, January 1974.

General

1. Except in Honduras, no delegates to the Working Party had succeeded in motivating the authorities to study the conclusions and recommendations.
2. Each country was tackling as best it could the problems of MCH care and was looking to the midwife to take a leading role in this.
3. Some of the delegates were not ideally placed to promote the implementation of the recommendations, but as a result of the follow-up were becoming more related to the authorities.
4. Most of those interviewed praised the ICM for the work done and offered their co-operation.

Costa Rica

Costa Rica was the only country to have a postgraduate midwifery course and to use the nurse-midwife widely. Students from overseas were being accepted in limited numbers. With international help they were creating a course to train nurses and midwives in family planning. Nurse-midwife tutors were being trained in the USA, and it was hoped to offer the course to train professionals in other countries. Family planning was an integral part of the basic training courses.

El Salvador

Interest was shown in the recommendations on midwifery training because a new 3-year programme on Mother and Child Hygiene had been initiated at the university. It was felt that this course did not meet the needs of the country. The School of Nursing had revised its MCH course, and it could be developed to train nurse-midwives, in which case the university's course would be unnecessary.

Guatemala

It was agreed that the Midwifery Association, together with the Mother

and Child Division would strive to strengthen the Association and that nurse-midwives trained in other countries should be admitted. They would try to organize a midwifery postgraduate course for nurses and try to give existing midwives access to work in the maternity services. They would discuss with the School of Nurses a plan to allow midwives access to that School following studies at the Midwifery Schools, but the Director of the School of Nurses was uncertain about accepting this. Both nurses and midwives needed to fight together to face the serious problems in MCH. Relations between the professions had been tense but the leaders wished to change this.

Honduras

This country had taken most account of the recommendations and hoped to continue using them as a guide to improve MCH care. They were trying to get places on the postgraduate midwifery course in Costa Rica until they could create their own course. The School of Nursing had revised its mother and child programme. They were hoping to expand the role of the auxiliary midwife in MCH. Training and control of TBAs was to be intensified. They asked for help in persuading the USAID representatives to support the recommendations.

Nicaragua

There had been little discussion of the recommendations, but opportunity was taken to discuss them with heads of the nursing organizations who expressed great interest. The School of Nursing had revised its MCH course with a view to expanding the nurse's role. The Ministry of Health were to send 3 nurses to Costa Rica for the postgraduate midwifery course as they were trying to create a midwifery course for nurses. Training of TBAs had been initiated and there was a project for a national survey of TBAs. The Obstetrical and Gynaecological Association did not agree with the recommendations, but the Ministry of Health was very sympathetic, so that there was a possibility of implementing some of them.

Panama

The midwifery school was expected to open during 1974. The university had a course of Education and Investigation in MCH for nurses which was being attended by students from all over Latin America. The Ministry of Health would resume training and control of TBAs. The Children's Hospital was giving a course for nurses to train them as paediatric technical assistants.

The MCH programme of the School of Nursing was revised frequently and covered all steps in the maternity and child cycle, particularly those of national concern. Measures being taken to improve MCH were in accord with the recommendations. Contacts would be initiated with doctors and with the nursing authorities to start activities designed to implement the recommendations.

Second follow-up. November 1975

Costa Rica

(a) *Midwifery education*

All midwives were nurses with one additional year of training. There were approximately 400 in the country but not all were in practice. The basic curriculum was 3 years, the second year being largely MCH/FP. All students were taught the theory and practice of family planning in clinics; the practical tuition involved education and services. In their third year students had rural experience. There were 5 MCH instructors in a school with 150 graduates annually.

By law students should serve for one year in rural areas but this was seldom done because of the poor living conditions.

The midwifery course had 3 instructors and could accommodate up to 24 students, but there were only 18 at the time of the visit. Students from other Central American countries were accepted; the curriculum was very comprehensive and included family planning.

There were 3 one-year courses for auxiliary nurses and it was planned to start a 2-year nursing course within the next year to train 400 additional nurses over a period of several years.

(b) *Organizations*

All nurses and nurse-midwives belonged to the College of Nurses which is both a State body and a professional organization. Midwives had recently formed a Maternal and Child Health Committee to oversee this area of practice, partly as a result of the recommendations of the Working Party and partly to counter the threat of the Medical College taking over responsibility for some midwifery functions. A special midwifery section had been formed based on this Committee, and was seeking approval for membership of ICM.

(c) *Recognition*

Midwives were well accepted by medical colleagues in both government and private posts.

(d) *Health Services*

These had been provided partly by government and partly by the private Social Security system. All hospitals were being turned over to Social Security leaving government to concentrate on preventive health. Social Security was just beginning to experiment with some rural work.

(e) *Family planning*

Both health service groups offered services and educational programmes were run by church and other private bodies. The Demographic Association of Costa Rica was also active in con-

trolling funds, keeping statistics, providing supplies and organizing mass communication.

(f) *Women's Health Care Technician Programme*

This was a 3-month course run by the Social Security Education Division under the auspices of the College of Medicine and with the assistance of Harbor General Hospital, Los Angeles, where most of the instructors had been trained. The training was all clinical, and included family planning, prenatal care, child growth and development, normal gynaecology and cytological screening. Entrants had to be nurses or nurse-midwives, but auxiliary nurses might be accepted later. While it was agreed that the course was excellent, it caused some problems:

(i) The title 'Technician' was inappropriate as it implied a lower grade.

(ii) Midwives already practised family planning on their own, while the College of Medicine insisted that they practised under medical supervision.

(iii) Midwives found the course repeated much of their own training, while nurses found it inadequate.

(iv) Midwives on the course are supervised by nurses in areas where the midwives feel they have more knowledge than their teachers.

(v) Neither the midwifery training course nor the College of Nursing are in any way linked with the programme.

(vi) The stated aims of the course are preparation for work in rural areas, but it is totally geared to an urban clinical setting.

(vii) If auxiliary nurses were to be trained, should they be allowed to insert IUDs? Midwives thought this should be left to a doctor, and auxiliary nurses would not be competent to work in rural areas on their own.

(viii) The training of auxiliary nurses by the College of Medicine by-passed the College of Nursing which by law was responsible for auxiliary nurse training programmes.

(ix) The course was started without consultation with the nurse-midwife in charge of MCH at the Ministry of Health.

Personal impressions of the course were (i) it provided excellent training in clinical family planning and could be used as a model for other Latin American countries. (ii) It provided no family planning education, KAP techniques, community development or psychosexual counselling techniques. (iii) It presented legal problems which needed to be resolved for the protection of graduates. (iv) Most of the problems could be resolved by forming a working relationship between the College of Medicine and the College of Nursing. There was an open state of war

between them, possibly due largely to clashes of personality between the programme director and the Director of the School of Nursing. (v) The programme had been conceived without much knowledge of political realities in nursing and midwifery in the country and had damaged the midwifery profession by taking out of its hands continued education in family planning. It ignored existing organizations and was creating a new profession. (vi) Before auxiliary nurses were trained all relevant bodies should agree on a delegation of functions for all classes of health personnel from doctors to TBAs.

Recommended

1. That ICM should continue to work with the MCH Committee with a view to its being admitted to membership of ICM.
2. Other countries should look at the Costa Rica midwifery curriculum as it provided an excellent model.

El Salvador

(a) *Nursing training*

Two schools ran a 3-year training course with a fourth year of rural practice before the students graduated. There was strong emphasis on MCH, and sex education and family planning theory and practice were also included. There were plans for two 5-month MCH courses to start in 1976, one for nurses and one for auxiliary nurses. There would also be a 2-month FP/MCH course for nurses, similar to the one in Costa Rica. Auxiliary nurses were trained by a 10-month course given at four centres, each with 30-40 students.

(b) *Family planning*

The role of nurses and midwives was very limited and services which existed were almost always given by physicians. However, there were hopes that this would change shortly. General attitudes to family planning were not enthusiastic and the university, especially the medical school, was totally opposed.

(c) *Midwives*

Midwives were few in number and their role was ill-defined.

(d) *TBAs*

Training was carried out at local level but the Ministry of Health had plans for a new national training course with revised curriculum which would be paid for out of UN funds. About 70% of births were attended by TBAs.

(e) *Legislation*

There was none, but the Nursing Association was trying to prepare a draft. The ICM ought to maintain contact here and urge the formation of a committee to prepare midwifery legislation.

The greatest needs were for definition of the role of the midwife and the writing of nursing legislation.

Guatemala

(a) *Midwifery*

The 100 (approx.) single trained midwives had graduated from a school that was now closed; not all were practising. They formed the membership of the Midwives Association which did not admit nurse-midwives because of opposition from older members, but it was realized that this must change and at least they should admit nurse-midwives trained abroad. They also realized that a new midwifery programme was needed and that this must be postbasic to nursing training. Nurse-midwives occupied the leading positions in MCH/FP, so that the single trained midwife worked outside the major health services. The need for these groups to work together was stressed.

(b) *MCH/FP*

The government, the social security organization and APROFAM were involved, and there were 32 nurse specialists in MCH in the country, some of whom had been trained by two 3-month courses run by the Ministry of Health. These specialists were now helping to train student nurses. All government work was in rural areas. The Ministry of Health also ran a yearly MCH seminar. All the Social Security work was in the capital at one large maternity hospital and several clinics. APROFAM had 8 clinics in the city. In general the family planning programme was not very strong and nurses and midwives played little part in it, although some nurses and auxiliary nurses were being trained in the USA to work in Guatemala.

(c) *Nursing education*

There were two nursing schools with a 3-year course and a total of 210 students, and 3 schools for auxiliary nurses with a 14-month course each with 50-60 students. There was talk of shortening the auxiliary nurses' course and starting a course for auxiliary midwives. Auxiliary nurses carried out most deliveries in rural areas. Training was also given to health education promotors, who worked in rural areas, to health technicians and primary health providers, also for rural areas, who had an intensive course on simplified medicine sponsored by USAID.

The School of Nursing was very hospital orientated and standards were very high, but some felt that it was not preparing students to meet health needs outside the hospital setting. The course included a limited amount of family planning. It was hoped to start a 6-month training course in 1976 to prepare nursing

educators, with emphasis on community health. INCAP provided facilities for training in nutrition and MCH.

(d) *TBAs*
There were about 5000 in the country. There was an intensive training programme and 80% of those trained had been on annual retraining courses. They were trained in family planning but their only role was in education and referral.

(e) *Associations*
The Midwifery Association and individual nurse-midwives would try to form one organization. The integration of midwives more fully into MCH services and the expansion of the midwife's and nurse-midwife's role to include family planning were to be aimed at.

Recommended
ICM should use the services of INCAP.
ICM should maintain contact with member organizations in Guatemala and urge them to work with nurse-midwives.
Midwives should be integrated into the health system by using them as instructors in the auxiliary midwifery programme. This was suggested to the Ministry of Health and to the midwives.
In future visits members of the Midwifery Association should accompany ICM representatives to all meetings to bridge the gap between midwives and health officials.

Honduras
(a) *Training*
There was no midwifery training, but all seemed to favour the starting of a course. Lack of funds and lack of instructors were problems. It was suggested that students might be sent to Panama for training.
Nursing training schools were short of students because the profession was held in low public esteem. The course was of 3 years, plus one year's social service. After a further 1-2 years' study nurses could receive a degree. One semester was devoted to MCH, including limited family planning theory but no practice. It was admitted that MCH training was weak but there were plans to revise the curriculum to remedy this. Nurses were being more involved in prenatal care and in deliveries and child care. Special short courses were being held to train them in these extra duties.
There were four 1-year courses for auxiliary nurses. TBAs were trained by a 12-day, 8-hour-a-day, programme supported by UNICEF. After training, TBAs were supervised by nurses or auxiliary nurses. They had to report all births at their local health centre. Health promoters had a 1-year course in health education.

(b) *Family planning*
Family planning had been integrated into MCH programmes. There were now 36 health centres with family planning facilities, with nurses acting as educators. It was planned to make nurses responsible for giving all services. Some were being trained in the USA and when they returned it was hoped to start a family planning training programme.

(c) *Legislation*
There was said to be both nursing and midwifery legislation, but no details were available.

(d) *Organizations*
There was a Nurses Association. The President was interested in forming a midwifery section within it.

Impressions
The atmosphere was favourable towards midwives, but local resources for starting a training programme were very short, both as regards finance and professional help. Future plans involved the training of large numbers of para-professionals but there seemed to be no provision for supervision and/or training of instructors, so that training may be poor and follow-up supervision inadequate, leading to further problems.

Nicaragua

(a) *Training*
There was no midwifery training, and midwives practising in the country had been trained abroad. At talks with the Minister of Health, Director of the School of Nursing, and Chief Nurse, Ministry of Health, it was agreed that a basic midwifery course was a good idea and it seemed possible that this might be taken up.
There were 4 schools of nursing, one government and 3 run by religious groups, which had about 170 students on a 3-year course. Maternity and family planning were included in the course.

(b) *MCH/FP*
There were 125 government health centres; nurses gave obstetric care in 50 of them while others were covered by auxiliary nurses. Most offered family planning services. No family planning services were being offered at the largest maternity hospital due to lack of space while reconstruction was in progress. The Demographic Association had 6 family planning clinics in Managua and had trained 30 TBAs in family planning education. They and other helpers also dispensed supplies.

There were plans to start a 3-month family planning course similar to the one in Costa Rica. 16 nurse-midwives would go to Los Angeles for training and then return to act as instructors.

The School of Nursing and the Ministry of Health were participating.

(c) *Organizations*
There was a Nurses Association, and it was suggested that a midwifery committee be started which might form the starting point for a post-basic midwifery training programme in the School of Nursing. This was thought an excellent idea.

Personal Observations
Several new programmes were about to be started and there was a favourable opinion towards midwifery.
ICM should maintain contact and respond if possible to requests for help.
ICM might start a newsletter for Latin American countries who are beginning to form Midwifery Associations.

Panama
(a) *Training*
There were 2 nursing schools in the country, one at the University of Panama with a 3-year course, and one at Los Santos, a rural area, with a 2-year course. Graduation followed after a 2-year internship after the training course. A 2-semester midwifery course was available to graduates at the University of Panama. There were about 600 students at the University school and 100 at Los Santos.
Since 1971 the University of Panama had had a PAHO sponsored MCH programme aimed at preparing instructors in MCH for all Central America. In 1974 a midwifery programme had been offered and a second was then in progress. There were places for 26 students, including 6 from other countries, but there were no foreign students on the present course because of lack of scholarships. It was hoped that a paediatric nurse practitioner course could be started in 1976 and that a master's degree programme could be added later.
The midwifery course included family planning theory and practice, up to insertion of IUDs, and child growth and development. Classes were given by the nurse-midwife director and by doctors. The nurse-midwife instructors were lent to the course by the Ministry of Health and by the Social Security. There were several 6-month courses for auxiliary nurses who carried out normal deliveries in rural areas.

(b) *Practice*
The government services used midwives for all obstetrical services in both urban and rural areas. The Social Security organization had a maternity hospital but did not use midwives to attend births, but only for pre- and postnatal care and family planning.

As more and more doctors were trained, the role of midwives would be less in labour and delivery and more in other obstetric and family planning services. There seemed to be little contact between obstetricians and midwives.

(c) *MCH/FP*

Both Ministry of Health and Social Security had responsibility for health services. In some rural areas both bodies worked together and maintained a single health centre. Family planning services were offered at all centres and both doctors and nurses were trained by means of an intensive 1-week course. TBAs were trained by nurses or nurse-midwives at local level but there was no co-ordinated programme. Sex education was given in secondary schools. Normally doctors made initial family planning contacts, and control was carried out by nurses or nurse-midwives in towns and by auxiliaries in rural areas.

Between 1973 and 1975 12 nurses, 4 nurse-midwives and 2 auxiliary nurses had received family planning training abroad.

The Ministry of Health, with the School of Nursing and Harbor General Hospital, Los Angeles, was devising a new women's health course including extensive family planning clinical work for nurses, nurse-midwives and auxiliary nurses. The details had not yet been worked out.

A private family planning association worked mainly in education and research.

(d) *Organizations*

There was an active nursing organization which was totally professional and had no statutory powers. The President was interested in forming a midwifery branch within the organization, and possibly joining ICM. Information and an explanation of how this was being done in Costa Rica would be sent.

(e) *Legislation*

At present there was no midwifery legislation. A study of nursing and midwifery legislation was being made so as to draft suitable legislation for the future.

VII. Outcome, Proposals for Future Activities and Achievements

(a) ***Outcome***

1. The recommendations were to be presented to the respective governments for implementation where applicable. 50% of the delegates reported that the recommendations were presented and discussed.
2. Proposals for post-Working Party activities to promote the implementation of the appropriate recommendations.

(b) ***Proposals for Future Activities***

1. To start a 3-month family planning training course after instructors return from the USA.
2. To establish a midwifery section within the Nursing Associations.
3. To request the re-opening of the midwifery school in Panama.
4. Training and supervision of TBAs.
5. Further follow-up visits.

(c) ***Achievements***

1. Midwives formed MCH Committee.
2. Midwifery section established in Nursing Association in Costa Rica.
3. Permanent Committee of Nursing personnel to study Working Party objectives in Costa Rica.

APPENDIX I

List of Participants

Costa Rica

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Panama
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Sra. Hilda de Eastmond,
Enfermera Obstetrica,
University of Panama.

APPENDIX II

List of Papers Presented

1. Aims of Maternal and Child Health and Population established by the American Ministers for the next ten years and its implications for Central American Countries.

   Dr. Manuel Villa Crespo,
   WHO / PAHO Representative,
   Costa Rica.

2. Mother and Child Services Organization.

   Dr. Gloria M. de Lopez
   Obstetrician,
   St. Thomas's Hospital,
   Panama.

3. Basic Needs of Mother and Child.	Dr. Napoleon Diaz, Sub-Director, No. 4 Regional Health Centre, Guatemala.
4. Family Planning in the Continuous Education of the Midwife.	Miss M. Zapenas, WHO/PAHO Consultant. Mrs. Hilda de Eastmond, Instructor in Mother and Child Nursing, Panama. Mrs. Ana Maria de Alfaro, El Salvador. Miss Beverly Taylor, Honduras.
5. Midwifery Training and Practice	Instructors in the Mother and Child Postgraduate Training Programme, School of Nursing, Costa Rica.
6. Educational Technology applied to Mother and Child Health and Family Planning.	Members of the Costa Rican Educational Technology Center.

FRANCOPHONE CENTRAL AFRICAN WORKING PARTY, YAOUNDE, CAMEROON, 28th SEPTEMBER – 6th OCTOBER, 1973

Participating countries: Cameroon, Central African Republic, Chad, Republic of Congo, Gabon, Malagasy Republic and Zaire.

I. Preliminary visits

1. Mr. Roger Fenney, Field Director, made two visits to the region to explain the purpose of the Working Party and to solicit official support and attendance. No detailed record of these visits is now available.

2. Of the countries invited, Equatorial Guinea, Rwanda and Burundi chose not to send representatives.

II. The Working Party

1. ***Attendance.*** Those attending comprised:
   (a) 34 representatives from Cameroon (16); Congo Republic (3); Gabon (2); Chad (3); Central African Republic (3); Malagasy Republic (3); Zaire (4).
   (b) 2 ICM staff members.
   (c) 7 advisers and consultants from IPPF (1); WHO (6).
   (d) 4 observers from other interested agencies.

2. ***Organization***
   Shortly before the Working Party began, Mrs. P. Whest-Allegre was appointed as Family Planning Consultant. Unfortunately she was taken ill and had to resign from this position. Her successor, Mme. Kone, was not able to attend the Working Party until the third day.

3. ***Summary of Proceedings.***
   Two papers were presented:
   (a) Prof. Agr. H. Nkoulou spoke on the *Training and Practice of the African Midwife from the Paediatrician's Point of View.* He discussed (i) health statistics in the less developed countries, (ii) priorities in health, social and educational protection of the mother and child, and (iii) the implications of these factors in the training and the role of the midwife in less developed countries. Maternal, perinatal and infant mortality rates were all much higher than in developed countries. Perinatal and infant mortality were 50% higher in premature babies and those with low birth weight than in babies born at term and of normal weight.

Priorities lay in reducing the mortality figures, reducing the number of babies prematurely born and those with low birth weight, and preventing pathological conditions arising during pregnancy and labour. Midwives had a vital part to play, and it was important to train all types of paramedical/personnel, including TBAs, to work in a preventative rather than a curative role. Education in nutrition, general health, sex and family planning were vital. Training in prenatal and intranatal care should be designed to prevent maternal and infant mortality. Training in elementary child care should concentrate on general hygiene, nutrition, and prevention of infection, including vaccination. In all types of training, recognition of abnormal conditions calling for referral to doctors or hospital needed to be stressed. All this required the ready co-operation of specialists and technicians of all kinds, but was essential if the future manpower of Africa was to be safeguarded.

(b) Dr. P. C. Mafiamba spoke on *Elementary Mother and Child Care*. He reiterated the points made by Prof. Nkoulou and emphasized the importance of health and hygiene in the home, nutrition, family planning, and general improvements in social life and education.

There were six main topics for discussion during the Working Party, and these were discussed in small groups and in general sessions by the participants.

1. A comparison of the present Maternal and Child Health programme in each of the countries represented.
2. The functions and responsibilities of midwives of all categories.
3. The training of midwives and ways of revising the training syllabus.
4. Family planning/family spacing and how this could be integrated into the role of the midwife.
5. Legislation.
6. The role of traditional birth attendants.

The following condensed report of the group discussions deals with the role of midwives of all categories in MCH/FP services:

(a) *The Professional Midwife*

She is a senior staff member in the Public Health services and is directly responsible to the Chief Medical Officer of the Health Centre in all technical matters. She is responsible for the general hygiene of the premises and the proper care and use of the equipment with which she is supplied. It was agreed that her duties were as follows:

1. *Prenatal Care*

(a) Confirmation of pregnancy by interrogation and clinical and laboratory examination

(b) Recognition and referral to a doctor of abnormal or potentially abnormal conditions.
(c) Complete examination of the patient to exclude pelvic, cardiopulmonary and oral problems.
(d) At regular intervals to measure blood pressure, examine urine, check weight, test blood for anaemia and prescribe iron for its control, encourage quinine therapy.

2. *Intranatal Care*
(a) Recognize the onset of labour and reassure the patient.
(b) Supervise and conduct labour under aseptic conditions.
(c) Administer oxytocic and antispasmodic drugs as necessary.
(d) Recognize and refer to a doctor abnormal or potentially abnormal conditions.
(e) Perform an episiotomy and repair uncomplicated tears of the perineum.
(f) Apply and use the vacuum extractor if necessary.
(g) Care for patient following a caesarean operation.
(h) Treat haemorrhage if it occurs and give a blood transfusion if necessary.
(i) Conduct breech and multiple delivery.
(j) Prescribe antibiotics if infection occurs.

3. *Postnatal Care* – i. *To the child*
(a) Establish respiration and intubate if necessary.
(b) Apply appropriate medication to the eyes.
(c) Examine child to exclude obvious abnormalities.
(d) Maintain body heat by covering child.
(e) Apply bicarbonate to the umbilicus.
(f) Make periodic clinical examinations of the child.
(g) Vaccinate at the appropriate time.
(h) Ensure that the Emmel test is done.
(i) Advise mother about childhood diseases including malnutrition.
(j) Supervise height and weight and keep a development chart.
(k) Administer antimalarial quinine therapy.
(l) Organize social assistance and social aid home visits.

Postnatal Care – ii. *To the mother*
(a) Supervise involution of the uterus.
(b) Give local care, observing lochia and condition of perineum.
(c) Take and record blood pressure.
(d) Ensure that the urinary bladder is being voided.
(e) Look out for uterine complications.
(f) Teach the primipara to breast feed her baby.

(g) Recognize and treat postpartum infections and refer these to a doctor.
(h) Teach the mother how to prevent another pregnancy occurring too soon in order to ensure the health of her baby and the continuation of breast feeding. It is advisable to give such advice in the presence of both parents so that each knows the reason for planning future pregnancies.
(i) Under no circumstances to prescribe contraceptives unless the patient has had a medical examination.

4. *Health Education*
(a) Motivation of the mother to attend MCH clinics.
(b) Organization of programmes on nutrition with particular reference to lactation, artificial infant feeding and hygiene of relevant equipment, baby foods and weaning, maternal nutrition.
(c) Encouragement of mothers with social or psychological problems to keep their babies.
(d) Teaching of maternal and child hygiene, hygiene in the in the home and hygienic preparation and handling of food.
(e) Teaching of the principles of family planning excluding abortion.

5. *Family Planning*
It was accepted that some countries had organized family planning programmes for socio-economic reasons, others included it as an integral part of the health service, while others had only private family planning organizations. While it was recognized that each country and each family must make its own policy or decision, there was general agreement that:
(a) family planning should be in the context of maternal and child health.
(b) all midwifery personnel should be informed about family planning as a means of protecting the health of mothers and babies.
(c) wherever family planning services are permitted, all levels of midwifery personnel should be serving as motivators.
(d) family planning clinical skills should be included in the training of all professional midwives.
(e) for midwives already in practice short courses in family planning should be organized.
Participants reported that where professional midwives had attended a one month special family planning training course (three weeks of theory and one week of practice), they made

a contribution to the family planning service which was very much appreciated and they had a good deal of confidence from parents.

6. *Administrative Responsibilities*
The professional midwife directs and supervises the medico-social and auxiliary personnel at maternal and child health clinics and in maternity departments. Her duties include:
(a) Organization of her department and the planning of activities.
(b) Direction and control of the maternity services and maternal and child health clinics by: (i) seeing that stocks of pharmaceutical preparations and equipment are available, (ii) making an inventory of the contents of the premises and of the equipment, (iii) supervising records and documents, (iv) notifying births and deaths, (v) controlling the disposal of materials, (vi) regularly inspecting the premises, (vii) holding periodic staff meetings, (viii) co-operating with other services, (ix) collaborating in research on maternal and child health.

7. *Desirable Qualities in a Professional Midwife*
(a) A sense of responsibility.
(b) An ability to work as a member of a team.
(c) An ability to co-ordinate.
(d) A high capacity for active work.
(e) An ability to organize, delegate and motivate.
(f) An ability to collaborate with superiors.
(g) An ability to educate and advise.
(h) An awareness of the problems in the community.
These qualities would be maintained and improved by a periodic review of her technical skills and by refresher courses organized by the Public Health Services.

(b) *The Auxiliary Midwife*
The auxiliary midwife is trained at a nursing or midwifery training school, but for a shorter period. She must have a good knowledge of the local language.
1. *Team role*
The auxiliary midwife may work in maternity departments or in maternal and child health clinics under the control and supervision of a professional midwife whom she may assist or on whose behalf she may act. In health or social centres she is responsible for maternal and child health care activities and is administratively under the instructions of the person in charge of the centre.

2. *Functions*

The functions of an auxiliary midwife are very similar to those of a professional midwife, but she must realize her limitations and refer cases outside her ability to her immediate superior or to the nearest medical centre. She must be technically very well trained and be given a long training in a large maternity unit under the supervision of a professional midwife or doctor.

In maternal and child health centres she must organize: prenatal consultations for expectant mothers; infant consultations; instruction on nutrition; postnatal consultations; home visits if necessary; health education.

Her skills should be maintained by medical review and periodic refresher courses.

3. *Desirable Qualities in an Auxiliary Midwife*

(a) A high awareness of her professional duties.
(b) Kindness and friendliness.
(c) An ability to collaborate with others.
(d) Respect for rules and regulations.
(e) Willingness and ability to help trainees.
(f) Good moral character.

(c) *The Traditional Birth Attendant*

In some African countries TBAs are integrated into the work of maternity units and work on instruction from, and under the supervision of, professional and auxiliary midwives. They attend normal deliveries, dress the umbilical cord, and look after the hygiene of the premises and the cleanliness of the equipment.

It was agreed that the professional midwife in Africa cannot alone cope with the amount of work expected of her, and she should be assisted in her duties by:

(i) *Social Assistants and Social Aids* in education in sex, nutrition and hygiene and in pre-marital, and pre- and postnatal education.

(ii) *Auxiliary Midwives* in prenatal consultations, non-complicated deliveries, early diagnosis of pregnancy, recognition of complications, advising pregnant women to attend a medical centre at least once or twice, giving hygienic care.

There was some divergence of opinion on the role of the TBA. Some thought that they should be identified and consideration given to providing training for them in order to reduce or prevent any possible damage their present practice might be doing to the patient. Others thought that they should practise only in remote regions where no health centres existed. They recommended that the health services should be augmented so that in time the TBAs would be abolished.

III. Recommendations

The Working Party participants in Yaounde:

1. Request the establishment of professional and auxiliary midwives' training schools in each of the countries represented.
2. Request that each country identifies its public health needs and determines the midwives' tasks in relation to these needs.
3. Suggest that a comprehensive professional midwifery training is indispensable because of the miscellaneous functions that will be assigned to midwives, and insist particularly that the following subjects be included: public health, nutrition, health education and family planning.
4. Request that a good practical training be provided by efficient senior staff and that reports be issued on individuals at the end of each training course.
5. Suggest the organization of educational exchanges between teachers and students from different African countries.
6. Suggest a training programme be established within schools and that each country has the opportunity to refer to the training syllabus agreed at the Yaounde Working Party.
7. Suggest that the traditional birth attendant will gradually disappear due to the training of a sufficient number of professional and auxiliary midwives. However, in the countries where this category of midwife exists, it is necessary to identify and register them and provide them with an elementary training, enabling them to forecast and conduct a normal delivery. The seminar recommends that they be supervised and given refresher courses and that each village provides premises from which they are able to practise.
8. Request the establishment of national legislation for the protection of mother and child primarily, but also to regulate and protect the practice of the professional and auxiliary midwives and the traditional birth attendants.
9. Suggest that the promotion prospects of the professional and auxiliary midwives be revised for the level of each country.
10. Suggest that a professional internal seminar be arranged.

IV. Follow-up Action Plan

1. The seminar's recommendations must be communicated to the participants and to their Ministries of Health in order that they may be forwarded to the relevant departments.

V. Evaluation

The following comments relating to the organization of the Working Party were included in the recommendations for consideration when

future meetings in the region were being planned:

1. That the African seminars take place every three years.
2. That a bi- or trilingual seminar involving all the African countries be arranged.
3. That the interested countries be simultaneously informed at least six months in advance through the Foreign Affairs and Public Health Ministries.
4. That the travelling vouchers be sent to the participants at least one month before the commencement of the Working Party.
5. That the per diem allowance to the participants be at a sufficient rate to take into account the cost of living in the host country and, when necessary, that the participating countries should augment this allowance to cover full costs.
6. That there be collaboration between the host country and the international organizations present in the country in order to ensure a better organization of the seminar.
7. That the programme of the meeting should include a visit to health centres, maternity hospitals, MCH centres, etc., and a visit of cultural interest.
8. That the administrative formalities be made easier for the participants.
9. That the participating countries appoint their delegates early enough to allow for a better preparation of seminar material.

VI. Follow-up Visits including Evaluation of Results, Proposals for Future Activities and Achievements

Follow-up visits were made in March/April 1975 to the countries concerned except the Malagasy Republic.

1. ***Cameroon***

(a) Government approval had not yet been given for family planning, but a pilot study was being carried out in one MCH clinic where more than 100 women had accepted the free family planning services offered, and it was hoped that this would encourage the government to review its position. Some doctors recognized the need and were prepared to support midwives in maternity clinics who wished to offer family planning.

(b) A Midwives Association had been formed but was not yet officially recognized by the government. Once recognition had been received, the Association would be the link in the provision of MCH/FP services and would offer family planning training.

(c) A 15-day working party on Methodology of Teaching had been proposed, but could not be funded by ICM as MCH/FP was not included in the programme.

(d) A study of TBAs on a national basis was being considered.
(e) Legislation was being introduced.

Central African Republic

(a) A national institute for training 15-20 midwives annually had been created, with an annexe for training auxiliary midwives.
(b) A working party had been proposed to discuss midwifery training.
(c) 70 TBAs had been trained, financed by UNICEF, but the Government and WHO would prefer to have auxiliary midwives.
(d) The government opposed family planning and there was in any case a shortage of personnel to teach it.
(e) The Minister of Health and the President of the Women's Association were in favour of a Midwives Association. The Regional Field Director suggested that family planning training should be given in the Women's Association, and the Minister agreed in principle.

Chad

(a) The only existing school for nurse-midwives was not functioning because of lack of candidates. The standards at the school had been low.
(b) There was still government opposition to family planning, but demand for information and supplies from young unmarried girls (some of whom already had several children) had led the head of the Nursing School to organize a conference for teachers to emphasize the importance of their role in family planning education. Supplies and information were promised, but this offer could not be fulfilled by ICM because of government opposition to family planning.
(c) There were 30 TBAs in the country who had received training in aseptic principles and elementary hygiene in a Pilot Centre. They had received a delivery kit at the end of their training. They were regular in their supervision of patients, who were delivered at Health Centres. There was a shortage of finance to get the TBAs together and organize their training.

Congo Republic

(a) They would like to consider the possibility of post-university training for midwives and asked for details of French training schemes.
(b) The government had not yet declared its position on family planning, but one Minister had taken some action. There was no official theoretical family planning training, but the head of the Midwifery School would like practical training done there. They would like French information on family planning.

(c) There was no Midwives Association, but midwives had formed a syndicate.
(d) A Sanitary Education Team had started some classes on sex education at one of the colleges.

Gabon

(a) The first four points of the Working Party's recommendations had been implemented.
(b) Nothing had yet been done about exchanges of students and teachers in other African countries, but midwives were trying to find an answer to this problem.
(c) The Regional Field Director encouraged midwives to pursue their plans to set up an Association which could provide them with a course of studies and which would promote the role of the midwife in a country where there were only two obstetrician/gynaecologists in practice in the capital.
(d) TBAs existed and gave services, but were not officially recognized.
(e) Students were sent each year to Dakar, Senegal, for training in family planning but did not practise themselves, cases being referred to the obstetrician/gynaecologists.

Zaire

(a) The government was trying to standardize nursing programmes.
(b) The President of Zaire was in favour of family planning. It was hoped to create a family planning service within the University.
(c) Two Associations were handling 'desirable births' – the Public Health Department and the Medical Foundation of Co-ordination (financed by USAID).
(d) There was a centre where motivation sessions were held by auxiliary midwives and IUDs inserted free.
(e) Training in family planning had been given to many paramedicals, including nurses, nurse-midwives, auxiliary nurse-midwives and auxiliary midwives. Certificates were given on completion. However, some doctors thought that training of paramedicals should be done gradually and that they should not be given too much responsibility unless strictly supervised.

APPENDIX

List of Participants

Cameroon
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ANGLOPHONE EAST AFRICAN WORKING PARTY, NAIROBI, KENYA, 29th NOVEMBER – 8th DECEMBER, 1973.

Participating countries: Botswana, Ethiopia, Kenya, Lesotho, Mauritius, Swaziland, Tanzania, Uganda, Zambia.

I. Preliminary visits and preparations

1. Two months before the Working Party, visits were made to most of the countries in the region to explain the purpose of the meeting and to solicit official support and attendance. Of those invited only one country, Malawi, chose not to send representatives. The government of Malawi expressed interest in the programme but felt that it was not in their interest to participate at that time.
2. Detailed reports of the preliminary visits are not available.
3. One month before the Working Party, Mrs. Perpetua W. Kanyoko was appointed Regional Field Director.

II. The Working Party

1. ***Attendance.*** Those attending comprised:
   (a) 29 representatives from Botswana (4), Ethiopia (4), Kenya (4), Lesotho (3), Mauritius (2), Swaziland (2) Tanzania (4), Uganda (3) and Zambia (3).
   (b) Guests from UNICEF, WHO, Kenya National Nurses Association, University of North Carolina.
   (c) 6 representatives from ICM and 2 from USAID.

2. ***Organization.***
   (a) Delegates and guest speakers presented papers giving background information directed to one or more of the objectives.
   (b) Delegates then divided into three groups to discuss the various topics and form conclusions.
   (c) The chairmen and rapporteurs of each group met to formulate a consensus report which was then presented to all the delegates for amendment and approval.
   (d) The four approved consensus reports form the final recommendations of the Working Party.

3. ***Summary of proceedings and papers***

   The Working Party was opened by Mrs. E. Muringo Kiereini, Chief Nursing Officer, Ministry of Health, Kenya. After welcoming the delegates she introduced the Hon. 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 forming national policy. He then introduced His Excellency the Vice-President of Kenya and Minister of Home Affairs, the Hon. Daniel Arap. Moi.

Vice-President Moi set the tone for the Working Party by stating that the East African nations could not afford specialists and it was therefore important that midwives expand their role to include the entire maternity cycle and the care of young children. He spoke of the hardships created by having too many children and the need for planning the size of families. He saw this as part of the responsibility of midwives.

Miss M. Bayes, Executive Secretary of ICM and Project Leader, gave an account of the work of ICM, the origins of the ICM/FIGO Study Group and its aims and objectives, which were the aims and objectives of the Working Party. She explained how USAID had provided funds for the work of the Study Group to continue. Mr. Jones, Regional Director of UNICEF then spoke of the involvement of UNICEF in maternal and child health and family planning programmes. Both speakers stressed the need to involve the TBA in all aspects of midwifery and family planning until such time as there were sufficient professional trained personnel available.

Following brief reports from each country on their present achievements in maternal and child health and family planning, papers were given to open a discussion on the scope of MCH services.

Dr. J. L. Molapo, Director of Health Services, Lesotho, spoke first on *The Minimum Needs of the Mother.* These he listed as (i) good general health, including good nutrition, eradication of parasitism, and preventive and curative medicine; (ii) supervision during pregnancy, labour, the puerperium and between pregnancies; and (iii) child spacing.

The Minimum Needs of the Newborn Child were discussed by Professor N. O. Bwibo, Department of Paediatrics, University of Nairobi under the following headings: (i) Provision of a proper place and adequate facilities for the birth; (ii) Proper facilities for care of the newborn, including premature babies; (iii) Facilities for preventative and curative services. He stressed the need to have properly trained staff available at all times.

Sister Lydia M. M'muthara, IPPF Mobile Unit, Meru, Kenya, spoke on *Maternal and Child Care Services in a Rural Area.* These consisted of prenatal care, child welfare and family planning. She described the work of the clinics and the categories of personnel involved. In child welfare the important aspects were general

hygiene, nutrition and immunization. Three groups were involved in family planning: the government, which provided premises and drugs used in training and in clinical work; the Family Planning Association of Kenya, which dealt with education and motivation of clients, and the IPPF which had eight mobile teams in various rural parts of the country. She went on to speak of the work of these teams and of the increase in acceptance of contraception. However, rumours of adverse effects spread rapidly and could undo much of the work done. Enrolled midwives were being trained to insert IUDs and administer the pill. All those involved in rural development were aware of the need for family planning if the life of families in rural areas was to be improved.

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 on how long this care should continue. This first discussion ses set the general tone of the meeting, and throughout it was taken as a 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 and child health/family planning services should be organized, and papers were presented on different aspects of this subject.

Mrs. Perpetua W. Kanyoko, Regional Field Director, spoke on *Family Planning as Part of Maternal and Child Care Services*. The main hindrance to establishing this as a fact was lack of midwives trained in family planning. Pre-service training was undertaken in few developing countries, but was a goal to be achieved as soon as possible. In-service training meant giving family planning instruction to the midwives who were running health centres, and a course needed to be worked out which was acceptable to the Ministry of Health.

Mrs. Grace Mtawali, Senior Training Officer, FPA Tanzania, described *The Integration of Family Planning into Training Programmes*, starting from the basis that family planning was an integral part of all health care and social development. In Tanzania family planning was included in the courses for nurses, nurse-midwives and medical students. In the case of nurse-midwives it consisted of in-service training. She said that teaching should be made interesting by demonstrations, discussions, and study projects. Tutors themselves needed continuing instruction and motivation in order to keep up-to-date. Evaluation was necessary to check the work of students and to maintain the value of the course content. In a separate paper

on *Family Planning in the World and in Tanzania* (Mainland), Mrs. Mtawali described the work of the FPA both internationally and in Tanzania, and the relationship between the Association and other Associations in the world through IPPF.

In discussion 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 training be given to all graduate midwives.

The role of the different categories of midwife was then discussed. The subject was introduced by Mrs. K. S. Sowanyana (Uganda) in a paper entitled *The Role of the Midwife of all Categories in the Maternal and Child Care Programme*. Miss S. Rush (Ethiopia) then spoke on *The Identification and Training of Traditional Birth Attendants including Motivation for Family Planning*. She described the work of the TBA in Ethiopia and the training course which had been established for them.

In the discussion which followed there was much disagreement on whether traditional birth attendants should be officially recognized. 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 TBAs. 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.

Training was the next subject covered, and papers were read by Professor N. O. Bwibo, Professor of Paediatrics, University of Nairobi, on *The Paediatric Content of Midwifery Training Programmes* and by Miss C. M. Mudie, Kenyatta School of Nursing, Nairobi, on *Educational Methods and Curriculum Development*. Prof. Bwibo dealt with the paediatric content of the training programme for each category of midwife. In the case of the TBA the aim was to reduce neonatal deaths from infection and trauma due to unskilled delivery and, in the long term, to reduce infant mortality. The auxiliary midwife should have the same type of elementary instruction, but with a little more depth, while the professional midwife and nurse-midwife should be taught to practise a wide variety of nursing skills so as to be able to advise on nutrition, preventive medicine, immunization, etc. Family planning should be an important part of all training.

Miss Mudie dealt with the technical aspects of teaching and how, from her experience, a curriculum had to be designed to fit local conditions and requirements.

The final topic was *legislation*. Mr. R. J. Fenney took this as the title of his paper and said that the first objective of legislation was to identify the existing practitioners, and the second to establish an effective method of licensure, in order (a) to confer status and (b) to provide control of practice. Legislation had to meet the needs of each country and should allow for changing situations.

Mr. Lawrence Mungai, Assistant Registrar, University of Nairobi spoke on *The Importance and Necessity for Legislation in the Medical Profession* and gave examples from cases which had arisen; Mrs. Kanaiya, Registrar, Nurses and Midwives Council, Kenya, described the *Legislation and Licensure of Midwives in Kenya.*

4. ***Consensus reports of discussion groups***

(a) *Maternal and Child Health* was defined as the physical, emotional, spiritual and social well-being of the mother during reproductive age, the unborn child and all children up to puberty. It included: preventive, curative and promotive services – good nutrition; child care up to puberty; immunization; health education; prenatal; intranatal; postnatal and inter-pregnancy care; family counselling, e.g. genetic counselling, sex education, marriage guidance.

(b) *Family planning* was defined as education and counselling given to families to space their children as they wish, as well as to help the childless couple. Services should include: general education of the public regarding fertility and venereal diseases; counselling of patients; provision of family planning methods and medical checks, e.g. for malignancy, fertility, infertility, diagnosis and treatment of venereal diseases; family planning education taught to elders. Family planning should be wholly integrated into MCH services.

(c) A *midwife* was defined as a person who, having been regularly admitted to a midwifery education programme duly recognized 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. Principles and practice were the same for registered and enrolled midwives, but the responsibilities differed. Functions were: Care for mother and child during the maternal cycle; care for the welfare of the family and teaching of the family, the community and subordinate staff; co-ordinating and co-operating with other services including immunization, nutrition, health education and total family

welfare, in which she acts as a social worker; combining preventive, promotive and curative services; keeping records and data for statistical purposes. Responsibilities included: administration, including job descriptions and job analysis; teaching; research, social and clinical; health education; nutrition; family planning programmes; carrying out emergency measures within her capacity in the absence of a doctor; carrying out functions within the policy of the Ministry; participating in social activities in the community she served; the registered midwife was responsible for the work of the enrolled midwife.

(d) *Traditional Birth Attendants.* It was agreed that they existed everywhere in the African continent, but in accepting their services there were two schools of thought: (i) that the general public should be educated without encouraging or discouraging the activities of the TBA, and (ii) that TBAs should be identified, trained and registered. The functions of the TBA were outlined as motivating the public to take advantage of available health services; giving health education; identifying easily recognizable complications and referring them to the nearest health unit; giving simple advice to the mother on normal child care; giving basic care within her capacity to mothers during the maternal cycle; maintaining hygienic standards throughout. Supervision of the TBA by a trained midwife was essential.

(e) *Training* should equip the midwife in her expanding role to identify health problems and to motivate, teach, counsel and provide family health services with special emphasis on maternal and child care. The introduction of family planning into the curriculum should be supported by legislation; midwife tutors should be prepared to teach family planning; family planning should be integrated into the teaching of all categories throughout midwifery training so that the midwife is able to function as a family planning practitioner. It was suggested that family planning could be introduced into the course in anatomy and physiology, in public health, in postpartum care, when teaching vaginal examinations, when teaching principles of communication and motivation, when teaching about drugs related to hormones, when teaching the theory and practice of MCH.

In-service training was defined as training aimed at upgrading skills that the midwife already has; i.e. to keep up to date with developments in her field. It was recommended that in-service courses be held at regular intervals and include an introduction to new concepts in the theory and practice of MCH, including family planning, teaching and paediatric practice. TBAs should have in-service education and the midwife should be responsible for this.

Postgraduate training aimed at upgrading or increasing the

expertise of the midwife, for which she was given an added or advanced diploma, e.g. in public health nursing, teaching and paediatric nursing.

III. Recommendations

1. That those countries which had 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. 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 registered and enrolled midwives are considered as professional midwives.
7. That countries should make the registration of births and deaths compulsory.

IV. Follow-up Action Plans and Evaluation

1. It was agreed that the Regional Field Director should acquaint herself with the needs of the countries, and the progress made in the implementation of the recommendations, by regular visits and correspondence.
2. A newsletter should be produced and circulated to all the countries to enable the conference participants to keep abreast of activities in other countries.
3. The report and recommendations of the Working Party be sent to the governments of each country.
4. Follow-up activities should be through the Ministries of Health in co-operation with the delegates who attended the Working Party.

V. Follow-up visits

Botswana, June 1974 (First follow-up)

1. The Chief Nursing Officer thought that the country could not support separate Nursing and Midwifery Associations.

2. There was no training programme for auxiliary midwives or TBAs.
3. Community health aides were being trained in family planning and sent to work in rural areas, in their own villages.
4. Family planning courses were available for midwives, nurses and auxiliary nurses under the Meharry project.

Botswana, February 1976 (Second follow-up)

1. Great progress was being made in the development of the health care programme. There was a co-ordinated MCH/FP programme and the results were becoming apparent. Nurse-midwives were being trained and formed the backbone of the health services, in particular in MCH/FP.
2. At the government training school at the National Institute, Gaberone, the curriculum was being constantly adapted and kept under review, and the recommendations of the Working Party regarding training of nurse-midwives had been almost entirely implemented.
3. It was planned to have a health centre in each village, with emphasis on health education, including family planning, infant care, nutrition and breast feeding. The semi-nomadic life of the rural people added to the problems of providing care in these areas, and rural aid posts were being established. Community health aides had been trained in family planning and sent to work in their own communities. Family welfare educators were being trained for rural work. They were primary school leavers whose main role was that of educator or motivator in the village system, but they would assist in clinical work at centres.
4. The Botswana/Meharry Project in MCH/FP provided an 8-week in-service training course in public health, family planning and MCH for nurses and midwives and this had been of considerable benefit but because of the problems of manning the health service during the absence of nurse-midwives on the course, courses were usually not full. Only two of the three centres were operating as one of the tutors had left and had not been replaced. This training could be opened up to personnel from other countries if hostel accommodation were available, and the provision of such accommodation was a major priority.
5. The training of tutors should be organized on a regional basis, with candidates accepted from each country on a quota system. After basic training each country could then give specialist training if desired. The need to co-ordinate the activities of funding bodies with the already expressed interest of the Commonwealth Secretariat was stressed.

Ethiopia, February-March 1975 (First follow-up)

1. There were plans to train 75 nurses and midwives in family planning during the next year and to train doctors in MCH/FP.
2. They aimed to improve nutrition through the MCH programme.
3. They were keen to identify and train TBAs and to evaluate their activities and the training programme.
4. The Medical School was to close in November 1975 and all expatriate staff would leave.
5. The Minister of Health was unable to make decisions without the approval of the Revolutionary Government, so very little was being done. Unless funding for full training of midwifery tutors could be provided by ICM/USAID, little result could be expected.
6. The incidence of venereal disease in the country was very high.
7. There was need for keeping more accurate records in prenatal clinics.

Ethiopia, April–May 1975 (Second follow-up)

1. Midwives were no longer being trained and the only school at Asmara was closed, because of the war in that area.
2. Present lack of interest in the midwife due to the fact that midwives had been mostly hospital oriented, with little or no community work.
3. The community nurse was responsible for MCH in rural areas, and in most countries would be called a nurse-midwife.
4. Health assistants were being trained in MCH and public health by an 18-month course; there was also a 7-month course for dressers which included a little MCH.
5. Waiting areas were being built near rural health centres for the use of expectant mothers. Mothers were only transferred to provincial hospitals in case of emergency.
6. Evaluation of the training of TBAs was not working well, and UNICEF funds for this training had been delayed, probably because evaluation was not available. The Women's Welfare Association might help in this.
7. The Family Guidance Association had just completed its first training course for nurses and midwives, and hoped to have trained 75 by the end of the year, from both government and missionary personnel. There was good liaison with the MCH department and the training seemed a good mixture of MCH and family planning. When trained, midwives offered all family planning services except injectables, which were not used in Ethiopia.

8. It was recommended that community nurses should be recognized as nurse-midwives in order to form a stronger Association and this was eventually agreed to.

Kenya, March 1974 (First follow-up)
Research was proposed into the work of TBAs. They were not yet recognized by the government.

Kenya, January 1976 (Second follow-up)

1. Community nurse training was designed to provide a comprehensive nurse/midwife/public health nurse at the enrolled or assistant level. The community nurse would ultimately replace the enrolled nurse. Family planning was supposed to be part of the course, but theory was kept to a minimum and there was no practical application. It was not being integrated into the MCH concept, perhaps because of religious convictions.
2. A degree course was being developed for nursing and midwifery tutors, but so far there had been few vacancies for students from outside Kenya.
3. Family planning was now included in the curriculum of student nurses and midwives and was taught as an in-service subject to trained staff.
4. The whole of the IPPF structure in the region was under review because of funding problems. The local FPA had taken over regional training and was no longer able to maintain the internal training programme.
5. Suggested that a regional seminar on MCH and family planning be arranged for tutors, experienced midwives and health services directors, perhaps with the help of ICM/FIGO and IPPF.

Lesotho, June 1974 (First follow-up)

1. One Working Party delegate was to spend 9 months in the USA studying MCH/FP but was totally unenthusiastic.
2. There was no auxiliary midwife programme and no plan for one. The government did not want to train TBAs.
3. The private hospital association of Lesotho was thinking of starting a two-year training programme for public health assistants.
4. Aides working in the Catholic Relief Services programme were given a short course on health and nutrition. It was generally agreed that the CRS work was largely responsible for the generally good nutritional health of Lesotho children.
5. There was general opposition to training non-professionals in, e.g. MCH. Mass health education of the public was favoured instead.
6. The Medical Practice Act forbade nurses and midwives from

practising family planning despite the limited medical supervision and protection available. Several midwives had been trained in the USA under the California project; although the government did not hinder their work, they did not actively support it.

Lesotho, February 1976 (Second follow-up)

1. There was a great shortage of medical staff, and nurses and midwives tended to be attracted to better pay and terms of service, either in South Africa or in other neighbouring countries. The present limited establishment of nurses and midwives did not meet the demands of a developing service. The aim of the Ministry was to develop a rural health service as quickly as possible using available staff.
2. The nurses and midwives were being trained as nurse practitioners. They then performed both curative and preventative function in family planning and MCH work. Nutrition, family planning and the health of the young child seemed to be priorities in assessing needs.
3. Much interest was shown in the idea of training TBAs, organizing transport in rural areas, and the building of maternity waiting houses in district hospitals.
4. Hospitals and centres were short of facilities and necessary equipment.
5. Enrolled nurses were still being trained at one Mission Hospital, but the government was discouraging this and trying to replace it with community nurse or public health nurse training.
6. There was need to clarify the role of enrolled midwives and MCH assistants at Mission Hospitals.
7. The FPA was training nurse practitioners unofficially in family planning techniques, but mistrust still existed between the government and the association and there was no attempt to integrate these services into government programmes. In fact there was little co-operation within the country between the various health agencies.

Malawi, May 1975

1. The Director of Medical Services was interested in the recommendations of the Working Party, especially those affecting training and utilization of TBAs.
2. The Minimum Care Programme (Miniplan) aimed to provide primary health care, especially MCH, to all parts of the country. It was based at district level with a medical assistant as co-ordinator, dealing mainly with children, and where possible with a midwife to give prenatal and maternal care. Rural health and homecraft workers had been trained to provide instruction in family health, nutrition, MCH and home economics, and as a result the general health and welfare of the community was improving.

3. Deliveries at Queen Elizabeth Hospital, Blantyre, had risen from 2000 to 8000 in six years, making adequate care and teaching very difficult.

4. Training of registered midwives was carried out at only one school, which had 26 pupils. Enrolled midwives and nurse-midwives were also trained at Mulanji Mission Hospital where standards of competence and teaching facilities were of high quality. This hospital had 3-4000 deliveries annually, and referral work by enrolled and vernacular trained midwives was good in an area where total annual deliveries was probably about 25,000.

5. The Midwives Council were interested in setting up in-service refresher courses for enrolled and registered midwives.

6. Only trained midwives were legally allowed to attend at childbirth, which was obviously unrealistic. Identification and the type of training needed by TBAs was discussed, and how their work could be integrated into that of enrolled midwives at health centres.

7. There were problems over the training of tutors from Malawi. British courses were too much orientated to UK conditions, and there was great competition for entry into courses in Kenya. It was suggested that training of nursing and midwifery tutors should be arranged on a regional basis with a national quota for places, and that ICM/FIGO Joint Study Group ought to be involved in an advisory capacity. The Commonwealth Secretariat were organizing preliminary meetings to discuss this.

8. There was no government policy on family planning, but services were provided to anyone who asked for them. The attitude both of the general public and at the Ministry was now more liberal and there was need for midwives to help in providing services. With infant and child mortality falling sharply there would be an increasing demand for child spacing. Most mission hospitals offered some form of family planning on demand. The need to instruct men in the concepts of MCH/FP was stressed.

9. MCH services were increasing fast and it was estimated that 80% of children received health care.

10. Government approval was not forthcoming for the setting up of a Nurses and Midwives Association.

Mauritius, February 1976

1. MCH and family planning work had been operating under the Ministry of Health since 1972 but it was felt that the services were not yet fully integrated.

2. Although the theory and motivation of family planning were included in the student midwives' curriculum, they were taught as separate subjects and there was little attempt to integrate them. Practical

training was not given because family planning services were almost exclusively provided by doctors and motivation of clients solely by family planning educators.

3. No health education was carried out in hospital by staff members.
4. The FPA carried out family planning services in hospitals, but to no consistent pattern. The Association's activities were greatly curtailed by the government and the sole responsibility of the Association at that time was in information, education and communication. Because the consultant was a Roman Catholic motivation was very limited and only the rhythm and temperature control methods of contraception were permitted.
5. The members of the Midwives Association were interested in further training in family planning. They said that, due to their religious conviction, many midwives did not even motivate clients towards family planning.
6. There appeared to be a dichotomy of purpose and opinion between MCH and family planning workers, but this, fortunately, seems not to affect acceptance of family planning.
7. Ministry of Health officials requested a critical appraisal of the whole integrated system of MCH and family planning, as they were very concerned about the practical difficulties encountered in the delivery of health care.

Swaziland, June 1974 (First follow-up)

1. Family planning was official government policy and was integrated into the work of all MCH and health centres. Several nurses had been trained under the Meharry Project and were visiting rural areas. Refresher courses were held regularly.
2. Identification and training of TBAs had never been considered.
3. Proposed that USAID send a health planner to survey the health situation in the country and work out a comprehensive health plan.

Swaziland, February 1976 (Second follow-up)

1. There was a great shortage of trained nurses and midwives due to a 'brain drain'.
2. There was a lack of training facilities.
3. There was a high drop out of pupil midwives from the only registered midwife training school in the country, which was run by Roman Catholics. The training offered by this school did not prepare midwives for their multipurpose role.
4. It was understood that the government was to receive aid from the USA to build multipurpose training schools.
5. Tutors were being trained in Nigeria.

6. Enrolled nurse-midwives would be given the opportunity to train as general nurses.
7. Mrs. Abigail Dlamini, delegate to the Working Party, worked at a health centre which was visited. The clinic attendance for MCH/FP services was very high.
8. An excellent MCH/FP centre was attached to one of the hospitals. Prenatal care was given and there were young child, nutrition and family planning clinics. Nurse-midwives were taught to insert IUDs and to manage family planning services.

Tanzania, January–February 1976

1. Family planning was still a separate service in MCH clinics.
2. Training courses for nurses and midwives would include re-orientation in family planning and MCH.
3. The government nutrition unit was developing a high risk selection card system for pregnant women and young children.
4. AID MCW programme was providing six training schools with an 18-month course for school leavers, including MCH, family planning, nutrition and immunization. Many of the activities during the course would be carried out at the 'young child clinics'.
5. Scandinavian MCW Project was providing 12 training schools to function similarly to those under the AID MCW programme.
6. There was a noticeable lack of health education materials and these were offered.

Zambia, May 1975

1. There was only one midwifery training course (at Lusaka) but it was hoped to start a second at Ndola.
2. There were as yet no Zambian midwifery tutors. A course for tutors and administrators had been proposed but had been repeatedly postponed. There was unlikely to be any progress without funding from ICM/USAID.
3. The midwives' curriculum did not include family planning, but they received some formal lectures and attended clinics. An announcement of government policy was awaited.
4. The Nursing Council of Zambia was reviewing spheres of practice of midwives. Legislation was outdated and midwives were fulfilling many functions outside those legally permitted. There were no plans at present to join ICM.
5. The University Department of Obstetrics was developing a post-partum family planning programme with a mobile team visiting 17 centres in and around Lusaka weekly. This was funded by a grant from the Population Council. The programme also provided family

planning teaching for midwifery and medical students. It was hoped that it would eventually be a midwife based service.

6. The general impression was that little progress had been made since 1973, except at the University Department of Obstetrics.

VI. Recommendations from Follow-up Visits

1. Follow-up visits should be an ongoing exercise. The Ministries appreciated the interchange of ideas and would like the project to continue.

2. Where possible the visits should be joint ones with an obstetrician and the Field Director. The presence of an obstetrician facilitated access to senior medical personnel in government departments.

3. In each country there should be a liaison committee of government, voluntary, advisory and donor agencies for all health matters. This would avoid duplication and financial wastage.

4. Letters of observation and recommendation should be sent to governments through the Ministry of Health following each country visit.

VII. Proposals for Future Activities

1. Research into present activities of TBAs and their training before developing further training programmes.

2. To promote family life education programmes for the school population.

3. To stimulate governments to utilize midwives trained in family planning.

4. To work towards improvement of MCH/FP services.

5. To extend family planning training to midwives and doctors.

6. To organize visiting family planning teams for postpartum services.

VIII. Achievements

1. Integration of family planning into MCH services in Lesotho and Swaziland.

2. Family planning incorporated into the midwifery curriculum in Botswana, Ethiopia, Lesotho and Kenya.

APPENDIX I

List of Participants

Botswana
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APPENDIX II

List of Papers Presented

1.	The International Confederation of Midwives	Miss Marjorie Bayes Executive Secretary, ICM
2.	UNICEF	Mr. Jones Regional Director
3.	Maternal and Child Health	Dr. J. L. Molapo Director of Health Services Lesotho
4.	What Constitutes Minimum Needs of the Child	Professor N. O. Bwibo Department of Paediatrics University of Nairobi
5.	Maternal and Child Care Services in a Rural Area	Sister Lydia M. M'muthara IPPF Mobile Unit Meru, Kenya,
6.	Family Planning as Part of Maternal and Child Care Services	Mrs. Perpetua W. Kanyoko IPPF, Nairobi
7.	Integration of Family Planning into Training Programmes	Mrs. Grace Mtawali Senior Training Officer F.P.A. of Tanzania
8.	Family Planning in the World and in Tanzania (Mainland)	Mrs. Grace Mtawali Senior Training Officer F.P.A. of Tanzania
9.	The Paediatric Content of Midwifery Training Programmes	Professor N. O. Bwibo Department of Paediatrics University of Nairobi
10.	Educational Methods and Curriculum Development	Miss C. M. Mudie Kenyatta National School of Nursing Nairobi
11.	The Contribution which can be made by the Traditional Birth Attendant	Miss S. Rush Teacher, TBA Course Addis Ababa, Ethiopia
12.	The Role of the Midwife of all Categories in the Maternal and Child Care Programme	Mrs. K. S. Sowanyana Public Health Administration i/c Courses, Kampala, Uganda

13.	The Identification and Training of Traditional Birth Attendants including Motivation for Family Planning	Miss S. Rush Teacher, TBA Course Addis Ababa, Ethiopia
14.	Legislation	Mr. R. J. Fenney London
15.	Importance and Necessity for Legislation in the Medical Profession	Mr. Lawrence Mungai Assistant Registrar University of Nairobi
16.	Legislation and Licensure of Midwives in Kenya	Mrs. Kanaiya Registrar, Nurses and Midwives Council, Kenya

CARIBBEAN WORKING PARTY, BRIDGETOWN, BARBADOS, 16th – 24th MAY, 1974.

Participating countries: Barbados, Belize, Dominica, Guyana, Haiti, Jamaica, Trinidad and Tobago.

Through the generosity of IPPF, representatives from the following territories were also able to participate:

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

I. **Preliminary Visits**

Approximately two months before the Working Party visits were paid to the islands and to Belize by the Regional Field Director accompanied in most instances by Miss Kate Lorig, Professional Co-ordinator, ICM. The purpose of these visits was to explain the purpose of the Working Party and to solicit official support and attendance. No detailed report of these visits is now available.

II. **Organization**

A local committee was set up in Barbados under the chairmanship of Mrs. Perlita Hinds.

III. **The Working Party**

The proceedings were opened by Mrs. Gertrude Eastmond, Acting Minister of Health and Welfare, Barbados. She said that the birth rate had fallen markedly in the previous ten years but the population was still greater than could reasonably be supported. In 1973 96.9% of births took place in institutions. The MCH services also provided pre- and postnatal care and child health clinics, while private organizations offered additional facilities for confinements and for child care. A national Nutrition Centre had been established to give community education in nutrition, to follow up all cases of malnutrition on discharge from hospital and to provide appropriate training for medical and paramedical personnel connected with child care and nutrition.

Nurse-midwives were playing an important role in the MCH services.

Family planning services had been available in Barbados for the past 20 years and midwives had taken part in providing services. The need for family planning and the need to control the size of families was highlighted by the problems of unwanted children and unnecessary pregnancies, especially among teenagers, and by the world food crisis and high cost of living. The nurse-midwife was in an ideal position to help with this problem, but technical skills were not enough and they

needed to appreciate the necessity of family planning as a health measure and their duty to teach and guide those in need.

Dr. I. Gogan, PAHO Medical Officer in Barbados, then presented the key note address entitled *The Ten Year Health Plan of the Americas.* He described the origin of the ten-year plan and the realization that, although morbidity and mortality had been reduced, there was still insufficient improvement in general health and well-being. Approximately 40% of the population of the region were without access to the minimum of health services, due not only to lack of resources but also to neglect of traditional methods and personnel using them, and over-concentration of manpower in urban as against rural areas. The plan focussed attention on the control of communicable diseases, maternal and child health, nutrition, and the physical, biological and social environment. The need was for all categories of personnel to be trained to realistic levels rather than for specialists trained to unrealistic and highly sophisticated levels. The health auxiliary was needed for community health education, supervised by professional nurses and supervising the empirical health worker, and guiding individuals, families and groups to greater health responsibility.

The Ten Year Plan was incorporated into the policy of PAHO/WHO and became the guide for co-operative activities of the organizations with member governments. It was hoped that it would provide a basis for identifying health problems and the means of solving them. It was essential that all countries followed up with policies and national goals that defined what they proposed to do and that they prescribed ways of achieving their aims. Some suggested areas were: provision of a safe water supply and adequate housing and sewage disposal; chronic malnutrition and infection; the low birth weight child and the effect of maternal nutrition; family planning and birth spacing.

Miss Marjorie Bayes, Executive Secretary ICM, took as title *From the Beginning* for her account of how the FIGO/ICM Joint Study Group was set up and how it came to recommend that family planning should be included in the training and practice of midwives. She went on to describe the generous grant of funds from USAID for the holdings of Working Parties in various parts of the world. She stressed the need to use all available workers, especially TBAs, in bringing both MCH services and family planning to those living in rural areas.

What Constitutes Maternal and Child Care in the Caribbean was summarized by Dr. G. M. Cummins as:

(1) Identifying local needs in preventive health care and the interplay of genetic, environmental, parasitic and nutritional patterns.
(2) Regarding the unhealthy child of today as the suboptimal parent of tomorrow.
(3) Ensuring that women in the child-bearing years were conscious of

their responsibilities to the children they might bear, and that they should not embark on pregnancy without due thought.

(4) Caring for mothers during pregnancy to the ultimate well-being of their future children.

(5) Providing measures to combat both infertility and too-frequent pregnancies.

(6) Educating and utilizing all available grades of health workers.

Mrs. G. Omphroy-Spencer spoke on *What are the Priorities for Maternal Care*? She quoted the vital statistics for Jamaica. Although birth and death rates were both falling, the rate of natural increase was sharply up and overall population had risen considerably, leading to problems of employment, illiteracy and social behaviour. Maternal mortality had been much reduced. Priorities were: more prenatal care; attention to nutrition; family planning; dissemination of education and information by midwives, nurses and community health aids and by family life education in schools; greater training and use of TBAs; general expansion of health services; a national maternity survey.

Priorities for Child Care were dealt with by Dr. Keith McKenzie (Jamaica). Most child deaths occurred in the 0-5 age group and of these about 60% occurred in the first year. The principal causes were 'perinatal', gastro-enteritis, non-viral pneumonia, malnutrition and avitaminosis. Priorities therefore were prevention and treatment of malnutrition and gastro-enteritis and promotion of breast feeding for this purpose; investigation of perinatal morbidity and mortality; immunizations; family planning.

Dr. F. C. Ramsey (Jamaica) spoke on *The Place of Nutrition in the Priorities of Maternal and Child Health.* He outlined the problems of high risk mothers and low birth weight babies and summarized the findings of the National Food and Nutrition Survey, Barbados, 1969, which revealed considerable malnutrition, growth impairment and morbidity. The need was for an integrated approach to maternal and child health, using the resources of all caring agencies. In assessing priorities equal weight could be given to family planning and nutrition. but it was a fact that reduction in infant mortality was a prerequisite for successful family spacing. Services provided must be adapted to local needs and resources available. He recommended that (1) a MCH Co-ordinating Committee be established in the Ministry of Health with the Chief Medical Officer as Chairman. (2) A MCH Officer or professional with a special interest in MCH should be responsible to the Minister for planning and implementing MCH services. (3) Training in managerial skills and of health aides should be stressed in MCH services. (4) Consideration be given to a National Food and Nutrition Policy. (5) A medical nutritionist or person with special interest in nutrition should be responsible for updating the teaching of nutrition and

motivating colleagues to include nutrition education in all MCH activities.

Maternal and Child Health and Family Planning was covered by Dr. A. Wynante Patterson (Jamaica). She gave details of the development of MCH services and the statistics relating to population, professional personnel, numbers of deliveries, clinics and services offered. Family planning had only recently been integrated into the MCH services.

Maternal and Child Health and Family Planning in Barbados was dealt with by Miss Elayne Scantlebury. She gave details of pre-, intra- and postnatal services and of the various MCH services provided. A new Act had been passed in 1973 to replace and update the Midwives and Nurses Registration Act of 1932. There was one training school for professional midwives.

The situation in *Trinidad and Tobago* was described by Dr. A. Bhadwansingh. The government provided MCH services and the family planning programme was being integrated into it; in some cases family planning was combined with prenatal and child weifare clinics and with postpartum services. Cancer surveillance and screening for VD were also being offered. Medical graduates were trained in MCH but not all of them in family planning; some refresher courses had been held. MCH/family planning was now part of the training of all nurses, and in-service short courses had been held for those already trained. Clerks were being trained for recording and reporting. Community education in MCH was largely the responsibility of nurses at clinics and on maternity wards. Community education in family planning was better covered.

Dr. Desmond Noel (Grenada) spoke on the situation in Grenada, Carriacou and Petit Martinique. He reviewed the statistics for births and for maternal and infant mortality, and described the arrangements for pre- and postnatal care, the workings of child health clinics and the personnel available. Government policy allowed freedom for the development of family planning services.

In *Haiti,* said Dr. Jn. N. Cadet, the Division of Family Hygiene was now responsible for all activities relating to MCH/FP. Immediate objectives were a reduction in maternal and infant mortality of 10% a year over five years and a decrease in fertility of 20%. They were considering opening 40 clinics for MCH/FP services throughout the country. Two pilot clinics sponsored by UNFPA had been organized to test the practicality of the scheme. Services offered included pre- and postnatal care, family planning, paediatric clinic and a cancer detection scheme in clinics attached to hospitals. Continuing evaluation of the results at the two clinics was in progress.

Dr. Lionel A. Clare said that in *Belize* MCH services were offered at hospitals and by the Public Health Department at health centres. Rural communities were covered by mobile clinics. A professional midwife

was always present at deliveries in hospitals and centres and in the domiciliary midwifery service in Belize City. In rural areas domiciliary deliveries were usually done by TBAs, who referred complicated cases to midwives, who themselves referred to hospitals or clinics. The domiciliary midwifery service in the city consisted of one inspector of midwives and two domiciliary nurse-midwives. Their duties included supervision of qualified midwives in private practice and supervision and training of unqualified midwives allowed to practise in rural areas. Child care was given at hospitals, at home by private professional midwives and in well-baby and welfare clinics. There was no organized programme of family planning because of the low population density. Services were available on request, and they were happy to join in and discuss problems on the basis of general family health.

In describing the *Role of the District Midwife in Family Planning*, Mrs. Hazel Sinclair (Jamaica) said that the midwife was ideally placed to sponsor family planning. She had close rapport with the mother, could use her influence to remove socio-cultural objections; could stimulate and encourage drop-outs and had access to the whole family. She performed the dual role of deliverer and postponer.

The Role of the Hospital Midwife in Family Planning Programmes was discussed by Mrs. P. Hinds (Barbados). She began by giving details of facilities available in hospitals and clinics and of training and legislation. Family planning was now included in the curriculum of all pupil midwives. Midwives gave family planning advice in pre- and postnatal clinics, on the wards and in the outreach programme (continued care in the home after delivery). Receptiveness to teaching in the outreach programme had been especially marked. One nurse-midwife with post-basic training in family planning worked in the Department of Obstetrics, Queen Elizabeth Hospital.

The Traditional Birth Attendant Haiti was presented by Mrs. Antoine Cesar Stenschke. She said that, due to the general shortage of trained personnel, 80% of deliveries were still attended by TBAs. They were largely illiterate and ignorant of the birth process, but were held in high regard by the majority of women. The techniques employed for the protection of mother and baby could be divided into hygienic (6.9%) and non-hygienic (93.1%). A weekly training day for TBAs had been run since 1955 and 70-80 attended regularly. After attending four classes they were tested and the successful ones given a delivery kit. The TBAs generally understood the need for family planning and were willing to co-operate in a family planning programme, but much education was necessary.

Mrs. Belle Lovell spoke of the *TBA in Belize*, and described the six-month training course which had been established. On completion of training they received a UNICEF kit. They were not allowed to practise

in urban areas where certified midwives were available. They were periodically supervised by Inspectors of Midwives and by attendance at prenatal clinics.

Family Life Education – Its Relevance for Health Workers was discussed by Mrs. Carmen (Jamaica). She described the background and origins of the programme which was designed to educate young people to a proper appreciation of roles and responsibilities within the family, including the sexual aspects. It had now been accepted by the Ministry of Education for inclusion into school curricula in September 1974.

A paper on *Selected Health Problems and Needs Associated with Jamaica Family Life having implications for Family Life Education* had been prepared by the Bureau of Health Education, Ministry of Health, Jamaica, with the assistance of Mr. S. P. W. Street, Chief Medical Officer. Problems were listed as: *Needs of children and young people*: food, tiredness and sleep, safety, prevention and control of illness and disease; development of emotional stability and adaptability; recreational outlets; use of drugs. *Needs associated with the functions of the family and responsibilities of parenthood*: reproduction; inadequate housing and living environment; poor sanitation and hygiene; perpetuation of family patterns; gender roles and social status; home management; child care.

Mr. R. J. Fenney, Field Director, spoke on *Legislation.* He classified MCH legislation into three groups: (i) legislation on registration (e.g. of births) and reporting (e.g. of communicable disease); (ii) legislation on licensing of personnel or of services (e.g. hospitals); (iii) legislation regarding action (e.g. immunization, examination, etc.). In dealing with the second of these -- licensure and definition of practice – he said that the purpose of legislation was twofold – to protect the public and to protect the practitioner. The first steps in legislation to establish a profession were to define the profession and to identify the practitioners, and then to confer status on, and establish control over, the licensee. It was essential to define the limits of practice. In practical terms he stressed the need to identify and license the TBA so as to use all the workers available rather than to attempt to train an elite group of professionals. Training needed to be adapted and the needs of individual countries and legislation must take account of possible future developments in training and practice and not be too rigidly framed. It should cover retraining as well as initial training.

Paediatric Content in Expanded Areas of Training for Midwives was covered by Dr. Keith McKenzie (Jamaica). Traditionally the midwife had sought to ensure the health of the baby at birth by encouraging prenatal care. At the end of the neonatal period, the care of the baby was handed over to the public health nurse or health visitor. If the midwife was to act in the role of community health worker and continue in child care, she would need further training in: (i) normal develop-

ment in infancy and childhood; (ii) nutritional care of infant and young child and encouragement of the mother to breast feed and advice on weaning; (iii) immunizations; (iv) public health aspect of childhood illnesses; (v) promoting good family relationships.

Expanded Areas of Training for Midwives – Implications of Nutrition was dealt with by Miss Patricia Pena (Barbados). She outlined the nutritional needs of the pregnant woman and child and explained how the midwife in the MCH services was ideally placed to give advice on nutrition. To enable her to do this she needed additional training in this subject and she detailed the areas which ought to be covered. In addition, in-service refresher training was necessary if the midwife was to be kept up-to-date and able to give nutrition education to her patients.

Miss Helen Christian (Trinidad and Tobago) spoke on *Family Planning and how it could be integrated into the Midwifery Curriculum.* The government had incorporated family planning into basic and postbasic nursing curricula in keeping with the terms of an aid agreement with International Bank for Reconstruction and Development. A family planning reference manual had been prepared and was used in all nursing education programmes, and the theoretical teaching was supplemented by practical work in family planning clinics. The positive health aspects of family planning were stressed in relation to mother, child, family and the community.

Family Planning Manpower was discussed by Dr. Willard Boynton, Office of Population, USAID. He outlined the need for family planning because of population trends and the aid available from international organizations. The health of the mother and of all the family were vital considerations. The principal problems were adequate coverage and continuation rates. He concluded that: (i) midwives had a duty to offer family planning to protect the health of mother and child; (ii) midwifery training must include family planning; (iii) midwives must participate in family planning, or it will not succeed; (iv) midwives must co-operate willingly in family planning work with doctors who supervise them and with auxiliaries whom they supervise. (v) family planning must become an acceptable part of our culture if the population problem is to be solved.

Miss Thelma Grant, Downstate Medical Center, New York, spoke on *Continuing Education in Family Planning.* She described the family planning training course for foreign trained midwives which had been run since 1968 and which had been supported by USAID since 1971. There were three training sessions a year, each of 12 weeks. All contraceptive methods were taught, including insertion of IUDs. She went on to discuss continuing education. The center provided further education for overseas personnel, training for the professional nurse so that she

could take more responsibility in family planning, training for nurse-midwives to upgrade and augment their knowledge of family planning, and training for lay counsellors in family planning in the Community Health Services. In addition, in-service education was given to all staff at least once a year. Education in schools was developing in a number of countries and the Center had given help in a number of projects. Social workers were now being involved and training was being given. Artificial aids were being prepared as part of the teaching programme. Finally she discussed the newest contraceptive devices in use at the Center and their efficiency.

The final paper was by Miss Kate Lorig on *Curriculum Development.* She said that planning what to teach involved an assessment of the needs and the setting of objectives. Modern teaching methods had to be adopted – participation, audio-visual aids, etc. Evaluation of the results of teaching and interpretation of the evaluation were essential.

IV. Consensus Reports of the Discussion Groups

(a) *Topic 1. Priorities of Maternal and Child Health in the Caribbean*

1. *Education*: Family life education including nutrition, breast feeding, sex education and family planning. It should be given by primary and secondary schools, social groups (youth clubs, scouts, guides, sea cadets), professional groups (doctors, nurses, teachers), military, paramilitary and police, expectant parents, government social agencies.

2. *Child Care*
   - (i) Prevention and treatment of malnutrition – by breast feeding, use of indigenous food, knowledge of foods, balanced diet.
   - (ii) Prevention of gastro-enteritis and infection in the new-born.
   - (iii) Family planning/child spacing, with special emphasis on high risk mothers.
   - (iv) Immunization.
   - (v) Maintenance of statistics.

3. *Identification and Training and Utilization of all available Manpower for Maternal and Child Health*
   More use to be made of influential community members, specially trained community health aides as in St. Vincent and Jamaica, professional midwives and doctors, and TBAs.

4. *Improved Communication at all Levels*
   - (i) Professional to patient and vice versa.
   - (ii) Professional to professional.
   - (iii) Involvement of all grades in decision making.

5. *Improved Intrapartum Care* -- in labour and immediately after delivery.
6. *Training and Facilities for Resuscitation and Management of Premature Babies.*
7. *Improved Managerial Skills in Running Delivery Suites.*
8. *Review Schedules of Prenatal Clinics with a view to eliminating Unnecessary Visits.*
   Working hours of clinics should be adjusted to suit both working and non-working mothers.

(b) ***Topic 2. The Expanded Roles and Functions of all categories of Midwives***

Assuming that the midwifery curriculum and in-service education includes MCH, family planning, family life education, nutrition, child care and care of the non-pregnant woman, the roles and functions should be as follows:

1. *Maternal and Child Health*
   (i) *Nurse-midwives and midwives* – planning, programming, implementing, evaluating, training and supervision.
   (ii) *Auxiliary midwife* – implementing depending on training received.
   (iii) *TBA* – implementing.
2. *Family Planning*
   (i) *Nurse-midwives and midwives*
   Educator, motivator and case-finder.
   Provider and dispenser of all contraceptive services.
   Follow-up in order to detect problems and keep supplies.
   Co-ordinator of family planning team (managerial skills).
   Referral service for all health problems.
   (ii) *Auxiliary midwife and TBA*
   Up to the level of her training.
   Educator, motivator and case-finder.
   Distributor of pills, condoms and conventional methods.
   Referral.
3. *Family Life Education*
   (i) *Nurse-midwives and midwives*
   Interpersonal/Intra-family.
   Health and hygiene.
   Sex education and contraception.
   Nutrition.
   (ii) *Auxiliary midwife*
   Up to the level of her training.
   (iii) *TBA*
   Can be useful depending on her personal qualities.

4. *Nutrition*
   (i) *Nurse-midwives and midwives*
   Teach and demonstrate.
   Follow-up care, especially to pregnant women and puerperal women in breast feeding.
   (ii) *Auxiliary midwife*
   Useful in every way depending on training.
   (iii) *TBA*
   Can be useful depending on her personal qualities.

5. *Child Care*
   (i) *Nurse-midwives and midwives*
   Notification and registration of births.
   Care of newborn – weaning.
   Advise, demonstrate and follow-up on nutrition in homes, schools, clinics.
   Referral and follow-up to immunization programme.
   Advise and recommend in care of underprivileged child.
   Knowledge of available services and planning of all child care services.
   (ii) *Auxiliary midwife*
   Depending on training.
   (iii) *TBA* Could be used in:
   Notification and registration of births.
   Care of newborn – weaning.
   Advise, demonstrate, follow-up on nutrition in homes, schools and clinics.
   Referral and follow-up, immunization programme.

6. *Care of the Non-pregnant Woman*
   (i) *Nurse-midwives and midwives*
   Pre-pregnancy – advice on family life education, family planning and nutrition and the expanding role of women.
   Immediately Post-pregnancy – continuing health education.
   Interpregnancies – continuing education using formal and informal opportunities.
   Infertile women – Advice with referral to the appropriate agencies.
   Post-menopausal – general health advice.
   (ii) *Auxiliary midwife*
   Depending on training.

(c) ***Curriculum Content for Training all Categories of Midwives for their Expanded Roles***

1. *Traditional Birth Attendants* should be instructed in:
   (i) *Family planning* – methods of communication; history

and methods of contraception; side effects of contraceptives; knowledge of referral agencies.

(ii) *Child care* – notification of births and deaths; detection of abnormalities in the newborn; resuscitation of the newborn (mouth to mouth, disposable mucus extractor); knowledge of immunizations; safety measures and prevention of home accidents; methods of recording and reporting information.

(iii) *Nutrition* – knowledge of use of local foods (preparation, combination, tasting); reinforcement of breast feeding.

2. *Professional midwife – basic training.* The following should be added to the curriculum if not already included.

(i) *Family planning* – history of contraception; methods of contraception (traditional, modern); side effects and complications of contraceptives; theory and clinical practice (pre- and postnatal clinics, IUD and diaphragm insertion; communication, interviewing, counselling of the entire family; sexuality (anatomy, physiology, function, physical and psychological responses); demography; genetics; family economics; infertility; problems of teenage pregnancy and high parity.

(ii) *Child care* – normal growth and development of embryo and fetus; all aspects of prenatal examinations (serology, haemoglobin, blood grouping, sickling, urine, clinical examinations for rubella, cervical and urethral swab); nutrition of pregnant wo[illegible] [illegible]phasis on preparation for breast feeding); re[illegible] [illegible] of newborn including intubation; care of the umbilicus; examination and recognition of abnormalities in the newborn; physical, mental and emotional growth and development; comprehensive immunization programme; weaning and the establishment of independent feeding; continued nutrition of the mother; preventive aspects of common childhood disorders (malnutrition, gastroenteritis, helminthiasis, skin infections, detection of allergic disorders); notification and registration of births and deaths; care of handicapped and retarded children and their families including information on referral; safety measures and the prevention of accidents (home visits should consider the whole family).

(iii) *Nutrition* – Introduction of basic principles; cost, value and content of local foods; composition and structure of foods, menu planning; understanding of balanced diet; dietary factors for various age groups (metabolism and calorie content); malnutrition, allergies; infant feeding

(breast feeding and supplementary when necessary); nutrition in child and adult illness; handling and preparation of food; technique of teaching nutrition; protection of food from contamination; disposal of waste.

3. *Professional midwife – postbasic training.* The content is the same as for the basic training: the objectives are as follows:
   (i) *Family planning* – the midwife will be able to advise on the control of human fertility and to provide family planning services in order to improve the health of the population and protect the environment.
   (ii) *Child care* – The midwife will have knowledge of normal growth and development; she will know and carry out the recording and reporting of births and deaths; she will know about community facilities for children; her function will be to improve the quality of life for all children in the community in order to lower the incidence of child morbidity and mortality.
   (iii) *Nutrition* – the midwife will have correct concepts of a balanced diet and be able to impart them meaningfully; she will be able to teach and demonstrate the use of locally available foods.
   (iv) *Family life education* – the midwife will be able to prepare individuals for responsible parenthood; she will understand and encourage harmonious relationships within the family.

(d) ***Ideal Maternal and Child Health/Family Planning Programme for a Caribbean Country.***

1. *Objectives*
   (i) To promote the improvement of maternal and child care in order to achieve optimum health for the entire family.
   (ii) To provide a programme for the training of personnel to enable them to give good quality care.

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

2. *Education programme*
   Planned curriculum for schools which will include: health Education; sex Education; family Life.
   Education of expectant parents in: personal hygiene; nutrition; breast care and feeding; weaning; family planning; preparation for labour and confinement; recognition of abnormalities; benefit.

3. *Prenatal care programme*
   Prenatal services should be designed to encourage regular attendances. They should be flexible enough to take account of all the circumstances of the mother's life. Screening should include:
   (i) Blood investigations such as Haemoglobin, VDRL and Group, investigation for sickling etc. Random blood sugar should be done in the presence of glycosuria.
   (ii) Complete physical examination including a review of breast anatomy.
   (iii) A thorough family, medical, surgical, obstetric and social history.
   (iv) Routine urinalysis.
   (v) Routine inspection of the vulva and a vaginal swab/smear, where indicated.
   (vi) Blood Pressure, weight, height should be recorded.
   The process of communication and education should go forward and rapport is therefore established. This may be supplemented by informative pamphlets which may have to be the main means of communication and education.
   The patient is then screened for risk and allocated to the appropriate available programme for antenatal care and delivery.

4. *High risk patients*
   These include: primigravidae at the extremes of the childbearing period; parity greater than five; multiple pregnancy; previous caesarean section or a history of previous gynaecological surgery; bad obstetric history (habitual abortion, stillborn or perinatal death); medical complications of pregnancy including diseases of the central nervous system and psychological disorders; previous history of hypertensive complications of pregnancy including pre-eclampsia; a primigravid breech or any form of unstable lie or presentation; previous obstetric haemorrhage and complications of the third stage; the syndrome of prediabetes; any suspicion of foetal abnormality.

5. *Preparation for delivery*
   The patient should be instructed in: nutrition including dental

hygiene; preparation for breast feeding; parentcraft; relaxation and exercises which profitably may include the father; the phenomena and sensations of the actual delivery. For domiciliary delivery, preparations will include visits of the health team to the home to assess and become acquainted with the home and the family; all prenatal patients should have care by midwife, obstetrician, physician and social/medical worker as indicated.

6. *Delivery*

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

In the puerperium, supervision and education ensure adequate postpartum care including: the establishment of breast feeding; the avoidance of puerperal sepsis; maintenance of good nutrition.

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

7. *Puerperal Care Programme*

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

   ii. *Child welfare appointment* – these should be scheduled at this time.

   iii. *Preparation of the family* – the family must be prepared for the arrival of the mother and the new born child so that the child is accepted into the environment.

Family Planning Education is advocated in the postnatal period: from a health point of view; as a responsibility to parents; as a means of population control.

8. *Training of Personnel*

Training of midwives, nurses, doctors, social workers, teachers, others including medical secretaries in: prenatal care and education; intranatal care; postnatal care, follow up and family planning; immunization procedures; child care.

9. *Implementation*

   (i) Proper utilization of well trained personnel.
   (ii) Provision of adequate facilities.
   (iii) Create ideal environment.
   (iv) Adequate remuneration.

10. *Plan for Action*
    (i) The government should be the driving force in such a programme which would have involvement of the Private Sector as well as organizations previously involved in MCH/FP programmes.
    (ii) A committee should first be set up in the country involved.
    (iii) Members of such a committee be drawn from:
    Health Services personnel; nutritionists – government and private; mothers and fathers; social and community workers not involved in Health Services; MCH/FP Officer or officers selected by committee should be Ministry of Health personnel.
    (iv) Funding of such a committee and programme should initially be by the government.
    (v) The government has control of salary structure as well as setting up of standards to be maintained.

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

12. *Functions of Committee*
    (i) Planning of programme.
    (ii) Identification of specific priorities for particular territory.
    (iii) Advise government as to the approach and methodology to achieve aims of the programme.
    (iv) Budgeting.
    (v) Evaluation.

13. *Facilities*
    (i) Utilization of all available facilities for efficient functioning of programme.
    (ii) The domiciliary service or facility be maintained or expanded when necessary.

V. Recommendations

(a) ***Overall***

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

2. All governments in the Caribbean area should introduce

family planning as an integral part of all health services. (One delegate from Belize voted against this recommendation.)

(b) ***Traditional Birth Attendants***

1. Since Traditional Birth Attendants already exist in some communities – it is recommended that they be identified, recruited and trained.
2. Where necessary midwives should be prepared to teach and supervise Traditional Birth Attendants in all aspects of Maternal and Child Health.
3. In the basic course midwives should be taught about the presence, purpose and usefulness of Traditional Birth Attendants and the role Traditional Birth Attendants play in communities where midwives do not exist. Traditional Birth Attendants should be brought in for discussions.

(c) ***Midwifery as a profession***

1. The professional advancement for midwives should be regularized in view of the fact that they will be acquiring expanded roles and functions.
2. Personnel following specialized training should be allocated in such a way as to make use of their newly acquired skills.
3. Practising midwives should be included in planning and policy making at the highest levels.
4. Midwives should be invited to participate in all medical meetings dealing with Maternal and Child Health/Family Planning.
5. Midwives should promote their profession by every means available especially through their organizations, mass media – e.g. radio, television, newspapers.
6. Stimulation should be given to the organization of a professional body for midwives in each territory. These should be so constituted as to be able to seek recognition and affiliation with International Confederation of Midwives.

(d) ***Midwifery Training***

1. Schools of midwifery should have adequate libraries and students taught how to use them.
2. Research should be included as part of the midwives' expanding role.

(e) ***Health Services***

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

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

(f) ***Recommendations for Follow-up of Working Party***

1. As soon as possible delegates should report on the Working Party deliberations and recommendations to: their immediate staff; their Ministers of Health; midwifery tutors; pupil midwives; staff senior to themselves; local Midwifery and Nursing Associations and Councils.
2. Regular meetings of this nature should be held on a regional basis at intervals between one and two years.
3. The Regional Field Director of the Caribbean Working Party should visit the countries periodically to discuss the implementation of the recommendations with all members of the Health Team involved in Maternal and Child Health/Family Planning Services.
4. The Regional Field Director should keep in close touch with all participants through correspondence.
5. A report should be sent by each country and territory advising the International Confederation of Midwives how they are progressing towards implementation of the recommendations.
6. The possibility of members of the Maternal and Child Health Team making inter-territorial visits should be explored.
7. Representatives of the Caribbean Working Party should attend Working Parties in other parts of the world and vice-versa.
8. At future Working Parties, field visits should be included in the programme.

VI. Resolutions

1. ***The Career of Midwifery***

The participants of this Working Party

Recognizing

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

and recognizing

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

and further

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

do resolve

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

and do further resolve

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

2. Whereas we recognize that early discharge of postnatal patients from hospital is inevitable and that a Domiciliary Midwifery Service is absent or inadequate in most of the countries represented
   Be it Resolved

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

3. Be it Resolved that

   in order to maintain and improve on the standard of midwifery practice in the Caribbean Area and to enhance the role of the midwife as a professional person, a Caribbean Midwives Association be formed.

   Two examples of the objectives of such an Association would be:
   (i) To initiate research.
   (ii) To provide means of publication.

VII. Follow-up Visits

Grenada – first follow-up, August 1975

The Working Party recommendations were discussed. There had been some integration of family planning into basic nursing and midwifery training. There was no government policy on family planning, but no hindrance to it. The birth rate was low so that the problem was not vital. Nurse-midwives could give advice if they wished and the local Association ran four clinics supported by IPPF. Untrained field workers operated in rural areas; they received some in-service instruction in community care from nurses.

The only midwifery training was postbasic to nursing training, and

about 15 nurse-midwives were trained annually. Nutrition was an ever-growing part of the curriculum and there were malnutrition clinics.

There was a Nurses Association but no Midwives Association, although attempts were being made to have a combined Association.

It was agreed that midwives must take on the role of educator in community health.

The practice of TBAs was illegal although some still practised. The Chief Medical Officer saw no justification for including them in the health team. There were medical stations in outlying districts, one of which had an experimental delivery unit which had succeeded in reducing the incidence of 'BBAs'.

Child welfare clinics were held weekly and an immunization scheme was in progress.

– second follow-up, July 1976

There had been no intake of student nurses for over two years. The nurse training curriculum had not been revised to include family planning but the postbasic midwifery training had been much improved.

The Chief Medical Officer was concerned that, in spite of repeated recommendations, no steps had been taken to improve MCH services.

Family planning continued to be provided by the FPA and nurse-midwives were involved, but it was not part of MCH services. The Association ran a training programme for field workers. Nurse-midwives agreed that the term 'family planning' was misunderstood and ought to be changed. A recommendation to start family life education in schools had been turned down but a Seminar by the Family Life Education Council had been planned for September.

Immunizations were still being done routinely but they were not compulsory.

The Nurses Association was not functioning and advice was given to help get it started again.

The country would need much help for some time. Personnel were conscious of the needs and would continue to press for improvements.

Jamaica – first follow-up, August 1975

Training of midwives and nurses had been lengthened to include more on family planning and nutrition and the importance of breast feeding was being emphasized. In-service training for existing personnel in these subjects was to begin shortly. In general, training was being remodelled to reflect the Working Party recommendations and there was close liaison between midwives and obstetricians.

There was no postnatal care of mothers or babies discharged after 24 hours.

TBAs were not recognized, and their recognition was opposed by midwives. Suggested that they be trained until they could be phased out.

The Association was active and keen to promote the expanding role of the midwife. The need for more promotional opportunities for midwives needed to be recognized.

The National Family Planning Board was co-operating with midwives and nurses in MCH. TBAs received no instruction in family planning. There was need for more motivation of adolescent girls in family planning.

– second follow-up, July 1976

The question of training TBAs was again raised, but strongly opposed by midwives who thought that most areas were sufficiently staffed by midwives. The need to upgrade the midwife was recognized and was being planned. A new midwifery school was ready to be opened but needed a tutor, preferably a MTD.

The USAID representative was interested and involved in the work of midwives. He had been approached for assistance in carrying out seminars and obtaining equipment and would be willing to help. USAID worked in close co-operation with the National Family Planning Board.

Family planning was well accepted; training in this subject continued to be given to students and midwives by the Board. Operation Friendship carried out full MCH/FP services, all run by nurse-midwives.

Training curricula were still being developed and appeared to be on the right lines, emphasizing community health.

There was need for midwives to give more support to their Association if they wished to be recognized as an important force in MCH services.

Barbados – first follow-up, September 1975

The recommendations of the Working Party had been discussed and it was agreed that expansion of MCH services was urgent. The training of nursing assistants was thought to be good, but there was no need for auxiliary midwives. In-service training was already being given in a limited form in nutrition, family life education, family planning and neonatal resuscitation. Postnatal care through the district services was an objective.

A family programme existed and was acceptable to all, but there was no enthusiasm for family life education in schools. Nurses and midwives were receiving training.

Compulsory immunization had existed for a long time.

No separate Midwives Association was ever likely to be formed.

In general the recommendations of the Working Party had been implemented; many had already been in force, and these were being strengthened.

– second follow-up, July 1976

Not much more progress had been made. Postnatal clinics were in operation, but more needed to be done. Nurses and midwives wanted more involvement in family planning; they were receiving some in-service training, and family life education talks were being given to in-patients.

Midwifery training was totally in hospital and there was no community experience. Some nutrition was included but little on family planning. Curricula needed to be reviewed. The Nutrition Centre was preparing a manual for all health workers.

The FPA had asked for medical help and this was being considered; nurses from family planning clinics had asked to attend postnatal clinics at Queen Elizabeth Hospital. No outreach follow-up programme for family planning had been organized.

Suggestions made: involve student nurses and midwives with medical students in family planning training, and generally improve this training. Give nutrition craft talks to mothers at prenatal clinics.

Belize – first follow-up, September 1975

Facilities included a School of Nursing and 18 rural health centres staffed by public health nurses (these are registered nurses, registered midwives and trained public health nurses). Staff also included rural health nurses (practical nurses) who had one year's nursing and one year's midwifery training.

TBAs operated in rural areas but were not allowed to work in the city. Some had received six month's training after which they were registered, received a certificate and a midwifery kit. They were supervised periodically. They were said to deliver 25% of mothers in rural areas. Many TBAs were reluctant to come forward for training.

The amount of nutrition in the nurses' training course had been increased, and there was more about family life education in the new midwifery curriculum about to be introduced.

The Nurses and Midwives Association had been re-established. Practical nurses were not members, but it was hoped to persuade them to join. The Association hoped to foster more in-service training.

There was no compulsory immunization of children before school entry; no follow-up of postnatal patients because of shortage of staff and no use yet of co-operative prenatal cards. Moderate progress had been made in family life education.

There was need to use the skills of all trained personnel and to promote the profession of midwifery.

Suggested that: classes on preparation for parenthood be held separately from prenatal clinics; registration of births be improved; TBAs who were trained might hold classes in rural areas.

– second follow-up, July 1976

The MCH programme was a tripartite structure by government, UNICEF and PAHO/WHO. Emphasis was on taking services to the community. A seminar had taken place attended by midwives of all categories, including TBAs. In one rural area visited, TBAs worked well together with rural health nurses.

Basic training for midwives was not going on but was discussed. It was hoped to reintroduce it soon so as to phase out TBAs. There was post-basic midwifery training for rural health nurses; the curriculum included family life education, nutrition and child care.

There was still no postnatal follow-up in Belize City, but immunization was shortly to be made compulsory for school entry.

Membership of the Association was increasing and it was agreed to strengthen the role of the midwife in its constitution.

Co-operative prenatal cards were still not used.

All were agreed on the need to improve MCH services, to establish post-natal follow-up in the City so as to reduce the incidence of gastro-enteritis and malnutrition, and to provide more in-service education.

Trinidad and Tobago, first follow-up, September 1975

There were two midwifery training schools and an on-going programme for those already trained. It was hoped to set up a unit for in-service education. Family planning was gradually being introduced into the course.

MCH/FP was being integrated into the Health Service and a new hospital, concentrating on MCH was to be built in a rural area. A Family Planning Institute was to be built. The practice of TBAs was illegal.

It was hoped to organize a Midwives Association and a constitution had been drafted.

A co-operative card for prenatal visits had been drafted.

Family planning would eventually be part of MCH services. The target was to open 10 new clinics annually, but this was not being met because of the need to refurbish existing clinics, and some areas were more needy than others. There were altogether 71 clinics, 8 of them for males only. 46 were integrated with pre- and postnatal and child and VD clinics. Midwives were involved in all cases. All methods were used, orals being the most popular. There was no follow-up of drop-outs. Few midwives were trained in family planning but efforts were being made to provide training and some in-service education was being provided. Training was designed only towards providing services.

Of the recommendations of the Working Party, some had been imple-

mented in advance of the meeting; others were now partly implemented; others not at all.

– second follow-up, July 1976

Midwifery and nursing curricula had been completely revised with greater content of nutrition and family planning.

In-service education of nurses and midwives in family planning had taken place and a further programme for hospital and community midwives was planned.

A Midwives Association had not yet started. The constitution that had been drafted would allow for a Midwives Section of the Nurses Association.

Postnatal care was still inadequate.

In family planning training there was now more emphasis on counselling and nurse-midwives were also to be trained in IUD insertion.

Haiti, first follow-up, January 1976

There was no midwifery training school, but the need for one was accepted and there was talk of setting up a course at the Isaie Jeanty Hospital. It was planned to expand the training of auxiliary workers. One school existed and it was hoped to open a second. These were multi-purpose health workers assigned to district MCH/FP clinics; they also assisted in the supervision of TBAs in rural areas. Their training included nutrition and family planning. Financial assistance to develop this training was being sought from Canada.

MCH/FP was well organized and variously financed. There were 22 integrated clinics, including four in the capital, staffed by nurses and auxiliaries. It was hoped to have 22 more over 10 years.

Community health workers took a three year course, including MCH/FP.

TBAs were trained to take part in the MCH services and to become members of the health team. Their curriculum seemed satisfactory – one day a week for 4/5 months after which they received a certificate and a delivery kit. A training manual was nearly ready; family planning was included in it. There was emphasis on asepsis to combat neonatal tetanus, and ATT was given at all MCH/FP clinics. UNICEF were responsible for TBA training.

8 nurses had been trained in family planning in the USA; some nurses undertook insertion of IUDs and they were studying how to train others to do this.

ICM were asked to help in curriculum and equipment for midwifery training.

– ***second follow-up March/April 1976***

1. In all services seen, nurse-midwives were involved in administrative work only; services to patients were provided by nurses and auxiliaries.
2. There was great need for more midwives to: improve maternity services in urban hospitals; provide clinical teaching and supervision to students in training hospitals and health centres; conduct training courses for TBAs; improve maternity and MCH/FP services at district hospitals; assist with patients referred by TBAs; supervise TBAs and auxiliaries at village level.
3. Training of TBAs was much appreciated and more cases were being referred to nurses and to hospitals. There were plans to train 20/25 TBAs in each of 20 existing MCH/FP clinics that year.
4. There were conflicting views on the type of professional midwifery training needed. National thinking tended towards a 3-year course while officials of aid organizations favoured shorter courses to meet immediate needs. (In correspondence in October/November it was said that plans for training would shortly be finalized.)
5. Information was obtained on the use of oral contraceptives and equipment for IUD insertions.

St. Vincent, June 1976

Family planning was now government policy through MCH clinics. The local association had not been included in the programme but continued its work. The government services were taking over, because they were free and were offered at prenatal clinics. Tubal ligation was offered as part of services.

Family planning was now included in nursing and midwifery training. In-service training for district nurse-midwives had begun to update their knowledge in family planning and nutrition. It was hoped to send five more nurses to Downstate Medical Center, New York, for family planning training. Midwives had not been involved in planning the national programme.

There were now 33 district clinics all staffed by nurse-midwives. All offered family planning advice, and six offered services.

Co-operative prenatal cards were not being used and there was no postnatal follow-up.

Immunization of children was routine, but not compulsory; it could not be afforded.

There was no thought of starting a Midwives Association or a special branch. There was a Nurses Association and most members were nurse-midwives.

A 3-day family planning seminar had recently been held for Public Health Inspectors and Community Development Officers.

Dominica, June 1976

Family planning and nutrition were included in the training for nurses and midwives. Student midwives took a one year postbasic course. This did not yet include community midwifery, but student nurses had one month in community health. In-service training was lagging due to lack of transport from rural areas. A 2-day family planning seminar for midwives had been planned for later in that month.

The MCH/FP programme was developing but there was room for further action. Nurse-midwives were very much involved, but there was a general shortage of staff. The family planning service was a national one and included female sterilization.

Postnatal follow-up in the capital was done in hospital clinics, and in rural areas by nurse-midwives.

There was a Nurses Association but no plans for a Midwives section in it.

St. Lucia, June 1976

No visit was possible, but progress made was discussed with the two delegates to the Caricom Workshop in Nursing Education in Antigua.

There was very good progress in developing MCH/FP services and family planning was well accepted.

Midwives were taught by a 14-month postbasic course which included very good family planning and nutrition sections. The additional two months was spent in community work. Postnatal follow-up was well organized.

St. Kitts, June 1976

Good progress was reported in implementing the recommendations of the Working Party, but there was concern over the increased number of hospital deliveries for which there was no follow-up care. Liaison was not good between hospital and community health personnel.

There were two single-trained midwives in practice; all others were nurse-midwives. Little family planning was included in the courses and the tutor was to discuss how this could be improved. There was no in-service education for hospital staff. Co-operative prenatal cards had been introduced. From 1977 pre-school immunization would be compulsory.

Family planning clinics were organized and managed by nurse-midwives for the FPA, there being no national programme. Family planning in hospitals seemed to be very limited. Talks had been given to school leavers and a clinic for teenagers recently started, but this had not been well received. There was to be a seminar on nutrition for public health nurses and nurse-midwives in the community field in July; hospital staff were not included.

The Nurses Association was lying dormant.

Montserrat, June 1976

Family planning had government approval but was not fully integrated into MCH. Postpartum contraceptive advice and examination, and advice on nutrition, were given to all mothers. All methods were used. Field workers gave advice in rural areas. Community workers were trained as motivators. There was a high drop-out rate, but follow-up by field workers. It was hoped that family planning might become part of MCH services after 1977. Sex education was given in schools and to school leavers, and there was a plan for seminars on sex education for teachers. Family planning and nutrition were well covered in student midwifery training and in-service training was continuous. Two nurse-midwives had been trained in family planning. Breast feeding was encouraged; immunization was now compulsory for school entry. There was a Nursing Association but no thought of a Midwives branch, as most members were nurse-midwives.

Antigua, June 1976

Midwifery training was one year postbasic. The content of family planning, nutrition and community health had been increased. In-service education was regular for community workers and ad hoc for those in hospitals. Midwives were being trained for administration and other expanded roles, and were fully involved in planning and policy making.

There was some improvement in prenatal care and a draft co-operative card had been prepared for consideration. High risk clinics had been established; student midwives gave parentcraft classes under supervision.

Breast feeding was encouraged but postnatal follow-up was limited and needed improvement.

Legislation was being enacted to make pre school immunization compulsory.

Family planning was not part of MCH, but the government did not hinder it.

There was a Nursing Association but it was thought that there was no need to consider a Midwives Association or a separate group within the Nurses Association.

There was still much to be done to improve training, upgrade midwives, and develop MCH.

Guyana, August/September 1976

Training had been expanded in family planning theory but there was still little clinical content. There had been no in-service education lately.

A study was shortly to be carried out on high risk patients and it was hoped to get students involved as part of learning experience and to

help them realize the role of the midwife in research. (It was later reported that this project had been completed but its value was somewhat lessened by poor records.)

Postnatal follow-up was still inadequate between 2 days and 6 weeks.

The prenatal co-operative card project had been partly implemented.

No meetings of the Midwives Association had been held because members did not attend.

VIII. Proposals for Future Activities; Achievements

(a) *Proposals for future activities*

1. Re-opening for midwifery school (Haiti).
2. Upgrading of midwifery education.
3. Advisory service needed for improvement of health education, including family planning.
4. Promotion of the midwife's involvement in policy making.
5. Development of midwifery sections in nurses associations.
6. Utilization of various health personnel as family planning motivators.
7. Midwives and nurses to insert IUDs.

(b) *Achievements*

1. Midwifery training period increased to accommodate expanded areas of training (Jamaica).
2. Midwives now receiving family planning training.
3. Family planning education programme for youths.
4. Formation of Midwives Association (Guyana).
5. New midwifery schools soon – Haiti requested advice on curriculum.
6. Postnatal clinics started. Family planning clinics integrated into postnatal clinics in some areas (Antigua, Guyana, St. Kitts).

APPENDIX I

List of Participants

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Belize
Mrs. Belle Lovell
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St. Lucia
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Miss Kate Lorig
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APPENDIX II

List of Papers Presented

1.	The Ten Year Health Plan of the Americas	Dr. Irial Gogan PAHO/WHO, Barbados
2.	From the Beginning	Miss Marjorie Bayes Executive Secretary, ICM
3.	What are the Priorities for Maternal Care?	Mrs. G. Omphroy-Spencer Jamaica
4.	Priorities for Child Care	Dr. Keith McKenzie, Jamaica
5.	The Place of Nutrition in the Priorities of Maternal and Child Health	Dr. F. C. Ramsey University of the West Indies
6.	Maternal and Child Health and Family Planning	Dr. A. Wynante Patterson Jamaica
7.	Maternal Child Health/Family Planning in Barbados	Miss Elayne Scantlebury Barbados

8.	Maternal and Child Health and Family Planning Programme – Trinidad and Tobago	Dr. Andrew Bhagwansingh Trinidad
9.	Maternal and Child Health/ Family Planning Programme in Grenada, Carriacou and Petit Martinique	Dr. Desmond Noel Grenada
10.	Overview of the Program of Maternal and Child Health and Family Planning in the Division of Family Hygiene in Haiti	Dr. Jn. N. Cadet Haiti
11.	Maternal and Child Health/ Family Planning in Belize	Dr. Lionel A. Clare Belize City Hospital
12.	The Role of the District Midwife in Family Planning	Mrs. Hazel Sinclair Jamaica
13.	The Role of the Hospital Midwife in Family Planning Programmes	Mrs. P. Hinds Barbados
14.	The Traditional Birth Attendant – Haiti	Mrs. Antoine Cesar Stenschke Haiti
15.	The Traditional Birth Attendant – Belize	Miss Belle Lovell Belize
16.	Family Life Education – Its Relevance for Health Workers	Mrs. Carmen Jamaica
17.	Selected Health Problems and Needs Associated with Jamaica Family Life Having Implications for Family Life Education	Bureau of Health Education Jamaica
18.	Legislation	Mr. R. J. Fenney, ICM
19.	Paediatric Content in Expanded Areas of Training for Midwives	Dr. Keith McKenzie Jamaica
20.	Expanded Areas of Training for Midwives (Implications for Nutrition)	Miss Patricia M. Pena Barbados
21.	Family Planning and how it could be integrated into the Midwifery Curriculum	Miss Helen Christian Trinidad and Tobago

22.	Family Planning Manpower	Dr. Willard Boynton Office of Population, USAID
23.	Continuing Education in Family Planning	Mrs. Thelma Grant Downstate Medical Center, New York
24.	Curriculum Development	Miss Kate Lorig ICM

FRANCOPHONE WEST AFRICAN WORKING PARTY, DAKAR, SENEGAL, 17th – 23rd NOVEMBER, 1974

Participating countries: Dahomey (now Benin), Ivory Coast, Mali, Mauretania, Niger, Senegal, Togo

Upper Volta and Guinea did not accept the invitation to attend.

I Preliminary visits

No detailed record of these visits is now available.

II Organization

Mrs. Kone-Diabi, ICM Regional Field Director for Francophone Africa was responsible for planning and organizing the Working Party. She was assisted by other ICM staff and consultants, and by a local planning committee consisting of four members.

III The Working Party

(a) *Attendance:* Those attending comprised:

(i) 24 participants from Dahomey (3); Ivory Coast (3); Mali (3); Maritania (2); Niger (3); Senegal (8) and Togo (2).

(ii) 4 male nurses and social workers from Senegal.

(iii) 23 observers and speakers from Senegal (11); Dahomey (1); Cameroon (1); USA (1); WHO (9).

(iv) 5 representatives of ICM

(b) *Chairman*

Professor P. Correa, Chief, Department of Obstetrics and Gynaecology, Faculty of Medicine and Pharmacy, University of Dakar, served as Chairman of the Working Party.

(c) *Programme*

The programme was organized around five themes:

(i) Problems and priorities in maternal and child health in West Africa.

(ii) Search for a common concept of family planning for West Africa.

(iii) Organization and development of family health services including family planning and the role of the midwife in these services.

(iv) Integration of family planning in the training of midwives of all categories.

(v) Place and role of traditional birth attendants.

A full day was spent on each. In the mornings papers were read, and in the afternoons the participants split into three discussion groups to consider the themes in greater depth. Reports from each

group were given to plenary sessions and formed the basis of the final report and recommendations.

(d) Summary of proceedings

The Working Party began with five opening addresses. Mrs. Kone-Diabi, Regional Field Director, ICM, summarized the topics which would be dealt with and emphasized the complex problems of the controversial topic of family planning which needed to be solved. The aim of ICM was to help governments improve the quality of care given to mothers and children. She thanked all those who had given permission for the Working Party to be held and those who had made it possible.

Professor P. Correa, the Chairman, congratulated the ICM on their initiative in organizing the meeting. He said that it was important to respect the independence and culture of each nation and to take in information from whatever source and use it as seemed best. Family planning should be a comprehensive scheme for family welfare and should be regarded as just one aspect of the problem of raising living standards of the developing countries. Midwives because of their wisdom and maturity, would know which new ideas they should accept and which reject.

Professor Sankale, Dean of the Faculty of Medicine and Pharmacy, University of Dakar, spoke of the paradox of medicine seeking to save life and at the same time trying to limit births. It was the quality of life that was important, and the health of the mother affected all other considerations. Responsible parenthood was required and only the midwives and obstetricians fully understood how family planning could be accepted and practised in African countries.

Speaking on behalf of Miss M. Bayes, Executive Secretary, ICM, Mrs. Denison then gave a brief history of ICM, its objectives and world-wide plans to improve the quality of MCH care, with emphasis on the training of TBAs.

Finally, Dr. Papa Gaye, Director of Public Health, Senegal, representing the Minister of Health and Social Affairs, stressed the importance of caring for the mother and child and the vital role of the midwife in this function. Family planning had to be looked at in the whole context of professional ethics on the one hand and of the well-being of the family and the needs of the community on the other.

The participants in the Working Party were then introduced, country reports given, and the organization of the Working Party explained.

The general subject for Monday's sessions was *Problems and*

Priorities in Maternal and Child Health in West Africa. The proceedings opened with a paper by Senior Professor E. Alihonou, Chief in Obstetrics and Gynaecology, The University, Cotonou, Benin, on *Maternal and Child Health in West Africa.* He listed the reasons why the health of mother and child were so vital, and the problems which arose in general health and in the particular areas under review – pregnancy, delivery and the puerperium and infant and child care. The solution to these problems lay in the provision of MCH services and in setting up the organization required to deliver these services. Integration of all available resources was necessary and members of health teams should have clearly defined functions. Evaluation of the results of the development of services was important and depended on the keeping of adequate records.

Problems and Priorities in Maternal and Child Health in West Africa was the subject of a paper by Dr. Papa Gaye, Director of Public Health, Senegal. After describing the problems common to all West African countries he went on to outline the particular problems of MCH care. High mortality and morbidity were due to lack of supervision of mothers and children because health coverage was poor and to ignorance of the population on questions of health and nutrition. He suggested the following order of priorities: i. Maximize the number of supervised deliveries by means of more maternity centres, more trained staff (including TBAs); ii. give health education and develop preventive medicine (immunization, family planning, dietetics); iii. improve the standard of living. Co-ordination of these activities required planning.

The Role of the Midwife in the Framework of Nutrition in West Africa was dealt with by Dr. Thianar N'Doye, Director of BANAS in Senegal. He explained how environment affected nutrition and described the programme of nutrition and health protection for the vulnerable groups in Senegal. The midwife was the main source of health care to mother and child, but often lacked training in nutrition, although paediatrics helped to make up the deficiency. There was need for changes in the training courses and for greater provision of specialist and postgraduate courses.

Health Education was covered by Dr. Ibrahima Beye, Assistant Chief Medical Officer of the Health Education Bureau, Ministry of Health and Social Affairs, Senegal. Health education was 'the learning of laws leading to a healthy life'. It was justified on both health and economic grounds and was based on individual and social need, grounded in the culture and traditions of the country. Its aim was to create a new concept of health and illness within the community, and its agents were all those involved in the health services of the country. The midwife was now less involved in the

processes of delivery and more concerned with total MCH care. Not only did she provide services, but she acted as educator in the total context of family life, and especially in a preventative role.

The final talk on this general topic was given by Professor M. Vovor, Gynaecologist/Obstetrician, Director of the Togo School of Midwifery, and the afternoon was spent in discussion of these subjects.

On Tuesday the theme was *The Search for a Common Concept of Family Planning for West Africa,* and the views of the church and of communicators were given as well as those of doctors and midwives. Mr. L. Savane, Head, Office of Statistics, Senegal, spoke of family planning in the context of the population problems of Africa, and of the different views of those in overpopulated countries and those where population growth was acceptable. Africa needed to decide what it wanted. Laissez-faire policies had not worked, and it seemed best to integrate family planning into MCH so as to keep a proper balance in the provision of services and to counter the evils of uncontrolled abortion.

Mrs. d'Erneville, Journalist and Director of Broadcasting and Television Programmes, Senegal, spoke of the need to present family planning in a way which did not offend the traditions and ethics of African family life. Sex education needed to stress the responsibilities of parenthood and required co-operation between the medical profession and journalists.

Abbe Leon Diouf, Vicar-General, Senegal, restated the official Roman Catholic view on contraception, i.e. the general moral prohibition of artificial methods and of abortion, and acceptance of the rhythm method only.

Professor Amar Samb, Faculty of Letters and Human Sciences, University of Dakar, presented the Muslim view by reporting on the seminar held in Rabat in 1971 to examine the effects of social changes, including family planning, abortion and sterilization, on the Muslim family. There had been a majority who thought that contraception was not contrary to the teaching of Islam, but abortion was only acceptable if there was risk to the health of the mother or the likelihood of an abnormal child being born. Abortion was not acceptable as a means of birth control. Most were in favour of sterilization.

Mrs. M.A. Savane, Chief Editor, *Family and Development,* Senegal, spoke on *Sex Education within Family Health.* She described how 'Western' influences had permeated African life and added a new sexual dimension to the traditional initiation rites of young people. Sex education was necessary and should build on the old traditions.

It should take place in the home and in schools and should be part of the training of teachers.

After the views of a paediatrician, Senior Professor Mohamadou Fall (Dakar), and of an obstetrician, Senior Professor Fadel Diedhou (Dakar) had been given, Mrs. Siga Sene, Vice-President of the Economic and Social Council of Senegal, presented the midwife's point of view. She said that in the face of traditional practices to counter sterility and to space births, and of being compelled to witness the sad state of women and children suffering from sterility or illness or from the hazards of untrained assistance, family planning seemed to the midwife the best means of improving the happiness and well-being of family life. Planning was necessary at national level to achieve these aims.

Discussions followed these presentations and reports were made to the plenary session on Wednesday morning.

The next theme was *The Organization and Development of Family Health Services including Family Planning and the Role of the Midwife in these Services.*

Dr. Diop Leye, Gynaecologist/Obstetrician, Lubke Hospital, Dakar, Senegal spoke first on the *Integration of Family Planning into MCH Centres and Public Health Programmes.* The reasons for adopting this course were (1) medical – for the health of mother and child; (2) efficiency – it was the best way of spreading the acceptance of family planning; (3) economic – it took advantage of existing structures; (4) psychological – it preserved confidentiality. Integration was achieved by training at the professional level (including the co-operation of TBAs); using contacts with women at any stage of the MCH cycle; the use of all media and of personal contact for communication and education; and the development of government policy. It was essential to retain a balance between MCH and family planning and to have adequate organization of staff, premises, funds and supplies.

Professor Bocar Sall, Surgeon-in-charge, Du Point G. Hospital, Mali described the *National Programme of Birth Control in Mali,* which was established following legislation in 1972. A family planning centre was set up in Bamako under the Ministry of Health and Social Affairs and was managed by a Malian doctor. Its activities fell under four sections – medical, research, information, education and statistics. The medical section comprised 15 doctors, midwives, social workers and male and female nurses, all nationals, and all trained in family problems. Their work involved information and education of patients, supply of contraceptive services and examination of sterile couples. The indications and the various methods were still being considered. Some branches had already

been opened and others were being planned. Family planning was being introduced into the training course for midwives.

Miss Susan Nalder, Public Health Nurse-midwife, then presented a paper by herself and Dr. G.S. Walter, Obstetrician, Director of Public Health, both from the Maternal and Child Health Project of the University of California Santa Cruz in Dahomey. The subject was *The Expansion of Maternal and Child Health Services.* She listed three factors giving rise to poor health: unhealthy environment, inadequate health organization and lack of communication and transport. Expansion of services implied improvement of quality as well as quantity; care better related to the needs of the community; better utilization of existing resources. Action should be related to examination of existing services and reorganization where necessary. The participation of TBAs should be encouraged. Midwives should be leaders of health teams and not necessarily be devoted only to giving clinical care. Overall leadership devolved on the Ministry of Public Health who needed to decide policy and priorities, establish regulations, create an administrative structure and suitable training facilities, and ensure that the senior personnel under his authority carried out all the tasks necessary to produce continuous improvement in MCH services and the provision of data for evaluation purposes.

Visits were paid to the local branch of the Blue Cross and in the afternoon group discussions took place, reports on which were given as the first item on Thursday morning.

The fourth topic – *The Integration of Family Planning in the Training of Midwives* was then taken. Miss M. Pellegrin, Superintendent Midwife, School of Midwifery, Senegal, was the first speaker. She said that there was no official family planning training in the Midwifery School at Dakar, but the subject had been dealt with in the third year as part of public health. This had meant clear identification of the objectives of the training to fit into government health policies. The subject was now integrated into every aspect of the course and in-service training was a regular part of the system. She emphasized the need for continuous education and refresher courses.

A paper on *The Midwife in Family Health. The Role and Formation of the Health Services – The Need for Evolution* was then presented by Dr. Jean Martin, responsible for MCH training, Univeristy of North Carolina, Representative of African Centre Project for Education in Social Sciences, Yaounde, Cameroon. She began by stressing again that family planning was an integral part of family health, but only a part of it, and the fact that a widening of the role of the midwife did not imply any diminution of the

need to train her for her traditional functions. She referred to the nurse-midwife training programme of the University of Lagos, which equipped midwives to fulfil a wide role in rural areas under the supervision and encouragement of doctors. The supplementary health functions for which nurse-midwives were being trained were (i) *obstetrics:* management of normal pregnancy and labour; recognition of high risk cases and their referral; health education, especially on nutrition; some practice of obstetric pathology and emergency treatment of complications; resuscitation of mother and newborn; postpartum supervision and encouragement of breast feeding; health education re care of the newborn; supervision of and collaboration with TBAs. (ii) *gynaecology:* gynaecological examination; digital curettage; advice in common conditions. (iii) *family planning:* advice on various aspects, including sterilization; knowledge of available methods; general supervision and advice on side-effects; preliminary investigation of sterility. (iv) *supervision of children:* growth and normal development; recognition and treatment of common complaints; preventive measures. (v) *public health — community health:* health education; health teamwork; home visiting; learning how to teach. These new items should not only be part of basic training but also be the subject of continuous refresher training.

Dr. Roger Castadot, Expert in Training, Population Council, New York, then spoke on the *Integration of Family Planning in the Training Programmes of Midwives of all Categories.* He said that the problem was how best to meet the needs of the country with limited funds available. The training of various categories of midwives made different demands on resources, but each had their own role to play, including the TBA. The extent of family planning training offered would depend on the objectives and on the ability of the personnel and the functions expected of them. Teachers needed to be free of bias and also to be familiar with the work environment of their pupils. Methods of training should employ all modern teaching devices and evaluation must be carried out throughout training and afterwards.

There followed a talk on *Midwifery Training in the Ivory Coast* by Mrs. Kone, Midwifery Teacher, Abidjan School of Midwifery, after which Mrs. M. Deves, Jurist of the Economic and Social Council of Senegal, spoke on the *Integration of Family Planning in National Development Planning.* All countries were establishing national development plans, and the logical sequence was a demographic policy leading to family planning being integrated into a development plan as the pivot of economic and social development. Midwives and nurses had a role to play in convincing government officials to inaugurate and carry through such policies.

Group discussion on the Integration of Family Health in Midwifery Training followed and the groups reported to the plenary session on Friday morning. After this a visit was paid to the Touba Toul Maternity Hospital, Khombole, where Miss A. Koate, Health Worker, Centre of Social Paediatrics, gave a talk on *TBAs in Senegal,* followed by an address by Mrs. M.L. Naassou, MCH/ Family Health Midwife, Togo, on *Rural Midwives* in Togo. She described the traditional practices employed in delivery and child care by the TBA and the need for their supervision and training. A new category of auxiliary midwife had been set up to meet the great need for trained personnel. They had an 18-month course, and 317 had been trained (there were only 187 professional midwives). Details of the curriculum were given. Her role was both preventative and curative to both mother and child. WHO had given assistance in this project.

At the plenary session on Saturday the Working Groups reported again; evaluation of the seminar was conducted, the final report discussed and approved and group discussions held on plans for implementation of the recommendations by individual countries.

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

IV Reports of the Working Groups

(a) ***Problems and priorities in maternal and child health in West Africa.***

Common problems were:

1. Socio-economic and cultural characteristics:
   Ignorance of rural populations on health matters,
   Strong traditions preventing health education,
   Low percentage of school attendance by rural population,
   Influence of poor income and low purchasing power of money,
   Economic dependency.

2. Health aspects.
   Inadequate health services especially in rural areas.
   Shortage of staff and uneven distribution of personnel – mainly allocated to cities although 70–80 per cent of population lived in rural areas.
   Inadequate supply of pharmaceutical preparations.
   The unfriendliness of the health centre leads women to prefer the services of the TBA.
   Lack of transport and poorly maintained vehicles.
   Absence of supervision.

The most deprived groups were: rural populations, low-income families, children aged 0–5 years, mothers.

It was agreed that TBAs should be given proper training and close supervision as they took care of most deliveries in rural areas and were even preferred in many cases in areas where health centres existed.

In order to promote a solution to the problems:

1. The midwife must be represented in government decision-making organizations.
2. The midwife must be given polyvalent training.
3. There must be efficient supervision.
4. The midwife must have training in education, organization and administration.
5. Close co-operation between all members of the health team was essential.
6. The TBA should be integrated into the health team.

(b) ***Search for a common concept of family planning for West Africa***

1. **Population problems**
   (i) Family planning, interpreted as birth control, would not solve the problem of the rapid population increase in the region (2.6% per year) especially as the value of such a policy would not be seen for a long time.
   (ii) It was recognized that better standards of living and the improvement in the status of women were accompanied by smaller families.
   (iii) Poverty and ignorance hindered development.

2. **The basis and characteristics of an African family**
   (i) Broadly speaking, Africa was pronatal and couples were encouraged to reproduce. Maternity meant stability for the married couple; sterility led to polygamy and divorce.
   (ii) Traditional rites were part of sex education.
   (iii) In their so-called traditional societies, family planning employed for birth spacing and for the treatment of sterility was in practice.
   (iv) Rules of conduct dictated by religious beliefs or animism were accepted by all.

3. **Rationale of family planning**
   (i) Breast feeding must be encouraged because it contributed to the establishment of a close mother/child relationship.
   (ii) From the religious point of view, family planning had a positive effect when it brought happiness to the husband

and to the family. The problem of the techniques used lay with the conscience of the individual.

(iii) The African family accepted family planning as treatment of sterility and for the spacing of births, and in this sense it formed part of the health services.

(iv) Family planning was aimed at regulating fecundity and thereby pregnancy, which must never be terminated unless the mother's health was at risk.

(v) Family planning must encourage the father to take a more active part in family life and educate young people to understand and recognize their responsibilities in sex matters.

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

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

The attitude of African governments to population growth control was not easy to define since each country had its own views. The wish to limit was easier than the actual limitation, and it took 20 years to get results. Countries such as Egypt, Pakistan, Ghana and Kenya had had nothing but disappointment in their population control and a new approach must be considered if effective solutions were to be found. Cameroon believed that it could still let its population increase; Ghana had a population policy but had since reviewed its programmes; family planning and birth control were tolerated in Nigeria but there was no government population control policy. One did not advertize a population control policy; problems had to be reviewed in a broad way in order to achieve results.

The question was raised of the possibility of reaching a middle attitude between Islam and Roman Catholicism. Mr. Samb emphasized the fact that both groups had heavy responsibilities. According to Abbe Diouf the difference lay in the means by which family life was promoted.

Mrs. d'Erneville said that Africa had had the wrong introduction to family planning and that its ground was badly prepared. She underlined the need for population information by broadcasting, and the Senegal Broadcasting Corporation had attempted to popularize certain issues by calling on the help of technicians, e.g. midwives, doctors, in approaching some taboo subject. However, delicate

problems such as sex education and family planning had to be handled with great caution.

It was agreed that sex education should be given at school. Mrs. Savane pointed out that schools reached only part of the population and only the public authorities could act in a positive manner. Only if sex education was understood could it function properly and public authorities must adopt a definite attitude. There was a psychological and pedagogical problem in that African young people were unaccustomed to a straightforward and natural approach to sex education.

(c) ***Organization and development of family health services, including family planning, and the role of the midwife in these services***

1. **The Role of the Midwife**

   It was agreed that the role of the midwife should include: information and education; administration; medical and paramedical services; research; evaluation.

2. **Organization**

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

3. **Legislation**

   The midwives considered that a predominant place should be given to legislation to safeguard the mother and child by defining the responsibilities of each member of the health team. They also wished to see the establishment of an insurance scheme for the protection of practitioners in the event of complications arising.

(d) ***Integration of family planning in the training of midwives of all categories***

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

There were differences of opinion on the training of auxiliaries. Some thought that the training of different categories of personnel for the same task was dangerous, and problems of re-classification would occur should the country ever have enough qualified staff. Dr. Castadot thought that auxiliary staff were not needed in countries where health services were available everywhere, but that was not the case in West Africa. In countries with inadequate health services it was advisable to train auxiliary personnel to be responsible for certain tasks. Each country had to decide for itself.

On training programmes, one participant warned of the dangers of including more topics in the existing curriculum; he thought that theory should be shortened in favour of the practical aspects. This view was shared but with some reservations. Theoretical knowledge was vital in the training of senior personnel. It was important that the content of the training programme should vary according to the category of personnel being trained and that the training of auxiliary midwives should be limited to a certain number of techniques which should be repeatedly practised, e.g. vaccinations.

The modern tendency was to establish a basic core training from which different groups of students branched off for a limited period during nursing or midwifery training. This seemed to be economical and likely to promote team spirit but some said that the grouping of students did not necessarily ensure teamwork and could result in exceedingly large classes.

There was great need for the publication of African textbooks, especially manuals of practical care, such as those which had appeared in Nigeria.

The problems of continuity in training and of refresher courses were examined. The functions of the midwife had to be considered in terms of the community's needs, but midwives were undertaking tasks for which they were not trained. It was important, therefore, to further her training in the following areas: gynaecological problems; the teaching of sex education; teaching in organization and administration; pedagogical training; psycho-sociological training and the teaching of approach and communication methods; family planning and contraceptive methods; civic education; practical training; and teamwork and the sense of responsibility.

The lack of continuity in training and of refresher courses was deplored. Training could not give everything to the student; the desire for improvement had to be present also. It was necessary to promote and establish permanent systematic refresher training by means of: periodic refresher courses; inter-departmental meetings; conferences, seminars, opportunities for travel, group discussions; periodicals; participation in writing articles for newspapers and journals. Refresher courses were primarily the responsibility of midwives, supported by doctors and public health authorities, and should be held within services, in training schools, counties, districts and at national level.

The participants insisted on the importance of continuing evaluation by observation during training and service. This could be done by direct observation in the field, questionnaires, activity reports, reports on individual progress and files on discipline and behaviour.

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

All agreed that the standards of general education required of those entering midwifery training should be higher, and that aptitude tests should be introduced.

(e) ***Place and role of traditional birth attendants***

This discussion resulted from a visit to Touba Toul, a small village 100 km from Dakar, where a rural maternity service had been set up consisting of delivery huts built by the population and managed by TBAs who were identified and periodically given refresher courses by government, whose primary objective was to reduce the infant mortality rate caused by umbilical tetanus, which had been very high in rural areas.

This experiment showed that TBAs were to be reckoned with; they had the confidence of the women and assisted at more than 80% of confinements. Their primitive methods of working could have grave consequences where there was dystocia and their ignorance of the essential rules of asepsis could cause infection. It was important to know them, train them for simple tasks, and to supervise and control them. The first positive result of the experiment had been a sharp decline in the incidence of neonatal tetanus.

The Togo experiment of training auxiliaries was discussed and thought to be a good solution under existing conditions, but when enough qualified midwives had been produced, the problem of rural midwives who could not attend refresher courses would have to be considered.

The groups reached the following conclusions:

TBAs existed in all countries of the region and assisted at more than 50% of confinements; they had great influence in the community; their advice on methods and traditional practice for conception or contraception was an advantage; after being trained, the TBA could help to bring new concepts of health to her own community. They should be integrated into health teams with junior status, and as far as possible should not be employed in institutions.

The objectives of their training should be: abolish inexperienced methods of practice; give simple education in elementary hygiene and child welfare; teach the basic methods of conduct of pre-, intra- and postnatal care; give elementary care to the newborn and to the mother after delivery (cut and dress umbilical cord, care of eyes, vulval toilet); report births and deaths in their own community for registration.

Their area of practice should be in their own community; control should be exercised by mobile teams, on the spot evaluation of their practice could be undertaken by the team in unannounced control visits according to number of normal deliveries attended; absence of complications during delivery and postnatally; absence of umbilical tetanus.

Solutions for the future seemed to be either to form an intermediate body of auxiliary midwives who would mostly practise in rural areas, or to increase the number of pupils in midwifery training schools in order to provide satisfactory health services as quickly as possible.

V Final Report and Recommendations

(a) *Problems and priorities*

The common characteristics of the countries were:

Geography: hostility of the environment.

Politics: subdivision into states.

Population: underpopulated, but with high population growth rate (2.6%). Mothers and children formed 60–70% of the population. Deprived groups : rural populations, low income groups, mothers and children aged 0–5 years.

Socio-economic and cultural factors: economy strongly dependent on industrialized countries; low income; primitive working conditions; poverty, ignorance, illiteracy and low school attendance.

Health aspects: High rates of morbidity and mortality; inadequate health services; insufficient and bad distribution of personnel, especially in rural areas; lack of pharmaceutical products; lack of transport; absence of supervision.

Health problems: Poor hygiene; prevalence of infectious diseases; undernourishment and malnutrition; parasitism, anaemia; absence of reliable statistics.

It was difficult to dissociate problems and to identify priorities, as each country had its own peculiarities. In spite of all these negative factors, the fight was to promote family health. To answer the health problems, the midwife, who was an essential member of the health team, had to receive an adequate training.

(b) *Search for a Common Concept in Family Planning*

Family planning, which included birth control or birth limitation, was not an efficient way to reduce population growth rate quickly. The effects of such a policy were long-term (taking about 20 years), by which time the data which had motivated these policies were

unreliable. Increase in standards of living and improvement in the status of women were accompanied by a reduction in family growth.

The characteristics and structure of the African family were discussed and the following conclusions reached:

1. Fertility was still very important in their culture.
2. Traditional or religious beliefs dictated the behaviour of the group.
3. Traditional education included a sexual education phase practised with initiation rites.
4. Family planning, in the form of birth spacing and treatment for sterility was still practised by traditional methods.

It was agreed that family planning should be designed to fight sterility; respect the biological rhythm of the family; promote breast feeding; encourage the father's participation in family life; educate young people to understand and recognize their responsibilities in sex matters.

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

(c) ***Organization and Development of Family Health Services – Role of the Midwife***

For the sake of efficiency, new structures should not be created, because of poor human and financial resources. Neglected or non-existent services should be developed and integrated into services already existing.

The role of the midwife could be summarized as: information and education; administration; medical and paramedical services; research, evaluation.

The Working Party recommended the establishment of legislation to study and define the responsibilities of each member of the team and to standardize techniques for the minimum procedures which a midwife was permitted to carry out.

The Working Party recommended an insurance scheme for the protection of midwives when complications occurred.

(d) ***Training and Improvement of the Practice of Midwives***

The functions of the midwife should be considered in terms of the needs of the community, but the midwife was not always trained to fulfil some functions she was expected to perform. It was necessary to: intensify gynaecological training; add the teaching of

sex education; teach organization and administration; give pedagogical training; develop psycho-sociological teaching and methods of approach and communication; train midwives in family planning including contraceptive methods; include civic education; develop practical training; develop her sense of responsibility and her awareness that she belongs to the health team.

The lack of continuing training and of refresher courses was deplored. Refresher courses should be held in an institution. They were primarily the responsibility of midwives, supported by doctors and public health authorities. They should be held within services, in training schools, counties, districts and at national level. Continuing evaluation during training and during service was important.

An African Federation of Gynaecologists, Obstetricians and Midwives should be created from the national associations already existing or to be created.

Midwives should be associated with central organizations concerned with conception.

It was recommended that governments review teaching programmes in the light of defined objectives. There should be a regional conference to study the problem of the co-ordination of teaching programmes and the validity of diplomas. Standards of education required of entrants to midwifery training should be higher and aptitude tests introduced.

The problem of revaluing the profession was debated.

(e) ***Place and Role of the Traditional Birth Attendant***

The TBA still existed in all countries of the region and assisted mothers in more than 5[illegible]% of confinements. They were usually old but had great influence in their community. It was agreed that their practice should not be institutionalized as their numbers would reflect adversely on the obstetrical standards of the countries.

The majority agreed that it was necessary under existing conditions to register and train TBAs for simple educational and technical tasks, and to supervise them.

For the future, the possibilities were either to form an intermediate body of auxiliary midwives who would mostly practise in rural areas, or to increase the number of pupils in midwifery training schools in order to reach precise objectives laid down in the national planning framework, and to make rural zones more habitable. It rested with each country to experiment and apply solutions appropriate to their needs.

At the close of their report, the participants expressed their thanks to the Chairman and to all other members of the Working Party; to ICM for having given them the opportunity to meet each other and reach towards a better understanding; to the Dean of the Faculty of Medicine who had afforded such comfortable working conditions; and to the Minister of Health who had given permission for the Working Party to be held, thus allowing midwives to update their knowledge and improve their practice.

VI Evaluation Questionnaires and Analysis of Replies

1. Q. Do you consider that we have achieved the aims of this Working Party?

   A. Yes – 19; No – 0; Partially – 3.

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

2. Q. Which sessions have you found to be most interesting, interesting, least interesting?

   A. *Most interesting:* The concept of family planning (15); Integration of family planning in midwifery training (11); Problems and priorities in MCH (12); Role of the midwife (10).

   Interesting: Traditional birth attendants (4); Auxiliary midwives (3); Nutrition (3); Training (3); All (3).

   Least interesting: None (22).

   Give reasons for your choice: Most frequent comments were: richness of the discussions on family planning; all the sessions had responded to the realities of their situations and needs; family planning was a new, controversial and important subject; TBAs were a reality in their countries and integration posed real problems. One participant commented that contraception was an individual rather than a general problem.

3. Q. Do you think the content of the programme was of value to your country?

   A. Yes – 20; No – 1; Yes and no – 1.

   If no, please explain.

   One said that family planning already existed in his country; another that the problem of the TBA did not exist in his country.

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

   The majority commented on the need to encourage government officials to provide a structure in which people could make a

choice regarding family planning; the need to encourage the development of MCH services which included family planning and other important health services; the need to inform and motivate the public on family planning and later to create a pilot centre for family planning consultations and services; the need to include family planning in the training of midwives; the value of organizing midwifery associations to be concerned with their problems.

4. Q. What additional help do you need in implementing the Working Party recommendations in your country?
   A. Support of our governments; money; materials and assistance of experts; training of key personnel in family planning; legislation; support of WHO and other external agencies; additional seminars.

5. Q. Has this Working Party provided a background for introducing family planning into midwifery training programmes?
   A. Yes – 21; No – 1.
   The participant who said no explained that family planning had been included in his country's training programme for the past two years.

6. Q. How has this Working Party influenced your own thinking about the expanded role of the midwife and family planning?
   A. It had helped some to see the increasingly critical need to integrate family planning in the training of midwives. Other comments were: the harmonization of births was not new – the need was to adopt more effective methods; the discussion had given to 'family planning' an acceptable meaning which conformed to our ethics; I shall return to work in family planning with more courage and determination. Only one participant said 'no influence'.

7. Q. How do you feel about (1) organization of the meeting; (2) group discussion methods: (3) library and resource materials?
   A. (1) Very useful – 16; useful – 5; not very useful – 0.
   (2) Very useful – 17; useful – 3; not very useful – 0.
   (3) Very useful – 5; useful – 8; not very useful – 1.

8. ***General Comments***
   Almost all the participants thought that the programme was too full (we should have had ten days and time might have been better planned). Others appreciated the high level of discussion; it had served as a refresher course; the recommendations should be sent to governments; a seminar of this type should be held every three or four years and should include both anglophone and francophone countries as well as additional categories of health personnel; more preparation of the participants before the seminar would have been

helpful; the resource material seemed to over-influence the discussion.

VII Follow-up Visits

Dakar, Senegal, March 1975

The purpose of the visit was to see Mme. Kone-Diabi and to obtain an account of her activities and to sort out problems of communication which was done.

Meetings had been held with senior government officials and with midwives and on the whole it could be said that the objectives of the Working Party had been reached. The impact of the Working Party in Senegal had been great and the subject of family planning was no longer taboo. A meeting of midwives had been held on 9th March to study the status of midwives and consider their role in International Women's Year, to re-establish the Midwifery Association and consider affiliation to ICM.

Rennes, France, February 1975

A meeting of doctors and midwives from developing countries was held to determine the theoretical and practical content of family planning training to be taught to overseas pupils at the Rennes school. The chairman was Dr. Pierotti, Chief of the MCH section. The title of the course had been changed to 'birth regulation' which better interpreted the African view that sterility as well as birth spacing had to be dealth with. Problems that had emerged over the two years for which the scheme had run were: (1) the different educational standards of the students; (2) the teaching was more theoretical than practical since they could not create the local conditions applying in each country in order to give practical training. It was desirable that the school should move to an African country, but at that time only Tunisia and Zaire were in a position to organize practical training.

Conclusions were:

1. The criteria of recruitment should be basic educational standards plus motivation.
2. Suitable family planning methods were the pill and the IUD and (in Tunisia and Zaire) Depo-Provera.
3. Doctors, midwives and nurse-midwives from Zaire were acceptable personnel for clinical work; the non-clinical aspects could be performed by all members of the health team.
4. In the Rennes course, African pathology needed to be stressed, and in practical classes simulation methods should be adopted. Evaluation at the end of training should eliminate incompetent students.
5. A list of minimum material necessary to start a pilot centre was established.

6. The role of the midwife in the investigation of sterility and its management was laid down.
7. Progressive transfer of the school to an African location was an objective.

Togo, March 1975

The Association for the Family's Welfare had been founded. It was recognized by government and the Planning Minister was President. There was much public interest. The Association had organized a Working Party on Family Welfare and Development attended by delegates from Togo and many African countries, which meant that people whom it had been hoped to see were not available. From discussion with some of the representatives from Upper Volta, it appeared that their absence from the Working Party in Dakar had been due to a misunderstanding.

The Zong family planning centre had been opened in December 1974 and had been organized by Mme. Naassou and equipped by IPPF. Attendances had been good.

A refresher course in family planning would shortly be given to auxiliary midwives.

The Midwives Association was applying for membership of ICM. They were also asking for assistance to enable delegates to attend the Lausanne conference.

Ivory Coast, May 1975

There would be no government policy on family planning but it was known and accepted that those who wished it received advice and services from Professor M. Sangaret of the Treichville Maternity Hospital. He was shortly to establish a family planning service at the hospital and would need models and supplies. The future of family planning in the Ivory Coast would depend on him and his team for the next few years.

Although there were only 409 midwives and 75 maternity hospitals with a total 3,248 beds (of which 509 were in the capital), the government wished to eliminate TBAs. Many still practised but the government ignored them. The 5-year plan ended in 1975 had called for the training of 100 midwives a year, which would have covered requirements, but only half this target had been achieved.

Eleven midwives would attend the Lausanne ICM conference, three of them sponsored by the government.

A visit was paid to the Treichville Maternity Hospital with Mme Soumah, chief supervisor, and a meeting held with the Assistant Secretary of the Midwifery Association. In general, midwives were personally in favour of family planning.

The Midwifery School was visited and a meeting held with the Director. The reasons for failure to meet the five-year plan were shortage of places at the school, high entrance standards, and few opportunities after qualification which discouraged entry to the profession. A new technical college for women would open in 1976, where girls with 'O' level standard would initially receive a general paramedical training, followed by a 3-month specialized training for sanitary and social technical diploma; nursing, midwifery, child nursing or teaching; medical and social secretary. The Director asked to see a copy of the curriculum of the Dakar Midwifery Training School. The theory of family planning was included in the third year of the existing midwifery training course.

Cotonou, Benin, August 1975

The political situation in the country had changed and the delegates to the Working Party had left their previous posts. Nobody at professional level seemed prepared to take responsibility for action.

A visit was paid to the Health Minister. The government was totally in favour of family planning as a means of making the population conscious of the great needs of the country. Midwives were being trained in family planning under a grant from the USA. The Minister felt that services had to be offered in MCH and maternity centres, but there were too few of these and he talked of introducing family planning into all educational courses. A pilot centre attached to a MCH centre would be a great help.

TBAs conducted 80% of deliveries. There were estimated to be about 300 of them – one to each village. It was planned to construct delivery huts as in Senegal at the end of the year. Aid from UNICEF was expected. TBAs would receive a salary based on the number of deliveries conducted in the year. Healers were in practice and the Minister was trying to conduct a census of them and to bring them together for a congress later in the year.

VIII Outcome, Proposals for Future Activities, Achievements

(a) ***Outcome***

1. Recommendations were produced for presentation to each government, midwifery and other health personnel for implementation where applicable.
2. The promotion of a better understanding between midwives within the region.

(b) ***Proposals for future activities***

1. To present concrete family planning programme proposals which would motivate governments to accept family planning as part of national health services.

2. To stress the importance of health education and MCH care inclusive of family planning.

(c) *Achievements*

1. Integrated MCH/family planning services in Benin.
2. Establishment of midwifery schools in Mauritania.
3. Formation of a midwives association in Niger.
4. Continuing education for midwives and auxiliary midwives.

APPENDIX I

List of Participants

Ivory Coast

Dr. Kouadio Bohoussou
Chief, Obstetrics and Gynaecology
Faculty of Medicine
Abidjan

Mrs. Camara Kone
Midwife Teacher
National School of Midwifery
Abidjan

Mrs. Suzanne Amand
Midwife, Gynaecologic Consultation Clinic
Treichville Hospital, Abidjan

Benin

Prof. Eusebe Alihonou
Chief, Obstetrics & Gynaecology
The University, Cotonou

Mrs. Eleonore Coco
Midwife Teacher
The University, Cotonou

Mrs. Justine Kouassi
Midwife, National Health Service Bureau
Dantokpa, Cotonou

Mali

Prof. Bocar Sall
Surgeon in charge
Hospital du Point G.
Bamako

Mrs. Diawara
Midwife Teacher
Secondary School of Health
Bamako

Mrs. Sy
Senior Midwife
Gabriel Toure Hospital
Bamako

Mauritania

Mrs. Ba (nee Khady Sy--
Child Welfare Midwife
Chief, Department of MCH Services
Nouakchott

Mrs. Guisse
Maternity Hospital
Nouakchott

Niger

Dr. Halima Garba
Obstetrician/Gynaecologist
Central Maternity Hospital
Niamey

Mrs. Amsou Maiga
Midwife Teacher
Niamey

Mrs. Ramatou
Midwife
Central Maternity Hospital
Niamey

Senegal
Prof. Paul Correa
Chief, Department of Obstetrics and Gynaecology
Faculty of Medicine,
University of Dakar

Dr. Diop Leye
Gynaecologist/Obstetrician
Lubke Hospital
Dakar

Mrs. Rama Gueye
Midwife at the 'Repos Mandel'
Dakar Surburban Area

Mrs. Fatou M'Bengue
Principal Midwife
Medina MCH
Dakar

Mrs. Amanatou N'Daw
Midwife Teacher
School of Midwifery
Dakar

Miss Marcelle Pellegrin
Superintendent Midwife
School of Midwifery
Dakar

Mrs. Siga Sene
Senior Midwife
Vice-President, Economic and Social Council
Dakar

Mrs. Aminata Sene
Senior Midwife
Maternity Hospital Rufisque

Togo
Prof. Mawupe Vovor
Department of Gynaecology and Obstetrics; Director, School of Midwifery
Benin University
Lome

Mrs. Marie-Louise Naassou
MCH/Family Health Midwife
Social Centre of Family Health
Lome

Male Nurses and Social Workers of Senegal
Mr. Lamine Drame
Director, National Nursing School of Senegal
Hospital A. le Dantec
Dakar

Mr. Ibrahima Dieng
Qualified Nurse
Dakar

Mrs. Toure (nee Niang)
Social Worker
Dakar

Mrs. Liliane Niang
Social Worker
MCH Centre Ouagou Niayes
Dakar

Observers and Speakers
Miss Susan Nalder
Public Health Nurse Midwife
MCH Project of the University of California
Cotonou, Benin

Dr. Roger Castadot
Expert in Training
Population Council, New York

Dr. Jean Martin
African Centres Project for Education in Health Sciences
Yaounde, Cameroon

Dr. Papa Gaye
Ministry of Public Health & Social Affairs
Dakar, Senegal

Senior Prof. Mohamadou Fall
Paediatrician
A. le Dantec Hospital
Dakar, Senegal

Senior Prof. Fadel Diedhiou
Gynaecologist/Obstetrician
A. le Dantec Maternity Hospital
Dakar, Senegal

M. Leon Diouf
Vicar-General, R.C. Parish Cathedral
Dakar, Senegal

Mr. Amar Samb
IFAN Director, Islamologue
Dakar, Senegal

Mr. Landing Savane
Demographer, Statistics Register Office
Dakar, Senegal

Mrs. A. D'Erneville
Journalist, Senegalese Radio and Television
Dakar, Senegal

Mrs. M.A. Savane
Chief Editor, 'Family and Development'
Dakar, Senegal

Mr. Beye
Health Service Head Office,
Ministry of Health and Social Affairs
Dakar, Senegal

Mrs. Madeleine Deves
Jurist, Cabinet Office
President of the Economic and Social Council
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Miss Astou Koate
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WHO Observers
Miss Elizabeth Barton
Public Health Nurse Midwife
Family Health Department
Geneva, Switzerland

Dr. Atayi
Representative
Dakar, Senegal

Dr. Martha Liguetti
Dakar, Senegal

Miss Thi Ky N'Guyen
Nurse-midwife
Dakar, Senegal

Miss Janine Labracherie
Nurse Tutor
Dakar, Senegal

Mrs. Marie-Claire Delahaye
Dakar, Senegal

Miss Italia Dorego
Dakar, Senegal

Miss Marie Guimond
Dakar, Senegal

Miss Jacqueline Perrou
Dakar, Senegal

ICM Personnel
Mrs. A Kone Diabi
Regional Field Director
Dakar, Senegal

Mrs. Micheline Denison
Representative of General Secretariat
London

Mr. Roger Fenney, CBE
Field Director
London

Miss Elizabeth Hilborn
Technical Adviser to the Working Party
Maryland, USA

Mrs. Martine Day
Secretary
London

APPENDIX II

List of Papers Presented

1.	Maternal and Child Health in West Africa	Senior Professor E. Alihonou Benin
2.	Problems and Priorities in West West Africa	Dr. Papa Gaye Senegal
3.	Role of the Midwife in the Framework of Nutrition in West Africa	Dr. Thianar N'Doye Senegal
4.	Health Education	Dr. Ibrahima Beye Senegal
5.	Family Health	Professor M. Vovor Togo
6.	Population, Development and Family Planning in West Africa	Mr. Landing Savane Senegal
7.	Roman Catholic Viewpoint of Family Planning	Abbe Leon Diouf Senegal
8.	Islam and Family Planning	Professor Amar Samb Senegal
9.	A Journalist's View of Family Planning	Mrs. A. d'Erneville Senegal
10.	Sex Education within Family Health	Mrs. M.A. Savane Senegal
11.	The Midwife's Point of View of Family Planning	Mrs. Siga Sene Senegal
12.	Integration of Family Planning into Maternal and Child Health Centres and Public Health Programmes	Dr. Diop Leye Senegal
13.	National Programme of Birth Control in Mali	Professor Bocar Sall Mali
14.	The Expansion of Maternal and Child Health Services	Miss Susan Nalder Benin
15.	Integration of Family Planning in Midwifery Training	Miss M. Pellegrin Senegal
16.	The Midwife in Family Health. The Role and Formation of the Health Services – the Need for Evolution	Dr. Jean Martin Cameroon

17.	Integration of Family Planning in the Training of Midwives of all Categories	Dr. Roger Castadot New York, USA
18.	Midwifery Training in the Ivory Coast	Mrs. Kone Ivory Coast
19.	Integration of Family Planning in National Development Planning	Mrs. M. Deves Senegal
20.	Traditional Birth Attendants in Senegal	Miss A. Koate Senegal
21.	Rural Midwives in Togo	Mrs. M.-L. Naassou Togo

LATIN AMERICAN WORKING PARTY
BOGOTA, COLOMBIA, 16th – 24th JANUARY 1975

Participating Countries: Argentina, Bolivia, Brazil, Chile, Colombia, Dominican Republic, Ecuador, Mexico, Paraguay, Peru, Uruguay, Venezuela

I Preliminary Visits

Preliminary visits were paid by Miss Kate Lorig, Professional Co-ordinator, ICM, and Miss Lola Ortiz, Regional Field Director. Records of visits to only two countries, made in August 1974 to Colombia and in November 1974 to Colombia and the Dominican Republic, are now available.

Colombia

1. The Minister of Health, some of his departmental heads, and representatives of USAID, all approved the draft programme especially the emphasis on the work of the TBA.

   PAHO Officials were most helpful and promised all assistance.

2. Plans for the Working Party were discussed and arrangements confirmed.

3. **Country situation**

   (i) **Personnel**: There were about 15 nurse-midwives, mostly teaching MCH in Schools of Nursing; about 2,900 nurses, many in supervisory posts and in administration, but with more being trained the numbers in active practice will increase; about 7,500 auxiliary nurses who perform the bulk of the MCH work; 3,500 health motivators working in rural areas; TBAs, some of whom were trained.

   (ii) **Education**: There were seven schools of nursing, some attached to universities. As an example, the Universidad de Valle, Cali, offered:

   3-year basic nursing course, including MCH and family planning. Nurses are trained to administer pills and insert IUDs. After one year in practice, nurses can return for a fourth year and get a university degree.

   16-week MCH Certificate course, including full family planning training.

   One-year midwifery course for trained nurses or those with the MCH certificate, to produce nurse-midwives.

   18-month postgraduate course for master's degree.

The courses were available for all of Latin America, not only for Colombia, and entry was arranged through PAHO. There was a trend towards integration of training and functions of nurses and midwives and it was hoped that the Working Party would foster this.

(iii) **Family planning**: This was in a state of flux because a new government was in power. Family planning was opposed by the church, but the Ministry of Health was pressing on with its programme.

(iv) **Legislation**: There was said to be no midwifery legislation in Latin America except perhaps for Brazil and Chile. Control was by either the Ministry of Health, Professional Organizations or the training schools.

Dominican Republic

1. **Training**

There were two schools each offering a 3-year course to those with secondary education. At one, students could take a college degree after a fourth year. All nurses had one term of obstetrics and family planning. About 20 nurses were trained annually. There had been a postgraduate one-year midwifery course for nurses and 12 had been trained.

Nursing auxiliaries, after 8 years' basic education, received 6 months training. They handled deliveries and were involved in family planning especially in rural areas. It was thought that some might insert IUDs.

In 1975 the government planned to start a new programme for technical nurses as two years of the regular high school programme.

There was a great lack of nursing educators and many nurses left the profession because of low pay.

2. **Family Planning**

Family planning was given in hospitals and clinics throughout the country, with technical assistance from the United Nations. A private association worked closely with government and was responsible for all public and professional education in the subject.

II The Working Party

(a) ***Attendance*** – Those attending comprised:

(i) 29 delegates from Argentina (2); Bolivia (3); Brazil (2); Chile (3); Colombia (2); Dominican Republic (2); Ecuador (2); Mexico (1); Paraguay (3); Peru (3); Uruguay (3); Venezuela (3).

(ii) 16 consultants and observers from PAHO, University of Chile, Pathfinder, Instituto de Neonatalogia y Proteccion Materno-

Infantil de Peru, Asociacion Chilena de Proteccion de la Familia, Association Uruguaya de Planificacion Familiar e investigaciones sobre reproduccion humana, International Federation of Gynaecology and Obstetrics.

(iii) 5 ICM personnel

(b) ***Organization***

In addition to the usual objectives which had been common to all Working Parties, it was decided to consider the question of a common name for the professional midwife.

(c) ***Summary of the Proceedings***

The Working Party was opened by Dr. Norberto Martinez, representing the Minister of Health, Colombia, and head of the MCH Division of the Ministry.

The keynote address was delivered by Dr. Eduardo Sarue, PAHO representative in Colombia. He gave an overview of the health problems and health statistics in Latin America and then outlined for the participants the recommendations for mother and child care and family planning in the Ministers of Health Ten Year Plan for the Americas.

On behalf of ICM its Vice-Chairman, Mrs. Olga Julio de Mellado, gave a brief history of ICM, its aims and achievements and wished the Working Party success in meeting its objectives.

On the second day midwives gave brief presentations on specific programmes in which they were participating. The highlight was a talk given by a Peruvian midwife on the use of home-made visual aids for nutrition education to low income mothers. She showed food charts and papier mache food models which she had made.

In the afternoon all the participants went to Profamilia, the IPPF affiliate in Colombia, where they were told of the general need for family planning programmes in Latin America and also heard about the work of nurses in the family planning services in Colombia. This produced much heated discussion and showed the need to differentiate between family planning and population control. In most Latin American countries family planning was the aim – the voluntary right of parents to plan their families in such a way as to have children when they wanted them. Many midwives and doctors doubted the ability of nurses to prescribe pills safely and insert IUDs, but various Profamilia physicians confirmed their success in carrying out these functions.

On Saturday morning there were several scientific presentations by doctors dealing with laparoscopy techniques, sex education, prostaglandin and nutrition research. These talks were well received and stimulated many questions. Especially interesting was a report by

Dr. Franz Pardo from the Instituto Colombiano de Bienestar Familiar on research into the importance of good nutrition during the last trimester of pregnancy.

In the afternoon the participants divided into three groups for the first discussion topic – Obstacles and Suggestions for the Midwife's Participation in Mother and Child Care and Family Planning Programmes in Urban and Rural Zones. Much of this period was spent in exchanging ideas about the midwifery profession. Many countries had large numbers of unemployed midwives and midwives who were poorly utilized. In some places severe limits were put on midwifery practice by governments. There was also some discussion about nurses participating in the Working Party, but it was explained that this was a study on MCH/FP and therefore all delegates had an equal right. Afterwards representatives of each group met to formulate the consensus report.

On the fourth day the role and functions of midwives came under review and talks were given on expanded midwifery functions in family planning, gynaecology and supervision. The subject of gynaecology provoked much discussion, many doctors believing that midwives were unprepared to diagnose and treat any gynaecological pathology. On the other hand the Ecuadorian midwife stated in a paper that midwives in her country had received specialized training and referred anything for which they were not prepared.

Also discussed was the need for a common name in Spanish for the Latin American midwife. Two groups chose the name 'Obstetriz' and one group 'Matrona'. On day 5 during a general meeting the following resolution was passed: We suggest that the name Obstetriz be used in all official activities related to international organizations, respecting and maintaining at local level the traditional name in each country.

The discussion groups then considered the second topic – The New and Expanding Functions of the Midwife. All agreed that in those countries accepting family planning, all phases of family planning and sex education should be midwifery functions. The only real divergence of opinion came in the discussion of the midwife's role in the administration of anaesthetics.

Wednesday was spent examining ways in which the new functions could be integrated into basic and postgraduate education. Several papers were presented showing how family planning had been included in basic and postbasic courses in Chile, Colombia, Ecuador and the Dominican Republic, and the subject was then discussed by the groups. It was readily agreed that new functions should be incorporated into the curriculum but there were many obstacles. In many cases midwives did not teach at all and so had little influence

on course content. In other cases universities were totally opposed to family planning.

The final topic brought out the most discussion. In the morning papers were given describing the training of TBAs in three countries and then Agnes Lima, the PAHO consultant, gave a review of courses in Latin America. Several participants felt that furthering the TBA's role would be hindering MCH. Many felt that one should not even consider training TBAs until all midwives were employed and there was a strong feeling that for professionals to work with TBAs would be lowering the standards of MCH care.

The Working Party closed with speeches by Mr. John Tomkinson and Dr. Norberto Martinez. Both expressed satisfaction with the work of the group but reminded the participants of the need to work with TBAs if real strides were to be made in MCH care. On behalf of the participants, Mrs. Juana Gonzalez thanked the organizers for providing them with the opportunity to exchange experiences, and expressed the gratitude of every participant for the attention they had received during the Working Party.

(d) ***Summary of Papers Presented***

1. **Psychoprophylactic Training during a decade and one year in Sucre, Bolivia, 1961–1971.** Mrs. Teresa D. de Sardan, Midwife. Mrs. de Sardan said that psychoprophylactic preparation for childbirth was based on avoidance of ignorance, elimination of fear and distracting the attention during labour and delivery. She gave examples of the training courses she ran. Relaxation and physical education were also important and she described exercises that were useful. Family planning education was given as part of her class instruction.

2. **Role of the Midwife in Sexual Education within a Community.** Dr. Cecilia Cardinal de Martin, Director of the Sexual Education Programme, Bogota.
   She defined sexual education in three ways, each based on the view that it meant the acquisition of values and behaviour; the acknowledgement of one's own sexual condition and that of others; and responsibility, both personal and to others. Had midwives the qualities and training to be educators? Once the midwife understood her role she could accept it and her training should be adjusted to include it. She was in an ideal position to carry out this function in the community.

3. **Commentaries about some aspects of MCH and Family Planning in Paraguay.**
   The first family planning clinics, which were privately run, opened in 1966 and a government service began in 1972 under the Department of Family Protection and closely co-ordinated

with other health services. The subject was still controversial, and an educational programme had been set up aimed at different levels of the community with a view to facilitating more open discussion.

MCH care was made difficult by social, economic and cultural factors. Both maternal and infant mortality were high and it was felt that the existing MCH programme was not well suited to the problems. Also there was a shortage of staff to man existing services.

Family planning was well accepted but it was important to educate the husband and to maintain a friendly and dignified approach.

4. **Nutrition of the pregnant woman and how to provide knowledge to mothers of low socio-economic levels.**
Nutrition was an important problem during pregnancy, and the effects were seen during the puerperium when lactation began. However, the general nutritional state of the mother, even before pregnancy, was even more important, and influenced growth and development of the child. Nutritional standards during pregnancy and lactation had been laid down and education of the family was needed to see that the mother received an adequate diet, and that the number of children in the family was considered.

5. **Role of the Chilean Midwife in Family Planning.** Miss Oriele Zencovich.
The Chilean government placed special emphasis on maternal and child health and gave particular attention to family planning. The programme relied very much on the midwife for its success, and was able to do so because of the high esteem in which midwives were held in Chile and because of government priorities in this area, especially in simplifying family planning technology and authorizing professional midwives with adequate training to prescribe and apply contraceptives under medical supervision. This delegation of authority was backed up by the Medical College, the Chilean Association of Obstetrics and Gynaecology and the College of Midwives.

The role of the Chilean midwife in family planning was threefold – (i) administration – organizing, supervising and evaluating the MCH programme, (ii) functional or clinical, and (iii) teaching, including information, motivation, communication, training and research.

6. **The Midwife's Role in Gynaecology – Early detection of cervical cancer.** Piedad Erazo de Vallejos, National Federation of Midwives, Quito, Ecuador.

She described the importance of the midwife in the detection and treatment of vaginal discharge and of early cervical cancer.

7. **The Midwife as a Supervisor.** Julia Withington, Argentina. Supervision was training, advising and supporting subordinate personnel so that they knew and understood what was expected of them and could develop their own function responsibly. To do this the supervisor must have adequate knowledge and experience. Supervision needed to be planned and evaluated and be carried out continuously and with tact and impartiality. Supervision of TBAs was highly important but not easy because of the rural conditions in which they worked and their low standards of education.

8. **Training of Midwives in Family Planning.** Oriele Zencovich, Chile.
The development of family planning teaching for medicals and paramedicals in Chile was described. The three stages in evolving a teaching programme were: determination of the problems and formulation of objectives; construction of the course content; implementation and evaluation.

9. **Family Planning Training as a complement in the continued education of Midwives.** Sra Piedad de Echeverria, Ecuador. As family planning was not included in the University's basic midwifery course, the Midwifery Associations combined in 1973 to run a postgraduate family planning training course. Following this, the health authorities invited the midwives to co-operate with the Population Department in organizing two courses in family planning in 1973 and 1974, and a large number of midwives working both in government service and in private practice were trained. After evaluation these courses had continued in an improved form. If other countries expressed interest in such courses, a regional plan could be prepared and international agencies approached for funds.

10. **Continued Education for Nurses and Nurse-midwives in the Dominican Republic.** Angela Margerita Baez, Nurse-midwife. Because of general shortage of trained personnel, the post-graduate obstetrics course for nurses was stopped and nursing training revised to incorporate MCH/FP. They also trained and supervised TBAs. There were 28 trained nurse-midwives, who worked in the training schools for nurses and auxiliary nurses and in MCH education programmes.

    Nursing auxiliaries had 6 months training, with over 40% of the time devoted to MCH care and family planning. Special 6-month courses, with 4 months spent on MCH/FP, were given to auxiliary nurses who were to work in the 147 rural clinics.

11. **The Participation of the TBA in Mother and Child Care and Family Planning in Costa Rica.** Haydee G. de Badilla, Nursing Supervisor.
It was now accepted that the participation of the TBA in maternal and child care was indispensable. In Costa Rica her training and activities were authorized by law. They worked in rural areas where there was usually no possibility of other medical help, and in two rural provinces they were responsible for 41.1% and 30.9% of deliveries in 1972. TBAs were part of the rural community and were accepted and trusted. They co-operated in family planning and were often consulted for information and advice; general training in family planning and family health was part of their training.

12. **Experience of the Training of TBAs in the Portuguese State (Sub-State) of Venezuela.** Miss Margarita Barrios.
TBAs played an important role in midwifery care, especially in rural areas. A training programme had been set up to teach them their duties and obligations, what they should not do in abnormal deliveries and what are their functions in such a case, the age at which infants and pre-school children should be immunized and all about the immunization procedure. The course lasted 20 hours, 16 of which were practical. Audio-visual aids were used and good results achieved.

13. **What to do to promote the Utilization of TBAs in Latin America.** Miss A. Lima (PAHO/WHO)
Early attempts to involve TBAs in official health programmes and to survey overall midwifery needs in Latin America were described. From this survey was produced in 1969 a Guide for Orientation and Supervision of TBAs, which had been used in various countries for local experiments. The Ten Year Plan of the Health Ministers of the Americas had included proposals for fuller usage of the TBA, and the WHO report on The TBA in Maternal and Child Care and Family Planning – Guide for her Training and Utilization had highlighted the need to continue to include TBAs in health care plans and to train them for their specific functions.

The first Latin American Seminar on the Training and Utilization of TBAs in Maternal and Child Care and Family Welfare Programmes was held in October 1974, with doctors and midwives from 15 countries participating. Training of TBAs was now being undertaken in Bolivia, Ecuador and Peru. In Colombia the government accepted the need to use the TBA in the development of the health services and was experimenting with wider use of the TBA in both urban and rural communities.

III Consensus Reports of the Discussion Groups

(a) *Obstacles and Suggestions for the Midwife's Participation in MCH and Family Planning Programmes in Urban and Rural Zones.*

1. **Functions**

In view of the realities and health needs of developing countries we recommend:

(i) Midwives should carry out the functions for which they are trained.

(ii) Maternal and Child Health and Family Planning administrative bodies at all levels should create positions for midwives.

(iii) Midwives should be included in the administrative structures of the Ministry of Health and the health care team at all levels.

2. **Resources**

We recommend that:

(i) A sufficient number of maternity beds be provided to ensure all mothers' rights to a hospital delivery.

(ii) All mothers have a minimum of six prenatal visits.

(iii) Midwives be integrated into giving care to the newborn.

(iv) In countires where family planning is acceptable, midwives should participate fully in family planning programmes.

(v) In light of her university training and her activities on behalf of the community, there should be an improvement in the socio-economic situation of the midwife.

3. **Supply and demand of services**

Because of the excessive demand in our countries for maternity care, and because a large percentage of our mothers are without care, we ask that:

(i) all available midwives be utilized for direct patient care,

(ii) resources be allocated for creating midwifery schools.

4. **Professional and Inter-Professional relations**

We recommend that each professional practise in the sphere for which he or she was trained, and is recognized, in order to achieve harmonious working relationships within the health team.

5. **Teaching role of midwives:**

We suggest that:

(i) Midwives become part of the university teaching team for midwifery programmes.

(ii) The need for postgraduate courses to update their knowledge be considered.

(iii) The creation of scholarships at national and international level be promoted.

6. **Programme formation**
The midwife should participate in the planning, realization and evaluation of all maternal and child health programmes at the national, departmental, provincial and local levels.

7. **Other recommendations**
We ask that the World Health Organisation and other international organisations invite the International Confederation of Midwives to participate in all activities related to maternal and child health.

(b) Make suggestions to incorporate new activities in the midwife's role according to the levels of activities and in relation to other staff working in mother and child health and family planning.

The new functions for the midwife will depend on the maternal and child health/family planning situation in each country.

For improved maternal and child health and family welfare we suggest that midwives develop extended functions related to family planning, nutrition and gynaecology, such as:

1. Sharing responsibility for planning, activating and evaluating maternal and child health programmes at the national, regional and local levels, both rural and urban.

2. New Activities.
   (i) Family Planning — education, prescription, control and follow-up of reversible contraceptive methods. Research.
   (ii) Nutrition — Evaluation of the nutritional state of the mother and the newborn. Nutrition education of the mother in accordance with her socio-economic level; breast feeding should be emphasized. Prescription of supplementary nutrition for the mother and the newborn.
   (iii) Gynaecology — Detection of gynaecological pathology and referral to a physician. Emphasis should be on the detection of cervical, uterine and breast cancer.
   (iv) Attention to normal maternal and infant morbidity and the calling of a physician in an emergency in accordance with pre-established regulations and procedure.
   (v) Participation in sex education programmes.
   (vi) Giving anaesthetics in obstetric cases in the absence of an anaesthetist and under the supervision of an obstetrician.

(c) How to incorporate new areas of training, including family planning into the basic and continuing education programmes of the midwives. Legislation relating to these new areas of training.

1. We have identified the following as expanded midwifery functions: family planning, gynaecology, nutrition, anaesthetics, teaching and research. We, therefore, recommend that in

accordance with each national situation, schools of midwifery incorporate in their curricula the knowledge, attitudes and skills necessary to produce competence in these functions.

2. We recommend that in accordance with the curricula in force and the needs of each country, postgraduate courses be created to update the midwife who also should share the responsibility in the planning, execution and evaluation of these courses.

3. There are several obstacles to integrate expanded functions into midwifery practice:
   (i) the health policies of some countries;
   (ii) lack of midwifery organizations in some countries;
   (iii) lack of sufficient financial resources;
   (iv) lack of communication and co-ordination between the health policy bodies and the universities.

   To overcome these obstacles, we recommend:
   (i) the creation of schools of midwifery be promoted;
   (ii) Governments and/or organizations be requested to provide the necessary financial resources for midwifery training;
   (iii) that ways should be found to promote communication and co-ordination between health policy bodies and universities;
   (iv) that schools of midwifery should be directed by midwives who have had appropriate preparation for this task.

(d) The functions of traditional birth attendants in maternal and child health and family planning.

1. It is the feeling of this group that mothers of all social and economic levels should be attended by professionals. At the present time there are many unemployed underutilized and/or misutilized midwives. Therefore, countries should first utilize all existing professional maternal and child health manpower.

2. If after utilizing all available professional manpower there are some populations served by traditional birth attendants with resulting high mother and child morbidity and mortality, then midwives should advise, train and supervise traditional birth attendants, the purpose being that through improved practice there will an improvement in maternal and child health.

IV Recommendations

1. Governments should use all available professionals in order to avoid the emigration of midwives and other members of the health team.

2. Where there are unemployed and/or under employed midwives posts be created so that traditional birth attendants can be gradually eliminated.

3. Universities should create regional midwifery schools in order to increase the number of professionals.

4. Governments should make a rural internship compulsory for midwives.
5. We recommend that the name 'partera' should not be used for the traditional birth attendants because in some countries this is the name of the professional midwife.

V Follow-up Visits

First follow-up, May–October 1975

Argentina

Little was being done to implement the recommendations because of political unrest. An invitation to mediate over the re-opening of the midwifery school was not accepted. Family planning was not government policy.

Bolivia

The recommendations had been presented to the Minister of Health but not discussed; there had been little attempt at implementation.

The country appeared to have a workable MCH programme but little progress would be made in family planning while the Roman Catholic Action Group maintained its strong opposition and refused to work with government or the university. There was said to be a government family planning policy but it had not been published. Bolivian obstetrician/gynaecologists had made family planning and sex education a major theme of their recent meeting. The National Centre for Protection of the Family was opening a MCH/FP clinic in a rural area. There were plans for a 7-day conference at Sucre in mid-1976 to include all midwives and to give MCH personnel a basic knowledge of family planning and information on new techniques.

All nurses now graduated as nurse-midwives and a two-year updating course for existing nurses and midwives was expected to start in 1976. There were about 450 nurses and 1,300 auxiliaries. The training of auxiliaries was by a 6–12 month course, including a good deal of MCH. They supervised TBAs in rural areas. 25 TBAs had been trained and they hoped to train a further 125. Training was by teams of rural nurses and auxiliary nurses – there were 13 teams – and the training lasted 50 hours – one day a week for nine weeks.

The Midwifery Association had been disbanded by government. They were hoping to get approval for a Nursing Association and it might then be possible to have a nurse-midwives or midwives section within it.

There was great need for training in nutrition and public health.

Brazil

The delegates had tried to pass on the recommendations of the Working Party to colleagues and medical associations. BEMFAM, the private family planning association was arranging for midwives to take a

15-day family planning course. It was hoped to arranged a MCH conference.

The government had no family planning policy but allowed BEMFAM to function as an IPPF affiliate. Midwives were not involved in family planning, and there seemed little that could be done, although midwives were keen to become involved.

The country was said to have an adequate MCH programme. TBAs were scarcely recognized, although there was some talk of giving training to them. Midwives had the same status as nurses; they were not recognized as competent to attend deliveries. Nurses could take an additional one-year course to become nurse-midwives, but the number who did this was not known. The general impression received was that nursing was less advanced in Brazil than in other Latin American countries.

It was planned to hold a Pan-American Congress of Midwives in Brazil in 1976. The Midwives Association were actively trying to have the Midwifery Schools re-opened, but it was pointed out that they would have to be willing to take part in teaching for this to be possible.

Chile

All the recommendations had been implemented except that nutrition was still not in the training curriculum.

They were planning to participate in the Midwives Congress and Seminar.

Their family planning programme was said to be the best in Latin America. Evaluation of ten years of this programme was to be subject at an obstetrician/midwives congress later in the year.

Colombia

Good MCH and family planning programmes and good training courses for TBAs (supervised by trained auxiliaries) had already been in force.

The project's theme of the midwife's promotion of family planning could not really be achieved as they did not want midwives as such. Auxiliaries, who received one year's training, were the backbone of the rural health programme. There was no possibility of forming a Midwives Association.

MCH nurse specialists were being trained by a one-year course.

A request that an obstetrician should visit Venezuela to discuss their internal problems was not supported by ICM. It should be discussed by the Joint Study Group and possibly a member of the Group plus a midwife should make the visit.

Dominican Republic

Midwife delegates had not shared the recommendations with colleagues and there was a general lack of communication on the part of the

delegates. Letters were subsequently sent asking the delegates to share the recommendations for discussion and implementation.

The country seemed more concerned with training of auxiliaries to the detriment of the professional body, and the number of trained nurse-midwives was dwindling. No midwifery courses had been held for some years.

Family planning services were good and all areas of the country were covered. Education in family planning was also good.

The Nursing Association was small and not very active.

Ecuador

Family planning was much in evidence but lacked co-ordination. Midwives were involved both personally and through health centres, but the subject was not in the midwifery curriculum, nor was it official government policy. Asked for information about courses in Latin America, and Chile promised to send details. Literature was asked for and sent. Some FP training courses had already been arranged through PAHO and Fathfinder.

Mexico

The MCH/FP picture was very confusing, services being provided by government and by private organizations with other international bodies also working in this area. There appeared to be no comprehensive plan for rural health services or for training, with no standardization of courses or course content. With an increase in the number of doctors and the training of obstetric nurses, the profession of midwifery seemed to be in danger of closing down. There might be a possibility of forming a nurses/midwives section of the OBGYN Society but the question of the status of the obstetric nurses, who formed the majority would have to be settled if affiliation to ICM was asked for.

Paraguay

Family planning had originally been part of the MCH programme but was operating separately. If outside aid were withdrawn, it was doubtful if government would continue to finance it. Pathfinder/USAID were funding a pilot MCH/FP programme in a very isolated area and were also training TBAs there. TBAs were generally accepted, but there was no government training programme nor were they recognized as part of the health team. It was suggested that auxiliary midwives be trained to work with and supervise TBAs.

Many trained nurses and nurse-midwives left to work in Brazil and Argentina, but a substantial pay increase was due to take effect in 1976.

Family planning was linked to cervical cytology. Practice was in the hands of doctors only, with midwives acting as educators. Family planning theory was included in midwifery training courses.

There were plans to set up a Midwives Confederation from the five existing Associations, but there was much jealousy among the groups.

Literature on MCH/FP and on membership of ICM was asked for and sent.

Peru

Many of the recommendations had been implemented, and midwives had contributed greatly to this. As a result of the Working Party they now had a midwife representative in the Ministry of Health and had been given a licence to function as a College of Midwives.

Family planning was against government policy but doctors and midwives were allowed to practise privately.

Help was asked for to support a request that midwives be enabled to train in public health and funds be provided for this, and this help was promised.

The midwives were arranging a seminar on the Function of the Midwife at National Level.

Uruguay

The position of midwives was serious. They were being replaced by doctors and two out of three thousand were unemployed. Relationships between the Ministry of Health and midwives were at a very low level, and this, and the attitude of the Faculty of Medicine at the University, were preventing the objectives of the Working Party from being met. Doctors would not be associated with midwives individually or with their Association.

It was thought that any future follow-up visit must be arranged through the Ministry and that a doctor should be involved in any future visits.

Family planning existed, but solely as a means of combating abortion. Midwives were only involved in auxiliary positions and it was thought inadvisable to make any recommendations about their training at that time. While no support could be offered to midwives, a letter of encouragement was sent.

Venezuela

Doctors seemed to be opposed to the training and practice of midwives. Doctors attended all deliveries and were opposed to nurses and midwives being involved in family planning other than as auxiliaries. 16 nurses had taken midwifery training in 1971 but were not recognized as midwives. No further courses had been held and a 6-month postgraduate course in MCH was thought to be better. Until opposition was removed, there was little hope in improving general health care. However, some short courses on information in family planning were being given.

Offered to send a doctor on the next follow-up visit to find out why

the Venezuelan doctors were so opposed to the training and practise of midwives.

Second follow-up, April–May 1976

Ecuador

Gauyaquil – The midwives in that region were actively participating in MCH and family planning programmes. They seldom had opportunities for further training and badly needed refresher courses in these subjects. The midwives were actively working to reorganize the professional organization, the College of Midwives. Training of TBAs was a function of the Department of Nursing, but the newly appointed midwife at the Provincial Health Office had been asked to develop this programme in the province of Gauyas. There were thought to be about 200 TBAs in the province, and the course would start soon. The College of Midwives had opened a maternity hospital in a poor suburb of the city, but this had had to close because of labour disputes. The midwives were confident of obtaining support to re-open it. Midwives were being trained in MCH/Family Welfare by a national 4-week course, the fifth of which had just taken place.

Midwifery training at the University of Gauyaquil lasted six years. No formal training in family planning was given but information and practical experience were gained during residence in hospital and at rural centres. It was hoped that ICM could advise on further training for the teaching staff.

The FPA was active and its work was slowly being integrated into the health plan of the country.

Quito – A meeting was held to describe what had been done since the last visit.

1. Training of TBAs was done by the MCH Division, Ministry of Public Health. Local midwives collaborated, but the Nursing Division was responsible for the programme. 100 were trained in 1975.
2. A programme of Voluntary Team Work in rural areas of the Province of Pichincho had been presented to the authorities but no action had yet been taken.
3. The family planning training course to be sponsored by Pathfinder had been delayed. The authorities wanted it geared towards MCH. A new programme was presented and a first course had taken place in Guayaquil.
4. No study days or programmed professional meetings had taken place since the last visit.
5. Two midwives and one nurse had assisted at a travelling seminar on MCH sponsored by PAHO and had visited Chile, Colombia and

Uruguay. One midwife was attending a family planning course in Chile.

6. Schools of Midwifery were encouraging their graduates to join the Colleges of Midwives.
7. Midwives were dissatisfied with a ruling by the Ministry of Public Health that they should work an 8-hour day.
8. Midwives had attended a Seminar on detection of cervical cancer arranged by the Federation of Gynaecologists and Obstetricians.

At a meeting with the Minister of Public Health and the Chief, in charge of Department of Development, training was discussed and all agreed that every training course had to include MCH.

Colombia

The Chief of MCH was well informed of the Working Party's recommendations. MCH cover had increased considerably since 1970 but was still inadequate. In the new National System of Health, priority was given to rural areas, to MCH and to children under 15 years old.

Practical manuals were being prepared for all levels of health personnel. There was still a great shortage of trained professional staff and the health authorities believed that all personnel should be multi-disciplinary.

Family planning was focussed on the improvement of maternal and child health and was well accepted by the church. Profamilia had increased its services in both urban and rural areas and held training courses for nurses who performed 60% of the clinic work. Doctors were being trained in male and female sterilization.

'Community action modules' were being developed in rural areas and it was hoped to have set up 200 of them in 1976, each with 6 health promoters, who were local girls with 6 months' training in maternal and child care, nutrition, family planning, first aid, tuberculosis and sanitation. Some training of TBAs was continuing; they were supervised by health centres. Courses for health promoters and TBAs were being revised to give more emphasis to family planning and nutrition, and those of auxiliary nurses to include more on prenatal care, family planning, and training and supervision of health promoters.

Population growth was declining, and the family planning programme was believed to have had some effect. A survey showed that knowledge, acceptability and use of family planning had greatly increased over the past two or three years.

Visits were paid to training schools and the curricula discussed.

Dominican Republic

USAID was sponsoring a programme with the basic health services of the Secretariat of Public Health in the training of health promoters in rural areas.

The final report of the Working Party had not been received; copies of the provisional report had been distributed but not discussed.

Action taken:

1. The MCH content of the curriculum for nurses and auxiliary nurses had been revised and extended with more emphasis on practical experience in delivery and family planning.
2. The National Council of Population and the Family (NCPF) was revising and printing manuals on the functions, standards and techniques for different levels of personnel working in family planning, and a guide for supervisors in family planning.
3. Both delegates had been invited to join the training department recently organized within NCPF.
4. Four nurse-midwives and one nurse were going abroad for 12 weeks to be prepared in the training of nursing personnel on 'Assistance to the Woman'.

The TBA training programme had been stopped as the budget had not been renewed.

A request was made for information about how nurse-midwives could organize as a group to entitle them to membership of ICM. Audio-visual and other teaching aids were requested.

Comments for Future Action

1. Family planning programmes were being developed in each country according to government policy, but the Ministry of Health in Ecuador would like assistance in training.
2. Ecuadorian midwives would like help in re-organizing schools of midwifery and in preparing teaching staff.
3. In all countries midwives and nurse-midwives asked to receive regularly up-to-date information on teaching aids and bibliographies on midwifery, MCH, family planning, and the training of TBAs.

VI Proposals for Future Activities and Achievements

(a) ***Proposals for Future Activities***

1. Doctors need to be motivated to accept midwives as professional colleagues.
2. Promote the federation of five Midwives' Associations (Paraguay).
3. The extension of FP/MCH services to the rural population.
4. Formation of a midwifery section within the Nursing Association (Bolivia).
5. Registration and utilization of TBAs.

(b) ***Achievements***
25% of the countries represented reported that almost all the recommendations were implemented.

APPENDIX I

List of Participants

Delegates

Argentina
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Dr. Luis Tisne Brousse
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Chilean Association of Family Protection
Mrs. Mirta Rivera
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Neonatal and Mother & Child Protection Institute of Peru
Dr. Juan Denegri Arce
Lima

Family Planning Association of Uruguay
Mrs. Mildred Rios de Cobo
Montevideo

Personal Interest
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FIGO/ICM and ICM Representatives
Mr. John Tomkinson
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Mrs. (Dr.) Piedad de Echeverria
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EAST ASIA WORKING PARTY, MANILA, PHILIPPINES, 4th – 11th APRIL, 1975

Participating countries: Hong Kong, Indonesia, Laos, Philippines, South Korea, South Vietnam, Taiwan.

Representatives from Cambodia and Japan were unable to attend.

I. **Preliminary Visits.**

Preliminary visits to the region were made by Miss Bayes and Mrs. Brohier during February and March 1975.

Taiwan

Two meetings were held with the Minister of Health, his Deputy and the Chief Nursing/Midwifery Officer. The USAID representative was notified of the visit.

Family planning was integrated into MCH services and the MCH midwives had had some training in the subject. In the basic midwifery curriculum little time was given to family planning but there were plans to prepare a new integrated midwifery/FP course. Midwives provided some family planning services assisted by field workers, but thought that they should be trained to provide education, counselling and full delivery of all methods including IUD insertion, so as to provide a service in rural areas. Doctors were opposed to midwives inserting IUDs but the President of the OB/GYN Association thought that it might become possible if midwives were trained. Government had tried to involve private midwives but the response was said to have been poor, although the private midwives themselves, as members of the Midwives Association, expressed their willingness to assist.

The Provincial Family Planning Committee, Taiching, had been training field workers for family planning but the results had been less good than expected and they were beginning to realize that midwives could do the work better and should be trained for the purpose.

The Chief Nursing Officer hoped that the Working Party would enable better relationships to be estabished between midwives and the medical profession.

Laos

The USAID representative was most helpful with arrangements and in providing background information. The Minster of Health gave an interview and was interested in the Working Party. The Director of MCH/FP had been instructed to appoint the delegates. The midwife director of the Midwifery School thought that the first choice of obstetric delegate had insufficient experience, and after discussion with

the MCH/FP Director a change of delegate was agreed. Little information was obtained on how midwifery training was organized. Although family planning was part of MCH services, the staff were inadequately trained for this service, and drugs and equipment were in short supply.

Indonesia

Discussions were held with the USAID representative, the Chief Health Officer, Jakarta, and with the Director-General of Medical Care, Department of Health. The Indonesian family planning programme was said to be the best in that part of the world. Midwives made a great contribution to MCH services although there was a shortage of all paramedical staff. TBAs had been trained and utilized as motivators, but it was thought that they could contribute more to MCH/FP services, leaving motivation to field workers. It was planned to set up 3400 health centres in rural areas and family health workers were being trained to deliver primary health care, supervised by professional midwives. The Indonesian PPA trained paramedical and non-medical personnel, and also trained midwives in IUD insertion.

There were good relationships between midwives and the medical profession and this was commented on by both professional associations. Midwives approved of the national family planning programme and were actively engaged in it. They recognized the need to train and supervise auxiliaries and TBAs.

A meeting was held with a group of TBAs who had been trained and appeared to have a good concept of MCH/FP. They were said, however, not to be typical of the majority of rural TBAs.

South Korea

Meetings were held with representatives of government and professional bodies and with the USAID representative.

All midwives in South Korea were nurse-midwives, but few nurses went on to take midwifery training because pay and conditions of service were not sufficiently attractive. This had also caused many government midwives to go into private practice. There was a great need for midwives and it was suggested that assistant midwives be trained in MCH/FP for work in rural areas, where they would be supervised by professional nurse-midwives. The Midwives Association agreed that assistant midwives could serve the community better than field workers. The private midwives, most of whom were members of the Association, were anxious to have family planning training so as to be able to provide services, especially in rural areas. There were plans to include family planning in the basic midwifery curriculum and to train midwives to insert IUDs.

The national family planning programme was very progressive, but much still needed to be done. The Planned Parenthood Federation of

Korea supported the government programme by providing information, education and communication services.

South Vietnam

Meetings were held with government officials, the USAID representative, the Private Midwives Association, OBGYN Society and with government midwives.

Private midwives were anxious to be trained in family planning and to give education and services at their own clinics. The Minister of Health was considering a pilot project to use them in delivery of family planning services. The private midwives were prepared to accept supervision.

There were two types of midwifery training — a three year course for professional midwives and a one-year course for assistant/rural midwives. So far these courses had contained little on family planning, but the curricula were being revised.

The President of the OBGYN Society, who was also Director of the Midwifery School, had no objection to midwives inserting IUDs provided that they were well trained. Government midwives were anxious to form a national Midwives Association and to affiliate to ICM; they formed a committee to work out proposals.

Philippines

Discussions were held with senior government officials and with local professional organizations. A meeting of the local planning committee was arranged, who reported on their preparations to date.

It was suggested that TBAs should be represented at the Working Party in view of the part they played in the health services.

The problems arising from the existence of two Midwives Associations were discussed, and how they might be amalgamated. One of them was a member of ICM.

The possibility of licensing privately practising midwives to function as family planning workers was also put forward. The President of the private midwifery schools was anxious to improve the education of midwives, especially in family planning. From discussions with government midwives who had had family planning training, the need for refresher training was evident.

Hong Kong

Meetings were held with representatives of the Ministry of Health, the Midwives Association, Obstetric Association and the Family Planning Association.

Japan

A short visit gave opportunities to meet midwives and it was hoped that they would send an English speaking midwife to the Working Party at their own expense.

II Organization

A Local committee was set up in Manila comprising representatives of the Department of Health, Family Planning and MCH, OBGYN Society, Midwives Association and the Midwifery School.

III The Working Party

(a) ***Attendance.*** Those attending comprised:

(i) 21 participants from Hong Kong (3); Indonesia (4); Laos (3); Philippines (3); South Korea (4); South Vietnam (2); Taiwan (2).

(ii) 25 observers from Philippines (15); Hong Kong (1); Indonesia (1); Taiwan (1); Vietnam (1); UNICEF-Philippines (2); WHO-Manila (1); Downstate Medical Center, New York (1); USAID-Manila (1); USAID-Washington (1).

(iii) 5 staff members of ICM

(b) ***Summary of Proceedings***

The Working Party opened with an address of welcome from the Hon Dr. Clemente S. Gatmaitan, Secretary of Health, Philippines. He stressed the importance of the midwife in promoting the care of mother and child especially as in the Philippines two-thirds of the population came in these categories, and the need to expand the role of the midwife to meet the health problems that faced them. Both the infant and the maternal mortality rates were much too high, and many of these deaths could have been avoided if better services were available.

They planned to extend health coverage in the rural areas and to recruit and train up to 5,000 additional midwives to staff the new Barrio Health Stations, and to equip them to fulfil much wider community responsibilities than before. This decision was forced upon them by the large increase in population and the lack of acceptance of family planning, especially in rural areas, and by the extent of the malnutrition which resulted from having large families.

This address was followed by a paper on *The Extent and Nature of MCH Problems in Developing Countries* by Dr. A. M. Angara, Chief, MCH Division, Department of Health, Philipppines. He said that populations in developing countries were predominantly rural, with the majority in the younger age groups. The level of education was generally low and the influence of cultural tradition strong, especially in matters affecting maternity and children, so that the need for educators was paramount. Resources available for health expenditure were small and services tended to be concentrated in urban areas. If health care in rural areas was to be improved, auxiliary personnel and TBAs had to be used.

Although health statistics were inadequate, there was no doubt that maternal and child mortality were too high; maternal deaths due to haemorrhage were due to lack of prenatal care; a high proportion of births were attended by untrained personnel. Much morbidity and mortality was preventable and in developing countries resources were being diverted more and more to MCH care. The principal areas of need were: utilization of auxiliary workers and TBAs; better logistic support and better co-operation between government and the community; regular training and refresher courses for all health workers; acceptance and practice of family planning; encouragement of breast feeding and education in nutrition.

In the Philippines the need to continue to utilize the TBA had been accepted and after training they now worked alongside and in practical co-operation with rural health midwives.

The remainder of the first day was taken up with explanations of procedural matters, introduction of the participants, election of chairmen, etc., and by a talk by Miss Marjorie Bayes, Executive Secretary of ICM and Project Director, on *The Expanding Role of the ICM,* in which she traced the development of the FIGO/ICM Joint Study Group and the establishment of the link with USAID which had funded the Working Party project. She stressed the need for training midwives in family planning and in particular the part that the TBA could still play in MCH care.

On Saturday, after country reports had been presented, the subject of *The Priorities in Maternal and Child Care in Developing Countries* was dealt with from different aspects. The first speaker was Mrs. Ivy Woo, Midwifery Tutor, Hong Kong, who spoke on *What are the Priorities for Maternal Care?* She described how the better provision of prenatal care and hospital delivery had greatly reduced the maternal and infant mortality rates. Problems arose during the puerperium because shorter stay in hospital, due to shortage of beds, had meant a reduction in immediate postpartum care. It was here that the midwife had an important role to play in care and in encouraging family planning, which was a high priority for Hong Kong, where the need to control population growth was vital.

Child Care Priorities in Indonesia were covered by Dr. Sudijanto of the Social Paediatrics Division, University of Indonesia, Jakarta. He showed how the high proportion of young people in the population, and the low health expenditure that the government could afford, produced an unsatisfactory situation for child health. Infectious diseases and malnutrition were widespread, and this led to a low development of intelligence. Priorities were the provision

of basic health care to mothers and children, both curative and preventive. Care needed to start during pregnancy and continue through delivery and throughout the life of the infant and pre-school child. Family planning was most likely to succeed if it was based on, and part of, MCH care.

Dr. Keith Masters, Consultant Obstetrician, FIGO/ICM Joint Study Group, took as subject *What Place has Family Planning in the Priorities of Maternal and Child Care in Developing Countries?* He emphasized the need for family planning in countries with a high proportion of the population in the young age groups and how this was best co-ordinated with MCH work. The midwife was the best person to undertake the delivery of family planning services and the degree of her involvement needed to be adapted to the level of her training. TBAs should be encouraged to play their part and to realize that family planning would not take away their livelihood. This concept fitted in well with the need for an expanded role for midwives at all levels.

Dr. Minerva Belen-Inciong, Executive Director, Nutrition Foundation of the Philippines spoke on *Nutrition – A Priority for Maternal and Child Care.* She said that malnutrition was widespread in the Philippines leading to much disease and lack of growth and development. The Philippines Nutrition Programme defined the infant and pre-school age groups and pregnant and nursing women as its priority targets. Its action programme was fourfold – food assistance, nutrition education, health protection and food production. MCH care was seen as playing an important part in these aims, and the midwife was an important member of the health team.

What Place has Health Education in Maternal and Child Health and Family Planning Programmes and the Role of the Midwife as Health Educator? was the subject of a talk by Mrs. Bui Quang Hue, National Chief Midwife, MCH/FP Services, Republic of Vietnam. She spoke of the need to educate the mass of the population in the necessity for preventive health measures and to tell them what health facilities were available. It should be a high priority in MCH services, since MCH/FP had the widest coverage and reached the most numerous part of the population.

The person best placed to give health education was the midwife, both in institutions and in the home. In Vietnam it was a recognized part of the midwife's duties and had been included in basic training curricula for over 10 years.

The last of this group of papers was given by Mrs. Ellisea V. Loanzon, Chief, Midwifery Service, Manila Health Department, on *What Place has a Private Midwifery Service in Priorities?* In the

Philippines, although exact statistics were not available, there seemed to be a large untapped supply of midwives working in private practice. With further training they could be brought into wider use in government programmes for maternity care.

The remainder of the day was given over to consideration of the first Discussion Topic – The problems encountered in the MCH/FP programmes in the developing countries and suggestions for recommendations for their solution.

On Sunday a social programme had been arranged, and on Monday morning a consensus report of the first Discussion was presented, discussed and approved.

There followed a presentation on *Maternal and Child Health/ Family Planning Services and to what Extent are Midwives Involved?* in which a number of speakers explained the situation in their own country. Dr. C. Mullins, Obstetrician, Hong Kong, described the development of MCH/FP services in that territory and how some of the FPA clinics had been taken into government service, leaving the Association more free to develop its work in the areas of education and research. There was a comprehensive scheme for pre-, intra- and postnatal care of the mother through hospitals and health centres, in all of which the midwife was fully involved.

Dr. Muki Reksoprodjo, Secretary-General, Indonesian Society of Obstetrics and Gynaecology, Jakarta spoke of the limited health resources in his country compared with the huge need for services. The involvement of midwives was increasing as more MCH centres were opened, not only in providng maternity care, health education and family planning services, but also in training TBAs and forming part of the health team in family planning education and motivation. The training of midwives had been adapted since 1972 to these new demands and 56 midwifery schools were operating. A problem was that, by law, newly graduated midwives had to work initially in rural areas where, because of age, they were not always accepted. The Midwives Association had been active in policy making and in curriculum revision and midwifery would continue to be recognized as a special branch of nursing with its own training requirements.

Dr. Yu Han Ki, Obstetrician, South Korea, described the family planning programme in his country, which had resulted in a substantial decline in population growth. Induced abortion had also become more widespread. Increased MCH/FP care had considerably lowered the maternal and infant mortality rates, and this trend was expected to continue in spite of reduced government spending on the MCH programme.

The situation in Laos was dealt with by Mrs. Sngaan Ngondara, MCH physician. The MCH services comprised pre-, intra- and postnatal care, well-baby clinics, health education classes, sick baby clinics, family home visiting and family planning ('family well-being'), which had been government policy for the last 2 years. Midwives and auxiliary or rural midwives were responsible for services outside the main health centres.

Dr. Guillerma Naval-Sahagun spoke on the services in the Philippines. Infant and maternal deaths had decreased as increased care became available, but the birth rate had not declined significantly. More than 75% of deliveries were carried out at home, mostly by midwives or untrained personnel. In rural areas development of care was hindered by cultural traditions and the unwillingness of trained staff to work in these areas. Midwives and nurses were greatly needed to support the comparatively small number of doctors in the country. There were 49 schools of midwifery, 38 of them private. Midwives worked in hospitals, clinics, health units and in the community, and 23,000 had been licensed and registered. They were involved in preventive care, health and nutrition education and family planning as well as in maternity and child care, and their training had been adapted to their expanding role. In family planning midwives prescribed pills, inserted IUDs and gave general advice on methods. Training in family planning had been given to doctors, nurses, midwives and motivators.

Miss Nguyen-Kim Dung, Supervisor Midwife, Ministry of Health, Saigon, described the role of the midwife technician and assistant midwife technician in South Vietnam, of whom there were 1,435 and 3,478 respectively, about 75% of them working in government services. Under-six clinics had now been set up to provide overall care to mothers and children and had replaced the former well-baby clinics and out-patient clinics for sick children. These enabled midwives to carry through total family care in one place. These clinics formed part of MCH services, which also included all maternity and family planning services. Family planning had been carried on in South Vietnam since 1967. The MCH services had 138 family planning clinics mostly run by midwife technicians. IUD insertion was only done by physicians. Services were available only to married women with one living child and the written request of both partners. There were plans to improve and develop these services.

In Taiwan, said Mrs. P. Huang, the government attached much importance to MCH services. Maternal and infant mortality and been decreasing substantially and the majority of births were now attended by trained personnel. The tremendous population

increase had given rise to an active family planning programme, in which midwives and nurses played a considerable role.

This presentation was followed by general discussion, and in the afternoon the groups met for discussion of the second topic – The extent to which midwives of all categories and TBAs could be involved in the delivery of MCH/FP education and services. The presentation of reports on this discussion was made on Tuesday morning.

There followed a Panel Discussion on *The Expanding Role and Scope of Practice of all Categories of Midwives and TBAs in Family Planning.* Dr. T.H. Sun, Executive Secretary, Provincial Family Planning Committee, Taiwan, outlined the purposes of family planning as control of birth rates, promotion of maternal and child health, and betterment of family life in general. These objectives were achieved by education, motivation and provision of services. Midwives were excellently placed for education and motivation and were able to supply services although prescription of pills and insertion of IUDs required additional training. The participation of midwives was important because of the shortage of physicians, especially in rural areas whereas midwives were more evenly distributed; because midwives had good professional knowledge and were widely respected; they had a close relationship with the public who had a preference for female workers; and there was need for co-operation between different categories of worker. Dr. Sun went on to review the participation of midwives in family planning programmes in Asia which showed that progress had not been as rapid as expected because of laws and regulations affecting midwives' practice, the opposition of physicians, lack of incentives for midwives, and lack of supervision after training. He recommended action to solve these problems.

Mrs. Song Seon Chon, President, Korean Midwives Association, described the role of the midwife in family planning in South Korea. Her functional role included motivation and education; follow-up and supervision of acceptors; loop insertion in rural areas; management and organization of family planning clinics; statistics and research; participation in national mass education and community development programmes. In administration the nurse-midwife was the senior person in the health team in planning and developing nursing and midwifery activities in the MCH programme.

Miss Nelida K. Castillo, Nursing Programme Supervisor, Department of Health, Philippines, spoke of the expanding role of the TBA in the Philippines. It had been thought that the TBA would disappear from the scene, but limited and uneven distribution of

resources, difficulties in communications and socio-cultural traditions had combined to retain preference for her services. The role of the TBA in maternity care was well-established. In family planning she could act as educator and motivator and deal with problems and side-effects, referring patients to a health centre for advice and services; she could also serve as an outlet for supplies. In child care she could identify symptoms and refer for treatment and give guidance on preventive measures.

In the Philippines trained TBAs had become informal members of the health unit. They were supervised by midwives and public health nurses. An evaluation of their training and utilisation in the health team was in hand. Training of TBAs began in 1954 but of 9,000 trained only 6,000 were believed to be still in practice. There were about 26,000 untrained TBAs. Training by rural health unit midwives and public health nurses was continuing with UNICEF assistance.

The final speaker in this panel presentation was Mrs. Marilynn Wender, Nurse-midwife, Downstate Medical Center, New York, and her subject was *The Need for Specialized Training to prepare the various categories of Midwives for their Expanded Roles.* She described the family planning training given to midwives at Downstate and the content of the curriculum. Although foreign trainees at Downstate had been mainly professional midwives and nurse-midwives, midwives at all levels were needed to give family planning services which should be an integral part of MCH training and include nutrition, family life education, physical assessment and paediatrics. Some form of family planning training should be given to all categories of midwives, including TBAs, to enable them to work in their assigned area.

The remainder of Tuesday was taken up by Group Discussion of Topic No. 3 – The expanding role and scope of practice of each category of midwives and TBAs in family planning and health education. The consensus report was presented for discussion and acceptance on Wednesday morning.

Next followed a paper on *Population Planning in a Developing Society* by Dr. R. Esmundo, Executive Director, Population Commission, Philippines. He said that population planning was a means of change which sought to improve the condition of man in a developing society. It was not family planning alone, but encompassed the whole of man's environment, to confine the physical growth of population to a manageable and comfortable level, so that life had meaning for all. It was the task of planners to lead people to choose the best options for themselves.

Mr. Atty Lazaro R. Banag, Jr., Executive Director, Professional

Regulation Commission, Philippines then spoke on *The Importance of Professional Legislation for Midwifery Practice.* Having defined midwifery and stressed the need to professionalize and protect, he referred to the lack of qualified midwives and the need, therefore, to make use of TBAs. The government had accordingly initiated training for this group, restricting it to those who were already practising in rural areas. In the 20 years since training began in 1954, 9,200 had been trained. The Philippine Midwifery Law had been amended to permit their practice. Their activities were being evaluated because it was known to vary considerably, sometimes to the detriment of mother and child, but in many places they played a most important role and their practice was being broadened to include participation in community activities including family planning.

Turning to training, Miss Barbara Patterson, Field Director, ICM, spoke on *Curriculum Development.* She said that curriculum planning first needed a philosophy. Thereafter the steps were to assess the need, set the objectives, plan the course and evaluate the results. This could be described as a preparative phase, implementation or development phase and improvement or evaluation phase. Considerations which influenced educational objectives were the students themselves, the nature of the work they would have to do, the nature of the subject under consideration and the philosophy of the school. The evaluation of objectives as applied for example to family planning, involved appreciation of client/patient behaviour. She ended by listing the principles of planning and of evaluation.

Next came a talk by Mrs. Huynh Thi-Hong, Chief Midwife Instructor, School of Midwifery Technicians, An-Giang Province, Vietnam, on *Introduction of Combining Family Planning with MCH Subjects in the Basic Curriculum for Training of Midwives and Other Health Personnel.* She said that in Vietnam midwife technicians had formerly worked in MCH clinics only, but the need for family planning services had prompted the government to include family planning in the services provided by the clinics and to set up training courses for midwives working in the clinics. So far 129 physicians, 15 nurse-technicians and 84 midwife-technicians had received family planning training. A revised basic midwifery curriculum had been in effect since 1974 and MCH and family planning were included, although there were some difficulties in giving practical family planning training due to lack of knowledge on the part of the teachers.

On Thursday the subject was *Expanded Areas of Training for Midwives.* The first speaker was Dr. Fe Del Mundo, Medical Director, Children's Medical Center Philippines Inc., Quezon City,

and his subject *Paediatrics*. He asked if there was need for midwives to be involved in child care, and if so, were they adequately trained to do so. The answer to the first question could easily be answered by the demographic needs of the country and the high incidence of infant and child disease. About 27% of the basic midwifery course was therefore devoted to paediatrics. Since midwives were being expected to undertake more and more paediatric work, he recommended that basic courses be lengthened by three months to allow additional practical paediatric experience, preferably in rural areas; that annual refresher courses in development in child care should be given, and particular emphasis placed on preventive aspects.

After Miss H. Fillmore, Regional Nursing Adviser, Family Health, WHO Manila, had spoken on *Nutrition*, Miss Virginia Orais, Family Planning Training Officer, Office of Health, Education and Training Philippines, took up the subject of *Family Planning*.

Two further papers on education were then presented. Miss Perla Pinto, Family Planning Training Officer, Department of Health, Philippines spoke on *The Correct, Important and Selective Use of Communication Media for Effective MCH/FP Education*, and said that communication was vital to any development programme but in family planning it was complicated by cultural patterns and personal behaviour. However, their commitment as communicators was a source of strength. The four elements in communication were the source, the message, the channel and the receiver. The source might be a person or, e.g., the radio and each had to be adapted to the needs of the receiver. The message had to be carefully planned and consistent. Channels could be numerous and should be utilized according to availability and need. The receiver was not passive, but a human being, and the communicator needed to know all there was to know about her. Communication was not easy and fell into no particular pattern; selective use of the different media was therefore necessary.

Miss Orais dealt with *Expanded Areas of Family Planning Training for the Expanded Role of the Midwife*. She said that midwives were often called upon to perform duties beyond their capacity but the gap could be closed by proper training which should be related to the tasks in hand and the overall objectives of the service. Most now believed that family planning was best provided as an integral part of MCH. Some short training courses in family planning had been offered since the early 1970s, but the function of the midwife was limited to information education and communication. Later some training was introduced into the basic curriculum and latterly delivery of a comprehensive service by nurses and midwives had brought about a 12-week training pro-

gramme available to any nurse or midwife with previous family planning training and experience. Trainers were trained at Downstate Medical Center, New York. Trained workers were now in practice with satisfactory results and this showed the potential for continuing education of the health worker in other related spheres. For midwives, continuing education to maintain and improve her skills was essential.

On Thursday afternoon Group Discussion took place on Topic No. 4 – How can the new skills necessary for the expanding role of midwives be fully integrated into the basic and postbasic training of all categories of midwives? The consensus report was presented on Friday morning and approved. Further recommendations were then put forward and follow-up action plans proposed, and evaluation of the Working Party discussed.

In the final session, reports were given by Group Chairmen and after discussion final recommendations were adopted.

The Closing Address was given by the Hon. Dr. Clemente S. Gatmaitan, Secretary of Health, Philippines. He said that he would be ready, within the limits of their resources, to consider the proposals that would be made, especially as they would be directed towards improving the health of mother and child. The working Party had come at an opportune time when the government was strengthening its population programme and involving midwives more and more. He outlined proposed changes in midwifery training, possibly with increase in the length of the course, called on all midwifery groups to demonstrate their unity, and show her motivation to her profession and to membership of the health team as a whole.

IV Consensus Reports of Discussion Groups

(a) Problems encountered in the MCH/FP programmes in developing countries.

1. Uneven distribution of health services and the standard of Health Care due to
   (i) Poor communication;
   (ii) Reluctance of trained persons to work in rural areas.

   Recommendations

   (i) The provision of low-cost multi-purpose/comprehensive mobile teams and/mobile clinics. These should be adapted to the needs of local conditions in order to make health services easily accessible to all the members of the rural communities on a regular basis.
   (ii) Auxiliary midwives be evaluated to determine if training meets the actual service demands.

(iii) The inclusion of a period of practice in the rural areas as an experience in the latter part of the basic Midwifery training programme.

(iv) A period of compulsory assignment in the rural area after registration.

(v) The provision of incentives in order to attract health workers to take permanent posts in less-privileged areas. Such incentives should include adequate subsidized accommodation, transport facilities, and additional payment.

2. Limited resources and improper allocation of funds, facilities and manpower.

Recommendations

(i) Emphasis be placed on stimulating governments to provide adequate finance, facilities and manpower for the strengthening of Maternal and Child Health/Family Planning Programmes.

(ii) Attention should be directed to ensuring fair distribution of available funds to provide support for the rural Health Services.

(iii) To identify upgrade and utilize existing Traditional Birth Attendants as a member of the health team. The training criteria should meet WHO standards.

3. Low literacy level of the people.

Recommendation

That primary education be compulsory and greater efforts made to enforce this.

4. Public's ignorance of health education

Recommendation

Intensive information and education campaign on all aspects of health education should be promoted and attempts should be made to involve actively all influential members of the community.

5. Training health workers is not always directed towards the needs of the Community.

Recommendation

Each country should, as a matter of urgency, modify its curriculum of midwifery training not only to meet the needs of hospital practice, but also to cover adequately the situation in which the rural workers may find themselves.

It is recognized that while a certain basic standard of training needs to be formulated; to impose too high a standard may actually make the person less able to adapt to a rural situation.

6. Limited integration of MCH/FP Services.

Recommendation

To obtain maximum achievement of MCH/FP, services should be integrated with emphasis on legislation changes, provision of adequate training, incentives and adequate equipment, proper record keeping for evaluation of the programme.

7. Inadequate involvement and representation of midwives in decision-making processes at national level.

Recommendation

It is extremely important that midwives be involved (through their National Associations where possible) at all levels of policy and decision-making in Midwifery education, practice and leglislation.

(b) The extent to which Midwives of all categories and the Traditional Birth Attendants could be involved in the delivery of MCH/FP Education and Services.

1. ***Sphere of practice***

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in health counselling and education, not only for patients but also within the family and the community. The work should involve pre-natal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.

2. Categories of midwives are:
   (i) **Registered Midwives**: higher basic education required; graduated from midwifery school or basic nursing programme plus postgraduate course in midwifery.
   (ii) **Auxiliary midwives**: lower basic education required; graduated from midwifery school.
   (iii) **TBA**: may or may not have formal education; has simple training.

   R = Registered Midwives
   A = Auxiliary midwives
   T = Trained traditional attendants

3. MCH Services include pre- and postnatal care, care between pregnancies, care of mother and fetus, care of children from birth to school age.

4. ***Service involvement***

R/A/T Health education (nutrition, hygiene, etc.)
R/A General Examination
R Proper vaginal/internal examination

Where the need arises:–

R Minor complications:
R Twin pregnancy
R Uncomplicated breech
R Uncomplicated transverse
R/A Mild anemia, toxaemia of pregnancy
R/A Emesis gravidarum

Minor interventions:

R/A I–M injection
R I–V infusion Country Regulation
R Oxytocic injection
R Pain relieve injection
R Amniotomy – certain criteria
R Episiotomy and repair
R/A Repair of Perineal laceration
R/A Breech and Twin delivery

In Emergency:

Active Management of 3rd stage labour
Manual Removal of Placenta
R/A Contraction (controlled cord)
P.P.H.

No instrumental deliveries

R Postnatal examination
R/A Breast care
R/A Puerperal hygiene
R/A Dispensing 'pills' (non breast feeding)

Care of Newborn:

Rescucitation
Suction of mucus
Oxygen
Medication (inj)
Endotracheal tube

5. ***Recognition of Abnormalities***

Child Care:

Immunization (basic/booster)
Feeding problems
Tube feeding
Recognition of P.C.M. Dyspnoea
Dehydration

Simple treatment

6. ***Between Pregnancies***

Country Regulation on Family Planning

R/A/T Resupply 'pills'
R/A Dispense 'pills'
R Insert/Remove IUDs
R/A/T Information, education, communication

Training, research on public health aspects
Team building for family planning

R/A Pre-marriage counselling (lecturing in/out of school)
R/A Supervision of TBA.
R Upgrading of TBA

Trained TBA.
FP information/motivation
General health education
Nutritional guidance
Child care guidance

High Risk Group Identification – Country Regulation:
Antenatal care
Normal deliveriies
Referral system
Post-natal care

(c) The expanding role and scope of practice in each category of Midwives and Traditional Birth Attendants in Family Planning and Health Education.

Guidelines for Discussion:
Identify the functions and skills in the following areas in the expanded role of midwives

1. Family planning – education and service
2. Nutrition
3. Family life education
4. Child care.

Certain skills are felt to be fundamental to the successful carrying-out of any of the midwives' functions:

1. The ability to communicate and make use of available media;
2. Teaching skills;
3. Knowledge of local, social, economic and cultural factors.

The functions of midwives in family planning education are:

1. To provide knowledge on contraceptive methods, including the advantages, disadvantages and advice on possible complications.
2. Motivation.
3. Identification of potential acceptors within clinics, hospitals, schools, other institutions and the community at large.
4. Continuing follow-up and motivation.

5. Training of community leaders, e.g. teachers, village heads, etc.
6. Training supervision and co-ordination of related personnel.

Skills needed by Midwives to perform the above functions are:
1. Ability to form personal relationships.
2. Personal commitment.
3. Awareness of local legislation affecting family planning.
4. Ability to recognize the target population.
5. Ability to organize community resources.
6. Ability to the available means of transportation.

The functions of midwives in the provision of family planning services are:
1. Organization of family planning clinics.
2. Initial assessment including history taking, physical examinations, laboratory examinations, and interpretation of results with the referrals of problem cases.
3. Counselling.
4. Dispensing of contraceptive supplies including contraceptive pills, fitting of diaphragm and insertion of IUDs.
5. Record-keeping and reporting.
6. Follow-up of defaulters.

Skills needed by Midwives to provide the above services are:
1. Ability to organize and administer.
2. Interviewing and counselling techniques.
3. History taking ability.
4. Ability to pick out abnormal/unsuitable cases.
5. Practical skills.

The functions of midwives in nutrition are:
1. Assessment of nutritional status of the community, especially of the mother and child.
2. Education regarding diet with special reference to quantity, quality, variety, methods of preparation and storage and local taboos and food policies.
3. Co-operation with other workers in the field of nutrition.
4. Carry out medical management including interpretation and explanation.
5. Allocation and distribution of food supplements.
6. Participation in nutritional service and research.

The skills needed by midwives to fulfil the above functions are:
1. Ability to impart:
   (a) Knowledge of norms and growth and development;
   (b) Knowledge of nutrient values of all available foods and of methods of food preparation.
2. Ability to form good personal relationships with other members of the nutrition team.

The function of midwives in family life education are:

1. Sex education including venereal diseases, directed to the:–
   (a) Child in school, and through youth groups and
   (b) The parents, to help them answer their own child's questions.
2. To impart knowledge in home economics.
3. Instruction on matters of sanitation, hygiene and prevention of diseases.
4. Pre-marital counselling.
5. Detection of family problems and giving advice.
6. Referral of problem cases.

Skills needed by midwives to fulfil the above functions are:

1. Interviewing and counselling techniques.
2. Evaluation of growth and development.
3. Knowledge of human sexuality and detection of venereal diseases.

The functions of midwives in child care are:

1. Immediate neonatal care.
2. Identification of birth injuries and congenital abnormalities.
3. Education of parents in child care in relation to:–
   (a) Prevention of common childhood disorders;
   (b) Feeding problems especially weaning;
   (c) Early recognition of common childhood disorders;
   (d) Accident prevention;
   (e) Emergency measures;
4. Detection and referral of parasitism, skin diseases and emotional/behavioural disorders;
5. Detection and referral of handicapped;
6. Implementation of immunization programmes;
7. Assess growth and development;
8. Use of community resources for child care;
9. Care of the sick child.

Skills needed by the midwives to fulfil the above functions are:

1. Ability to undertake resuscitative measures including endotracheal intubation;
2. Ability to care for the low-birth weight child;
3. Assessment skills including the ability to carry out the physical examination of the young child and to know what is normal;
4. Asceptic techniques;
5. Paediatric nursing;

(d) How can the new skills necessary for the expanding role of the Midwives be fully integrated into the training of all categories of Midwives?

1. **Areas Identified**:–
   Family planning and education service
   Nutrition
   Family life education
   Child care

2. **Strategy**:–
   In order to achieve full integration of the new activities envisaged for the midwife into the present midwifery training programme, we recommend integration of instruction on the new areas into the existing curriculum wherever applicable, at the theoretical, clinical and field work level. Where this is not possible, to set up new courses of instruction. The necessity for such new courses in the education programme is most likely to arise in the following: family planning procedures; communication and teaching methods; organization, administration and supervising skills; gynaecology; paediatrics; demography; National Development Programmes; community resources; evaluation techniques; research techniques;

   It is recommended that in order to cover the subject matter adequately, thought be given to increasing the duration of the period of midwifery training.

   It is recommended that: –
   (a) The minimum education requirement for entry to midwifery training for professional midwives should be 11 years (10–12) of basic education or after completion of National Secondary Education;
   (b) Midwifery training for those without general nursing training should be 3 years;
   (c) The postgraduate midwifery training for registered nurses should be 2 years;
   (d) To pass a written, oral and practical examination given by the National Licensing Board;

   It is realized that for midwives who are already practising, it is unrealistic to expect them to undergo all the extra training outlined above, but it is recommended that courses geared to their sphere of activity should be provided for them.

3. **Continuing education programme**
   It is recommended that all registered midwives be provided with:
   (a) Opportunity for on-going in-service training, including attendance at refresher courses, workshops, and participation in already existing programmes;
   (b) Opportunity for career advancement.

4. **Legal/Administrative Obstacles: attitude of government;**

attitude of the medical profession especially Obstetrician/Gynaecologists; lack of acceptance by Board of Examiners; absence of credible representation for midwives; lack of legal protection.

Measures to Overcome obstacles should include:

(i) Establishment of strong Midwives Associations or Societies;
(ii) Use of community pressure groups;
(iii) Use of accumulative data;
(iv) Working through International organizations;
(v) Presentation to governments of the results of Seminars/ Working Parties on the relevant problems. Where a government representative is present, government shall be prepared to liaise with that representative on the possible implementation of the recommendations;
(vi) Midwives practice and training should be supervised either by Doctors or more highly experienced and educationally qualified practising members of their own profession.

5. **Recommendations**

(i) MCH and FP Services be integrated;
(ii) For her expanding role, the international definition of a midwife be accepted;
(iii) TBA's should be registered, trained and licensed within their sphere of practice.
(iv) TBA training should be in their own vernacular; general hygiene; information, motivation; attendance at normal birth; selection of high risk groups.

For the integration of MCH/FP, midwives of all categories should have:–

1. High priority to personal motivation and commitment.
2. Provision of basic and inservice training programmes, so as to acquire skills in: practice, communication, teaching, supervision, community co-ordination and co-operation.
3. That there should be nursing and midwifery representation within the Ministry of Health.
4. That the professional Midwives Association should initiate and support continuing education and research.
5. That auxiliary midwifery training be evaluated to determine if training meets the actual Service demands.
6. That private midwives be trained to enable them to participate in the National Programme.

To identify, upgrade and utilize existing TBAs as members of the training criteria should meet WHO standards.

It is recommended that the setting up of a fully integrated family planning programme be recognized by all countries as fundamental to the successful implementation of all programmes

designed to improve the quality of family life:–

That in order to implement the earlier recommendations, Delegates should report back and discuss the recommendations with student midwives, colleagues, nursing and others concerned with organizations, those responsible for midwifery training – Department of Health – Midwives Licensing Body, ICM, FIGO and other allied Agencies, professional and non-professional.

V Recommendations

(a) *Integrated Maternal and Child Health/Family Planning Services*

1. Family planning should be an integral part of maternal and child health services.
2. The fully integrated family planning programme should be recognised by all countries as fundamental to the successful implementation of all programmes designed to improve the quality of family life.
3. Emphasis should be placed on stimulating governments to provide adequate finance, facilities and manpower for the strengthening of Maternal and Child Health/Family Planning programmes.
4. In order to obtain maximum achievement of Maternal and Child Health/Family Planning, services should be integrated with emphasis on legislative changes, provision of adequate training, incentives and adequate equipment, proper record keeping for evaluation of the programme.

(b) *Traditional Birth Attendants.*

The Traditional Birth Attendants should be identified, trained and registered and licensed within their sphere to practise. This will enable the existing Traditional Birth Attendants to become useful extension members of the Health Team. The training criteria should meet the standards laid down by WHO.

(c) *Midwifery as a Profession*

1. The professional advancement of midwives should be regularised in view of the fact that they will be acquiring expanded roles and functions.
2. Practising midwives should be involved at all levels of policy, and decision-making in midwifery education, practice and legislation. This may be accomplished through their National Associations where possible.
3. Midwives should promote their profession by every means available, through their national organizations. They should

encourage their governments to accept the international definition of the midwife as a support to her expanding role.

4. The professional Midwives Association should initiate and support continuing education and research.

(d) ***Midwifery Training***

1. Provision of basic training as well as in-service training programmes for midwives to acquire skills in practice, communication, teaching, supervision, community co-ordination and co-operation.
2. Private Midwives be trained to enable them to participate in the national programme.
3. Auxiliary midwifery training be evaluated to determine if training meets the actual service demands.
4. Each country as a matter of urgency modify its curriculum of midwifery training, not only to meet the needs of hospital practice, but also to cover adequately the situation in which rural workers may find themselves.
5. The inclusion of a period of practice in rural areas as an experience in the latter part of the basic midwifery training programme.
6. A period of compulsory assignment in the rural area after registration.

(e) ***Health Services.***

1. Governments should provide low cost multi-purpose/comprehensive mobile teams and/or mobile clinics. These should be adapted to the needs of local conditions in order to make health services easily accessible to all the members of the rural communities on a regular basis. This would help to alleviate the uneven distribution of health services and the standard of health care.
2. The provision of incentives in order to attract health workers to take permanent posts in less privileged areas. Such incentives should include adequate subsidized accommodation, transport facilities and additional payment.
3. Promotion of intensive information and campaigns on all aspects of health education, with special emphasis on family planning. All attempts should be made to actively involve all influential members of the community.

VI Analysis of Evaluation Questionnaire

The Evaluation forms were completed by 23 delegates and the results are summarized as follows:–

(a) Delegates were unanimous in confirming that the group discussions had most impact and that they found the interchange of information and ideas both helpful and stimulating. Knowledge of other countries' situations and their approach to the problems encountered was felt to be of great value.

(b) 1. Small group discussions were enjoyed and it was generally felt that more time for these would have been beneficial.

2. Most delegates were very appreciative of the curriculum developments paper and would have liked more time allotted thereto.

(c) There was a general feeling that less time could have been spent on presentation of papers, other than the curriculum development paper, as the papers were considered to contain elements of repetition.

(d) *Summary*

	Very Useful	Useful	Not Useful
Paper presentation	15	7	1
Panel discussion	11	12	–
Large discussion group	7	14	2
Small discussion group	17	4	2

(e) Follow-up action intentions were stated by delegates as:–

1. Presentation of recommendations to Association and Government Departments to attempt motivation.

2. To attempts stimulation of training organizations particularly as regards curriculum development.

3. Several delegates their intention of:–
   (i) attempting to arrange seminars to further the Working Parties aims and to implement recommendations.
   (ii) planning projects to expand the midwives' role in family planning.

VII Follow-Up Visits

First follow-up

Philippines, April/May 1975

(a) ***Field Trips***

1. Midwives in family planning clinics were very service orientated and seemed not to recognize the importance of education and motivation.

2. The Roman Catholic Medical Mission had a thriving Family Planning/Community Development Programme, but this might have to close down through lack of funds.

3. TBAs were a dedicated group and well organized but needed further training. Their supervisors needed better training,

especially in family planning education, information and communication.

(b) ***Follow-up Meetings with Delegates***

1. Integration of the two Midwives Associations had been agreed and a new constitution was being formulated.
2. The Board of Midwives had been working on proposals arising out of the recommendations of the Working Party for revision of the Midwifery Law and strengthening the powers of the Board; revising the midwifery training curriculum and setting up a one-year postbasic midwifery course for nurses so that they could qualify as nurse-midwives; upgrading the status of midwives to give them greater responsibility.
3. The TBA observers at the Working Party had discussed the recommendations with colleagues. They said that they were now more confident to discuss family planning.

(c) ***Other Meetings***

Government officials were interested in the recommendations of the Working Party and would support them. The generally poor standard of midwifery education was admitted and plans for improvement were outlined. The need for integrated family planning training for midwives was accepted, as the present weakness in family planning training was known.

Korea, May 1975

The delegates, members of the Midwives Association and the Nursing Officer, Ministry of Health, had met and discussed the Working Party and the recommendations. The Midwives Association had made certain recommendations to the Ministry on training and conditions of service of midwives. The government was making proposals on pay, but it was reiterated that midwives would not work in rural areas, and of 1,000 MCH workers, only 300 were midwives. There were 29 midwifery schools in the provinces but only 88 nurses had taken midwifery training in the previous year. It was suggested that the Midwives Association should try to promote the idea of midwifery as a career.

Since 1973 midwives had been authorized to insert IUDs. The Korean Institute of Family Planning was training about 80 midwives a year in this procedure and the National Institute of Public Health was training midwives for MCH/FP services, including the insertion of IUDs.

One of the best midwifery schools was at the Ilsin Women's Hospital, Pusan, which was a Presbyterian Mission Hospital. Family planning was integrated into the course and private midwives could take refresher courses, which would be arranged by the Midwives Association.

A majority of doctors opposed insertion of IUDs by nurses, but there were hopes that this opposition would be worn down.

The USAID representative discussed the Community Health Care project which they were funding.

Taiwan, May 1975

A report on the Working Party and the recommendations had been submitted to government and the Directors of the Midwifery Schools, and had been discussed with colleagues at national and local level. One delegate had put forward plans for action following the pattern of the recommendations.

There was still considerable opposition from doctors to midwives inserting IUDs.

The Director, Bureau of MCH, strongly supported the inclusion of family planning into MCH services, but midwives would first need refresher courses and he was seeking funds for this purpose.

The Provincial Family Planning Committee would support and assist in implementing the recommendations. Their policy was now to replace field workers by midwives.

Indonesia, June 1975

The delegates had presented the Working Party Report and Recommendations to the Minister of Health and to the two professional Associations, and had themselves put forward proposals on educational standards of recruits to midwifery training, the integration of family planning in the curriculum and the use of private midwives as family planning workers in health centres.

The Midwives Association with the FPA hoped to arrange Regional/Provincial Seminars to stimulate self-motivation for family planning among midwives. The USAID representative would be prepared to help in this.

Summary of first follow-up

1. Much progress was shown within the countries visited.
2. All the delegates had presented the recommendations to their government personnel and other members of the health team.
3. Some of the delegates who were opposed to midwives performing certain functions in the role of family planning have been converted since the Working Party and in turn were trying to convert their medical colleagues.
4. Those obstetricians who already worked closely with midwives had been further stimulated to work in close co-operation with them and had been influential in getting some of the recommendations implemented.
5. TBAs in one of the countries had stimulated their colleagues to further participation in family planning activities.

6. Where government and medical personnel had in some countries been reluctant to meet midwives to discuss their role at high level, the follow-up visit had cleared the ground and some meetings had already taken place.

Second follow-up
Philippines, October 1975

Most of the Working Party recommendations had been or were to be implemented:

1. Legislative changes to allow maximum participation by midwives in MCH services and strengthening of the powers of the Board of Midwifery.
2. Provision of adequate training for all categories of midwives with the development of a 2-year basic midwifery curriculum including family planning.
3. Amalagamation of the two Midwives Association and close co-operation between PGS and IMAP.

There had been no government consideration of proposals for upgrading the status of midwives or a one-year postbasic midwifery course for nurses to qualify as nurse-midwives.

It was recommended that:

1. Family planning should not be taught as a separate subject, but be integrated into all aspects of midwifery training courses.
2. Practical training in IUD insertion should be compulsory not elective.
3. Midwives at rural health centres should visit the TBAs, especially those who had not been trained.
4. IMAP should take advantage of the readiness of authorities to assist in training private midwives in MCH/FP. A one-month course seemed the most suitable.
5. The Society of the Philippines Schools of Midwifery should plan to prepare Midwifery Educators to implement the new 2-year course.
6. All chapters of IMAP should meet to inform local members of the latest developments in the Association.
7. IMAP's application for membership of ICM would be discussed with Miss Hardy during her visit.

Korea, October 1975

Some of the recommendations had been implemented:

1. A midwifery section had been created at the Ministry of Health and Social Affairs.
2. Midwives were to be supervised by their peers.

Other recommendations on legislation, salary structure and training had not been implemented. The Midwives Association received no support from the OBGYN Society.

It was recommended that:

1. A meeting be arranged to discuss the training of private midwives in family planning.
2. The leaders of the Midwives Association in Seoul and those of the provincial branches should:
   (i) participate in the first training course in family planning so that they could organize seminars for their members.
   (ii) Co-operate with Nursing Colleges in informing third year students about the profession of midwifery.
   (iii) Have regular meetings with the private midwife members about improving the quality of service.
3. Family planning information education and communication materials should be obtained from the Planned Parenthood Federation of Korea for the members of the Midwives Association.

Taiwan, October 1975

Most of the recommendations of the Working Party had been considered favourably and action taken to implement them, but the insertion of IUDs by midwives was not accepted by most doctors and was contrary to the new medical law. There was no co-operation between the Midwives Association and the OBGYN Association in the implementation of the recommendations.

It was recommended that the two Midwives Associations should give support to modifications of the midwifery law, and that they, with the Nursing/Midwifery Division of the National Health Administration should support the new basic training curriculum for nurse-midwives. The pilot project involving private midwives in family planning training and services should be continued if evaluation showed good results. Supervision of private midwives should be strengthened because they performed about one-third of all deliveries.

Indonesia, December 1975

Most of the recommendations of the Working Party had already been or had since been implemented.

1. The Indonesian Obstetrics and Gynaecological Society strongly supported the National Association of Indonesian Midwives in its activities and planned to bring up the needs of midwifery training at the next convention of the Society in Medang in June 1976.
2. The NAIM accepted the idea of using PKKs (the new multi-purpose health worker) to perform normal midwifery, but insisted that midwifery training should be continued as postgraduate training

for PKKs and that the name Pidang (midwife) should be used for those with the additional training.

3. Instead of planning regional and provincial seminars on self-motivation for family planning among midwives, as mentioned in the report of the first follow-up, the NAIM had included in its plan of action a workshop on management and leadership for executive members.

Recommendations

1. The NAIM would send a letter to the Director of the Education Division offering co-operation in the PKK project and would nominate a representative to sit on the study sub-committee.
2. The NAIM would prepare a questionnaire to go to all branches to discover
   (a) The number of private practising midwives.
   (b) The number of private midwives who had been trained in IUD insertion, with details of the training.
   (c) Names and addresses of private midwives who wished to be trained in IUD insertion to be sent by NAIM to Chief, Bureau of Education or to the USAID Population Officer and further discussions should take place between them on this project.
   (d) A copy of any recommendations made in future by NAIM to be sent to USAID/Population/Indonesia for information and follow-up.
   (e) NAIM should prepare proposals for the functions of PKKs based on the basic training curriculum, which could be submitted to study sub-committees for consideration.

Third follow-up
Taiwan, July 1976
Purposes of visit

(i) To represent ICM and to participate in a MCH/FP Workshop for midwives of local health stations organized by the Institute of Maternal and Child Health.
(ii) To follow-up implementation of the recommendations of the Working Party.

(a) ***The Workshop***

1. The National Health Administration supported the Workshop by sending a representative to act as a panel member.
2. The staff of the MCH Institute made a point of conducting each of these workshops personally.
3. The director and chief of the nursing section of the local county health bureau participated actively in the Workshop.
4. Each midwife or public health nurse-midwife in the county had

a target for MCH work of 210 new prenatal cases annually, and was to be given a target of 210 new family planning acceptors from these prenatal women. The aim was motivation prenatally leading to acceptance postnatally.

5. In the project submitted to ICM, it was planned to hold four workshops for 200 midwives or public health nurse-midwives but only a total of 135 had attended so far. There were plans to hold a one-day meeting for those who had been absent.

6. Evaluation of performance would be done monthly by the MCH Institute and the Health Bureau and a report would be sent to ICM after 6 months. Further evaluation seminars would take place after one year and a final evaluation sent to ICM after completion of the project.

7. Workshops for midwives of local health stations had so far been held in six of the twenty counties and cities.

(b) ***Implementation of the Recommendations***

1. Family planning training for private practising midwives. Six one-day sessions had been held and four more were to be held. While the average performance of each midwife had improved, only 28 out of 80 who had attended so far had reached the target of performance set.

2. Association for Voluntary Sterilization of Taiwan (AVS) - Midwives worked under contract to AVS in providing family planning services and many of the patients seen by AVS were referred by midwives. In 1977 AVS were planning to set up five training courses in IUD inser[illegible] midwives. Trainers would take a 10-week course at D[illegible] Medical Center, New York.

3. Chinese Midwives Association - The Association had become more active; membership had increased and finances were improved. Their plan of action was to encourage more new members, to organize talks and seminars, to screen and evaluate books and teaching materials, to establish sisterhood with the Korean Midwives Association, and to publish one newsletter every trimester and a magazine yearly.

4. Midwifery Legislation and Practice - The Nursing/Midwifery Committee had not had opportunity to consider modifications of the Midwifery Law relating to the expanded role of midwives. Supervision of the practice of midwifery had been improved.

5. The Basic Training Curriculum - This had been revised according to the expanded role of the midwife in MCH/FP, had been approved by the Minister of Education and would be implemented in 1976/77. Family planning/MCH and nutrition were being

integrated into the courses, but midwives were not trained in IUD insertions.

South Korea, July 1976

1. ***MCH/FP services***
   For the five-year plan 1977-81, the Ministry of Health and Social Affairs would recruit 1,140 midwives for the health sub-centres and 1,320 midwives for health centres. 300 new maternity centres would be used to train midwifery students in MCH/FP.

2. ***Midwifery Profession***
   There had been proposals from both the Nurses and Midwives Associations for the establishment of a Nursing Bureau or a Nursing/Midwifery Bureau. The Ministry thought that no action could be taken in the near future. In the five-year plan the midwifery law would be reviewed to allow midwives to accomplish their expanded role in MCH/FP, especially IUD insertion. The salary of midwives would be increased to encourage nurses to take up midwifery training. A new health insurance scheme excluded private maternity nurses from the list of appointed institutions, and private midwives were afraid that they would suffer.

3. ***Midwifery Training***
   The Ministry would increase its subsidy for the basic midwifery training course to encourage nursing schools to offer midwifery training. A new basic nurse-midwife training curriculum was under study. The 300 new maternity centres would give practical training in the conditions in which midwives would eventually practise.

4. ***Family Planning Training***
   The number of government midwives being trained in IUD insertion was being increased, but the proposed training of private midwives for this purpose had not been taken further. Discussions were held with a view to promoting this.

5. ***Korean Midwives Association***
   This was much more active than before and was co-operating with the Korean Nurses Association in MCH/FP, midwifery training etc. It was establishing relations with the Chinese Midwives Association of Taiwan and was carrying out a special project among unmarried mothers.

Recommendations

1. The Korean Midwives Association and the Planned Parenthood Federation of Korea should prepare an official request for training of private midwives in IUD insertion and this should go to the Ministry via the MCH Bureau.

2. They should review the draft of the questionnaire to go to KMA members to obtain data and support for this application. They

should evaluate and send to the Ministry the results of the questionnaire to reinforce this request.

3. The KMA and the KNA should co-operate closely to deal more effectively with mutual problems.
4. Branches of the KMA should visit Nursing Schools to tell the students about midwifery training and practice.
5. The KMA should take legal advice about the implications of the new Health Insurance Law.
6. Private midwives should participate more actively in family planning by using materials supplied by PPFK.
7. The KMA should follow-up the five-year training course project for college graduated nurse-midwives.
8. The KMA should have frequent contact with the Public Health Nursing Instructors to follow-up midwifery activities in the public sector.

Philippines, August 1976

1. ***Midwifery Practice***
   From the beginning of 1976 a restructured health care delivery system had been implemented. For rural areas a five-year project had been put in hand with one or two midwives appointed to each rural health centre after a 4-week training course. This appeared to be working well. For the Manila Metropolitan area a new project envisaged a 4-bed maternity service in each of 39 existing health centres. 13 had been set up already, each staffed by 9 midwives and providing a 24-hour service.
2. ***Midwifery Law and Regulations***
   Proposed amendments had been agreed and a final draft was being prepared for submission for presidential approval. The presidential decree establishing the restructured health centres enabled midwives to perform a wider role in this new context.
3. ***Midwifery Training***
   The basic course had been extended from 18 months to 2 years. The curriculum had been revised and approved and would be implemented in 1976/77. Family planning training would include dispensing of pills and insertion of IUDs. A workshop for principals of training schools had been held to acquaint them with the changes.
4. ***Family Planning Training***
   Two-month courses in family planning for private practising midwives, concentrating on IUD insertion and pill dispensing were being set up under an 18-month study project by the Population Centre Foundation. In the 2 months following, each midwife

would have to perform 20 IUD insertions without supervision to obtain a certificate which would enable her to apply for a licence. PCF would provide all supplies and training materials. IMCH would co-operate in evaluation.

5. ***Postgraduate Training for Midwives***
After discussion, the Dean, Institute of Public Health, promised to accommodate one or two midwives annually for postgraduate training provided they had the academic requirements. The Institute might also organize a training course for a certificate of public health administration for midwife supervisors.

6. ***IMAP***
This was now officially registered and had organized branches in several cities. They were to hold an Annual Midwifery Convention in October.

Observations and Recommendations

1. In the public sector the utilization of midwives was gaining in importance and there was a greater development of the MCH/FP services.
2. In the private sector there was a warm reception for the training of midwives in delivery of family planning services.
3. IMAP had achieved very satisfactory integration. There was good co-operation between representatives of the two previous factions on the Board of Directors.
4. The amendments to the old Midwifery Law had met repeated objections from the Nursing Association and Board of Nurses but were well accepted by the Professional Regulation Commission.
5. All midwives seen said that the Working Party had brought them together and given them inspiration and support.

Fourth follow-up
Phillipines, October 1976

This visit was planned to help the President of IMAP with technical preparations for the third celebration of the Midwifery Week. Recommendations of this convention were:

1. The utilization by Manila Health Department of midwives for supervisory work should be extended throughout the country.
2. Midwives should be allowed to teach midwifery provided they had had some training in instruction.
3. Efforts should be made to speed up (i) promulgation of the new Midwifery Law and (ii) the provision of necessary materials for midwives working as nursing aides in maternity and paediatric services.

New Developments concerning Midwifery Training

1. The 2-month training course in comprehensive family planning, with emphasis on IUD insertion for 10 private midwives from Cavite began in October 1976 and good results had ensured.
2. Two midwives were to attend a 3-month training course in Family Health in Singapore from November 1976–January 1977 under sponsorship of WHO.
3. In Tacloban University a pilot project had been started to train local residents as midwives, nurses and doctors: a 2-year course for midwives, two years additional basic training in nursing for midwives to qualify as nurse-midwives, and a further 2 years' basic training in medicine for the nurse-midwife who wanted to become a medical doctor.
4. The Population Center Foundation, in co-operation with the Jose Fabella Memorial Hospital was still training government nurses and midwives in comprehensive family planning, with emphasis on insertion of IUDs and dispensing of other contraceptives.

VIII Outcome, Proposals for Future Activities, Achievements

(a) ***Outcome***

1. The Working Party has highlighted:
   (i) The midwife's present functions.
   (ii) The possible expanding areas in her training and role.
   (iii) The need for expanding her functions.
2. There is some change in obstetricians' attitudes towards the midwife – instead of being a pair of hands, she is now considered as a member of the health team.

(b) ***Proposals for Future Activities***

1. Continuing education for midwives.
2. Approval of government/midwives association joint project. Family planning training for private practising midwives in the Philippines.

(c) ***Achievements***

1. The union of two rival midwifery associations (Philippines).
2. Family planning training for private practising midwives with emphasis on IUD insertion.
3. Review of the midwife's professional status, economic welfare and midwifery education.
4. Co-operation between obstetric society and midwifery associations.
5. MCH/FP Training Workshop for government MCH midwives (Taiwan).
6. Review of legislation governing midwifery training.

APPENDIX I

List of Participants

Delegates

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Mr. Peter W. Bailey,
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Miss Belinda Brohier,
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London.

Mr. Harry Smith,
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London.

APPENDIX II

List of Papers Presented

1.	The Extent and Nature of MCH Problems in Developing Countries	Dr. A.M. Angara Chief, MCH Division, Department of Health, Philippines.
2.	The Expanding Role of the ICM	Miss Marjorie Bayes Executive Secretary ICM

3.	The Priorities in MCH Care in Developing Countires	**Maternal Care**: Mrs. Ivy Woo, Hong Kong **Child Care**: Dr. Sudijanto, Indonesia. **Family Planning**: Dr. Keith Masters, England **Nutrition**: Dr. M. Belen-Inciong, Philippines **Health Education**: Mme Bui Quang Hue, Vietnam **Private Midwifery Services**: Mrs. E.V. Loanzon, Philippines
4.	MCH/FP Services and to what extent are Midwives involved?	Dr. L. Mullins – Hong Kong Dr. M. Reksoprodjo – Indonesia Dr. Yu Han Ki – Korea Dr. Snguan Ngondara – Laos Dr. G.N. Sahangun – Philippines Miss Nguyen Kim-Dung – Vietnam Mrs. P. Huang – Taiwan
5.	Family Planning in National Development Programmes	Dr. R. Esmundo Philippines
6.	The Importance of Legislation	Atty. Lazaro Banag, Jr. Philippines
7.	Training Objectives, Needs and Curriculum Development	Miss Barbara Patterson Field Director, ICM
8.	Introduction of Combining Family Planning with MCH Subjects in the Basic Curriculum for Training Midwives and other Health Personnel	Mrs. Huynh Thi-Hong Vietnam
9.	Expanded Areas of Training for Midwives	**Paediatrics**: Dr. Fel del Mundo Philippines **Nutrition**: Miss H. Fillmore Philippines **Family Planning**: Miss Virginia Orais, Philippines
10.	The Correct, Important and Selective Use of Communication Media for effective MCH/FP Education	Miss Perla Pinto, Philippines
11.	Continuing Education in Family Planning especially in the Midwives' expanding role.	Miss Virginia Orais Philippines

WEST ASIA WORKING PARTY, KUALA LUMPUR, MALAYSIA, OCTOBER 17th – 25th 1975

Participating Countries: Bangladesh, Malaysia, Nepal, Sri Lanka, Thailand

I Preliminary visits

Preliminary visits were paid to Malaysia, Nepal, Sri Lanka and Thailand during August 1975. A proposed visit to Bangladesh was cancelled because of the political situation.

(a) ***General information***

(i) Each country had two grades of professional trained midwife, nurse-midwives and auxiliary midwives. Traditional birth attendants were recognized as trained and were officially in practice except in Sri Lanka, where few were said to exist and the government discouraged their practice.

(ii) Each country had some form of legislation governing the training and practice of midwives.

(iii) Each country had a national family planning programme, mostly integrated into the MCH services. Private associations worked in conjunction with the national bodies, but confined their operations to information and education.

(iv) Family planning was included in midwifery education to a varying extent.

(v) All midwives participated fully in family planning activities. Those in Thailand had the widest scope for practice. Sri Lanka and Malaysia did not allow midwives to insert IUDs, although in Malaysia there were proposals to extend the scope of the midwives' practice which might enable them to perform this procedure.

(vi) Midwives were respected and regarded as equal and essential members of the health team except in Sri Lanka, where their status was lower compared with other health professionals.

(b) ***Specific problems***

(i) **Malaysia.** No Midwives Association existed, and there was no time to discuss the formation of such an Association.

(ii) **Nepal.** Midwifery training under the integrated nurse-midwife training programme was admitted to be inadequate. The possibility of setting up a midwifery school was discussed. Discussion also took place on the possibility of forming a midwifery branch of the Nurses Association.

(iii) **Sri Lanka.** Only doctors were allowed to insert IUDs, and then only those with additional training and those who were specialists. The function of midwives in family planning was largely restricted to that of educators, motivators and distributors. The formation of a Midwives Association was discussed. Some problems arose with selection of delegates to the Working Party.

(iv) **Thailand.** There were weaknesses in the family planning programme due to shortage of supervisory staff and lack of motivation among the workers. The Thai Nurses Association members were involved in family planning, but members of other Nurses Associations in the region were not. It was suggested that the Thai Association should run a seminar for members of other Associations, but there was no enthusiasm for this proposal.

II The Working Party

1. ***Attendance.*** Those attending comprised:

(a) 16 representatives from Bangladesh (2), Malaysia (5), Nepal (3), Sri Lanka (3) and Thailand (3).

(b) 24 observers from Malaysia (21), Thailand (1), WHO Regional Office, Manila (1), IPPF East & S.E. Asia and Oceania Region (1).

(c) 10 resource persons from Malaysia (6), Thailand (1), US Dept of Health, Education & Welfare (1), IPPF Regional Office (1), FIGO/ICM Joint Study Group Committee (1).

(d) 3 officials from ICM.

2. ***Organization***

(a) A local organizing committee was set up consisting of a Chairman (Dr. Thomas Ng, Ministry of Health, Malaysia), 12 nominees of the Ministry of Health and 2 from the Malaysian Family Planning Board.

(b) A Rapporteur General was appointed to act as overall director of the Working Party. He was assisted by a Co-Rapporteur.

(c) Each plenary session had a chairman and a rapporteur who were responsible to the Rapporteur General.

(d) Delegates were divided into three groups for group discussion sessions. Group chairmen and rapporteurs were elected by the delegates and held office for the duration of the Working Party.

(e) A reports committee was formed, consisting of the three group chairmen, the co-rapporteur and the rapporteur general (who acted as chairman). This committee was responsible for con-

solidating group reports into consensus reports, which included recommendations made by delegates. The reports committee prepared the final report which was presented by the rapporteur general on the last day of the Working Party, and which was adopted unanimously.

3. ***Summary of Proceedings and Papers.***

The Chairman, Dr. Thomas Ng, welcomed the participants. He called for a change of attitudes towards family health care which would enable the midwife to fulfil many unmet needs in maternal and child health and family planning.

The Hon. Deputy Minister of Health, Encik Abu Bakar bin Umar, gave the opening address. He spoke of the problems of providing family health care in Malaysia and stressed the importance of the midwife's role. He said there was a continuing need to register and employ the TBA both in continuing care and in family planning, and he described the new category of community nurse which had been introduced, whose role covered both midwifery and basic child care.

Mrs. B. Brohier, Regional Field Director, invited the various deleates and participants to introduce themselves. She then outlined the aims and objectives of the Working Party and explained the programme, procedures and the grouping of the participants.

Encik Abu Kassim gave a talk on *The Role of Chairman, Rapporteur and Participant*, and demonstrated the use of 'cross-dialogue' in informal meetings.

Miss M. Hardy, Executive Secretary, ICM, and Secretary of the ICM/ FIGO Joint Study Group spoke on *The ICM/USAID Project* and described the history and the aims and objectives of the Working Parties. She also explained the conditions under which national midwifery associations could become eligible for membership of the ICM.

After discussion the groups met to elect group chairmen and rapporteurs.

The second day opened with the presentation of country reports describing the existing situation regarding maternal and child health and family planning in each of the five participating countries. All reports gave a statistical analysis of health services, categories and distribution of personnel and developments in MCH/FP. It became apparent that there were areas where improvements could be achieved, and all stressed the need for improved training programmes for all categories of midwives in total family care.

Dr. Siti Hasmah gave an interesting talk on *Some Aspects of*

Traditional Health Attitudes in Rural Areas and described the traditional practices and beliefs which hindered the development of good health care in rural areas.

Three background papers were then presented:

Dr. Frank N. Beckles, Chief, Primary Health Services Dept., US Public Health Service Hospital, Baltimore, spoke on *Family Health Care in Developing Countries.* He began by showing how the influence of the mass media affected behaviour generally, including attitudes towards family planning, and then went on to discuss the theme that health care throughout the world concentrated too much on centralized hospital facilities at the expense of primary health care at the periphery. He further urged the mobilization of traditional workers to provide family health care. Even if elaborate hospital and clinic services were provided, there was no guarantee that they would be used to best advantage. An integrated approach of preventive, promotive, curative and rehabilitative services was needed both for the family and the community, and services should be provided at the most peripheral practicable level by workers most suitably trained for the purpose.

Family Health Services in Malaysia were described by Dr. Raja Ahmad Noordin Director of Health Services, Malaysia. The existing three-tier system for providing family planning services was being changed to an integrated two-tier system by changing the role of auxiliary midwives to that of multi-disciplined community nurses. Until the full number of health centres were available throughout the country, mobile teams would be established consisting of doctors, nurses, midwives and drivers. There would probably be 50 teams by 1979, with the number being progressively reduced thereafter as health centres were developed. Another important development was the emphasis on the care of pre-school children. Among socio-economic indicators were birth weight and body weight. He also outlined the training programmes for all categories of midwives, including the TBA, who had to be trained to co-operate with trained personnel.

Family Planning Information, Education and Communication was dealt with by Mr. Robert Blake, UNESCO Regional Communication Adviser. He pointed out how variable was the response to advertising through the mass media and that person to person dissemination of information through audio-visual aids could be of much more value. The role of the TBA in moulding family attitudes was important. He showed one of his set of training film strips entitled 'How to use Satisfied Acceptors in Family Planning Motivation'.

Each of these papers was followed by discussion. The afternoon of

that day was taken up by the first of the group discussion sessions on the subject 'The Priorities and Problems in Family Health Services and in Family Planning Information, Education and Communication.'

The following day was a Sunday and a programme of social events was arranged.

The first item on the Monday morning was a presentation of the group reports on the first discussion topic. A brief general discussion ensued, recommendations were formulated and the consensus report accepted.

There followed a presentation entitled *The Extent to which Midwives and Traditional Birth Attendants are involved in Maternal and Child Health/Family Planning Services.* The speakers were Dr. P.H. Amarasinghe, Sri Lanka; Puan Mahelan Abd. Manap, Malaysia; Mrs. Mohan Tamrakar, Nepal; Miss Lamom Srichandrabhand, Thailand.

Sri Lanka. There was a general trend towards hospital confinements, but midwives in rural areas still had a wide responsibility for MCH and family planning. There were no TBAs in the country, but 2% of deliveries were conducted by relatives or women friends. The speaker discussed the role of field midwives in health education, maternal care and the continuing child care from birth throughout school age. In family planning midwives acted as motivators and distributors of supplies for which they took a small remuneration. They maintained monthly records of acceptors, drop-outs and side effects.

Malaysia. Puan Mahelan discussed the roles of the midwife and the new category of community nurse. Following the postnatal check-up, mother and child were advised to attend the MCH clinic at the health centre. The TBA was a respected member of the community and participated in cultural, traditional and religious customs connected with births, marriages and health. Their lack of technical skill was made up by age, experience and understanding of human relationships. TBAs were registered as untrained midwives at their nearest health centre, where formal short training courses (3 weeks to 3 months) were arranged. Delivery bags were checked and advice and guidance given, especially in recognition of cases unsuitable for domiciliary confinement which should be referred for medical care. They attended domiciliary confinements and remained as general home helps while giving postnatal care to mother and baby. In general they were health promoters in MCH and family planning and in some States were functioning with success as family planning motivators and suppliers of oral contraceptives.

Nepal. There were no certified midwives in Nepal. General nurses gave comprehensive services including MCH and family planning.

They planned, organized and directed clinic operations and supervised the delivery of services. The aim was to increase the number of family planning users, especially by instruction at postnatal visits. Under an experimental and developmental project, senior nurses were being trained to insert IUDs and to recognize anatomical contra-indications. Assistant nurse-midwives fulfilled similar duties with a lesser responsibility. TBAs were very active in rural areas and were being trained in aseptic techniques and pre-, intra- and postnatal care. A family planning programme had recently been introduced for them.

Thailand. Three categories of midwife were involved in MCH and family planning. The professional nurse-midwife had a 3½-year training and was able to perform more elaborate procedures in rural areas than the midwives of other countries. She conducted many abnormal deliveries on her own initiative, except high forceps and caesarean section. In family planning she was trained to insert and remove IUDs. The auxiliary midwife had 18 months training and undertook a similar role to the professional midwife in prenatal and postnatal care. She performed normal deliveries with episiotomy and suturing of the perineum, but did not undertake abnormal deliveries. In family planning she did not insert IUDs, but followed up patients who were using them. She was trained in family planning motivation and could prescribe the pill and condom. TBAs played an important role in the village as untrained attendants at childbirth. They were highly regarded and respected. Between 1960 and 1969 18,000 TBAs were trained by the government and UNICEF by means of a four-week course under the guidance of nurse-midwife supervisors at provincial level. They undertook normal delivery, with emphasis on safe technique and recognition of abnormal cases requiring referral. They played an important part in family planning motivation.

These papers were again followed by discussion.

Dr. J.Y. Peng, Center for Population Planning, University of Michigan, spoke on *The Expanding Role and Scope of Practice of all Categories of Midwives and Traditional Birth Attendants in the Field of Family Planning.* Dr. Peng began by quoting the WHO definition of the midwife and referred to the amendment by the Joint Study Group in 1972 which further emphasized family planning as an extended role and responsibility for the midwife. He went on to discuss the different categories of midwifery personnel operating in Asian countries and the functions which they performed. He concentrated particularly on the work of the TBA, as it varied from country to country and on the way in which TBAs were becoming involved in family planning activities. He concluded by stressing the need to incorporate into midwifery training those

aspects of the expanding role of the midwife which she was being expected to fulfil.

The afternoon of that day was taken up with the group discussions on the second of the set topics: (a) The expanding role of all categories of midwives and traditional birth attendants in family planning information education and communication, and (b) The traditional birth attendants as members of the health team. Presentation of group reports, discussion, recommendations and acceptance of the consensus report took place as the first item on the next day's programme.

The next subject to be dealt with was *Integration of Family Planning, Paediatrics and Nutrition with the Midwifery Training Programme of all Categories of Midwives.* The speakers were: Family Planning – Dr. Norlaily Datuk Abu Bakar, Health Officer in charge of Family Planning and MCH Unit, Ministry of Health, Malaysia; Paediatrics – Professor Prasong Tuchinda, Professor of Paediatrics, University of Mahidol, Bangkok, Thailand; and Nutrition – Dr. Virginia Guzman, Professor in MCH and Chairman, Dept. of Community Health, University of the Philippines.

Dr. Norlaily began by stressing that the training of personnel was an essential component of any family planning programme. If family planning was to be integrated into the health services, all concerned should be trained in its practice. She then discussed the case for family planning and its relationship with health, and the scope and focus of family planning activities. Motivation and education, she said, involved the knowledge by health personnel of birth control methods and of the health implications of child bearing on both normal mothers and those with high risks. She discussed the provision of related services such as vaginal examinations, 'pap' smears and even marriage counselling. In conclusion she recommended that the integration of family planning into the existing midwifery curriculum should be backed up by a simultaneous in-service training programme for practising health personnel.

Professor Prasong and Professor Guzman both emphasized the effect of malnutrition in a community on acceptance of family planning. Where the level of malnutrition was significant, maternal and child mortality were high and there was resistance to the idea of limitation of family size. Family nutritional levels, especially among mothers, potential mothers, the newborn and young children should be given a high priority in health planning at governmental level.

Family Planning Training Programmes in Malaysia were discussed by Dr. Low Sow Khin, who stressed the importance of training

supervisors and submitted a training programme with curriculum content, and Dr. J. Varughese, who dealt with the involvement of auxiliaries in family planning education and services. He emphasized the importance of training the trainers and the need to assess planning requirements, costs and the involvement of personnel.

The subject of family planning was continued on the Wednesday morning with papers by Dr. G.R. Amritmahal, Adviser on Training, National Family Planning Co-ordinating Board, Jakarta, Indonesia, and Miss Mazel Lindo, Downstate Medical Center, New York, USA.

Dr. Amritmahal's subject was *Planning of Family Planning Training Programme – Objectives, Needs and Curriculum Development.* He began by defining education, distinguishing between education and training, teaching and learning. He discussed the different ways in which programmes could be planned and stressed the need for task analysis, feedback and evaluation.

Miss Lindo spoke on *Continuing Education in Family Planning.* She described the opportunities available at several centres in the USA, including her own training centre at Downstate Medical Center, New York, for further training in family planning for midwifery personnel. She went on to outline new teaching methods and illustrated the principles of curriculum development.

A Panel Presentation then took place on *Legislation Governing the Training and Practice of Midwives.* The speakers were Puan Ranita Hussein, Legal Adviser, Prime Minister's Department, Malaysia; Puan Rosina Abdul Karim, Principal Matron, Ministry of Health, Mayalsia; Dr. Savitri Gurung, Senior Obstetrician/Gynaecologist Bir Hospital Kathmandu, Nepal and Professor S.S. Ratnam, Department of Obstetrics and Gynaecology, University of Singapore.

The panel presented the current state of legislation concerning the registration and practice of midwives in Malaysia, Nepal and Singapore, and there followed a lively discussion on the legal and moral responsibilities of midwives, especially following the patient's refusal to transfer to hospital for serious complications and emergencies.

Miss Margaret Hardy reiterated the resolution of the last congress of the ICM that midwifery should be considered as a separate service from general nursing, and that midwives should be legally registered and recognized as professionals in their own right. Dr. Raj Karim indicated that Malaysia had taken positive steps towards achieving this aim. The final consensus was that countries should legislate not only for midwifery practice, but most importantly for the protection of patients as well. It was apparent that certain

countries had not yet achieved finite legislation in this regard, although some had progressed further than others.

The third of the group discussions took place, on the subject of The Incorporation of Family Planning, Paediatrics and Nutrition in the Basic Midwifery Curriculum, with a consensus report being approved the following morning.

The final formal paper of the meeting was on *Family Planning in National Development* and was given by Dr. Rita Thapa, Senior Public Health Administrator, Ministry of Public Health, Nepal. Having defined development and its relation to family planning, Dr. Thapa analysed a developing society – the near absolute poverty in some countries, the high fertility pattern, its relationship to the high parity risks of maternal mortality and morbidity and its negative effect on child health. She discussed the various factors which motivate couples to have a large number of children, even at the risk of the mothers' lives. The decision regarding the optimum number of children desired by the average couple was the critical path for family planning in national development. Dr. Thapa described family planning in the Nepalese situation and presented some proposals for effective family planning for socio-economic development.

A stimulating discussion then took place on many aspects of national family planning campaigns and their effectiveness.

This was followed by the final group discussion on Family Planning Education and Service is the Responsibility of all Midwives.

The final day of the Working Party began with the formulation of the consensus report on the fourth discussion topic, and this was followed by an evaluation and the preparation of plans for national follow-up action programmes. After discussion and acceptance of the final report the closing address was given by Dr. Raja Ahmad Nordin, then Acting Director-General of Health, Malaysia.

There was general agreement among the delegates on the following principles:

(a) The expanding role of the midwife – to cover family planning education and service and maternal and child health care (preventative, curative and nutrition). Education of midwives should be designed to fit them for these tasks and legislation should permit them to fulfil their expanded role.

(b) Full integration of family planning into family health services should be achieved through the collaboration of all the organizations concerned.

(c) Traditional birth attendants should be identified, given appropriate training and registered before being licensed to

practise in their expanded role. To function effectively they required regular supervision.

(d) Family planning education and service should be undertaken by all categories of midwife, including traditional birth attendants.

III Consensus Reports of Study Groups

1. ***The Priorities and Problems in Family Health Services and in Family Planning Information, Education and Communication.***

(a) Family health was understood to include: MCH care, family planning, nutrition, school health, dental care, health education, compilation of statistics, environmental sanitation.

(b) Determining criteria were: geographical conditions, variable literacy rates (from 13-18%), cultural and traditional practices, the mortality rate which varied considerably, nutritional status, availability of trained personnel, availability of vital statistics.

(c) Priorities in maternal care were: reduction in maternal mortality rate, health education of public and in-service training of health personnel training and utilization of TBAs, increase in percentage of hospital deliveries, better natal and postnatal care with special reference to limitation of family size, improved collection of vital statistics and registration of births and deaths.

(d) Priorities in child care were: improved care of mother during pregnancy labour and puerperium and limitation of family size, improvement in nutrition and infant feeding from birth to school age, control of communicable diseases, especially gastro-enteritis, and immunization programmes, health education to the public and health personnel, improved collection of vital statistics.

(e) Top priority should be given to health education including instruction in the improvement of nutrition and family planning.

(f) Problems in planning were: non-availability of accurate vital statistics, incorrect interpretation of problem areas in health care, lack of co-ordination in planning and in implementation, inappropriate distribution of available funds within the health service, inappropriate choice of planning method and insufficient feedback for proper evaluation.

(g) Problems in implementation were: insufficient training personnel, unequal distribution of personnel in all the health services, frequent transfer of personnel so that time is spent in getting used to, and gaining the confidence of, the local population, financial resources which have been allocated were not always available.

(h) Problems of supervision of personnel: inadequate number of

suitably trained supervisory staff, improper lines of supervision resulting in staff receiving different instructions from different supervisors, security and weather conditions preventing adequate supervision.

(i) Problems of evaluation: This depended on the keeping of proper records and in all countries the problems were the same: No proper staff assigned to this task and records being kept by technical staff whose main duties were to provide health care, no proper feedback of information from the top downwards and vice versa, no standard system of compiling and analysing records.

(j) **Recommendations**

i. Planning and identification of the priority and problem areas in family health service should be considered as part of the overall development plan of the country.
ii. Proper identification of problem areas.
iii. The plan should be simple, practical and acceptable to the people.
iv. Good co-ordination between all government departments and voluntary organizations.
v. Planning of seminars should include all key personnel required by the planners – medical, administrators, midwives, economists and research staff.
vi. Health education of existing personnel by in-service training and refresher courses.
vii. Crash training programmes of new personnel.
viii. Incorporating family planning and general health education in schools, clinics and communities. This should include preparation for responsible parenthood with the ultimate reduction of the incidence of too early marriages.
ix. Expand basic health services in the rural areas by having more infrastructure, trained personnel and equipment.
x. Government should formulate national policies on food, nutrition, health and family planning.

(k) **Conclusion.** Since the various problems mentioned above involve various sections of personnel ranging from policy makers, health planners, health trainers and health educators to the field personnel at grass root level, the suggested priorities can only be incorporated in the family health services of any country by having an integrated approach and the collaboration of all these various levels of people involved.

2. ***The Incorporation of Family Planning, Paediatrics and Nutrition in the Basic Midwifery Training Curriculum.***

(a) In the present day concept of family health, the training of all categories of midwives, which is at the moment mainly

orientated towards delivery of maternal and child care alone, is felt to be inadequate. In order to prepare midwives for the expanded role they are expected to play, the training curricula should be reviewed and widened to include other aspects of family health such as family planning, paediatrics and nutrition. Before discussing how the training curricula can be developed an attempt is made to define the extent to which family planning, paediatrics and nutrition are included in the present basic training curricula of nurse-midwives and auxiliaries.

(b) The duration of training varied slightly in the five countries; some courses were more student orientated while others had a considerable service content. Only the basic concept of family planning was being given in the basic training curricula. The paediatric content varied, some countries including only care of the newborn while others covered the child from birth through school age. The inclusion of paediatrics depended largely on the availability of a paediatrician to teach. Nutrition was not being taught as a separate subject, but was merely included in general MCH. The training of auxiliaries in these subjects was even less than that of nurse-midwives.

(c) It was felt that the duration of the training period – 3 years general nursing and 1 year midwifery for nurse-midwives, and 2 years' midwifery training for auxiliaries need not be extended, but that space could be made for these additional subjects by revision of existing curricula, stressing those aspects thought to be most important.

(d) Where applicable other medical personnel, such as obstetricians and paediatricians, as well as health educators and nutritionists, should be involved as instructors.

(e) It was generally felt that the present concept of training was geared mainly to providing actual service, and that not enough importance was put on health education and motivation. Since these latter play a very important role in the efficient delivery of family health service, they should have a high priority in the training curriculum.

(f) All aspects of family planning, including the management of infertility, but excluding the insertion of IUDs, should be taught to all categories of midwives.

(g) In paediatric training, the aim should be for the midwife to be able to provide child care from birth through school age. This would include knowledge of: infant feeding and the importance of breast milk, management of low birth weight babies, ability to detect congenital abnormalities and genetic problems, communicable disease and immunization, the interaction of infection

and infestation with nutrition, assessment of growth and development, recognition of the well-baby, of departures from the normal and of critical signs such as dehydration and fever, ability to treat minor ailments.

(h) Since nutrition was a common problem in all countries, teaching of nutrition should be incorporated into the curriculum. Again the interaction of infection and infestation with nutrition should be emphasized.

(i) In the revision and expansion of basic training curricula of all categories of midwives to prepare them for an efficient delivery of family health services, the following constraints would have to be considered: manpower, money, materials.

(j) **Recommendations**

i. Family planning, paediatrics and nutrition should be incorporated into the basic midwifery curriculum, and this should be implemented by modification or review of existing curricula with emphasis on those aspects thought to be most important.

ii. Where applicable and available, medical personnel, especially obstetricians and paediatricians, as well as health educators and nutritionists, should be involved in instruction.

iii. Health education and motivation must have a high priority in the training curricula of all categories of midwifery personnel and TBAs.

iv. That the basic training curriculum be expanded to include all aspects of family planning. Considering the implications and potential for complications of the IUD as a contraceptive device, instruction in its insertion should be a specialist postbasic training for midwives.

v. The training of midwives in paediatrics should prepare them to provide care for the child from birth through school age. This should include: infant feeding and the importance of breast milk, management of low birth weight babies, ability to detect congenital abnormalities and genetic problems, communicable disease and immunization, interaction of infection and infestation with nutrition, assessment of growth and development, recognition of the well-baby; recognition of departures from the normal and of critical signs such as dehydration and fever, ability to treat simple minor ailments.

vi. That nutrition be identified as an expanded area in the training curriculum under the following headings: nutritionists and home economists be invited to participate as instructors with consideration for local dietary patterns, eating habits, local taboos, cooking practices, etc.; emphasis

on nutrition for the pregnant, postpartum and lactating mother; emphasis on breast feeding and to the correct diet on weaning from the breast and on the importance of mixed feeding.

vii. That the training syllabus be reviewed every 3 years after discussion with appropriate personnel at all levels.

viii. That refresher courses for midwives should be held at least every 5 years, including new advances in family planning methods.

ix. Instructors and supervisors should establish a good follow-up system to ascertain whether what was taught during the training period was being practised in the field.

x. All midwives should have a more attractive salary and career structure in view of the responsibilities undertaken in their expanding roles.

xi. The training of auxiliary midwives should be expanded and upgraded in view of the more important role they are expected to play in the delivery of health services, and entry requirements should be raised according to each country's educational criteria.

xii. Tutors must be specially prepared in these expanded areas of the midwifery curriculum – family planning, paediatrics and nutrition.

3. ***The Expanding Role of All Categories of Midwives and Traditional Birth Attendants in Family Planning Information, Education and Communication. The Traditional Birth Attendants as Members of the Health Team.***

(a) Present functions of all midwives

i. **Nurse-midwives**

Education. In all the participating countries nurse-midwives conducted health education either in an organized way or through an individual approach to their patients and the family members. Staff midwives carried out education and training of the newly qualified and junior staff under their supervision.

Services. Their functions were as follows: looking after the health of mothers during pre-, intra- and postnatal periods in hospitals, clinics and in the home; immunizations, treatment of minor ailments, and if necessary referral of a child to the appropriate centre; school health; care of newborn through school age; participation in special health programmes and in the investigation of maternal and child deaths; involvement in organized and in-service training; supervision and management; record keeping and submission of returns.

ii. **Auxiliaries.** In education they have the same functions and responsibilities as do nurse-midwives. As regards delivery of MCH services their functions are similar but their responsibilities are less. In some of the countries they are involved in administration, supervision and training of other personnel.

iii. **Traditional Birth Attendants.**

Education. Those who have had some training and come under the supervision of government staff give some MCH/FP education as required of them. Those who are untrained and unsupervised are probably not giving training in the right direction, if at all.

Services. In addition to looking after the mother in the pre-, inter- and postnatal periods, TBAs also help in domestic affairs and carry out the traditional rituals of the community.

(b) Areas where their functions can be expanded.

i. **Nurse-midwives.**

Education. Nurse-midwives should concentrate more on health education not only for the patient but also for her family and the community. Health education and motivation should therefore be more emphasized in the basic training curriculum, and health education materials suitable to the community should be made available. Nurse-midwives should be given regular refresher courses in health education, but only a small proportion of those on the field should be taken away from providing services at any one time.

Services. Where necessary and appropriate the functions and duties of nurse-midwives should be expanded to deal with more elaborate procedures, e.g. manual removal of placenta, setting up intravenous infusions and insertion of IUDs (as is being done in Thailand). Improving the existing referral system to the various centres by which feedback information is made available. Giving limited curative medical care for minor ailments.

ii. **Auxiliaries.**

Education. The role of the auxiliary could be expanded as for the nurse-midwife.

Services. Curative medical care for certain minor ailments can be delegated to auxiliaries.

Administrative. Reporting of births and maternal and infant deaths.

iii. **Traditional Birth Attendants.**

Education. It was felt that the TBA had tremendous

potential for giving MCH/FP education provided they could be trained and supervised. This involved the organizing of training facilities by the Ministry of Health or other appropriate authority.

Services. Since they already conduct a considerable proportion of deliveries in most of the countries, they should be trained in proper hygienic techiques. This would require legislation to be enacted requiring them to be registered. Training in modern methods of delivery, in aseptic techniques and education in nutrition should all be given.

It was accepted that TBAs in all countries supplemented the health programme of the government. In some countries it had been suggested that their role should be expanded to the fullest extent. All agreed tht TBAs were very influential and that most of them worked with true compassion for the patient and with little financial reward.

(c) Recommendations

i. Midwives of all categories, including TBAs, should put more emphasis on health education not only to the mother but also to the other members of the family and to the community.

ii. Greater emphasis should be given to health education and motivation in basic training curricula. Health education materials suitable to the community should be made available.

iii. All midwives should be given regular refresher courses at least every five years, and these should include health education and family planning.

iv. More elaborate procedures such as insertion of IUD and the management of maternal and paediatric emergencies, e.g. giving intravenous infusions and manual removal of the placenta, should be included in the basic midwifery curriculum so as to enable midwives to function effectively in isolation where medical aid is not readily available. Midwives assigned to remote areas should be given special refresher courses in these procedures.

v. There should be better liaison and two-way communication between hospital and field service to improve the standard of patient care, promote efficiently of service and ensure job satisfaction.

vi. Limited curative medical care of minor ailments should be part of a midwife's function.

vii. Reporting of all births and maternal and child deaths should be a standard procedure for all midwives.

viii. Immunization should be one of the essential functions of the midwife.

On the question of traditional birth attendants as members of the health team, it was generally felt that it was an accepted fact that TBAs in their own way supplemented the government's health programme. It was also felt that some TBAs, especially those who had not been trained in modern techniques and did not come under the authority's supervision, were probably having an adverse effect on the government's health programme. Instead of giving proper advice on diet and nutrition, they might advise patients to follow the traditional taboos to the detriment of the health of mother and child. TBAs could be more effectively utilized by:

1. Having a compulsory registration before they were allowed to practise.
2. Educating and training them to accept the modern concept of basic midwifery practice, nutrition and family planning.
3. Having them supervised by the appropriate authority.
4. Ensuring that they report births and maternal and child deaths.

4. ***The Delivery of Family Planning Education and Service is the Responsiblity of all Midwives.***

Because of the nature of their work, midwives of all categories including TBAs have the closest contact with the families in their communities. They have the respect and confidence of the people and are therefore the most appropriate personnel to deliver family planning education and services. Most midwives and some TBAs are aware of the importance of family planning motivation and methods but unfortunately the depth of the awareness is very variable. Not all midwives are involved in family planning education and services.

After analysing Information, Education and Communication (IE&C) the group agreed that effective IE&C programmes contributed to the achievement of the ultimate goal by (i) creating awareness of modern concepts of family planning in the individual or community and (ii) providing guidance with regard to the various methods which can be adopted, including the knowledge of the advantages and disadvantages of each.

In practical terms, midwives needed to:

i. analyse their own attitudes and accept the concept of family planning as a way of life.

ii. motivate continuously and at every opportunity.

iii. direct the motivation not only to mothers but also to husbands, other members of the family and the community.

iv. understand and respect people's behaviour, customs and religious background.

v. have a more intimate and closer relationship with the mother, the family and the community in order to gain the full confidence of the people they serve.

Recommendations.
That it should be the duty of midwives of all categories, including TBAs, to deliver family planning education and service through:
(a)sufficient political, administrative and technical support.

(b)efficient follow-up of family planning acceptors.

(c)identification and use of satisfied acceptors.

(d)high standards of service, including continuous availability of supplies.

IV Recommendations

The participants at the Working Party recognized (i) the broad range of primary health care needs that exist at the community level; (ii) that the midwife of all categories is usually the primary and continuing contact with the family unit and must therefore be fully equipped through training to manage a broad range of primary health care needs and (iii) that a potential overload of the midwife's functions could arise.

A. ***General recommendations***

In the light of the proposed expanded role of midwives of all categories, the West Asia Working Party strongly urged governments:

1. to conduct feasibility studies of such expanded roles before they were widely implemented, and

2. to conduct task and functional analyses at appropriate intervals after implementation of the recommended expanded roles in order to assess the effectiveness with which the expanded roles are carried out and to assess where tasks and functions need to be modified.

B. ***Specific recommendations***

The recommendations relate to the four subjects on which group discussions took place, and are listed under those subject headings.

1. **The priorities and problems in family health services and in family planning information, education and communication.**
   (a) Planning and identification of the priority and problem areas in family health services should be considered as part of the overall development plan of the country.
   (b) Problem areas should be properly identified.
   (c) The plan should be simple, practicable and acceptable to the people.

(d) There should be good co-ordination between all government departments and voluntary organizations.
(e) Planning of seminars should include all key personnel required by the planners – medical, midwifery, administrative including economists, and research staff.
(f) Health education of existing personnel should be carried out by in-service training and refresher courses.
(g) There should be crash training programmes for new personnel.
(h) Family planning and general health education should be incorporated into school programmes and also be given at clinics and in communities. This should include preparation for responsible parenthood and aim at the ultimate reduction in the incidence of too early marriages.
(i) Basic health services in the rural areas should be expanded by providing more infrastructure, trained personnel and equipment.
(j) Government should formulate national policies on food, nutrition, health and family planning.

2. **The expanding role of all categories of midwives and traditional birth attendants in family planning information, education and communication.**
   (a) Midwives of all categories, including TBAs, should give more emphasis to health education not only for the mother but also for the other members of the family and the community.
   (b) Greater emphasis should be given to health education and motivation in the basic training curriculum. Health education materials suitable to the community should be made available.
   (c) All midwives should be given regular refresher courses at least every five years, and these should include health education and family planning.
   (d) More elaborate procedures, such as the insertion of IUDs and the management of maternal and paediatric emergencies, e.g. giving intravenous injections, manual removal of the placenta, should be included in the basic midwifery curriculum so that midwives would be able to function effectively in isolated areas where medical aid was not readily available. Midwives assigned to remote areas should be given special refresher courses in these procedures.
   (e) There should be better liaison and two-way communication between hospital and field service to improve standards of patient care, promote efficiency of service and ensure job satisfaction.

(f) The midwife's function should include limited curative medical care for minor ailments.
(g) Reporting of all births and maternal and child deaths should be standard procedure for all midwives.
(h) Immunization should be one of the essential functions performed by the midwife.

3. **The incorporation of family planning, paediatrics and nutrition in the basic midwifery training curriculum.**
The participants strongly recommended that family planning, paediatrics and nutrition be incorporated into the basic midwifery curriculum. To this end they recommended that:
(a) Existing curricula should be reviewed or modified, giving emphasis to those aspects thought to be most important and leaving time for the addition of these new subjects.
(b) Medical personnel, especially obstetricians and paediatricians, as well as health educators and nutritionists, should be involved in instruction where applicable and available.
(c) Health education and motivation should have a high priority in the training curricula of all categories of midwifery personnel and TBAs.
(d) The basic training curriculum should be expanded to include all aspects of family planning. Considering the implications and potential for complications of the IUD as a contraceptive device, instruction in its insertion should be given to midwives as specialist postbasic training.
(e) The training of midwives in paediatrics should prepare them to provide care for the child from birth to school age. This should include:
i. infant feeding and the importance of breast milk.
ii. management of low birth weight babies.
iii. the ability to detect certain abnormalities and genetic problems.
iv. communicable diseases and immunization.
v. interaction of infection and infestation with nutrition.
vi. assessment of growth and development.
vii. recognition of the 'well-baby'; recognition of departures from the normal and of critical signs such as dehydration and fever.
viii. the ability to treat simple minor ailments.
(f) Nutrition should be identified as an expanded area in the training curriculum as follows:
i. Nutritionists and home economists should be invited to participate as instructors, with special consideration given to local dietary patterns, eating habits, local taboos, cooking practices, etc.

ii. There should be emphasis on nutrition for the pregnant, postpartum and lactating mother.

iii. Emphasis should be given to feeding, to the correct diet on weaning from the breast and to the importance of mixed feeding.

(g) The training syllabus should be reviewed every three years after appropriate discussion with personnel at all levels.

(h) Refresher courses for midwives should be held at least every five years, including new advances in family planning methods.

(i) Instructors and supervisors should establish a good follow-up system to ascertain whether what was taught during the training period was being practised in the field.

(j) In view of the responsibilities undertaken in their expanding roles, all midwives should have a more attractive salary and career structure.

(k) since auxiliary midwives are now expected to play a more important role in the delivery of health care, and their training is to be expanded and upgraded, entry requirements for training should be raised according to their country's educational criteria.

(l) Tutors should be specially prepared for the expanded areas in the midwifery curriculum - family planning, paediatrics and nutrition.

4. **The delivery of family planning education and service is the responsibility of all midwives.**

It should be the duty of midwives of all categories, including TBAs, to deliver family planning education and service through:

(a) Sufficient political, administrative and technical support.

(b) Efficient follow-up of family planning acceptors.

(c) Identification and use of satisfied acceptors.

(d) High standards of service including continuous availability of supplies.

V Country Follow-up Action Plan

Bangladesh

1. Information about the Working Party would be given to the Ministry of Health and the two secretaries (Health & Population Control and Family Planning), to obstetricians, gynaecologists, nurse-midwives and midwives of the country.

2. Attempts would be made to form a Midwives' Association.

3. They would try to persuade the Obstetrical and Gynaecological Association to consider membership of FIGO. Likewise, they would hope that the Midwifery Association when formed would join ICM.

4. No good field practice area existed in the country, although they were trying to put trainees into a field practice area for six months. Help would be needed to establish good field practice areas.

5. They wanted to register and train TBAs for use in MCH and family planning in rural areas. There had been training but this had been discontinued a long time ago. To do this they would need help from national and international agencies.

6. Vital statistics were poor and they would need advice and help in this.

7. To improve the MCH and family planning service, in-country seminars should be held once a year attended by representatives of the Planning Commission, Ministry of Finance, Ministry of Health, Education, Information and Broadcasting, Agriculture and Integrated Rural Development Programme, and those involved in the immediate implementation of MCH and family planning.

8. To implement these suggestions it would be helpful if the ICM visited our country and met the planners and secretaries of the Health and Population Control and Family Planning.

Malaysia

1. The Maternal and Child Health Unit would discuss the recommendations of the Working Party with the Director of Health Services. They would then be presented to the Director General of Health Services and Secretary General of Ministry of Health for clearance of policy decisions as required.

2. The final report and recommendations would be sent to all policy makers and administrators, including State Directors of Medical and Health Services, Deputy Director of Health Services, State Maternal and Child Health Officers, State Matron, Health Matron, and all other Maternal and Child Health personnel including those in training institutions and schools.

3. The Maternal and Child Health Unit would be responsible for planning and organizing seminars or workshops at national level to discuss and recommend on the future expanded role of the midwife based on local conditions. All these recommendations would be used as a basis for future programme planning.

4. The role of the TBA would be discussed and a training programme formulated after policy clearance was obtained from the Ministry.

5. It was intended to carry out feasibility studies of such expanded roles before national implementation in order to assess the effectiveness with which the expanded roles could be carried out, and to determine if tasks and functions needed to be modified.

6. It was planned to have meetings with those responsible for training

in order to incorporate the teaching of paediatrics, nutrition, family planning and intensification of health education training in existing curricula of all categories of midwife.

7. A policy decision would have to be made on whether midwives would be allowed to conduct more elaborate procedures, e.g. insertion of IUD, management of maternal and paediatric emergencies such as giving intravenous infusions and manual removal of the placenta. If this is agreed to, action would be taken to include these items in the basic midwifery curriculum.

Nepal

1. On their return they would approach the Ministry of Health, Department of Health Services, and the members of the National Planning Commission and explain their activities and reactions to the Working Party.
2. They would call a meeting involving the Dean of the Institute of Medicine, the Chief of the FP/MCH project, Nursing Administrator and the Chief of the Nurses Campus to discuss the proceedings and recommendations of the Working Party, the expanded role of the midwife, and how to get adoption of the recommendations by government and funds for development.
3. They would call a meeting involving all private sectors, e.g. Nepal Women's Organization, Nepal Nurses' Association, Nepal Medical Association, Family Planning Association, Nepal Red Cross, Lions Club, Rotary Club, etc., in order to generate full support and sympathy from them.
4. They would publicize news of their visit to the Working Party – their participation, the proceedings and their reactions to it – in their leading newspapers, Rising Nepal and Gorkhapatra.

Sri Lanka

Sri Lanka already had a comprehensive course for midwives which would change their role from that of a person mainly concerned with childbirth to one who was responsible for all aspects of family health, including family planning.

They recommended that:

1. A country seminar be organized by the Ministry of Health, with the Minister or Junior Minister as Chairman, to propagate the ideas which had come from the Working Party. Participants must include medical officers, paramedical personnel (especially midwives), officials in related government departments like the Treasury, Agriculture, Nutrition, Education and Planning. Representatives of the Family Planning Association should be invited to ensure co-ordination of the services to the public. The recommendations

of the seminar should be made public and to all personnel connected with family health.

2. To determine the effectiveness of the expanded role of the midwife, assessments at regular intervals should be made and the curriculum changed as and when required. Without feasibility assessments through feedback reports, the success of the programme could not be gauged.
3. A Midwives' Association should be formed, affiliated to the ICM.
4. A Midwives Journal, funded by government, should be produced by midwives regularly so that the problems and difficulties in the various areas can be highlighted. Interesting cases and new methods of motivation could be discussed.
5. Incentives could be offered to midwives working in remote rural areas. This might help those working under difficult conditions to feel more compensated and thus give a better and more efficient service.
6. The public, especially the village leaders, should be orientated to the new functions of the midwife in the family health programme, including family planning.

VI Analysis of Evaluation Questionnaires

A. *Administrative aspects*

1. **Travel arrangements:** Excellent (4); satisfactory (10); Reasonably satisfactory (2); unsatisfactory (0)
2. **Physical arrangements.** Excellent (9); adequate (3); fairly good (3); unsatisfactory (1)
3. **Accommodation and services.** Excellent (10); adequate (4); fairly good (2); unsatisfactory (0)
4. **Total length of Working Party.** Very satisfactory (6); adequate (6); too short (1); too long (2)
5. **Working hours.** Very satisfactory (1); satisfactory (10); too short (1); too long (3)
6. **Information given about Working Party.** Very helpful (8); helpful (5); of some help (2); of little help (1)
7. **Documentation to cover subject matter.** Excellent (4); satisfactory (11); fairly good (1); poor (0)
8. **Opportunities to become acquainted with other participants.** Ample (8); satisfactory (5); fairly good (2); poor (1)
9. Suggested improvements on administrative aspects included:
   (a) general instructions, draft programme and other information could have been sent out earlier.

(b) participants could have been made to feel more at home.
(c) would have liked more opportunity to meet personnel in the host country and to visit medical institutions.
(d) would have liked more free time (i) initially for acclimatisation and (ii) for sight-seeing and shopping.

B. ***Technical aspects***

1. **The participants.**
   (a) 4 members had not been outside their own country before.
   (b) 13 members had, and 3 had not, attended a similar meeting before.
   (c) 13 had been very eager to attend, 2 fairly eager and 1 rather reluctant.
   (d) 14 were very pleased and 2 fairly pleased to have been at the Working Party.

2. **Working Party Objectives**

   The agenda was designed to meet the following six objectives.
   1. To exchange information on the present situation of MCH/FP services in the countries.
   2. To exchange information on training and functions of all categories of midwives and TBAs.
   3. To identify common problems in MCH services especially in the rural communities and unmet needs in maternal and child care.
   4. To consider how the functions of the midwives of all categories could be expanded so as to assist in solving the problems and in contributing towards unmet needs.
   5. To suggest actions which were necessary to promote an expanded role for midwifery personnel and their motivation.
   6. To plan an appropriate follow-up action programme for each country in order to ensure implementation of the recommendations.

   Which objective did you consider the most important before the Working Party started? Objective 1 (4); objective 2 (2); objective 3 (7); objective 4 (2); objective 5 (3); objective 6 (0).

   Which objective was most satisfactorily achieved at the Working Party? Objective 1 (4); objective 2 (3); objective 3 (1); objective 4 (6); objective 5 (2); objective 6 (0).

   Which objective was least adequately achieved? Objective 1 (1); objective 2 (0); objective 3 (4); objective 4 (1); objective 5 (2); objective 6 (6).

   If you could have had a further two days to work on one objective, which one would you select? Objective 1 (1); objective 2

(2); objective 3 (4); objective 4 (1); objective 5 (5), objective 6 (4).

On which of the six objectives did you participate most in the discussions? Objective 1 (3); objective 2 (5); objective 3 (3); objective 4 (3); objective 5 (3); objective 6 (3).

3. **Usefulness of presentations.**
   (a) Family health care in developing countries: very useful (10); fairly useful (6); of little use (0).
   (b) Family planning information, education and communication: very useful (9); fairly useful (6); of little use (1).
   (c) The expanding role and scope of practice of all categories of midwives and TBAs: very useful (11); fairly useful (5); of little use (0).
   (d) Integration of family planning, paediatrics and nutrition into the training programme of all categories of midwives: very useful (14); fairly useful (2); of little use (0).
   (e) Family planning training programme in Malaysia: very useful (5); fairly useful (9); of little use (1).
   (f) Planning of family planning training programme: very useful (9); fairly useful (4); of little use (2).
   (g) Continuing education in family planning: very useful (7); fairly useful (5); of little use (3).
   (h) Legislation governing training and practice of midwives: very useful (10); fairly useful (3); of little use (2).
   (i) Family planning in national development: very useful (9); fairly useful (4); of little use (2).

4. **Time given to discussion of major issues.**
   (a) The priorities and problems in family health services and I.E. & C. adequate (14); too much (0); too little (0).
   (b) The expanding role of all categories of midwives and TBAs in family health services, especially in family planning, I.E.&C.: adequate (14); too much (2); too little (0).
   (c) TBAs as members of the health team: adequate (12); too much (3); too little (1).
   (d) The incorporation of family planning, paediatrics and nutrition in the basic midwifery curriculum: adequate (14); too much (1); too little (1).
   (e) The delivery of all family planning education and service is the responsibility of all midwives: adequate (15); too much (1); too little (0).

5. **Conclusions**
   Of the conclusions agreed upon, and the recommendations of the Working Party, how many reflect a need for change in your programme: all (2); more than half (5); less than half (9).

How many will be acceptable to you and your colleagues at home? all (3); more than half (10); less than half (3).

How many were already fully implemented in your country's programme? All (4); more than half (8); less than half (4).

6. **Opinions**

Which features of this Working Party pleased you most?

1. Information from the ICM.
2. Atmosphere of informality.
3. How the expanded role of all categories of midwives can be implemented.
4. The courtesy, and co-operation of the organizers, participants and observers.
5. Good co-operation – I was very pleased at the exchange of information on training and functions of all categories of midwives and TBAs.
6. The integration of family planning with MCH services.
7. Discussion which followed the reading of papers.
8. Group discussions.
9. Presentations of group discussions and reports.
10. Good organization.
11. Good co-operation.
12. Co-operation of all parties concerned.
13. Much friendliness and hospitality.
14. Presentation of group discussions and reports.
15. Panel presentation on legislation governing training and practice of midwives.

7. **Additional comments.**

Few additional comments were made, and some of these repeated points made elsewhere in the questionnaire. Noteworthy were:

(a) We have seen five countries work together in complete harmony.

(b) Should like another seminar to evaluate progress made in each country.

(c) Working Party has benefited me and I now know what to do to adopt and modify MCH and FP, IE&C services.

(d) Discussion should follow each presentation rather than at the end of a session covering two or three topics.

(e) The conference room was often too warm for concentration; the seating for observers was overcrowded and uncomfortable.

(f) The Chairman and Rapporteurs were worked a little too hard.

VII Follow-up visits, first follow-up

Follow-up visits were made by the Regional Field Director between January 20 and March 7, 1976. It was then possible to visit Bangladesh, and visits were also made to East Malaysia (Sarawak and Sabah) which had not been visited before the Working Party. These additional visits were therefore fact-finding as well as follow-up visits.

A. ***General conclusions***

1. All delegates had presented the final report and discussed the recommendations with the MCH/FP officials of the Ministry of Health and other members of the health team. There was unanimous support for the recommendations.
2. Programmes for training and utilizing TBAs were planned in each country except Sri Lanka where TBAs were said not to exist.
3. Midwives and nurse-midwives were working on the formation of Midwifery Associations, or midwifery branches of Nurses Associations.
4. Basic midwifery training programmes were being revised.
5. Obstetricians usually accepted midwives as trained professionals and co-operated with them.
6. As a result of the follow-up visits, groups of obstetricians and gynaecologists in two countries were seeking affiliation with FIGO.

B. ***Specific Matters***

1. **Peninsula Malaysia**
   (a) It was suggested that a Workshop on Curriculum Development for TBAs should form part of the follow-up activities and it was asked whether the ICM/USAID project could provide funds for it.
   (b) Hospital matrons were not yet involved in family planning activities and discussions about this were being pursued.

2. **Sarawak**
   (a) The Department of Health would be responsible for all MCH/FP services by 1977 and contraceptives would be issued free of charge. However, the National Family Planning Board (Malaysia) would not be able to supply contraceptives due to lack of funds and they were looking for assistance in this matter. IPPF and FPIA were suggested as possible sources of help.
   (b) The Department wished to train staff to provide family planning training and were looking for five or six scholarships for this. After training these people could be

responsible for the family planning training of all paramedical personnel and for the training of TBAs.

(c) The new category of worker known as community nurse was discussed, and it was suggested that community nurse-midwife was more appropriate as her functions embraced both midwifery and general MCH care. It was thought that it might be possible to recommend a change in title as the procedures for registration had not been finalized.

(d) A meeting was held with a group of 7 TBAs at a semi-rural MCH centre. They were found to be intelligent and hard working, and appreciated the invitation to the meeting. All had a good working relationship with the MCH midwife who conducted delivery and the third stage when it was possible to call her in. Some of the TBAs were capable of dealing adequately with abnormalities, and all appeared to have a right concept of family planning. The meeting provided an example of how selected TBAs, with proper training, could contribute greatly to health programmes.

3. **Sabah**

The view was expressed that to train and encourage TBAs was to perpetuate the existence of a class of workers with too low a standard. However, it was pointed out that, by encouraging TBAs now, their children might be motivated to take up full professional training in the future.

4. **Thailand**

(a) They were proposing to separate midwifery training from nursing training.

(b) There was also a programme to train trainers of TBAs.

(c) It was hoped to use Border Patrol Police to bring family planning education and service to rural populations living in politically sensitive border areas and in mountain areas.

(d) Auxiliary midwives and nurse-midwives did not get on well together. Auxiliary midwives would be unlikely to join an Association which included nurse-midwives and nurses.

5. **Bangladesh**

(a) The country hoped to achieve zero population growth by 1985. Sterlization as the principal form of contraception was receiving much support.

(b) The new category of Family Health Visitors were not registered as midwives as their training was thought to be inadequate. It was suggested that the training curriculum be upgraded so that they could be registered and therefore be eligible to join a professional association. The tutors were uncertain about the need to change the curriculum. A

workshop on Curriculum Development was planned and the reporter was invited to act as consultant.

(c) TBAs were now being superseded by family welfare assistants.

6. **Nepal**

(a) The delegates had been somewhat disappointed at the response of those with whom they had discussed the Working Party report.

(b) The position of auxiliary nurse-midwives was discussed. There was a great shortage of this category of worker. There was a lack of practical training facilities and a shortage of funds to develop them. Possible sources of funds were suggested.

(c) Instructors of auxiliary nurse-midwives should be fully qualified midwives with practical and field experience. As there were no such instructors available, it was suggested that 5 or 6 nurses should be sent overseas for training, and on their return be assigned to auxiliary nurse-midwife training. The British Council agreed to sponsor them for two years' training, provided that they returned to teach.

(d) Auxiliary nurse-midwives received refresher course training before beginning to work in the MCH/FP service, but they were generally so busy that they had little time for MCH/FP. They would not be allowed to insert IUDs until they were better trained.

(e) TBAs were recruited, trained and utilized. The younger ones were not well received but the older ones were more popular and were doing good work. One hundred had been trained in MCH/FP, nutrition and the principles of asepsis. The Department of Health was trying to identify TBAs so that they could be registered.

(f) Village healers outnumbered TBAs and were potential family planning workers, but there were no funds available to train them. The Chief of the Population Office, USAID, was enthusiastic about this and might be able to help.

(g) Sterilization was top priority in the integrated health service, while the Family Planning Association was lobbying to have the abortion laws liberalized.

7. **Sri Lanka**

Problems existed between nurses and midwives. Auxiliaries would not be eligible to join the Nurses Association through a proposed midwives branch. This was further discussed with officials of the Federation of Nurses Unions.

Second follow-up, August/September 1976

Nepal

(a) ***Delegates***

Dr. S. Gurung, Bir Hospital, carried out female sterilization as part of normal duties. Otherwise she had not involved herself in the implementation of the recommendations.

Mrs. Thakur, formerly Matron, Paediatric Hospital, Kathmandu, had been transferred to Bir Hospital and now had more opportunities to implement the recommendations – improving hospital standards, providing better nursing care, organizing educational classes for mothers, as in-patients or out-patients, on nutrition, child care, family planning, and setting up demonstration units for nutrition. She had also proposed that the Nursing School should send public health nurses to her hospital for practical training. She had tried to have the Midwives Association formed but with little success. She had been asked to function as an operating nurse, but had refused.

(b) ***Implementation of the recommendations***

1. MCH/FP training was being revised.
2. Nursing training, which included 6 months' midwifery training, could now be extended to include a further 6 months' midwifery. Those with additional training would be registered as nurse-midwives.
3. The role of auxiliary nurse-midwives had been expanded. They were now allowed to insert IUDs. Some had been trained in this and were performing successfully.
4. There was a move to train paramedicals without nursing or midwifery training to perform Mini Lap sterilization, but doctors, nurses and midwives had objected.
5. The formation of a midwifery branch of the Trained Nurses Association was in progress and advice and assistance were requested.

(c) ***Meeting with Secretary of Health***

He appreciated the status of midwives and their need to form an Association.

The family planning programme had made some progress and health workers had made a good contribution.

Training courses needed to be revised and follow-up improved.

Bangladesh

(a) ***Delegates***

Dr. Shamsun Nahar, Superintendent, MCH/FP Training Institute, had not been able to carry out any of the proposed follow-up

activities. Population control was being stressed at the expense of MCH/FP services which were badly neglected.

Mrs. Selma Begum, Co-ordinator, MCH/FP Training Institute, had been to the USA for training on development of family planning training programmes. She was working on the development of a new curriculum for family health visitors (auxiliary midwives).

Mrs. Jebu Nessa, Lady Health Visitor, MCH Training Institute, Dacca, was lost to follow-up as she was now stationed outside Dacca and no information on her activities was available.

(b) ***Implementation of the recommendations***

1. The midwifery training curriculum was being revised.
2. There were plans for training non-medicals and paramedicals for Mini-Lap female sterilization.
3. No efforts had been made to form a Midwives Association but the Superintendent of Nursing Services had undertaken to promote this.
4. TBA training was not yet organized as officials were engaged on revising the midwifery training curriculum.
5. MCH/FP services were still poor as all PCFP programmes were aimed at achieving zero population growth.

Sri Lanka

(a) ***Delegates***

Dr. Amarasinghe, Consultant Obstetrician, South Colombo Hospital, was not in a position to involve himself in any post-Working Party activities because he was not a government official.

Mrs. L. de Saram, Matron, General Hospital, Ragama, had no opportunity to be involved in implementation of the recommendations other than her usual duties of supervising family planning motivation at hospital level.

Mrs. Ranasinghe, Public Health Nurse, was in the same situation.

(b) ***Implementation of the recommendations***

1. Eight nurse-midwives had trained at Downstate Medical Center and were allowed to insert IUDs in pilot areas only. They were functioning satisfactorily, but a hard core of obstetricians were still opposed to the practice and limited it where possible. However, several medical officers of health had trained their staff nurse-midwives to perform insertions and were happy with their performance. The government was taking steps to make IUD insertion one of the functions of MCH/FP Midwives.
2. WHO had been conducting an in-country two-day Seminar for all levels of nurses and midwives.
3. No Midwives Association had been organized. The Chief Nursing

Officer, who was also President of the Sri Lanka Nurses Association, had done nothing to help midwives.

Summary of observations made

1. The midwives' expanding role is slowly gaining recognition. More and more of them are being trained in IUD insertion and are performing very well; in future they may even be allowed to perform the Mini Lap terminal method of contraception for women.
2. The training curricula of the different categories of midwives are being revised. In Nepal there is a WHO Midwifery Education Adviser. In Bangladesh and Sri Lanka the WHO Family Health Advisers are new and lack experience in curriculum development; hence they seek consultant advice and co-operation from the Field Director, ICM/USAID Project.
3. The above developments cannot be claimed solely as the outcome of the Working Party, but it is true to say that the Working Party contributed much stimulation in this area.
4. The Inter-Regional Seminar, as a post-Working Party activity, is another booster for the promotion of MCH/FP midwives as personnel capable of their recommended expanded role.
5. The midwives are facing numerous problems in their efforts to organise themselves into professional bodies. One of the main obstacles is the opposition from nurses, especially from the nursing educators. It will be some time yet before the midwives can emerge as skilled health professionals in their own right.
6. The Population Control/Family Planning Division of Bangladesh is rightly pursuing a population control programme with zero population growth as its target, but it is sad to note that this is being carried out at the expense of the MCH/FP services. MCH/FP services have not been sufficiently recognized as a parallel and complementary programme to the population control programme.

VIII Outcome, Proposals for Future Activities and Achievements

Outcome

The joint participation of midwives and obstetricians in the Working Party had brought about some changes in the attitude of the obstetricians towards midwives. There was now greater appreciation of midwives as professional colleagues.

Proposals for Future Activities

1. For Bangladesh, Nepal and Sri Lanka:
   (a) In-country training seminar.
   (b) Training seminars for trainers of TBAs in West Asia.
   (c) Inter-Regional Training Seminar on FP IE&C training for midwives.
   (d) Provision of advisory services on a basis of co-operation

2. For Malaysia and Thailand:
   None, because they have good family health programmes (including family planning).
3. Follow-up of the West Asia Inter-Regional Seminar participants.

Achievements

1. The West Asia Inter-Regional Seminar in Training of FP IE&C for midwives.
2. The recommendations were presented to the respective governments and midwifery personnel.
3. Several recommendations were implemented in stages:
   (a) Modification of the midwifery training curriculum and training period.
   (b) Training and utilization of TBAs.
   (c) Insertion of IUDs by midwives.
   (d) Formation of Midwives Associations; Sri Lanka Midwives Union has applied for membership of ICM.

APPENDIX I

List of Participants, Observers, Etc.

Participants

Thailand

Miss Lamom Srichandrabhand
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Bangkok

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Colombo

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Ragama

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c/o Medical Officer of Health
Werellagama

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Thapathaly
Kathmandu

Mrs. Mita Thakur
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Kathmandu

Bangladesh

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MCH Training Institute
Dacca

Mrs. Jebu Nessa
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Miss Kathleen Lo, SRN, SCM
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Observers

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Nurse-midwife
Family Planning Instructor
Ministry of Health

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Family Plannin[illegible]
Ministry of Health

Miss Raja Muhaini
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Ministry of Health

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Public Health Matron
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Family Planning Instructor
Ministry of Health

Miss Soon Eng Lai
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Johore

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Ministry of Health

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Miss Elizabeth Leong
Nurse-midwife
Public Health Matron
Sabah

Md. Anna Tay
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Public Health Sister
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Dr. Loh Sow Khin
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National Family Planning Board

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WHO
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ICM Officials

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Secretary
ICM/FIGO Joint Study Group
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Mr. Harry Smith
Financial Administrator
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Mrs. Belinda Brohier
Regional Field Director for Asia
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Members

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Dr. Norlaily Datuk Abu Bakar
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National Family Planning Board, Malaysia
Dr. Shamsuddin bin Abdul Rahman
Director-General

Dr. M. Subbrah
Director (Service)

APPENDIX II

List of Papers Presented

1.	The Role of Chairman, Rapporteur and Participant	Encik Abu Kassim B. Hj. Mohamed, KMN, Director, National Productivity Centre, Ministry of Trade and Industry, Malaysia.
2.	The ICM/USAID Project	Miss Margaret Hardy, SRN, SCM, MTD, DN, Executive Secretary, ICM Secretary ICM/FIGO Joint Study Group
3.	Family Health Care in Developing Countries	Dr. Frank N. Beckles, MD, Director, National Center for Family Planning Health Services and Mental Health Administration Dept. of Health, Education & Welfare U.S.A.
4.	Family Health Services in Malaysia	Dr. Raja Ahmad Noordin Raja Shahbudin, JSM, AMN, BCK, MBBS, MPH, DPH, Director of Health Services, Ministry of Health, Malaysia.
5	Family Planning Information, Education and Communication	Mr. Robert Blake, UNESCO Regional Communication Adviser UNDP, Malaysia.

6. The Extent to which Midwives and Traditional Birth Attendants are Involved in Maternal and Child Health/Family Planning Services	Dr. P.H. Amarasinghe, MBBS (Ceylon), MRCOG (Gt. Britain) – Sri Lanka Puan Mahelan bte Abdul Manap, SRN, SCM, HV, SN – Malaysia. Mrs. Mohan Tamrakar, CNM – Nepal. Miss Lamon Srichandrabhad – Thailand.
7. The Expanding Role and Scope of Practice of all Categories of Midwives and Traditional Birth Attendants in the Field of Family Planning	Dr. J.Y. Peng, MD, MPH, DPH, International Development Research Center of Canada, Associate Professor, Center for Population Planning, University of Michigan, U.S.A.
8. Integration of Family Planning, Paediatrics and Nutrition with the Midwifery Training Programme of all Categories of Midwives	Dr. Norlaily Datuk Abu Bakar, MBBS, MSc, Health Officer i/c Family Planning Maternal and Child Health Unit, Ministry of Health, Malaysia. Prof. Prasong Tuchinda, MD, DTM&H, Head, Department of Paediatrics, University of Mahidol, Bangkok, Thailand. Dr. Virginia Guzman, MD, MPH, Professor, Maternal and Child Health, Chairman, Community Health, University of Philippines.
9. Family Planning Training Programmes in Malaysia for Supervisors	Dr. Loh Sow Khin, MBBS, MPH, Director of Training and Medical Research, National Family Planning Board, Malaysia.
9a. Training of Auxiliary Health Workers in Family Planning	Dr. J. Varughese, MBBS, MPH, DPH, Director, Public Health Institute, Ministry of Health, Malaysia.
10. Planning of Family Planning Training Programme – Objectives, Needs and Curriculum Development	Dr. G.R. Amritmahal, PhD, Adviser on Training, National Family Planning Co-ordinating Board, Jakarta, Indonesia.
11. Continuing Education in Family Planning	Miss Mazel Lindo, CNM, MS, Downstate Medical Center, New York, U.S.A.

12. Family Planning in National Development	Dr. Rita Thapa, MBBS, MPH, Senior Public Health Administrator, Chief, Community Health and Integrated Health Service, Ministry of Public Health, Nepal.

ALL INDIA WORKING PARTY, NEW DELHI, INDIA, NOVEMBER 5th – 12th, 1976.

Participants: 23 States and Union Territories of India.

I. **Preliminary Visits**

(a) Visit to New Delhi, September 1974, by Mr. R. J. Fenney, ICM. There was general support for the idea of the meeting. The original proposal was that India, Ceylon and Malaysia should take part.

(b) Miss Patterson's visit to New Delhi, 6th-22nd November 1975. Planning was at a standstill because government had not yet approved the use of USAID funds. The Trained Nurses Association of India was keen that the meeting should take place.

(c) Visit by Miss Patterson and Miss Philip to New Delhi, Chandigarh, West Bengal/Calcutta, Tamil/Nadu/Madras and Maharastra/Bombay, July 1976.

Objectives of the visit

(i) To meet the Regional Field Director and discuss further plans for the Working Party, including venue, participants, etc.

(ii) To meet government and health team personnel in the five states and where possible to meet nominated delegates and personnel of non-government organizations.

(iii) To meet members of the local committees in order to review and discuss the draft programme to see that it met both the requirements of the project and local needs.

(iv) To meet USAID staff and discuss financial and other plans and seek guidance so as to avoid unnecessary problems.

Conclusions

The Working Party had been fully accepted and approved by government. All states visited were enthusiastic at the prospect of co-operation between doctors, nurses and midwives. It was constantly necessary to ensure that the number of nominated delegates was kept to the agreed figure and there were frequent problems with the selection of delegates. The USAID Program Division staff were extremely co-operative and helpful. A meeting was held with the local committee to discuss programme and arrangements.

Information from visits: IUD and male and female sterilization had taken precedence over the pill. Family planning was on the whole well accepted. During visits to various institutions the functions of new categories of workers were outlined; nurses, midwives and dais appeared to work together admirably.

(d) The joint visit (c) above took place during an extended visit by the

Regional Field Director to the various States between May and September 1976. During this visit programme planners and administrators of health care services (in particular MCH) were contacted, together with those involved in the training of midwives of all categories. Information was provided according to a questionnaire submitted in advance. The Regional Field Director met Directors of Health Services, Joint or Deputy Directors responsible for MCH/FP services and the Nursing Adviser (Assistant Director of Health Services (Nursing)), and in some states the Health Minister or Health Secretary. The general response of the authorities was most encouraging and the climate of the country seemed conducive for bringing about relevant changes in the approach to MCH care.

II. The Working Party

(a) ***Attendance:*** Those attending comprised:

(i) 57 nominated delegates from the various States and Union Territories.

(ii) 21 observers from government departments, Christian Medical Associations, voluntary organizations, Family Planning Associations, WHO, and other international bodies.

(iii) 2 representatives of FIGO.

(iv) 4 representatives of ICM.

(b) ***Organization***

Delegates were divided into four groups for the discussion sessions. Each group was given the same discussion topics, but related to a different category of worker, i.e. one group discussed each topic in connection with nurse-midwives, another with reference to lady health visitors, the third in relation to auxiliary nurse-midwives and the fourth in relation to TBAs (dais).

(c) ***Summary of proceedings***

Any attempt to present an accurate picture of the hectic life of the All India Working Party over eight days constitutes a tremendous effort that needs no apology for imperfection. Two factors make the Working Party memorable. First, the participation of the widest possible spectrum of experts representing varied disciplines and walks of life. Second, an unprecedented comprehensiveness of coverage that the central theme received from multiple perspectives. Furthermore the life of the Working Party was immeasurably enhanced by the sense of commitment, purpose and sincerity that every participant abundantly possessed. The historic character of the Working Party should be appreciated in terms of the interaction it brought about among all categories of personnel who touched the health scene either directly or indirectly. This justifies hope that the outcome of the Working Party's deliberations will have the benefit of dissemination and implementation.

Part, at least of the main orientation of the Working Party was manifested in the inaugural session by Dr. Sankar Ghose, the Planning Minister of the country who spoke on the "role of health workers in national development – a planners' perspective". It was highly appreciated to have the Planning Minister to inaugurate the Working Party as we are convinced today that Health Planning is an integral part of the total planning for development. Depicting the main trends in the current planning on Health, Dr. Ghose highlighted the need to make the fruits of the advances in modern medicine available to the far flung villages of the country. He affirmed the Government's commitment to abolish the intra-national disparity in the delivery of health care and pleaded for adequate changes in the existing structure, towards ensuring social justice.

In her opening remarks at the Inaugural Session, Miss Barbara Patterson, Project Director, ICM-USAID Project, presented in meticulous detail the genesis and growth of the ICM/FIGO Joint Study Group and outlined its history of activities and achievements to date. She emphasized the strong research orientation of the Study Group and its ultimate commitment to enhancing the image of MCH care all over the world. Touching the Central theme of the All India Working Party, Miss Patterson observed that midwives of today and tomorrow in their expanding role should be able to give total health care to the mothers and babies of the world which would include prenatal care and health and nutrition education, intra-natal care, post-natal care including Family Planning. Very often the midwife is called upon to supervise less qualified health personnel in her setting.

Tracing the evolution of health services in the country, Sri A.K.M. Ishaque, Deputy Minister of Health and Family Planning, in his Presidential Address observed that the system of health care delivery acceptable to the country must reflect the inherent characteristics of the community it serves. The Minister's recognition of the vital role that a community can play in the health efforts reflected the gist of current thinking on the subject. He was refreshingly frank in admitting that in the context of effective health care of the country as a whole the Auxiliary Nurse Midwives (ANM) have to play a central role.

Group work being recognized as a main strength of the Working Party, it was in the fitness of things to have a comprehensive introduction to the dynamics of group work expounded by Shri H. Nath, from the Department of Education and Training of the National Institute of Health Administration and Education. He highlighted the supreme need to define clearly and closely follow the objectives of the Working Party through all its deliberations

and an uninhibited participation thereof to contribute one's very best. He asserted that the Conference must commit itself to action in that each participant takes home some ideas and feels responsible for monitoring as well as a follow up action.

It was indeed befitting that Dr. B. N. Purandare whose distinguished association with one of the host agencies, i.e. FIGO as its President, has been only concluded, delivered the Key-note Address on "MCH and Family Planning Services in the developing countries – role of the midwife in health care systems" speaking on the FIGO's tryst with the challenge of Family Planning all over the world.

Dr. Purandare noted an attitudinal change on a global level in the recent past towards the acceptance of the concept and its implication. He observed that the acceptance of a small family norm should not be supplied to be a target of a vertical programme and highlighted the socio-economic-cultural determinants thereof. Dr. Purandare paid tribute to the Midwife's strategic importance in the Community setting and the considerable influence she wields or can wield in influencing life styles. He called for the enhancement of the professional preparation of the midwives and radical changes in existing curriculum, commensurate with the expanding role that they are called upon to play. He felt it desirable to give them a training in clinical skills related to midwifery imparted through a practice oriented training programme so that they can to some extent assume independent responsibilities in the rural setting.

The trend-setting session was chaired by Dr. Sanyal, Deputy Commissioner Family Planning, who advocated a determined effort to ensure the continued felicity of the family and the fullest enjoyment of health. From this human perspective, he went on to establish the need for the integration of MCH and Family Planning and that the stage is set for such an effort. He felt that the working party could contribute significantly to this conducive climate of opinion.

In the second Key-Note Address on "National trends in MCH and Family Planning services", Dr. E. Sebastian, Assistant Commissioner, Family Planning (MCH) traced the evolution of MCH and Family Planning Services in this country and revealed that in its beginning stages the effort to ensure the welfare of the mother and child was of purely voluntary nature and that medical attention for the mother preceded that for infants. She noted, further, that the concept of preventive maternity care is of relatively recent origin and that all efforts till then were directed towards providing assistance at the time of child birth. However, the importance of

Dais training as well as the training of supervisors, namely Health Visitors was recognized at the very beginning itself. She attempted a critique of Health Services in the post-independence era covering a broad spectrum of conceptual innovations that underlay the structural reorientation of health service from time to time. She emphasized the view that in the wake of greater acceptance of the small family norm, Government cannot absolve itself of the responsibility to provide improved services to mothers and children. This session was chaired by Dr. T. R. Tiwari. He struck a note of caution that the overriding priority now given to Family Planning though highly welcome should not be at the cost of maternal and child health services.

Following the presentation of the State reports, the topic "Training and Practice of all categories of midwives – whose responsibility – identification of existing problems", was taken up for discussion with Dr. B. Purandare in the chair.

The opening discussant, Dr. Anusuya Das, approached the problem from the general perspective and established the imperative need for making every midwife conversant with the day-to-day health problem concerning mothers and children in urban and rural communities so that she proves effective in ensuring their health in their total environment. Recognising the expanding role and newer responsibility of the midwife she established that the conventional milieu for the institution should be discarded in favour of training in the community setting and increasingly involving the Primary Health Centres (PHC) and the hospitals in the process. She strongly felt that only a low cost man power resource can be economically feasible in the country and the properly trained midwives of all categories in an integrated programme of MCH and Family Planning can deliver the goods.

With regard to the training needs of the country, she strongly felt that one of the fundamental defects in our training strategy is that we are not yet sure of the type of product at which we are aiming. Institutional goals as well as detailed instructional goals have to be spelt out and realised. According to her the main problems in the field of community Health Nursing Training are generally created either by administrative clogs or by lack of motivation among the trainers or the trainees and the outmoded training curriculum.

Dr. Ranee Christopher sounded nostalgic for the glory that the midwife in the past earned for herself and lamented the fall from grace that the profession had suffered thereafter and attributed it mainly to the poverty of the talent it attracts and inadequacy of the training programme to transform them. She wondered as to who would train the trainers which many of them needed. She was indignant about the gross disparity between the MCH services as

available to the have and have-nots but derived some consolation from the fact that the ANMs have achieved at least a moderate success in winning the confidence of the rural community.

Speaking on the nursing programme in general and the ANM training programme in particular Dr. (Miss) Kochhar felt that practical training in domiciliary midwifery should be given greater importance than it enjoys at the moment and that teaching and supervisory staff should accompany the students for domiciliary delivery. She decried the tendency among better qualified staff to stay in the hospitals rather than serve the rural centres and suggested that it should be made compulsory for qualified staff to spend part of their services in the rural centres.

On the question of lack of a standardisation of the optimum job efficiency acquired of nurses and of training of midwives in general, Miss A. Cherian felt that the Nursing Council of India and that of the States are primarily responsible. She felt it to be ironic that in several nursing councils doctors outnumbered the nurses. Nursing Council of India which is responsible for not only registering the enlisting but monitoring and maintenance of standards in proficiency, training and ensuring legal protection has not yet been able to amend the Nursing Council Act so as to bring under its ambit the ANM.

The role of Trained Nurses Association of India which is the only National Association of the nurses dedicated to the cause of the nursing profession in the country and the furtherance of standards of professional excellence in both Nurses' services and training was highlighted by its acting Secretary, Mrs. Nagpal.

In the discussion that followed, doubt was raised regarding the desirability of providing midwifery training as part of general nursing as the Hospital trained Nurses are hardly ever called upon to serve as midwives. It would be desirable some felt, to have the ANM provided with a comprehensive practice oriented training in midwifery. However, the consensus of the groups appeared to be that as the nurses of today are increasingly called upon to provide total health care of the family, it is essential to give adequate exposure to midwifery and paediatrics as part of the general training.

In a short session that followed, chaired by Dr. George-Joseph, an administrative perspective on the same theme was projected by Dr. (Mrs.) H. M. Sharma, Director, Christian Medical Association of India. She touched upon the various stages of practical implementation and the peculiar tasks at various stages.

As a prelude to group sessions discussing problems related to training of the different categories of Midwives in depth, a

plenary session was held where the four major categories of midwives, TBA, ANM, Health Visitor and Nurse/Midwife, were introduced through opening remarks by four experts.

In the first session chaired by Dr. Y. L. Vasudeva, Professor of Prev. and Social Medicine, Medical College, Rohtak, Dr. P. Ramankutty, Gandhigram Institute of Rural Health and Family Planning, appraised the group of perceptual action output model on MCH programme. In recognition of the fact that the substitution of the TBAs by fully trained workers cannot be achieved for a long time to come, he brought out the need to widen their activities and in that connection to provide the necessary training and facilities for them. He pleaded for action research to study systematically the parameters of TBAs role in the community.

Regarding the training of Health Visitors, Miss C. D. Sharma, Asst. Supdt., Lady Reading Health School noted that the demand for their services had increased after Independence but that they are unwilling to go to rural areas and this is accounted for, in their training programme. Mrs. P. K. Karthiyani, Nursing Adviser, Government of India, who chaired the session expressed concern that the course is not in many instances recognized and results in psychological trauma to those who are involved in it.

The session on the ANM training was chaired by Miss A. Kuruvilla, Dean, College of Nursing, CMC, Vellore, where the discussant Mrs. R. K. Sood, elaborating upon the various lucunae in the training programme, came to the conclusion that the current syllabus for the ANM is not suitable for preparing them to cater to the comprehensive health needs of 10,000 population.

Mrs. N. Lazarus, in her comprehensive critical survey of the training programme of the midwives of all categories, clearly indicated the areas in which the existing structure is inadequate and formulated both short-term and long-term strategies for their training and practice. In as much as the Dais cannot at once be replaced from the community without depriving them of what little they have, the only solution for the time being she argued, lies in providing them with an adequate minimum extent of training so that the risk factor may be eliminated. She emphasized the need to encourage ANMs to serve rural areas which cannot be achieved without making the community setting the main stage for their professional preparation. In the context of the imperative need to involve the nurse midwife more and more in the life of the community, she suggested that greater incentives may be given and training in midwifery be reinforced.

Any discussion on health services in the country must sooner or later address itself to the signal challenge of the effective health

care for all and this timely topic was taken up for a symposium by the Working Party with Dr. Butt, Director, Indo-Dutch Project, as the Moderator. For clarity of discussion the topic was further sub-divided into three approaches with Dr. Mamgain, Adviser, Evaluation Cell, Govt. of Haryana, speaking on the role of Multipurpose workers in this context, Prof. George Joseph of All India Institute of Medical Sciences, New Delhi, highlighting the community's role therein and Miss Kuruvilla, Dean, College of Nursing, CMC Vellore, speaking on the role of midwives in the delivery of MCH care. In her remarks, Dr. Mamgain vindicated the optimism that the Multipurpose worker scheme now in the process of implementation will answer the problems of health in rural India. Dr. George Joseph established the need to invite the community to share the responsibility for health and to identify the community's built-in potential for health. He emphasized that the creation of health awareness through formal and informal channels as basic to the total health of a nation. Miss Kuruvilla lamented the disparity between the training programmes in operation for the ANM and the Nurse Midwife and criticised the confusion on the role description of both. In recognition of the diversity and variety that the Indian sub-continent contains, she argued that we should think of health strategies and training programmes as feasible to state contexts within a broad flexible framework.

Speaking on the topic "Role of Supervision in Health Care system", Miss B. Walsh (WHO), attempted a definition of the exact implication of the term and found to consist in "working together, guiding and instructive and supportive role". She drew up some guidelines for effective supervision.

Miss K. K. Rao, (Deputy Director, Nursing, Gujarat) basing her observation on practical experience, brought out the importance of supervision in building up security and confidence in the health worker for promoting effective health care. It is a process of improving guiding and evaluating the work and not of fault-finding.

Miss Ruth Harner (Voluntary Health Association of India), emphasized the preparation of the supervisor not by class room teaching alone but by practice on the field based on a team concept.

Mrs. A. Thomas, Associate Professor of Nursing, NIHAE, advocated a system approach to the concept and noted that the training and practice of midwives should form a sub-system continuously informed by the total system of Health care of which it is a part.

Miss M. Philip, the Regional Field Director, ICM-FIGO All India Working Party, presented a birds eye view of MCH and Family Planning services and related training efforts in the country, high-

lighting the areas that need special attention. This report based on direct first-hand evaluation through field visits and on exploratory study through a questionnaire constitutes an important landmark of the All India Working Party.

The session on "Integration of Family Planning, Paediatrics and Nutrition with the training programme of midwives of all categories", was chaired by Prof. V. Hingorani, All India Institute Medical Sciences. Initiating the discussion Dr. Madhavi Sharma, of A.I.I.M.S. stated that the curriculum is the same for the Nurse Midwife and the Health Visitor as far as midwifery is concerned and felt it is of limited scope and needed drastic change. She presented a model for integrated teaching.

Prof. Y. L. Vasudeva elaborated upon the integration plan being tried out at Rohtak Medical College in which the training of doctors, nurses and multipurpose workers, is concurrently undertaken more or less in the same milieu from the teaching hospital to the rural home. Dr. Seeta Sinclair felt that the ANM/H.V. is the first member of the health team that the community meets and quite often the only one. She maintained that a good basic training in the care of the children of the vulnerable infant and preschool child is absolutely necessary for all cadres of health workers including the hospital nurse and family health workers.

Mrs. Karthiyani described the extent to which Family Planning programme is integrated within the two years of ANM curriculum and in that of the Multipurpose workers.

The session on "Training methodology and Curriculum Construction" was chaired by Prof. N. H. Keswani, Director and Dean, All India Institute of Medical Sciences, New Delhi. Opening the discussion, Prof. H. S. Gandhi, Dean, NIHAE, identified areas like knowledge, skills and terminal behaviour for particular emphasis and underscored the need for bringing about the required attitudinal changes in the professionals and para-professionals. He felt that the methods of teaching have to be adapted to this important objective. Once we recognize the building up of a cohesive team, as our ultimate objective in training, the need for the doctor to step aside willingly giving recognition to others, becomes very clear.

Mrs. Karthiyani speaking on national goals in training asserted that they should depend on the country's needs. She highlighted the need to evolve a suitable training model for the multipurpose workers so that the strategy implied in the scheme is fully realised. Speaking on evolving Curriculum Strategies, Dr. Sulochana Krishnan, Principal, College of Nursing, New Delhi, asserted that the present strategy of imparting training for ANMs in the hospital setting with hardly any provision for their assuming independent

responsibilities should be summarily discarded in favour of training in the community setting. She highlighted the need for emphasizing self learning, and continued education and research orientation.

Dr. H. S. Srivastava, Head of the Examination Reform Unit, N.C.E.R.T. introduced to the Working Party a conceptual model for curriculum construction in para-medical courses. He advocated an objective approach in evaluation so as to mitigate the disparities that otherwise exist.

Professor Keswani remarked in conclusion that the existing split between training and evaluation evidenced by examinations that exist in near isolation from the main stream of training cannot be continued. He maintained that Internal assessment was all important and that we should proceed to the realization that evaluation should become part of training itself.

The first panel forum of the Working Party proved to be of absorbing interest with Mr. Jagannathan as the moderator and Mr. Kakar, Mr. Abu Abraham, Dr. D. Banerjee and Prof. N. N. Pillai as panelists, on the topic "Family Planning: education, information and communication". Opening the discussion Abu Abraham, with the cutting clarity and incisive wit of a true cartoonist, exposed the poverty, the lack of any appeal or relevance of a good deal of the propaganda generated by governmental agencies on Family Planning. He lamented that the positive dimensions of F.P., the human implications thereof, are all often lost amidst the plethora of vapid words. He highlighted the socio-economic factors that influence the acceptance of the small family norm. Taking up from where Abu left, Prof. D. Banerjee wondered if the communication media have not become mere tools in the hands of vested interests. He noted with concern that Family Planning is often being identified with a set of birth control measures. He felt that the concepts of Family Planning should lead themselves to a free and frank discussion and that any curb on the mass media in this regard will be self-defeating. He pleaded that in our preoccupation with immediate results we should not violate the sense of human dignity. Answering Prof. Banjeree, Mr. Kakar acknowledged the central importance of education, but insisted that we cannot wait. He attempted a vindication of the National Population Policy. Mr. Kakar was convinced that the propagation of ideas of Family Planning should not be left to governmental agencies and that the voluntary and professional bodies have a great deal to do in abolishing the credibility gap. Prof. N. N. Pillai addressed himself to the human and social drama of communication and declared that the techniques and modes of communication in operation now cannot but let down the F.P. Programme. He noted with disappointment that there was no understanding between research on communication, techniques,

and actual programmes. He felt that Family Planning might well be a popular movement; but cautioned against the pitfalls thereof. The panelists worked up an appreciable degree of interest among the participants as was evident from the live discussion that ensued.

On the session devoted to "Family Health in relation to Family Planning" chaired by Dr. Timmappayya, Director, NIHAE, Dr. H.W. Butt (Indo-Dutch Project) noting the impact of I.M.R. on the acceptance of the small family norm, highlighted the pivotal role that child care, particularly nutrition plays in this context. He brought out the need to educate mothers to look after nutritional needs of children with locally available sources. Dr. M. Laugesan of NIHAE observed that monitoring of growth and development should be deemed as an indispensable facet of the process of communication between health workers and mothers in a community.

Dr. Shanti Ghosh, Head of the Dept. of Paediatrics, Safdarjung Hospital, New Delhi, emphasized aspects like the need for care of mothers during the third trimester of pregnancy, and the monitoring of intrauterine growth in order to avoid perinatal mortality. Identification of high risk mothers and high risk babies should be duly emphasized. The value of age-old practice may be recognized.

Dr. Bina Roy (who presented Dr. Deulkar's paper) discussed the factors determining family economics and the role of midwives in helping the mother to attain a sense of balance in family budgeting.

Throwing the topic "Family Planning in National Development" open for discussion by a Panel consisting of Prof. J. C. Kavoori, Prof. P. B. Desai and Dr. T. R. Tiwari and Smt. A. D. Malhotra, the Moderator, Col. Barkat Narayan observed that our concern in National Development should be for the enhancement of the quality of life. Prof. Desai felt that development has failed to act as a contraceptive in India for want of direct involvement of the people in the developmental process so much so that the structure of the society did not change. Referring to the population policy he asserted that it is the fundamental duty of every citizen to behave responsibly in the field of reproduction. He recommended that health is not merely a goal in itself but a vital input into the productive force.

The cultural conflict created by modern medicine in the rural setting engaged the attention of Prof. Kavoori who exposed the "sick syndrome" dominating the society. He pleaded that we must respect the sentiments and age-old value systems in the villages and abstain from the imposition of an alien culture on them from a position of power.

Dr. Tiwari wondered if there is genuine cohesion at the policy

making and implementation levels and noted the lack of convergence among the developmental agencies. The tension that often exists between the team objectives, the objectives of the individuals constituting the health team was identified by him as the major drag on the effectiveness of our programme. Smt. A. D. Malhotra pleaded for an integrated health philosophy in the country. She was optimistic that the multipurpose scheme backed up by a commensurate training programme will help solve many of the evasive issues in the delivery of health care.

In the symposium forum on "Beyond Family Planning" chaired by Dr. K. N. Rao, Prof. P. B. Desai felt that once the Family Planning programme attains its goals a vast amount of female labour will be available, the utilization of which should engage our attention at the earliest. He felt that a lot would depend on what we do simultaneously with planning and how we ensure participation of women in social life.

Dr. Mrs. Kamala Gopala Rao, highlighted the need for innovative mass education-communication efforts to enlighten the women of the country and suggested that any attempt to influence behavioural patterns through mechanical interventions will have unfortunate consequences. On the issue of the devaluation of the family and society she pointed out that legislation alone cannot solve a multidimensional sociocultural problem. We have to create a situation that induces in the woman a capacity for critical thinking.

In the session on "Health by the People" chaired by Sri J. P. Naik, Dr. Arole, Dr. P. M. Shah and Dr. Eric Ram, who are all actively involved in community health research appraised the Working Party of the three models evolved by them respectively all of which seek the participation of the community in the delivery of health care in varying degrees. Dr. Arole clearly outlined the areas in which community can be involved such as nutritional needs of children, child care, immunization, antenatal care. His strategy was to select middle aged illiterate women who after a short training course would serve as the village health worker. These workers were able to devise health educational materials in consonance with local ethos sometimes even utilizing traditional beliefs. He discovered that 80–90% of health problems can be solved at the village level without the expertise of the doctor and that of negligible cost.

Dr. P. M. Shah introducing the Palghar experiment established the feasibility of primary health coverage by the village health workers who could also be used to screen the community to identify the sections exposed to risks and therefore needed immediate attention e.g. children and pregnant women. His project devised a small medical kit with 6-7 common drugs which was found to be

adequate to meet the common needs. He was all praise for the community in its good will to put in the required investment.

Highlighting the need to evolve a health care structure that will not fail the vast rural population, Dr. Eric Ram maintained that the ANM can play a great role in improving the health situation in the villages. With the help of statistics he demonstrated the positive impact achieved by the voluntary health workers on areas like registration of antenatal cases, domiciliary midwifery care, nutrition education, child care, family planning and its follow-up, school health programmes, etc. He established that a delivery pack designed by his project for use by the Dais costing 50 ps. can help ensure a safe delivery. This was largely responsible for bringing down the maternal mortality to zero.

Summing up the discussions, Prof. J. P. Naik, with the perceptiveness of a social scientist observed that the village dai who even now conduct 70%–80% of all the deliveries has always been and will continue to be the most viable midwife in India. The lament of lack of resources he observed, betrays the poverty of imaginative planning in the country that fails to recognize the vast potential in human resources.

Opening the panel forum discussion on "Legal and Sociological Perspectives on the training and practice of the family health worker", chaired by Mr. Justice V. R. Krishna Iyer, Prof. D. Banerjee, identified the class hierarchy as the stumbling block in the way of her effective service. According to the existing power structure he pointed out that the health worker is expected to humour the dominant moneyed class and the poor has always been socially powerless.

Mrs. Padma Seth, highlighted the lack of security that the female health workers are beset by in the rural setting and brought out the need to extend the protective arm of law to cover their "responsibility risks". She went on to point out that sometimes the lack of adequate legal awareness tends to obstruct the enjoyment by the female health worker of whatever protection there is available at the moment.

Mrs. Tara Ali Baig observed that, though children under 16 constitute 42% of the total population, they are socially, legally and medically neglected. The non implementation of the child marriage Act is an instance in point. She invoked the issue of the registration of marriages and established the need for a medically healthy, genetic conditioning of the family to solve the problem of the genetically acquired handicaps in children. She felt that in a context where the female child is often considered a thankless burden, the

registration of female births and legislation to ensure her survival are very important.

Dr. Sulochana Krishnan exposed the anomaly that though in the rural setting the ANMs in their expanding role are expected to diagnose and prescribe, they are not legally protected. She called for the institution of positive laws that would improve her efficiency rather than act as a drag.

Concluding the discussion, Mr. Justice Krishna Iyer, observed that to be legally protected the family health worker must have scientifically acquired competence and skills depending on her tasks, which if lacking, she can be a burden on society. He agreed however, that health personnel of this category should be protected from the mishaps arising from the bonafide actions. Surveying the vast panorama of the Indian scene, Mr. Justice Iyer felt that there was an immediate need for a "new moral sanitation". He assured the Working Party that he would take the initiative in honouring these timely requirements pertaining to the legal protection of the family health worker in the Juridical Committee of which he happens to be a member.

Closing Session

During the last day of the eight days Working Party, the delegates worked very hard at finalizing their Reports, formulating their Final Recommendations and completing their Evaluation Questionnaires. The Rapporteur General read the Final Recommendations to all the participants. Their hard work was highlighted.

Closing Address

Shri B. D. Jatti, Vice President of India congratulated the delegates on their deliberations which resulted in the final recommendations. The recommendations were also presented during this session. Chowdhary Ram Sewak, Union Minister of State for Health and Family Planning highlighted the existing National Health Programme and the hope that adequate preparation of the midwife will promote better health systems.

III. Reports on the Group Discussions

The three topics were:

(a) Training and Practice of Midwives: Identification of Existing Problems.
(b) Training Strategy.
(c) Training Methodology and Curriculum Construction.

1. Working Group I – Traditional Birth Attendants (Dais)

Discussion I – Topic: Training & Practice of Midwives – Identification of existing problems

Report

Introduction

Group 'A' met in the Auditorium and following are the group members, Selection of Chairman, Rapporteur, and Recorder.

First the candidates introduced themselves so that we got the knowledge of the background of all candidates. Dr. Vasudeva was selected Chairman, Miss K. Biswas Rapporteur and Miss T. U. Annamma Recorder.

The Chairman of the group asked whether any of the members had experience in identifying and training the indigenous Dais.

1. Dr. Singh from Delhi explained some of the problems which she faced. The first problem which she mentioned was that the Dais were not exposing themselves.
2. People who identified themselves were not really practising Dais.
3. People coming forward for training were not local people though the training was meant for local people. Further discussion was based on the guide lines given.

Identification of the role of the indigenous Dais: the role as observed by the Group Members are:

1. Inducing abortion.
2. Ante-natal care and advice.
3. Constant home visits.
4. Massaging during Pre-natal and Intra-natal period.
5. Washing of clothings, infant feeding.
6. Enema before delivery.
7. Wash down during post-natal period.
8. Repeated Vaginal Examinations.
9. Injudicious use of drugs e.g. Pitocin or Syntocinon.
10. Poor habits.
11. Poor personal hygiene.

Discussion II – Topic: Training Strategy

Skills Practised:

1. In induction of abortion; usually untrained dais use Carrot seeds, and Calotropic seeds.
2. Delivery cases: all mothers who are in labour are given a thorough wash from head to foot. The abdomen is massaged with oil during labour. Repeated vaginal examinations are done and oil is applied to iron out the vagina. The umbilical cord is not cut until the placenta

is completely expelled. Normally it is cut with Bamboo Piece sickle or with a knife. The cord is tied with a piece of the end of mother's saree which the mother wears during labour, whether it is clean or dirty.

Family Advice Given by the Dais:

During the post-natal period, the restrictions on some foods are as follows:

1. Kangi is given for seven days in Tamil Nadu.
2. Water: no water is given to the mother for days in Kerala.
3. Colostrum feeding is not encouraged.
4. Every relative is supposed to feed the new born with finger tips.

Effects of the above skills practised as observed by the participants are:–

1. V.V.T., R.V.T.
2. Ruptured Uterus – Due to unidentified obstructed labour and due to wrong adminstration of injection of Pitocin in Cephalo-pelvic disproportion.
3. Maternal and foetal distress.
4. Eclampsia (influence of ghost).
5. Puerperal Sepsis.
6. Criminal abortion (septic abortion).

The question arose whether the above mentioned complications are only arising because of the fault of TBAs or are other health workers also to be blamed. This is also to be answered by the group.

Few studies have been conducted in the field:

1. Dr. V. Natarajan conducted a follow up study on trained Dais and an educational study on Dais in Tamil Nadu during 1973.

   Methodology – Interview
   Sample
   Findings: All religious groups were used and from each religion, all sections of the people practise midwifery. 60% of the Dais are illiterate and 40% are literate. 70% of the Dais work hard before labour. Majority sterilize instruments with boiled water. After receiving training their income comes down.

Second Study:

2. Dr. S. K. Sadhu conducted an exploratory study on Dais training programme in 1973.

   Findings:
   (a) Untrained Dais are preferred to the trained ones. This is because

the untrained Dais do all the work which the community expects.

(b) All the community practise midwifery.

Dr. P. R. Dutta has given a personal communication. He did a follow-up visit on the trained Dais and found out that 50% of the trained personnel were not in existence after three years of their Training. This is because many who received training were not truly practising Dais.

Reaction of the Community towards Dais Practice:

The reaction is most favourable and the Dai is well accepted. It has been observed however, that the community is eager to have improvement in the services soon after they are aware of the difference in the care given by the professional midwives.

Areas of work in which her co-operation is enrolled:

Co-operation is needed in the following areas:

1. In registration of ante-natal care, and registration of births and deaths.
2. In delivery services.
3. In post-natal care including baby eg. Perineal care in the mother and baby care as a whole.
4. Family Planning in the field.

Areas of conflicts:

Conflicts between Dais and the Trained Midwives. The Auxiliary Nurse Midwives (ANMs) areas of conflicts:

1. Professional insecurity.
2. Losing their identification.

Problems mentioned by Dais:

1. (a) Inadequacy in supply e.g. refills and drugs.
   (b) Lack of protection to cover up the mistakes.
   (c) Problems of co-ordination and co-operation.
   (d) Lack of recognition by all categories of Health Personnel.
2. Problems mentioned by Health Personnel
   (a) Difficulty in identifying the Dais.
   (b) Lack of co-operation from Dais to the extent of their knowing what is to be their functional role.

Training Programme:

The group elected Dr. Reddy as a Chairman because Dr. Vasudeva left for Harynana. The first thing the group discussed was whether the existing TBAs should be trained or new people should be recruited for

the training. Members of the group felt that only the existing TBAs should be trained.

The group further discussed the objectives of the training. Objectives discussed are as follows:–

1. To improve the midwifery services in the rural area by utilizing the existing personnel.
2. To introduce some knowledge of cleanliness and asepsis into the work of the Dai so that her practice is improved and the incidence of puerperal infections reduced.
3. To warn the Dai from crude and unhygiene methods of work and use of unscientific equipments.
4. To train the Dai to recognize conditions where she must seek assistance from qualified staff.
5. To help the Dai to be an agent between the maternity and child welfare services and to use the hospital services within the areas for the families whom she serves.

The above mentioned objectives are taken from the booklet named "Training of Dais" published by D.G.H.S. Excluding these, the Medical Council of Health has accepted three more additional responsibilities may be given to the Dais until the adequate number of professional people were available to serve the community. Despite this however, only a few of us wanted her to be a messenger of Family Planning.

Based on these additional responsibilities, the following objectives were added:

1. To help her to be a messenger of Family Planning and promotive services.
2. To enable her to diagnose minor ailments and treat them.
   (a) **Who should be responsible for her training?**
   All the members of the health team should take part but the ultimate responsibility to organize the course should be left to LHV/PHN/ANM/GNM depending on the availability of the person.
   (b) **Where should the training be carried out?**
   It should be done at the PHC. Dispensary with maternity homes where facilities are available, and the training area should be close to the Dai's home.
   (c) **Duration – How long?**
   Minimum of 35 hours distribution within a period of 2–3 months.
   (d) **Course content?**
   Though the course content is given in the guide sheet, it will be presented after critical analysis of curriculum.

Discussion III – Topic: Training Methodology and Curriculum Construction

1. **Methodology**: Demonstration and use of Audio-Visual Aids.
2. **Evaluation:**
   (a) Conducting practical and oral list. Observing her while conducting a normal delivery.
3. **What type of incentive should be given to sustain her interest during and after her training?**
   (a) Giving of a certificate after completion of training.
   (b) Monetary incentives during training D.A. of Rs 10/- session should be given.
   (c) After completion of training additional incentives of Rs 5/- must be given for referring ante-natal, intra-natal, post-natal and family planning cases.
4. **Who should supervise her in the field and how?**
   (a) Her immediate supervisor should be the ANM/LHV/PHN.
   (b) Occasional supervision by the Doctor.
5. **How often should they be supervised?**
   At least once in two months.
6. **How should her performance be assessed?**
   (a) By inspecting kits.
   (b) Supervise her at the time of confinement.
   (c) At the time of house visits.
   (d) Finding out the unregistered births and deaths.
   (e) Meeting the local leader.
7. **Periodical Refresher Courses:**
   Periodical refresher course should be given once per year. The suggested length of the course should be four hours within one or two days period.

   It should be given by LHV/PHN/GNM on the doctor's clinic day or days.

Working Group II
Auxiliary Nurse Midwives – ANMS

Discussion I – Topic: Training and Practice of Midwives – Identification of existing problems

Report

Chairman: Mrs. A. Kuruvilla

Rapporteur: Mrs. M. C. Xavier

Identification of the ANM under the multipurpose scheme.

The Auxiliary Nurse Midwife (ANM) is expected to be responsible for

the total health care of the family i.e. for about 8,000 population (including 1.5 thousand villages) of this 3-4 thousand are expected to receive intensive care and the remaining number are expected to receive only emergency services such as deliveries. She is expected to enlist the dais in her area, give ante-natal care, conduct deliveries, give post-natal care, immunization, treat minor ailments, detect abnormal cases e.g. habitual abortions, and be able to deal with andenlightenthe population regarding positive health and referral system.

Since she is serving the community, the group felt that the community would naturally recognize her as a health worker. In many cases, she is introduced to the community through the village Pradhan. However, the more mature she is, and if she is married, the more acceptable she will be to the community.

Regarding her present training it does not prepare her adequately for the responsibilities she has to face especially in relation to paediatrics and family planning, due to the lack of trained tutors and teaching facilities. The curriculum is not properly implemented, especially in the area of community nursing experiences and in the area of supervision.

Problems related to her practice are:

Lack of suitable accommodation, timely supplies of drugs, vaccines, stationery and the maintenance of proper records, due to inadequate preparation. Medical Officers in charge do not know the role of the ANM and how far their assistance/co-operation is to be extended.

Lady Health Visitors - (in PHCS) and Medical Officers in charge, should supervise the ANM activities.

Problems in her supervision:

1. LHVs do not spend sufficient time with the ANMs. They visit only on clinic days with the M.O. for short periods which means lack of proper technical guidance and support for her performance to be reviewed and assessed.
2. The D.P.H.Ns also hardly visit, or visit for only short intervals, so the same problems are encountered.

This can be remedied if the LHV spends the whole day and stays overnight when new workers are appointed and whenever indicated. The DPHN should make it a point to visit the sub-centres periodically.

Discussion II – Topic: Training Strategy

Discussion III – Topic: Training Methodology and Curriculum Construction

Reports

Chairman: Dr. Ranee Christopher

Rapporteur : Mrs. M. C. Xavier

Yesterday we reviewed some of the many problems encountered by the ANM. In continuation, it was emphasized that some sort of transport should be provided for her. In practice, it is found that the ANM is least considered for any facility that can be made available. Transport facility may consist of cycles, cycle rickshaws, and even bullock carts were felt to be better than having nothing.

This would, however, mean that the provision of approach roads must be a necessity. Involvement of the village Panchayat in co-operation with agencies like Government/Social might prove more effective. Involvement of the Panchayat was also a way of making the community feel responsible to provide some ways and means for the services which are offered to the people.

The question of who should supervise the ANMs was given much consideration. It was strongly endorsed by the group that the supervisory/individual should be a person who already knew the role of the ANM and has had working experience with the ANM. Such a person should be the PHN, and in her absence the LHV or FH. The M.O. in charge however would be ultimately responsible to the administration for the overall achievement.

In some backward areas like Arunachal Pradesh, there is great difficulty in getting girls from other States, to work there. As such local girls, often with lower educational qualifications are recruited for ANM training. Nurse midwives are very few in number, so the Medical Officer supervises the activities of the ANM which often involve activities which time may not permit such as the supervision of episiotomies and suturing. The recommendation therefore is for more Nurse Midwives.

It was unanimously felt that supervision of the ANM by male doctors, poses problems of a delicate nature. In order to avoid such situations, it was suggested that:

(a) One senior, mature ANM be posted to help and supervise the junior ANM.
(b) If no suitable senior ANM is available, a middle aged Ayah with no encumbrances from the local community may accompany and assist the ANM.

To make this problem felt by the community and give them an acute awareness it was suggested that: after all the ANM is there to give total care to the community and so community involvement again should be undertaken.

This may be done by having a Health Committee consisting of about four responsible, interested members of the community with the MO/PHN/LHV/FH supervisors attending as guests in an advisory capacity. This committee may not only project the needs of the com-

munity as perceived or expressed, especially by their women folk, but also be given a feed back of the difficulties encountered during the practice of the ANM or supervision by the supervisor, or both, and which may be in their power to rectify.

The group felt strongly that emphasis be placed on community Nursing experience, it is because of a lack of this why the ANM is apprehensive to work in the community. This naturally affects supervision. Therefore, community Health orientation is absolutely essential for anyone who has to supervise the ANM.

One problem which was projected by the group, was that the ANM was generally assessed or graded according to her motivation in Family Planning. It was felt by the group, that some uniformity for assessment be evolved in terms of what and who, bearing in mind that the ANM functions are many, including total health care of the family.

WORKING GROUP III
LADY HEALTH VISITORS – LHVs

DISCUSSION I – TOPIC: TRAINING & PRACTICE OF MIDWIVES – IDENTIFICATION OF EXISTING PROBLEMS

DISCUSSION II – TOPIC: TRAINING STRATEGY

DISCUSSION III – TOPIC: TRAINING METHODOLOGY AND CURRICULUM CONSTRUCTION

Reports

After reviewing the topics and guidelines given for the three discussion periods, the group concentrated on the "training strategy" of the Lady Health Visitors. They have critically analysed the existing curriculum prescribed for Health supervisor by the Indian Nursing Council.

The duration of the prescribed curriculum for a health supervisor is two years and the minimum qualification for admission is Higher Secondary (10 + 2) or any other equivalent qualification. This curriculum is formulated in a manner to fit into the three years University programme leading to a basic degree course; thus a student who wishes to continue in the three years programme can without delay enter in the further one year programme as a sequence to the three years programme. Those who do not want to pursue further study will be eligible for registration and examination by the Council or Board after completing two years. On success of the examination such personnel are qualified to practise as health supervisors.

The subjects which are covered under the two years programme are:

Part I

Community Health Nursing

1. Fundamental of Nursing
2. Nutrition, dietetics
3. Community nursing including preventive medicine, health problems and health services, communication skills and health education.

Part II

Microbiology, Medical/Surgical nursing with related Anatomy and Physiology Pharmacology and other specialities.

Part III

1. Paediatrics and Paediatric nursing, MCH, Obstetrics and Obstetric nursing, Mental Health, Psychiatric nursing, introduction to Psychology and Sociology.
2. Supervision Guidance and Counselling.
3. Evaluation & Education.
4. Administration.

The group felt that to some extent this curriculum if implemented as prescribed will be able to prepare Health Supervisors to perform their duties effectively. However, there is scope for improvement and it may be modified as follows:

1. Due weightage should be given to the theoretical and practical aspects.
2. Clinical aspects of FP such as insertion of loop, fitting of diaphragm and post partum programme under M.T.P. should be made clear.
3. Under Medical Care Common diagnostic procedures and treatment of minor ailments.
4. Preventive paediatrics and preventive obstetrics should be included.
5. Practical experience in community nursing should be given on a continual basis.

The group has further discussed the examination system. However, 25% marks for theory and practical should be given as an internal assessment.

Staffing Pattern:

The present staffing pattern prescribed, requires some modifications. The members of the group have worked out what is believed to be a realistic staffing pattern for a school whose annual intake of students is 30.

1. ***Principal/Superintendent*** – One
   Qualification: B.Sc. Nursing with post graduate qualification in Public Health. She must have at least seven years experience in the field of Public Health.
2. ***Vice Principal/Asst. Superintendent*** – One
   Same qualifications as above with at least five years experience in the field of Public Health.
3. ***There should be:***
   General Tutor – One
   Midwife Tutor – One
   Public Health Tutor – One
   Public Health Nurse – One

WORKING GROUP IV
NURSE MIDWIVES – N/Ms

DISCUSSION – TOPIC: TRAINING AND PRACTICE OF MIDWIVES – IDENTIFICATION OF EXISTING PROBLEMS

DISCUSSION II – TOPIC: TRAINING STRATEGY

DISCUSSION III – TOPIC: TRAINING METHODOLOGY AND CURRICULUM CONSTRUCTION

Reports
Chairman: Dr. P.V. George
Rapporteur: Mrs. N.J. Lazarus

Introduction:
The integrated maternity care in the hospital would really mean a Family Centred approach. If we believe in this concept there are many problems we could envisage and many of these we are already encountering.

1. ***Ante-natal clinic:***
   (a) Do we consider that when a woman is pregnant that the whole family is pregnant? – husband, mother, grand-mother, mother-in-law, and every one of the other children? If so:
   - Why cannot the waiting room be made much larger?
   - Why is the husband not allowed to accompany his pregnant wife at least for the interview and history taking?
   - If we believe that one of the factors which prevent pregnant

mothers from attending the clinic regularly is due to the children;
- where to leave them?
- who would take care of them?
The problem here is that there is no provision made for the children to be left at a suitable area in the clinic, when the mothers are being examined.

– We are adding to the psychological fears and anxiety of the pregnant women, when we close the doors to their husbands. For example, members of our group present at this Working Party, have stated clearly that they know of some pregnant women, who during history taking, when asked for the date of her last menstrual period (L.M.P.) will say: "Ask my husband", alas, there is no husband to ask, as he is barred from the clinic.
Even for Family Planning, information/advice the husbands are not included. The main stumbling blocks are hospital policies and at times the attitude of the medical staff.

(b) All have agreed that clinics are overloaded. Can there be separate timings for the pregnant women attending for their first visit? This would be applicable to both Primigravida and Multiparous women, since this group needs more attention at this stage than in their subsequent visits. The members of this group have been stimulated by the topic's exercise, and have already promised to explore the situation of clinic space and husband accompanying wives to the various clinics.

(c) Lack of equipment – e.g. gloves, syringes, needles.

(d) In some hospitals, Ante-natal Clinics (AN), Post-natal Clinics (PN) and Family Planning Clinics (FP) are held in the same place at the same time.
Is this ideal?
In some places, integration of F.P. services are carried out in the clinic with the regular obstetric patients.

2. ***Labour and Delivery (L&D)***

(a) Staffing pattern is really pathetic – In many hospitals, a total number of N/Midwives are allotted for Maternity and is spread throughout the different sections. This area needs a separate staffing pattern – as this is an intensive Care area – unfortunately, the load of work is unpredictable. This leads to job dissatisfaction among the N/M – very few like to stay on in L&D.

(b) Deficiency in the Nurse/Midwife staff performance is either due to the poor training which she received; or is due to insecurity

as to her deficient clinical experience or the poor example which is set by the medical staff.

(c) Need Competent Senior Nursing Staff – where are they? We used to have strict discipline which we do not find now. Considerable time spent in discussion was centred around the changing attitude of the younger generation both in the Medical and Nursing areas. How many Senior Medical Staff Members have control over their younger doctors? How many Senior Medical Staff Members have good relationship with their Senior Nursing Staff Members in their own department?

(d) It was brought to notice, that some husbands are asking to be with their wives during labour and delivery – but the response to that request is that our country is not yet ready for such an approach, and it is against the culture.

(e) P. natal patients should not be stagnated in the L&D area.

3. ***Eclampsia rooms:*** In some cases these are part of the labour room, in others they are separate rooms – and some hospitals have none.
   - Need special rooms which are fully equipped to meet emergencies and conduct deliveries.
   - e.g. resuscitation sets, O_2 suction, and drugs.

4. ***Post-natal wards:***
   (a) Shortage of professional personnel.

   (b) Organisation of P.N. Wards requires change. Progressive Care Unit concept needs to be implemented – An intensive care, intermediary care and minimal care area.

   (c) Need competent Head Nurse.

   (d) Lack of deliverance of health – education, as this a potential area and every mother needs to be aided to care for her new-born in hospital and in the home. Breast feeding measures require much emphasis.

   (e) Many hospitals have Post-Partum beds in the regular P.N. wards. Separate area for Post-Partum cases would be a great asset.

   (f) Infection is a problem when home deliveries are placed with hospital delivered patients.

   (g) Poor nursing care – No breast care given; no puerperal care given in many places. It is given in some places by Ayahs once a day. Voluntary agencies are very particular about this care.

5. ***Nursery:***
   (a) Many hospitals do not have a high risk nursery.

   (b) Some hospitals keep the high risk babies in the labour room.

(c) These babies require a separate area where continual observation can be carried out.

6. ***Role in Community:*** Every member underscored the point that a nurse-midwife is a better prepared person to deliver best goods to her customers in the community. The group discussed for a while what was meant by the term "Community". Community does not only consist of PHC and District Health Centres but it also includes the School Health Programmes/Immunization programmes in towns and cities. Further discussion was centred around the broad aspects or urban and rural sections. The following points were noted:–

(a) There was no post vacancy created for the Nurse/Midwife in many States. Much concern was shown over the fact that the present reorganisation of health care at a National Level, the Nurse/Midwife seems to have no place. A Nurse/Midwife is required for every 2–3000 population.

(b) In some States where posts are available, the Nurse/Midwives are reluctant to accept the post, due to the various reasons listed below, which have been discussed on many occasions:–
- No proper accommodation.
- No incentives.
- No security.
- No recognition of their ability.
- Inadequately prepared – for accepting or holding a post as a team leader.
- Inadequate clinical knowledge and practice to tackle obstetrical emergencies.
- Inadequately prepared for post of "Family Nurse Practitioner".

All the members unanimously agreed that the Auxiliary Nurse Midwives not only envisage, but have already experienced their changing role in the health care system both in the hospital and community areas, and this affects:–

1. Her job satisfaction.
2. The interpersonal relationship with all other health team members including the medical staff.
3. The total blame by the consumer of health (Patient and Family) for the ineffective and poor performance in the clinical field.
4. Blamed by high and low for not accepting posts.

Training Methodology and Curriculum Construction:

1. The group spent a long time in discussion on this aspect and all agreed that nurses should be trained for a period of nine months in midwifery. It was further stated that of the nine months spent on

this post-basic course, that six months must be institutional and remaining three in domiciliary. It was further stated that a minimum of 80 hours for formal instruction was necessary.

2. Long discussion period was centred around the question as to whether or not midwives should be an optional or compulsory area of training in the General Nursing Course. This matter is to be referred to the States and Nursing Councils. The group felt it was not necessary for trained nurses to have post-basic training in midwifery in order to gain promotion, or be employed in posts other than community and maternity services.

3. The syllabus for the Indian Nursing Council, should be strictly followed.

4. ***The content of the Course:*** There is great need for the teaching and practice in performing episiotomies and repair. This need is even greater in the rural areas, and where Medical Officers are in limited numbers.
   More hours should be allocated for the care of the new born, which is very lacking in many curricula.

5. ***Personnel and Refresher Courses:*** The group felt that qualified midwifery tutors and public health nurses, with the minimum of two years experience in clinical areas would be more of an advantage to the students. In addition, refresher courses for a period of one to two weeks duration, on a triennial basis should be arranged for the tutors.
   The personnel who take advantage of the refresher courses, should have promotional benefits where necessary.

6. The area of evaluation was discussed and on the whole, the group felt that the nurse-widwife should be evaluated along these lines.
   (a) Written examinations should be objective type and of short answers.
   (b) The practical examination should be carried out on the wards.

7. There should be legislations covering the practice of the nurse-wives.

8. The provision of posts of nurse-midwives to work in the rural health care system should be made.

9. Nurse/Midwives should be employed in part-time service if they so desire.

10. Retired nurse-midwives should be employed in the health care system. Their experiences may be of value in many aspects of health care.

IV Recommendations

Traditional Birth Attendants:

1. Only practising DAIS should be offered the Traditional Birth Attendant's (TBA's) training. There is no need at present to recruit new people to undergo training.
2. After implementing the presently devised training programme if the TBAs do not register for the training, say within a period of five years, they should be banned from practising Midwifery by Law.
3. All practising Dais should be registered by the State.
4. The job description of the Auxiliary Nurse/Midwife (ANM), Lady Health Visitor (LHV) and the Nurse Midwife (NM) should include the responsibility of training Dais. The basic training curriculum should also include this.
5. Orientation training courses should be organised for the supervisor cum teacher namely, the Maternal and Child Health (MCH) workers before imparting training to the TBAs.
6. Refresher Courses should also be given periodically.
7. In addition to simple equipment to conduct delivery, it should also contain antiseptics,medicines commonly needed for her practice namely laxatives, antidiarrhoeals, Methergine Tablets, Iron and Folic Acid Vit. A & D capsules Multivitamins and Nirodh for distribution. Besides this, there should be a postnatal bag, small and handy, and it should contain antiseptic, cotton swabs, pads, bandages etc. along with simple, common essential medicines and Nirodh.
8. The replenishment of kits should be done by the State Health Department in kind.

– Training and practice of ANMs in their expanding role

Recommendations:

1. It is strongly felt that ANMs should be made responsible for covering only a population falling within an area of five to eight Kms. and be provided a suitable conveyance.
2. Village level health committees should be constituted with influential local leaders as members and the health workers serving in an advisory capacity in it. This should not only facilitate greater functional relationship between the community and the health worker, but also serve as an effective feed-back mechanism.
3. In view of her work load, some clerical assistance on a part-time basis may be provided.
4. Supervisor should preferably be a Public Health Nurse (PHN) at least one per Primary Health Centre (PHC) initially and later increased to three. If health visitors are called upon to serve as community supervisors, they should be well experienced persons with adequate

training in community nursing. An ANM with five years of experience with additional supervisor's training is preferred to LHVs for supervision.

5. It is recommended that the Medical Officer should visit the sub-centre more frequently and not only on clinic days for a couple of hours.

6. Doctors who serve as Consultants, members of the nursing and health faculty should have community orientation training offered to them. It is desirable that an orientation training of three months duration should be offered even to tutors who are not directly involved in the training in community health nursing.

7. The group recommends that the first three months of the ANMs Training should be spent in the community followed by six months in the hospital for clinical training. Out of the next 15 months set apart for midwifery the first six months as well as the last three months should be spent in the community setting.

8. The Group recommends that of the ANM training, the first three months should be in the community and remaining six months of the first year be in the hospital. It was felt that the first six months be spent in community for midwifery training and the next six months in the hospital to expose them to abnormal cases. This would help her to be acquainted with how to recognize such cases in the field. The last three months should also be in the community.

9. The deficiency in the community health nursing component in General Nursing and Midwifery course should be rectified immediately so that those trained are better equipped to serve as community health supervisors.

10. Continuing educational programmes be held for all categories of personnel.

11. Translation of text-books in the regional languages was found to be essential A special Committee should be appointed for this purpose.

12. Suitable accommodation and physical facilities be provided in the rural areas which may also serve as demonstration models in the village setting.

13. The ANM be provided with suitable facilities for health education. The Health Education Bureau be requested to take up this urgently, to assist in the preparation of health teaching aids.

14. For those midwives who had erstwhile midwifery course be given additional course and be permitted to take the ANMs examination.

15. Time replenishment of drugs and equipment should be ensured.

16. State level nurse be appointed where there is none as expeditiously

as possible in backward areas like Andaman Nicobar Islands etc. Senior experienced and suitable persons be sent on deputation from States where they are available and deputation allowance paid to her.

17. For the proper assessment of the ANM a State Committee is to be formed to prepare a check list and it be recommended to NIHAE to undertake a study to prepare a guide cum check list that can be utilised for effective assessment of the ANM.
18. Help of voluntary organisation be utilised for and vice-versa as all are working for the health of the nation.
19. The group felt strongly that ANM schools should be independent institutions like Health Visitors Schools. This would facilitate the students receiving greater community orientation and field experience.

– **Lady Health Visitors**

1. The two years course recommended for the Health Supervisors by Government of India based on revised curriculum constructed by Indian Nursing Council to fit into the newer trend of Education System of 10 + 2 + 3, should be tried out in all States.
2. Training should be in the rural set-up. It was felt that a pilot study may be conducted to experiment on training models for example to have a modified placement to provide urban experience for the first six months and the rest of the 18 months in rural area. Up-graded Primary Health Centres (PHC) (under the minimum needs programme) to be utilised for training purposes.
3. Curriculum contents in relation to their expanding role should make provision for training and practice in the use of local anaesthetic agents for procedures like episiotomy, repair of perineum etc.
4. Control of post-partum haemorrhage, use of oxytocic drugs should be permitted. Resuscitation of the new born and the use of required drugs.
5. The group felt that in a professional practice, the Health Visitor should be permitted to start I.V. drip in obstetric emergencies such as ante-partum haemorrage. She would insert IUDs, identify and refer cases for medical termination of pregnancy, diagnose and treat the minor ailments.
6. The group felt that in order to carry out the above mentioned job functions, the Health Supervisor should be given legal protection.
7. The existing physical facilities, staffing pattern, transport facilities, etc. need to be improved considerably to carry out the training programme in a successful way.

– Nurse Midwife

1. The group felt that the duration of course in midwifery should be of nine months out of which six months must be institutional and the remainder domicilary. A minimum of 80 hours of formal instruction was felt necessary.
2. Indian Nursing Council Syllabus should be strictly followed.
3. The question whether Midwifery should be an optional/compulsory area of training in General Nursing Course, should be taken up urgently by the State & Nursing Councils.
4. State should not make midwifery compulsory for posts and promotions in areas other than maternity services & community services.
5. Course content:
   (a) The Nurse Midwife should have practice in performing an episiotomy and suturing same.
   (b) The course should have enough hours for the care of the new born.

Teachers

6. Regarding the teachers, the group felt that a qualified PHN and midwifery tutors with minimum of two years experience in clinical areas would be preferred. Refresher courses of one to two weeks duration should be given every three years.
   Promotional avenues should be opened to those who have had refresher courses.
7. Evaulation:
   (a) Written examination should be objective type and of short answers.
   (b) Practical examination on the wards.
8. Provide post for nurse-widwife in the rural health care system.
9. Legislations covering her practices.
10. Utilization of the experiences of the retired nurse midwife in the health care system.
11. Utilization of part time services of Nurse-Midwives.

V Evaluation Questionnaires and Analysis

Introduction

Fifty seven (57) nominated delegates from the various States and Union Territories attended the Working Party.

Eighteen (18) observers representing, Government Departments, Christian Medical Associations, Voluntary Organisations, World Health

Organisations, Family Planning Associations, and other International Associations, were also in attendance.

The 57 nominated delegates should have completed the evaluation questionnaire but instead, only 47 were completed by them, and two by observers on special request. The remaining 10 forms are accounted for as follows:

Five of the nominated delegates had a language barrier and were unable to fill in the questionnaire. They said however, that they were not too disappointed as they were able to participate through the group discussion by translation. These were five Auxiliary Nurse Midwives.

Three of the nominated delegates (three obstetricians) had to leave the Working Party a few days before the closing date, and were not present to complete the questionnaire.

Two of the 57 nominated delegates did not return the form.

The summarized report (breakdown) of the evaluation questionnaire is taken directly from the completed forms.

Abbreviations Used

ANM – Auxiliary Nurse Midwife
AIIMS – All India Institute of Medical Sciences
FP – Family Planning
GNM – General Nurse Midwife
LHV – Lady Health Visitor
MCH – Maternal Child Health
NM – Nurse Midwife
NIHAE – National Institution of Administration and Education
PHC – Primary Health Care or Centre
RM – Registered Midwife
RN – Registered Nurse
TBA – Traditional Birth Attendant
WP – Working Party

Evaulations

Administrative Aspects

	Good	Fair	Bad	Not applicable
1. Travel arrangements	39	1		9
2. Physical	33	8	2	6
3. Accommodation & Service	23	9	3	14

	Long	Adequate	Short	No comments
4. Total length of Working Party	9	31	8	1
5. Working hours	26	17	5	1

	Helpful	Some help	Little help	
6. Information given in Working Party	45	3	1	
	Good	Excellent	Fair	Poor
7. Documentation to cover the subject matter	1	31	15	2
	Ample	Fair	Poor	
8. Opportunities to become acquainted with other participants	33	16	0	

Added Comments

(The numbering in the margin corresponds with that as above. The number of persons making the added comments are in brackets ( ).

1. No difficulty arose during travel (one)
2. Room and Bathroom arrangements did not give rise to any problems (one)
3. Rate for lunch and dinners should be reduced to at least Rs five for ANM and LHV Nurses (one)
   Not enough space for groups (one)
   Bed bugs found in the cots (one)
   Rooms were not cleaned regularly (two)
   Sheets not changed (two)
   Beds were too small (one)
   Hostel staff not cordial (one)
4. It can't be called a WP. Therefore complete statements cannot be given (one)
   Short for discussions and reactions (two)
5. No comments were made
6. It is a very good approach to know the practices of all categories of midwives (one)
7. No comments were made
8. As there were questions and answers after each session opportunities were ample (one).

Suggested Improvements on Administrative Aspects

Question: What improvements on the administrative aspects would you suggest for future meetings of this nature.

Time should be allocated for sightseeing as most participants were from other States. Time off should be given so that delegates can relax and carry out private shopping (seven).

Air tickets should be received at least 2 or 3 days in advance. Some participants received theirs only 16 hours before scheduled flight (three).

The meetings should not be held during extremely hot weather as this loses their concentration, one suggested that it be held either during September to November or February to April (two).

Delegates should be given the chance to meet more often so that they can know and understand each others problems better. Hence group discussions should be increased (five).

Panel discussions were very lengthy so as a result, very little time was allocated for questions from the floor (one).

Programme was too tight but on the whole good (one).

Rooms for the delegates were scattered all over the hostel so some degree of fellowship was curtailed. Perhaps, if the rooms were together and all meals were taken at the same time there would be more opportunity for reactions (three).

Better accommodation could be provided e.g. hotel type which is much cheaper, comfortable and better varieties of food are provided (two).

Menu should be more varied so that it can cater for everyones needs, like those fasting and the vegetarian: Suggestions; vegetarians could be provided with fruit drinks throughout the day instead of breakfast. Those fasting should also be given fruits (three).

Efficient and more hostel staff ought to be provided (one).

Breaks between sessions would very much be appreciated so that participants can relax both mentally and physically (nine).

The Working hours were long and many of the participants lost concentration due to being weary (eleven).

Generally participants found that the length of the Working Party was too short to reach any agreements. Suggested time 2 weeks (five).

Information regarding the various presentations to be made at the conference should be given in advance at least 14 days, so that at the start all the necessary data can be collected (two).

Opportunities should be given to visit other institutions in the capital, as most participants will not have this opportunity on their own (three).

No attention was given to Health Education in the programme, which is a very important aspect of training of all categories of Nursing in role expansion (one).

ANM group had difficult categories and some were not clear about the 10+2+3 Educational system and multipurpose scheme. It would be very useful if these were clarified at a session (one).

Most of the speeches and papers were too long, causing our minds to be diverted so when planning in future have fewer experts talking (four).

If candidates are to stay in compulsorily, then it should be for all delegates and no exemptions should be made (one).

Improvement in documentation is needed. Copies of all speeches reports, etc. must be made available to all members of the WP irrespective of the fact that they are a participant or an observer (two).

The Regional Director being a person from South India – 75% of the speakers were from that area. In future, this practice should be abolished and equal opportunities should be given to other learned personnel (two).

Cyclostyled materials should not be distributed during a session (one).

Speakers should be persons who are already on the job, and not those who do not deal with the ANM, LHV, etc. such as Principals, Deans NIHEA who do not see these programmes (one).

It is more a panel series rather than a group talk (three).

Whenever any candidates are requested to attend any such seminars, it would be better to send information well in advance as the postal system in some areas is extremely poor (one).

Questions asked in the Questionnaire are not specified as only for mid-wives. So the reports brought prepared by State representatives are many and chiefly concentrated on Medical Officers (one).

There should be more demonstrational teaching (one).

Inter-group discussions should be encouraged (one).

The Working Party should call one observer from each State and one of the teaching personnel from the State should participate in this meeting (one).

The conclusion of the recommendations should be finalised in an organised way as the present method wastes a lot of time (one).

Mistakes can be made by anyone in the category of Health personnel but to condemn a MBBS doctor was not called for (one).

Remarks

On the whole the Working Party was well planned and well organised. ICM planning good and the project staff good.

Project Director – London, very good, kind and understanding.

Working Party Objective

See Over

	1	2	3	4	5	No comments
1. Which objective did you consider the most important before the Seminar started?	13	4	7	5	7	2

	1	2	3	4	5	No comments
2. Which objective was most satisfactorily achieved in the seminar?	8	7	17	8	7	1
3. Which objective was best adequately achieved in the seminar?	7	8	13	10	4	3
4. If you could have a further two days to work on one objective which one would you choose?	1	4	7	14	25	1
5. On which of the 5 objectives did you, yourself participate most in the discussion?	7	9	8	17	18	4

Appendix 1

Objectives referred to on page 8

Objective 1: To exchange information on States present situation of MCH/FP Services.

Objective 2: To exchange information on training and functions of all categories of Midwives & Traditional Birth Attendants.

Objective 3: To identify common problems in MCH Services especially the rural communities, unmet needs in Maternal and Child Care.

Objective 4: To consider how the functions of the midwives of all categories can be expanded so as to assist in solving the problems and in contributing towards the unmet needs.

Objective 5: To suggest actions which are necessary to promote an expanded role for midwifery personnel and their motivations.

Comments (Each of these were made by a single person)

1. Implementation of their training and practice.
2. Information on their training and practice.
3. Informations.
4. No comments made.
5. TBA or Dais
   I did not speak due to language difficulties at times.

Added Comments

1. Not all States gave proper information on existing facilities (one).
4. This area needed more exploration (one).
5. Some more discussions were perhaps necessary in forming further recommendations (one).
   This particular objective was not achieved to my satisfaction (one).

The reason being a) Conflict in term role
b) Much explanation would be necessary for many States, for the reason in recommending the "role expansion" (one).

Suggestion: A longer time for discussion on this particular objective may have promoted better understanding (one).

Agenda

	Very Useful	Fairly Useful	Of little Use
1. Group methodology Role definition of participants	34	15	
2. MCH and Family Planning services in the developing countries – Role of midwife in health care system	37	12	
3. National trends in MCH and Family Planning Services	34	13	1
4. State reports on MCH and FP	28	14	7
5. Practice and training of all categories of midwives – whose responsibility – Identification of existing problems	39	8	2
6. Traditional Birth Attendants and trained Dais	33	11	5
7. Effective health care for all	36	12	1
8. Role of supervision in health care system	33	13	3
9. Birds' eyeview of MCH and FP services in the Country	29	17	3
10. Integration of Family Planning Paediatrics and Nutrition with the training programme of midwives of all categories	42	6	1
11. Training methodology and curriculum construction	33	12	4
12. Family Planning Information Education and Communication	30	18	1
13. Family Health in relation to Family Planning	29	18	2
14. Feeding and Nutrition practice	29	16	4
15. Monitoring of growth and Development	26	16	7
16. Child Care	32	15	2
17. Family Planning	34	15	0

	Very Useful	Fairly Useful	Of little Use
18. Family Planning and National Development – Role of a health team	34	15	0
19. Beyond family planning	34	8	7
20. Health by the people	28	15	6
21. Legal and sociological perpective on the service and training of family health worker	34	12	3

Comments

All the topics discussed were very helpful but more was said about the role of a midwife towards the development of our country (one).

No. 10 Fairly useful because we are already doing it since it was recommended by Indian Nursing Council (one).

No. 19 Excellent (one).

No. 21 We strongly feel that we must have a Nurse Practice Act as legal protection for Nurses and Midwives (one).

No. 6 As the time passes the Dais should be replaced by the ANM or what is now called the Health Worker. Dais can be used as a helper to the mother for washing clothes etc. (one).

No. 11 The time will prove it is difficult to give an opinion at this time (one).

No. 12 Useful in urban areas but very poor in rural areas (one).

Evaluation of Group Discussions

	Very good	Good	Fair	Bad
(a) Stimulus	17	26	0	1
(b) Participation	11	29	3	0
(c) Relevance on return to your respective States with regard to implementation of the recommendations	Difficult to generalize as above: see comments below.			
(d) Relevance for future Working Parties		"		"

Other comments

Thanks to ICM, and the London Staff and especially to the Project Director for being so helpful, she was a very sincere woman (one).

Feel that we gained more than we contributed. Thanks to ICM, feel that we had good Working Party (two).

A wonderful opportunity (two).

A cheerful and clever Project Director; and a good Working Party (two).

A very well planned Working Party (five).

(a) Very stimulating; it encouraged participants to come up with many new ideas (one).

(b) Fairly good majority of the participants took an active part (three). Some acted as introverts (one).
Enlightened by valuable points by some members from the group (one). Some could not discuss due to language problems (one).

(c) Will approach Government and State Registered Council to convince them of the objectives of the Working Party (nine).
Central Government to take up issues with the State Government (one).
Meet Assistant Director of Nursing Services to put forward all recommendations made at the Working Party (one).

(d) It can be modified when new trends are introduced and made more flexible in nature to amend old ideas and put them into practice (one).
Very interesting and helpful to solve problems (two).
Useful. Will take few years more for all the States to take the scheme (one).
With assistance of the State Authority it will improve (three).
Very thankful and grateful to the people in charge for being given a chance to participate in the conference. I got a broad and enlightened view which cleared many doubts and gave me some new ideas (one).
Working Party should be held periodically i.e. every 2 - 3 years in each State (six).
Such WP should be organised to try and find out ways and means to overcome health problems (one).

Additional Comments

Very stimulating as there are many things revealed in a group discussion which some did not know at all (three).

Good participation as most members took part in the discussion (one).

Project Director from London gave very good and interesting ideas (two).

Instead of thinking or forseeing so many personnel of different categories being prepared for Nursing Services – I feel there should be two definite categories prepared for the institutions and the community.

These two categories are:
The General Nurse Midwife (GNM) and the Auxiliary Nurse Midwife (ANM). Preparation of such personnel could be done through the general system of Nursing Education.

Improvement in the training of midwives – Dais, LHV and ANM is needed, with special emphasis on community health. More time should

be devoted to group work and assignments, which would further help in the formation of recommendations instead of having so many guest speakers (one).

I was in the Traditional Birth Attendant group, and there was an Obstetrician who remarked "I am least interested" and until the end she said she was least interested. At least that was how she verbalized it. However, she kept making suggestions and was very involved in planning the curriculum – thus by participation and behaviour it must be observed that she was very much concerned about getting the TBA made into a safe practitioner in the rural areas. This was very interesting (one).

As the Working Party was very effective on the Training and Practice of Midwives of all categories, it has enlightened us with better ideas of improving the Training and Practice of Midwives of all sorts to give us a better community (one).

There is a great need and demand for similar working parties to be conducted to deal with the rising problems arising in FP services.

I am afraid to say, that the aim which was so clearly stated was not properly met in discussions, regarding the expanding role of the midwife. India being a very poor country does not require all these people with degrees but instead more enthusiastic workers (two).

With regard to the topic of supervision – the Public Health Nu s at district levels should be adequate. To add more people to this situation would be chaotic (one).

The Working Party was well organised, but all the participants including speakers should have borne in mind the aim of the WP (one).

In the future, or even in this WP more time should have been given to group discussions. Chair persons should have summarised the presentations, and bird's eye view of the sessions should have been given (one).

Regional Field Director should have included persons with broader experiences in steering committees (two).

Each member had the chance to participate and bring out their different types of problems in front of each other. Valuable suggestions were given by different people to solve these problems temporarily (four).

It is difficult to implement in each state. Some of the recommendations which can be implemented at Institute level, I will try myself to do so. There are other recommendations which will require higher authorities – and not through a particular institution (independently) (one).

Future Working Parties could be held at State Level, then we can implement the recommendations easier. Although we are the nominees

of the various States, we are somewhat unable to convince the higher authorities without your help (one).

There was lots of stimulation during the discussion period, which will help the nurse/midwife to assume responsibility in the MCH programme both in the hospital and rural community in the expanding role of the nurse/midwife (one).

Participation of the group was very good except for 2 or 3 people who were having language problems (one).

I can try to improve the methods of training by having Inservice Education Programmes for the hospital as well as for the community Staff. Despite this, the major part of the implementation of the recommendation, rests with the Administrative Authorities (one).

I believe the Working Party will help support the future needs of the country, in bringing out the problems but the States must evaluate the recommendations now to make it effective (one).

Very good participation. Everyone has a chance to air their views (three).

Will meet the State Assistant Director of Nursing Services, and put forward all the recommendations which were made at the Workshop, and will try as an individual to implement where relevant, also with the assistance and cooperation of the State Authority (one).

This Working Party has enlightened me with better ideas to help to improve the training and practice of midwives both in hospital and community care (one).

Similar Working Parties to conduct workshops as refresher courses, and to deal with everyday problems in MCH/FP Services are badly needed and would request future Working Parties (two).

Project Director from London an excellent organiser, firm, intelligent. We need more of her in India (one).

VI Follow-up Visits

In October/November 1977 follow-up visits were paid by Miss Patterson to seven states – New Delhi, Maharastra, Madhya Pradesh, Karnataka, Kerala, Tamil Nadu and Gujerat. The Regional Field Director was unable to make follow-up visits as her engagement had to be terminated because of her severe illness.

Objectives of the visit

1. To meet government personnel, delegates who represented their states at the Working Party and other members of the health team to see if and how the recommendations were implemented.
2. To offer assistance if requested and within the project's capabilities.

3. To give guidance towards implementation where the failure may be due to reorganization within a structure not requiring finance or legal adjustment.
4. To take the opportunity to discuss the new project with regard to the Training of Trainers of Rural Health Personnel including Dais.

Summary of Follow-up Visits

1. Despite the slow response from the various States, in response to the continued communication which was sent from headquarters with regard to the follow-up visits following the All India Working Party, much preparation was made by the State Governments, Health Directorates, and delegates in connection with the visit.
2. Nearly all the delegates were available for discussion. In many instances, the delegates were relieved from their posts to meet the reporter at a point suitable within a time limit of the visit, where it would be impossible for the reporter to reach the delegates. The Health Directorates and Medical Colleges made the arrangements for the delegates' release.
3. The Obstetricians who represented their States as delegates, and other members of the Medical Team, displayed much interest in the expanding role of the midwife and in many instances were the motivators towards all categories of midwives.
4. Representatives of the Trained Nurses' Association, and of the Indian Nursing Council who in many instances are active members of the Health Team, contributed greatly towards implementation of the recommendations.
5. Influential members of the State Governments, and Medical Team, were met by the reporter by prior arrangement. In a few instances arranged conferences with the Directors of the various Health/ Medical Education Divisions, and the Assistant Directors Health, Medical and Nursing, presented the aspects of the recommendations where implementations were either carried out, were under consideration or were not accepted by their departments. This display of interest and participation of the above mentioned personnel with regard to midwives is noteworthy.
6. Rural visits made by road, rail, and aeroplane where actual dais training, Auxiliary Midwives practice, Public Health Nurses and Lady Health Visitors supervision, and the village community involvement in Primary Health and Sub-Centres where seen in action revealed implementation of the recommendations which are vital to National development and better health care.
7. Family Welfare (former word used in India prior to the National Election) is included in the midwives curricula, and their part-

icipation in the programmes is established where it formerly was non-existent, or is continued.

8. There is some controversy between members of the Health Team in some of the States with regard to certain areas of the recommendations and its implementation by midwives; for example – performing episiotomies, and repairing perineums, where medical aid is unavailable, or not easily obtainable. The matter is under review by the State personnel concerned, and the promise of the best possible solution relative to quality care for all will take place.

9. The areas of the ecommendations which require changes of the Nursing/Midwifery Law and the financial support by Government may take a longer period, but the interest of all concerned if continued, will prove beneficial.

On the whole, the seven States have met the objectives of the visit, in one or more ways. With the Governments policy centred around Maternal and Child Health/Family Welfare the reporter believes that in due course further implementations will be carried out, which will contribute to quality care for many, if not all in India.

VII Outcome

1. First positive co-participation of obstetricians and midwives in an eight day study of MCH/FP. The true image of the midwives was revealed.

2. Formulated recommendations were presented to the respective States/Union Territories Health Authorities for implementation where applicable.

3. Post Working Party activities reports were submitted by delegates of five States within one month after the Working Party.

APPENDIX I

List of Participants

Delegates

Andaman Nicobar

Smt. Mary Jacob
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Miss E. Prem Das
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Arunachal Pradesh

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Mrs. S.L. Bansal
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Assam
Smt. Cornell Sangma
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Miss I.H. Dkhar
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Gauhati Med. College Hosp.
Gauhati.

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Smt. Jameela Begum

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Mr. Harry Smith
Financial Adminstrator
London, England.

APPENDIX II

List of Papers Presented

1.	The ICM/USAID Project	Miss Barbara Patterson Project Director
2.	Role of Health Workers in National Development – A Planner's Perspective	Dr. Sankar Ghose Minister of State for Planning
3.	Presidential Address	Shri A.K.M. Ishaque Deputy Minister for Health and Family Planning
4.	Group Work Methodology: Role-Definition of Participants	Dr. H. Nath Assistant Professor of Social Sciences N.I.H.A.E.
5.	Maternal and Child Health and Family Planning Services in the Developing Countires – Role of the Midwife in Health Care Systems	Dr. B.N. Purandare President, International Federation of Gynaecology and Obstetrics (FIGO)

6. National Trends in MCH/FP Services	Dr. E. Sebastian Asst. Commissioner (MCH) Ministry of Health and Family Planning
7. Training and Practice of all Categories of Midwives – Whose Responsibility? Identification of Existing Problems	*Medical Colleges*: Dr. Anusuya Das, Lady Hardinge Medical College, Delhi. *Central Government*: Miss R. Verghese, Superintendent, Lady Reading Health School, Delhi. *State Government*: Dr. Ranee Christopher, Asst. Director of Health Services, Bangalore. *Hospitals*: Dr. M. Kochhar, Medical Superintendent, Kasturba Gandhi Hospital, Delhi. *Nursing Council*: Miss A. Cherian, Principal, College of Nursing, P.G.I. Chandigarh. Professional Associations: Mrs. N. Nagpal, Secretary, Trained Nurses Association of India. *Administrators*: Dr. H.M. Sharma, CMAI/FP Project
8. Training and Practice of Midwives of all Categories	*TBAs*: Dr. P. Ramankutty, Principal, Gandhigram Institute of Rural Health and Family Planning. *Auxiliary Nurse-midwife and Health Visitor*: Miss R.K. Sood, Nursing Adviser, Ministry of Health and Family Planning. *Nurse-midwives*: Mrs. N. Lazarus, Professor of Nursing, CMC Vellore.
9. Effective Health Care for All	Dr. George Joseph Professor and Head, Centre for Community Medicine, AIIMS. Miss A. Kuruvilla, Dean, College of Nursing, CMC Vellore. Dr. M.C. Mamgain, Adviser, Co-ordination and Evaluation, DHS Haryana

10. Role of Supervision in Health Care Systems	Miss B. Walsh, WHO Nurse Educator Jimper Pondicherry. Miss K.K. Rao, Public Health Nursing Officer, DHS Gujerat. Dr. Ruth Harner, Voluntary Health Association of India, New Delhi. Mrs. A. Thomas, Associate Professor of Nursing, NIHAE. Mrs. P. Karthiyani, Nursing Officer, Department of Family Planning, Govt. of India.
11. An Appraisal of the Maternal and Child Health and Family Planning Services as an aspect of Total Health Care in this Country with special reference to the Health Programmes for Midwives of all Categories.	Miss Mariam Philip Regional Field Director
12. Integration of Family Planning, Paediatrics and Nutrition with the Training Programme of Midwives of all Categories	Dr. Madhavi Sharma, Chief Nursing Tutor, AIIMS Professor Y.L. Vasudeva, Dept. of Preventive and Social Medicine, Rohtak Medical College. Dr. S. Sinclair Associate Professor of Paediatrics, AIIMS.
13. Training Methodology and Curriculum Construction	*A Model for Curriculum Construction in Paramedical Courses*: Professor H.S. Srivastava, Head of Examination Reform, Unit NCFRT, New Delhi. *Continuing Education, Curriculum Planning and Teaching Methods*: Professor H.S. Gandhi, Dean of Studies, NIHAE. *Training and Methodology of ANM*: Nursing Adviser, Dept. of Family Planning, Ministry of Health. Dr. Sulochana Krishnan, Principal, School of Nursing, New Delhi.

14. Family Health in Relation to Family Planning	Dr. M. Laugesen, Community Health Consultant, Voluntary Health Association of India on *Monitoring of Growth and Development.* Dr. Shanti Ghosh, Head, Dept. of Paediatrics, Safdarfung Hospital, President, Indian Academy of Paediatrics on *Child Care.* Dr. Bina Roy (for Dr. Durga Deulkar) Professor, Lady Irwin College, New Delhi on *Family Budgeting.*
15. Beyond Family Planning	Dr. Kamala Gopala Rao Executive Director, Indian Academy of Medical Sciences. Professor P.B. Desai, Institute of Economic Growth, Delhi University.
16. Health by the People	Dr. R.S. Arole, Director Comprehensive Rural Health Services Project, Jamkhed Dr. P.M. Shah, Professor of Paediatrics, Grant Medical College, Bombay. Dr. Eric Ram, Project Director, Community Health, Wanless Hospital, Miraj.

'CENTO' COUNTRIES WORKING PARTY, ISTANBUL, TURKEY, 7th – 14th DECEMBER, 1976.

Participating countries: Afghanistan, Iran, Kuwait, Pakistan, Turkey.

I. Preliminary visits.

Preliminary visits were made to Turkey, Iran, Afghanistan and Pakistan between 1st and 24th July, 1976. It was not possible to visit Kuwait.

In Afghanistan the health officials were on holiday and it was possible to contact only one of the delegates to the Working Party. However, most of the expatriate professional staff were seen, who promised their assistance.

(a) *Turkey (Ankara, Istanbul)*

Much of the discussion centred on the administration of the Working Party – location, accommodation, transport, etc. – on the choice of delegates and speakers, and on the programme. A chairman and delegates were elected (although one of the latter had to be changed subsequently). The selection of a Regional Field Director raised problems, mainly due to language difficulties. The authorities promised to try and encourage midwives from local areas to attend and to endeavour to circulate in advance transcripts of the papers in the Turkish language, provided that they received the scripts in time. Meetings were held with officials of the Ministry of Health in Ankara, all of whom were most helpful although (with their full approval) the Working Party was to be held in Istanbul, and there was good liaison between the two cities.

The President of the Ankara Gynaecological Association was seen, and the USAID Population Officer contacted by telephone, but no meeting with him was possible as he was about to leave the country.

Discussion in Istanbul centred on the School of Health, where it had been agreed that the Working Party should take place, and several meetings were held with members of the staff of the school.

It was learned that there were four types of midwifery training course in Turkey. (i) A three-year course of which midwifery was an integral part, following five years of primary school education. This category was employed on rural work. The training was being re-organized and a new curriculum devised. (ii) A three-year midwifery course at a higher college of midwifery. Entrants had no previous nursing training. (iii) A full nursing training plus one year's midwifery for nurse-midwives. (iv) A course for public health nurse-midwives.

Family planning for the purpose of population restriction was contrary to official policy, but it was enthusiastically received as a help towards family health and welfare. It was appreciated that the term 'family planning' was better avoided. The practice of family planning was in the hands of doctors, with assistance from midwives, but it was hoped that midwives would be able to participate more and more. Oral contraceptives and IUDs were not normally used. Sterilization was not legally permitted except for medical reasons. In fact family planning as a whole was not readily accepted by the Turkish people, but it was agreed that if midwives could discuss it with their patients there would probably be a greater chance of acceptance.

(b) *Iran*

Meetings were held with various officials of the Ministry of Health, all of whom were most interested in the proposed Working Party and offered whatever assistance they could. The Ministry had delegated the selection of participants to the Iran Midwifery Association. Meetings took place with officers of this Association and with officers of the National Association of Iranian Gynaecologists and the Family Planning Association of Iran. The USAID mission was contacted and the purpose of the visit explained.

There were 30 schools of nursing within the Department of Higher Education. Some universities offered a bachelor's degree in nursing and a two-year postgraduate course for nurse-midwives. The Ministry of Health sponsored 6 schools of midwifery and 8 of nursing. Midwives took a four-year course after 12 years' general education; for rural midwives the course was six months following six years' general education, and about 1400 had been trained so far. About 1300 auxiliary nurses (bihyars) had also been trained by a two-year course in nursing and midwifery at about 90 centres. However, midwifery training was to be revised, as the nurse-midwife programme was not working satisfactorily. New midwifery schools would have to be started.

The Farah Maternity Hospital in Teheran conducted about 70-80 deliveries a day (140 a day in winter). Its family planning clinic had 8 beds for tubal ligation. Midwives inserted IUDs and carried out aspirations. Vasectomy was not accepted by Iranian men. Existing legislation did not visualize midwives undertaking certain family planning functions, but they were in fact practising most methods, and it was hoped that policies would soon be revised.

(c) *Pakistan* (Islamabad, Karachi)

Meetings were arranged by the Nursing Adviser, Ministry of Health, both with Governmen officials and with medical and midwifery staff at a government hospital. The USAID Population Officer, through his assistant, was most helpful in arranging meetings with government officials, and with a senior member of USAID.

Although the selection of delegates had not been confirmed, the Ministry of Health would be reminded that this needed to be done urgently. The government hoped to send 5 observers to the Working Party – 1 midwife and 1 gynaecologist from each province – and would probably sponsor them.

The different categories of health personnel under training included nurse-midwives, nurses, lady health visitors, nurse aides and TBAs. Lady health visitors received two years' training, one year of midwifery and one year on nursing activities related to health in rural areas. Latest statistics suggested that maternal mortality was 6 to 8 per 1000 and infant mortality 115 per thousand live births. It was believed that overall 90% of deliveries were undertaken by TBAs and that the figure was even higher in rural areas.

There were 8 midwifery training schools in Karachi, all of them very short of teaching staff. One school visited had 170 nursing students and 21 midwifery students. The hospital had 1200 beds and a total of 500 nursing personnel including students. Of 3000 deliveries per annum about 25% were abnormal. Large numbers of nurse-midwives had emigrated to the Middle East because of the better salaries offered there. The governement had taken steps to stop this by withholding diplomas until the number of years of service equalled the length of training (in the case of postgraduate training length of service had to be twice the length of training).

Family planning was taught in all courses.

At the beginning of 1976 there had been a seminar in Lahore on Training and Utilization of TBAs, sponsored by WHO, and a copy of the provisional final report was presented.

The College of Nursing offered a post basic one-year course in Ward Administration, and a two-year course for sister-tutor diplomas. Not many nurses were interested in training as midwives, because the salary and hours of work were thought to be unattractive.

The Pakistan Nurses Association was formulating a policy for the creation of a midwives branch.

Libraries seen had few textbooks, and not many of these were up-to-date. It was promised to send a list of organizations who could be approached for gifts of books.

II. The Working Party

1. *Attendance.* Those attending comprised:
   (a) 14 delegates from Afghanistan (3); Iran (3); Kuwait (2); Pakistan (3); Turkey (3).
   (b) 22 observers from Turkey.

(c) 4 resource persons – one each from Afghanistan, Iran, Pakistan and Turkey.
(d) Officials from WHO (1); University of California (1); FIGO/ICM and ICM/USAID (5).
(e) Other speakers from Turkey (11).

2. *Summary of Proceedings*

Dr. Burhanettin Ustenel, Director of the Zeynep Kamil College of Health welcomed the participants. He said how important it was that countries should discuss and share their problems, especially in regard to family planning. An address of welcome was also given by Mrs. Suheda Ozgur, President of the Midwives Association of Turkey. She thanked the government departments concerned for asking the Turkish Midwives Association to act as hosts and Dr. Ustunel and his staff at the Zeynep Kamil Hospital for all the help they had given in arranging the Working Party. The profession of midwifery in Turkey would be strengthened by the fact that they had met together in unity to discuss their problems.

The Under-Secretary for Health and Social Welfare, Dr. Osman Yasar, gave the opening address, describing the origin of organized midwifery services in Turkey and the development of training facilities. Due to the high concentration of population in rural areas, the training of village midwives had been reorganized. The training course for professional midwives had been increased to 5 years, the last two being spent in community service. Midwives had responsibilities throughout pregnancy and labour and in the post-natal care of the mother and of the child up to the age of 6 years. Her preventive role was most important. Maternal and child health and family planning were priorities in the health services under the Ministry of Health and Social Welfare, and the midwife had an important role to play in this. The number of midwives in the country was too small, and the Ministry was making an effort to increase the number of training schools, but in the meantime the services of the village midwife were an important factor in health care.

Miss Julia Withington, Field Director, asked the participants to introduce themselves and then explained the organization of the Working Party, and this was followed by a talk on *The ICM/USAID Project* by Miss Margaret Hardy, Executive Secretary, ICM and Assistant Administrator of the ICM/USAID Project. She gave an account of the work of the Project to date, and of the Working Parties that had been held. She stressed the importance of the midwife in MCH care and the need to train and utilize the TBA as long as there was a shortage of more highly trained staff.

The first session concluded with a Brief Report on Zeynep Kamil

Health College by Mrs. Muazzez Okay, Chief Assistant Director of the College.

During the first afternoon the groups met to elect chairman and rapporteurs for the group sessions, and afterwards films were shown.

On the following morning the proceedings opened with Country Reports given by Mrs. Fahima Arsala for Afghanistan, Miss Fatima Ashour for Kuwait, Dr. Nazaket Begum for Pakistan and Dr. Munerver Tuncer for Turkey. In each case statistics were presented on population and birth and death rates, on facilities available in each country for maternal and child care and on personnel available and their training.

There followed a panel presentation entitled *Family Health Care in Developing Countries.* Dr. Nezakat Akkerman, Ankara, Turkey, spoke first on *Administration and Management.* He said that the population was expected to rise from 37.5 million in 1972 to 42 million in 1977. Mothers and children aged 0-6 years made up 45% of the population. Legal family planning started in 1965. MCH services outside the socialized areas comprised 74 MCH centres in the provinces, each with 10 midwives, and 88 MCH branches in the towns with 3-6 midwives, and 785 MCH village stations with 1 midwife each. In the socialized areas there had been established since 1963 931 health units staffed by doctors and midwives and 3228 health homes staffed by midwives only. Between 1961 and 1976 the infant mortality rate had fallen from 165 to 114 per thousand live births.

Training and Utilization of Personnel was dealth with by Dr. Karima Rashidi, Afghanistan, under the following headings: (i) Planning and organization to be implemented at regional, provincial and peripheral (basic health centre) levels. (ii) Pre-service and in-service training of doctors and nurses. (iii) Seminars for doctors. (iv) Educational activities, including nutritional and family planning. (v) Evaluation and research for unified records – analysis of data; organizing field studies; identifying local health workers. (vi) Job descriptions of staff.

The third speaker, Mrs. Akhtar Sultana, of Rawalpindi, Pakistan, took as her subject *Resources Available, Supervision, Co-operation.* She listed the resources as (i) personnel – lady doctors, midwives, lady health visitors, family planning welfare visitors, motivators, auxiliary midwives, TBAs, vaccinators, and private doctors and nurses; and (ii) institutions – MCH centres, rural health centres, sub-health centres, government dispensaries, family planning clinics, pre- and postnatal clinics, private clinics and vaccination centres. The maternal mortality rate in Pakistan was 8 to 10 per 1000 live births,

the infant mortality rate 150 per 1000, and 50% of deaths occurred under the age of 5 years.

The remainder of the morning was given over to a paper on *Information, Education and Communication in Family Planning* and to the discussion which followed it. The speaker was Mr. Baki Durmaz, Division Director, Population and Planning Department, Ministry of Health, Turkey. He began by emphasizing that the introduction of family planning required trained staff, and for training one needed a programme which had to be attractive, properly adjusted to the people who were to be trained, and adequately adjusted to the culture of the community. Giving information was only part of the problem; there must be motivation to apply it, and the speaker went on to describe six problems of applying family planning programmes in Muslim countries, especially in rural areas. (i) *Influence of older members of the family.* Muslim societies were male dominated and the head of the family was the source of all authority. The number of children in a family was a source of pride to grandfathers. (ii) *What will others say?* Sexual matters were not discussed openly, and to talk about them was considered shameful. Women who used family planning did not want others to know about it, and the visit of a midwife or family planning worker could could be embarrassing. The idea needed to be spread that it was not shameful to use contraceptives. (iii) *Anxiety that it will be a sin.* Most people believed that God gave children, and to use contraceptives was to disobey Him, for He would provide all that was needed. However, they realised the harm done by too frequent conceptions but resorted to abortion when they were in trouble. This was the real sin because life was being destroyed. Family planning prevented mothers from being involved in such actions and so family planning was not considered sinful by Islam. In 1974, at a Muslim conference in Rabat, it was decided that 'According to the Muslim religion, to deliver a baby, to determine the number of children, to decide periods between birth and to use contraceptives is not a sin.' This had to be clearly and carefully explained to the public. (iv) *Fear of becoming sterile.* It needed to be explained that this fear was groundless and that pregnancy would follow when contraception ceased. It was a rumour started by those opposed to family planning. It was helpful to show satisfied acceptors as examples. (v) *That family planning will cause disease.* This idea was widespread, and illness in a woman using contraceptives was blamed on the method. This again was a psychological response to the spread of rumours, but indicated the need for frank teaching about the side effects of contraception. It was important to make clear that contraceptives did not cause cancer. (vi) *The larger its families are, the more powerful a nation will be.* The old argument of

military strength through large populations had been superseded by the force of modern weapons. Large families now tended to be a burden on the state, lowering standards of education and using up financial resources. Although the idea of family planning was often accepted, implementation was another matter. Education and motivation of the public were required, and this could be done by mass communication or by personal communication. Personal communication might take the form of either individual training or group training.

During the afternoon the three discussion groups met separately to consider the first Discussion Topic, – The priorities and problems in family health services and in family planning information, education and communication. General discussion of this issue took place in open session the next morning and a consensus report agreed.

There followed papers on *Current Participation of Midwives and TBAs in Maternal and Child Health and Family Planning*, when a delegate from each country spoke of her own situation. Mrs. Talat Shahgoli (Iran) described the categories of midwives in her country. The present training course accepted girls from high school and was of 4 years' duration. Another school was training auxiliary midwives by a 2-year course following 9 years' general education. These auxiliaries worked only in hospitals. For rural work the government had successfully trained local girls with primary education by means of a six-month course in midwifery and family planning. They were allowed to work only in the villages but played a considerable role in population control. Mrs. Sabira Nadir (Pakistan) told of 12 medical colleges, 27 nursing schools, and a large number of MCH centres. Since 1947 there had been an eightfold increase in the number of nurses. Seven public health schools had trained over 1627 health visitors; there were 2,000 midwives and 18,000 trained dais, but they needed about 75,000 trained personnel. MCH was an important part of the health service, and lady health visitors were responsible for running MCH centres. The functions of these centres included training of dais, family planning clinics, immunizations, health education, mothercraft and the collection of statistics, as well as pre-, intra- and postnatal care and infant care. Most midwifery services were provided by dais, who were competent to deal with normal deliveries. It was government policy to utilize the services of TBAs and a training scheme for them was shortly to be started.

Miss Fatma Acar described the participation of midwives and village midwives in MCH and family planning in Turkey. Village midwives were trained to provide MCH and family planning services, first aid, control of contagious disease, environmental health services, follow-up of social diseases (e.g. tuberculosis) and general health education.

However, the TBA was still often favoured by village women because the village midwife was often young and inexperienced and might not always be available. There was need to supply a midwifery service as a team effort, to provide more in-service training, to reward midwives suitably and to organize a public health nursing service.

Miss Kamila Weiss (Afghanistan) said that there was still a great shortage of health workers. The midwife and the Afghan dai existed side by side with some interdependence. The total number of dais was not known, but there were believed to be some thousands, in both urban and rural areas. All gave some services in each of the pre-intra- and postnatal periods and were often consulted in cases of illness and for advice on abortions, family planning and infertility. They preferred to keep their independence, but the government was investigating the possibility of incorporating them into a village health worker programme. In the government system there were 364 nurse-midwives, 264 nurses and 161 auxiliary nurse-midwives. The intake of students had been increased and they were giving priority to training auxiliary nurse-midwives who would serve in basic health centres in rural areas. It had been estimated that not more than 10% of all deliveries were conducted by trained personnel, and most of these were institutional. Family guidance was largely provided by special clinics of the Afghan Family Guidance Association, mostly in urban or semi-urban areas. MCH was now being added to the family guidance services offered. These clinics were staffed by trained midwives and nurses under the supervision of a doctor. Some home-visiting family guides were working from these clinics. There was a child health institute in Kabul. Priorities were reduction of maternal and infant and child morbidity and mortality.

Miss Mariam Al-Raqem (Kuwait) described the new modern Maternity Hospital in Kuwait and the services it offered.

A paper was then given by Mrs. Aygun Demren (Turkey) on *The Expanding Role and the Scope and Practice in the Field of Family Planning for all Categories of Midwives and Traditional Birth Attendants.* She spoke of the importance of the midwife in a Muslim community as being the one person who was acceptable to give care in all family matters. For this reason she should try to be involved in family planning.

There was a total of 584 clinics offering family planning services; gynaecologists and midwives were responsible for much of the clinic work. There were nearly half a million abortions annually, but the figure was falling as family planning became more widely practised. The great need was for more training and education both of midwives and of the public, especially of husbands. She thought that

there was no place for the TBA in family planning services, but with training they might be allowed to participate as motivators.

There followed an account of *Some Traditional Customs Used in Rural Areas by Traditional Birth Attendants* given by Mrs. Gulsun Algul. She mentioned a number of the practices associated with childbirth in rural Turkey.

During the afternoon the groups met to consider the second discussion topic – The expanding role of all categories of midwifery personnel and TBAs in MCH and family planning, and TBAs as members of the health team.

On the Friday morning visits were paid to maternal and child health and family planning clinics, and this was followed by a presentation on *Curriculum Development in Maternal and Child Care and Family Planning Training* by Mrs. Guney Cakirer, Assistant General Director, General Directorate of Professional Education, Ministry of Health and Social Welfare, Ankara. She spoke of the development of midwifery training in Turkey and outlined the two kinds of midwifery training programme which existed. (i) Rural midwives had had a three-year course following primary school education, but a five-year programme had just been introduced. Their duties mostly involved MCH and family planning services, but a wide range of health and community services and education was also included, especially in areas where the government's socialized programme was operating. (ii) Midwives were trained in health colleges by a four-year course following secondary education. They worked in MCH centres, national hospitals, labour clinics, family planning centres and health centres. Family planning was especially emphasized in the training.

A seminar for administrators and teachers at health schools had recently been held to teach the fundamental principles of teaching midwives, to introduce new teaching methods and to choose the most suitable methods and devices for family planning. There were 2,923 rural midwifery students and 1,090 midwifery students in the schools at that time.

The general discussion on Topic 2 then took place and a consensus report prepared. After lunch a visit was paid to the Florence Nightingale Museum at Scutari.

The next subject was *Integration of Family Planning, Nutrition, Paediatrics and Health Education in the Basic Midwifery Course.* A separate speaker dealt with each of the four aspects. Dr. Ayse Turmay Cetinel spoke on Family Planning. The government favoured family planning for health reasons and family planning was already being integrated into MCH services and into the basic mid-

wifery curriculum. The main role of midwives was in motivation, and in-service courses for existing midwives were a high priority, also the training of supervisory midwives who themselves acted as trainers.

Nutrition was dealt with by Professor Dr. Orhan Koksal, Paediatrician, Hacettepe University, Ankara. He stressed the need to restrict population growth, to increase food production, to improve child health and nutrition and to educate the community in family planning, nutrition and child care, and showed how the midwife had an important role to play in this. He then described the effects of malnutrition on maternal and child health and outlined the responsibilities and duties of midwives in eliminating these adverse effects.

Professor Sabiha Ozgur, Ege University, Ankara, spoke on *Paediatrics*, and listed the important areas in paediatrics which should be taught to midwives: (i) the social sciences – the psychology of the community; (ii) the biological sciences – anatomy, physiology and pathology; (iii) the caring aspects, including illnesses, malnutrition and child development.

Miss F. Munshi, Nursing Superintendent, Lady Dufferin Hospital, Karachi, Pakistan, covered the subject of *Health Education* and described integrated courses for midwives and nurses in family planning, nutrition and health education.

The final paper of the day was given by Miss Sattereh Farmah-Farmaian, Director, Tehran School of Social Work, on *The Integration of Family Planning with Social Welfare in Iran.* She described the great need to reduce poverty and the large size of families, and how centres had been established which provided an integrated approach to the whole problem. Facilities available at the centres were: day care for children, vocational, home making and literacy classes for young women, educational and recreational programmes for teenagers, cultural activities for adults, individual and family counselling, family planning services and social action programmes.

Group discussion of topic 3 took place on the Saturday morning. The subject was Integration of family planning, nutrition, paediatrics and health education in the training curriculum (a) in the basic midwifery school, (b) as continued education for midwives, and (c) for other health personnel.

On Sunday a sight-seeing tour was arranged, including a visit to a family planning exhibition being held at a local government house on the outskirts of Istanbul.

On Monday morning, after general discussion of Topic 3 and the preparation of consensus reports, Dr. Vedat Yeginsu, Obstetrician

Gynaecologist, Member of the Family Planning Organization of Istanbul, spoke on *Effects of Culture, Traditions and Religion on Family Planning in the National Development Programmes.* He described how family planning had been accepted and instituted in Turkey to meet present needs and how cultural traditions were beginning to break down, especially as more and more people came to live in the cities. He reiterated that Islam was not against contraception.

The subject of legislation was then dealt with. Avukat Cetin Akcaglayan, Legal Adviser to the Ministry of Health and Social Welfare, Ankara, spoke on *The Importance of Legislation Governing Midwifery Training and Practice.* Turkish law defined a midwife as a national who was a graduate from a school of midwifery whose diploma had been registered at the Ministry of Health. Turks who had graduated from foreign schools could have their certificates ratified by the Ministry. The scope of her function was to care for the pregnant woman, conduct delivery and care for the newborn, taking all necessary precautions to protect both mother and baby from all harm. She was forbidden to use any instrument or to prescribe drugs and must call a doctor when necessary. She was obliged to keep records of her practice.

Since 1943 there had been two categories of midwife. The village midwife could not work in a town unless, after 6 years' rural work and 6 months' practical experience at a maternity hospital she passed an examination. Otherwise there was not much difference in the way they performed their duties. He further explained the legal status of midwives in the public services.

Miss Hamdam Ghaffari, nurse-midwife, Family Planning Association of Iran, spoke on *The Importance of Legislation Governing Midwifery Training Practice by the Midwifery Association in Iran.* She described the various training courses available, the licensure procedures and the functions midwives could perform. Laws governing medicine and midwifery were enacted under the supervision of the Medical Council of Iran. The Midwifery Council, which was part of the Medical Council, was responsible for all disciplinary action concerning midwives, and generally assisted midwives to perform their functions more efficiently. She went on to describe the work of the Family Planning Association in Iran.

The obstetrician's viewpoint was put by Opr. Dr. Ertugrul Bayirli of the Zeynop Kamil Hospital, Uskudar. He reiterated the regulations governing the training and practice of different categories of midwives and went on to assert that wider responsibilities in midwifery practice and in family planning should be given to midwives.

This composite presentation provoked much discussion.

The final paper of the meeting, on *Continuing Education in Family Planning,* was given by Mrs. Mary Corcoran, Public Health Nurse Educator, UCSC/USAID Contract Team, Afghanistan. She spoke of the training and practice of the auxiliary nurse-midwife. About 50 students were admitted every six months to an 18-month course which consisted of midwifery, including family planning and public health nursing, and with an emphasis on preventive and health teaching. They worked in rural areas where the need was greatest, giving midwifery care, family planning services, preventive care including immunizations, and simple treatment of common diseases. They also gave teaching in these areas. The Afghan Family Guidance Association was providing family planning education and services in many parts of the country. The standard of teaching of auxiliary nurse-midwives was improving and three groups of teachers had been sent to University of California Santa Cruz for further training.

The fourth discussion topic – Actions needed to achieve the expanded role of all categories of midwives – was then considered by the groups and a consensus report on the subject was prepared the following morning.

In the Closing Session the participants made an evaluation of the Working Party and country groups met to prepare follow-up action programmes. The Final Report and Recommendations were then presented and the Working Party was brought to an end with a closing address by Dr. Hayrettin Kuram, Assistant Director of Health and Social Welfare, Istanbul.

III Recommendations

The following recommendations were made as a reult of the group discussions:

(a) *Topic 1.* The priorities and problems in family health services and in family planning information, education and communication.

1. *Community*
   Family health education for the community should be one of the priorities. The use of mass media (radio, television, posters, etc.) for assisting in the education should be adopted. Adult literacy programmes should be developed through the mass media method. Midwifery personnel should work in collaboration with religious leaders, community leaders, school teachers, social workers, volunteers and other relevant personnel, to achieve a successful outcome.

2. *Services*
   (i) Practising TBAs should be identified, trained and registered.

Continuous supervision of the TBA should be carried out by professional midwives.

(ii) Compulsory registration of births and deaths should be carried out by the maternal and child health team personnel.

(iii) The number of midwives be increased, especially of those practising in the rural areas.

(iv) The supervision of all midwives requires improvement with special attention given to the village workers. The supervisor should be a member of the health team, preferably a senior midwife, nurse-midwife or doctor.

(v) Incentives should be provided for trained midwives who respond to the challenge of working in rural areas.

3. *Education*

(i) Continuing educational programmes be held for all categories of midwifery personnel.

(ii) After the functions of the various categories of midwives are identified, suitable training programmes should be developed appropriate to their expanding role.

(iii) Family planning, nutrition, paediatrics and health education be integrated into the basic midwifery curriculum if not already included.

(b) *Topic 2.* The expanding role of all midwifery personnel and traditional birth attendants in maternal and child health and family planning.

1. Governments be motivated to accept the increased responsibilities of all categories of midwives in their expanded role.

2. Professional midwives should be taught and allowed to give local anaesthesia, perform dilation and evacuation after abortion, make episiotomies and repair them, use low forceps and, possibly, the vacuum extractor, and prescribe pills and insert IUDs.

3. Professional midwives in practice should be responsible for the teaching and supervision of traditional birth attendants.

4. Midwives of all categories should be responsible for the early identification of high risk mothers and their referral for medical attention.

5. The activities of the traditional birth attendant should be legalized. Therefore she should be identified, trained and registered. She should receive supervision, support and continual education. TBAs must be given suitable incentives to encourage their participation in health services and, depending on local factors, this could be done by a salary, or housing, or equipment and supplies, or transport, uniform, etc.

6. Traditional birth attendants be trained in accordance with the needs of the community and the country. This should include family planning motivation, simple health education, prenatal care, motivation of families for the immunization of their children.

7. Midwifery Associations should encourage their members to recognize and accept the traditional birth attendant as a useful member of the health team.

8. Non-midwifery and non-nursing functions should be allocated to other personnel, e.g. housekeeping.

(c) ***Topic 3.*** Integration of family planning, nutrition, paediatrics and health education in training curricula.

1. *In basic midwifery programmes.*
   (i) All categories of midwives require additional knowledge in family planning, nutrition, paediatrics and health education, and training programmes must be arranged specifically to meet these needs.
   (ii) Midwives working in isolated and rural areas should be allowed to prescribe simple medications for mothers and children. To do this they need additional knowledge in basic sciences. Course content would have to be decided according to the knowledge already possessed by the students.

2. *Continual Education.*
   (i) Continual education is essential for all categories of midwives to enable them to keep abreast of new developments. A refresher course should be compulsory every five years (more frequently if possible) for a midwife to continue in practice.
   (ii) Midwives who assume senior responsibilities, as in administration or teaching, must receive special training and education in their chosen field.
   (iii) The content of a continuing educational programme should be determined by good supervision of the performance of duties by midwives.
   (iv) Midwifery associations or councils and government departments such as maternal and child health and family planning should be responsible for the continuing education of the personnel through journals and newsletters. Help and assistance may be obtained from outside, e.g. ICM.

3. *Other health personnel.*
   (i) Other health personnel should be taught about family planning, nutrition, paediatrics and health education, to

be able to motivate and refer persons where and when necessary.

(ii) Motivation of men in family health should be done by male volunteers, teachers, male nurses, sanitarians, social workers, religious leaders, politicians and other well accepted members of the public.

(d) ***Topic 4.*** Actions needed to achieve the expanded role of all categories of midwives.

1. *On health policies.*
   (i) More emphasis should be laid on pre- and postnatal care and the care of children.
   (ii) Each country should improve the basic training curriculum for midwives, so that their graduates may obtain recognition for further studies internationally.
   (iii) On completion of their training, professional midwives should give at least two years of professional service in rural areas. This would enable them to supervise other midwifery personnel.
   (iv) Midwives should be instructed in the use and dosage of specific drugs for the relief of pain, control of haemorrhage and prevention of infections in mothers and babies.
   (v) Government attitudes towards early abortion should be more liberal. Midwives should be able to motivate, but take no active part in, the actual procurement of abortion. (Pakistan abstained from voting).
2. *On family planning.*
   (i) Family planning should be an integral part of midwifery training. Midwives should be able to instruct and take action in all methods with the exception of tubal ligation.
   (ii) Family planning training as in-service education, orientation or refresher courses should be provided for the training of qualified midwives without family planning knowledge.
3. *On co-operation with other professional organizations.*
   (i) All midwives should be members of their national association of midwives and take united action to improve recognition by their government of the unique service they perform. Where there is no midwifery association in existence, steps should be taken to initiate one.
   (ii) There must be close co-operation with non-governmental and governmental professional organizations such as medical, nursing, family planning, and IPAVS, and with non-professional organizations such as Scouts, Girl Guides, Rotary Clubs, APWA (Pakistan), Women's Institutions, etc.

4. *On legislation.*
   (i) Every country should establish a statutory body responsible to the government for the education of midwives and for the improvement of their status and working conditions.
   (ii) Continued education and refresher courses be compulsory for all categories of midwives at least every five years.
   (iii) Male and female sterilization should be made legal.
   (iv) Traditional birth attendants should be identified, trained and legally recognized.

IV Country Follow-up Action Plan

(a) *Afghanistan.*

1. The delegates from Afghanistan discussed in detail each of the recommendations for action made in the general session. Each recommendation was approved.
2. On their return to Afghanistan the delegates will present a report of these recommendations to the Director of the Division of Nursing and to the Minister of Public Health. The group will discuss ways of working towards implementation.

(b) *Iran.*

Iran was already implementing many of the recommendations from this Working Party. The following would be added.

1. Report to the National Association of Iranian Gynaecologists and Obstetricians.
2. Report to the Chief of the Department of Obstetrics and Gynaecology at Tehran University.
3. Report to the Medical Council and make some suggestions.
4. Report to the Midwifery Association of Iran.
5. Report to the Chief of the Midwifery School of the National University of Iran and use knowledge from this seminar to give information to the Midwifery School.
6. Report to the Ministry of Health.
7. Report to the Head of the Family Planning Association of Iran.
8. Suggest to the government authorities that legislation should cover some of the activities already being performed by midwives.
9. To present some of the topics to the midwifery and nursing schools.
10. Present recommendations and information to obstetric and gynaecology residents, also to interns and medical students.

11. Give information to midwives, assistant midwives and motivators who work in the Family Planning Association of Iran.
12. Include information in teaching midwives, assistant midwives, motivators and students (in high schools and nursing schools) and also the public.
13. Stimulate necessary activities for further education of midwives toward the expanded role.
14. To initiate publication of midwifery Bulletins or Newsletters.
15. Encourage co-operation between midwives and obstetricians, gynaecologists and paediatricians.
16. Suggest national seminars for midwives, obstetricians, paediatricians and other health personnel.

(c) ***Kuwait***

1. We shall try to form a nursing association. As all our midwives are also nurses the same association would be acceptable.
2. We shall recommend compulsory refresher courses at intervals of at least five years and also continuing education.
3. We shall encourage the suggestion that graduate nurse-midwives be assigned to work by contract for three years.
4. We shall suggest that family planning methods should be available particularly to space pregnancies and prevent pregnancies in high risk mothers.
5. We shall encourage the introduction of family planning into the training curriculum for nurse-midwives.
6. We shall encourage the publication and distribution of newsletters about nursing and midwifery to all midwives.
7. We shall suggest that an educational programme be started to train supervisors and teachers of nurses and midwives.

(d) ***Pakistan.***

1. We will inform the Ministry of Health, Social Welfare and Family Planning, the Pakistan Nursing Council, Pakistan Nurses' Federation and the Pakistan Medical Council of the usefulness of this FIGO/ICM Working Party.
2. We will try to form a Midwives' Section within the Nurses' Federation to be responsible for conducting their own affairs.
3. We will try to get the midwifery curriculum extended in order to include more about nutrition, paediatrics, public health and family planning so as to be acceptable for further studies, possibly in other countries.

4. We will try to acquire more teaching and more supervisory staff and increased financial support to improve our maternal and child health/family planning services.
5. We will recommend the appointment of a separate staff for making and recording medical and demographic statistics.
6. We will encourage the legislation, identification and training of our TBAs (untrained dais).
7. We will try to get regular periodic journals for midwives and other health personnel.
8. We will try to achieve better co-operation with other health personnel and other associations.
9. We will try to improve the status and working conditions of midwives.
10. We will try to arrange refresher courses, continued education and regular seminars for midwives at regional and national levels, to bring them up-to-date.
11. We will invite ICM Headquarters staff to visit for consultation and advice.
12. We will request ICM Headquarters to arrange a seminar in Pakistan for senior midwives and other health personnel who will subsequently train other categories of personnel.
13. We will ask for incentives to be given to midwives and other health personnel working in remote rural areas.
14. We will ask for the co-operation of the government in seeking the support of village leaders and religious leaders to help in the improvement of family health programmes.

(c) *Turkey*

1. To establish a statutory body responsible to the government for the education of midwives and improvement of their working conditions and status.
2. Suggest that a seminar at national level be organized by the Ministry of Health to expand the ideas gathered during this Working Party.
3. Recommend that the legislation for midwives should be in accordance with their responsibilities.
4. Recommend that a qualified midwife should be able to identify abnormal and pathological conditions including dystocia during labour.
5. The reorganization of services provided by midwives and the revision of midwifery education and training curricula.

6. Supervisory posts should be created for the supervision of midwifery personnel in the different health regions.
7. Promote the organization of orientation courses for newly qualified midwives.
8. Promote the organization of continual education through in-service and refresher courses for more qualified midwives, including family planning, to be compulsory every five years.
9. To encourage the midwives to learn other languages in order to benefit from journals of midwifery and better communications with foreigners.
10. Promote communication between countries in order to exchange knowledge on the new developments in obstetrics and gynaecology with regard to improving maternal and child health and family planning.
11. Approach ICM to obtain help on the provision of professional publications relating to midwifery.
12. Try to obtain short-term scholarships that will provide for the exchange of personnel between countries through ICM, WHO and others.

V Analysis of Evaluation Questionnaire

Completed by 12 delegates and 3 resource persons. The number in brackets indicates the number of answers.

(a) ***General***

1. Is this the first time you have been outside your own country? Yes (1); No (14).
2. Have you ever attended a Seminar or Workshop or intercountry meeting before? Yes (12); No (3).
   If so, where? Many times at home and abroad (6); Abroad only (2); In my own country (4).
3. Were you eager to attend this one? Very eager (12); fairly eager (3).
4. Are you pleased you attended this Working Party? Very pleased (11); Fairly (2); Not answered (2).

(b) ***Working Party Objectives***

The programme was designed to meet the six objectives listed below. We should be interested to know your opinion on whether these objectives were adequately met in the time allowed.

1. To exchange information between countries on the present situation of maternal and child health and family planning.

2. To exchange information on the functions and training of all levels of personnel in midwifery and family planning.
3. To identify problems and needs in maternal and child care such as family planning, nutrition, paediatrics and health education, especially in rural areas.
4. To study the means by which all categories of personnel in midwifery may expand their functions and contribute in solving problems and unmet needs.
5. To suggest necessary actions in the promotion and motivation of the expanded role of all midwifery personnel such as family planning policies, revision of legislation, curriculum modifications, post-basic training and continual education, working with traditional birth attendants, working with professional organizations.
6. To plan a follow-up programme for each country on the implementation of the recommendations.

Which objective did you consider most important before the seminar started? Objective 3 (9); objective 1 (2); objective 2 (1); objective 4 (1); not answered (2).

Which objective was most satisfactorily achieved in the Seminar? Objective 5 (4); objectives 3 & 4 (3 each); objective 1 (2); objective 2 (1); not answered (2).

Which objective was least adequately achieved in the Seminar? Objective 6 (5); objective 4 (4); objective 1 (2); objective 5 (1); not answered (3).

If you could have a further day to work on one objective, which one would you choose? Objective 5 (7); objective 3 (2); objective 4 (2); objective 6 (1); not answered (3).

On which of the 6 objectives did you participate most in the discussion? Objective 2 (5); objectives 3 & 6 (3 each); objectives 4 & 5 (1 each); not answered (2).

(c) ***Programme***

1. *Usefulness of the presentation.*
   (i) Country reports -- very useful (11); fairly useful (3); of little use (1).
   (ii) Family Health Care in Developing Countries – very useful (11); fairly useful (4).
   (iii) Information, Education and Communication in Family Planning – very useful (9); fairly useful (5); of little use (1).
   (iv) Current Participation of Midwives and TBAs in Maternal and Child Health and Family Planning – very useful (10); fairly useful (4); of little use (1).

(v) The expanding role and the scope and practice in the field of family planning for all categories of midwives and traditional birth attendants very useful (9); fairly useful (4); not answered (2).

(vi) Integration of family planning, nutrition, paediatrics and health education in the basic midwifery training curriculum – very useful (14); fairly useful (1).

(vii) Integration of family planning with social welfare in Iran – very useful (5); fairly useful (4); of little use (2); not answered (4).

(viii) Curriculum development in maternal and child health/ family planning programmes – very useful (10); fairly useful (4); not answered (1).

(ix) Family planning in nationai development – very useful (10); fairly useful (4); of little use (1).

(x) Importance of legislation governing midwifery training and practice – very useful (12); fairly useful (3).

2. *Time given to topics for discussion.*

(i) The priorities and problems in family health services and in family planning information, education and communication: adequate (13); too much (1); not answered (1).

(ii) The expanding role of all midwifery personnel and traditional birth attendants in maternal and child health/ family planning: adequate (11); too much (2); too little (1); not answered (1).

(iii) Integration of family planning, nutrition, paediatrics and health education in training curricula: adequate (7); too much (5); too little (2); not answered (1).

(iv) Actions needed to achieve the expanded role in midwifery: adequate (12); too little (2); not answered (1).

3. *Conclusions.*

Each topic was terminated after certain conclusions had been agreed upon. Of these conclusions or recommendations:

(i) How many reflect a need for change in the health programme of your country? All (2); more than half (8); less than half (5).

(ii) How many will be acceptable to you and your colleagues at home: All (9); more than half (6).

(iii) How many were already fully implemented in your country? More than half (7); less than half (8).

(d) ***Overall opinions.***

Please tell us in one sentence which specific feature of this Working Party pleased you most.

Maternal and child health and family planning (1).

Reflection of the Islamic countries' problems and various kinds of solutions required on the basis of this group meeting (1).
I was most pleased that all the participants were encouraged to speak (1).
In exchanging ideas; having common problems (4).
The group discussions were very beneficial as reports brought out different aspects on training and education of health personnel, especially in maternal and child health and family planning (1).
The co-operation, kindness, love and respect which was given us (1).
Group discussion (2).
Working sessions on recommendations (1).
No comments (4).

(e) ***Additional comments***
Thank you (1).
Exchange of information and views gave a broad sense of implementation and termination on the solution of the national problems. I should like frequent repetition of these kinds of international meetings (1).
I should like to have more Working Parties among countries. Some opportunities to see other countries' institutions such as maternal and child health. I should like to see some midwives' school curriculum other than the national (1).
This type of Working Party or Study Group can help developing countries to exchange ideas and identify problems which may be similar to our own country and may be helpful in finding solutions to some of the problems existing in individual countries (1).
The hospitality of the Turkish people was outstanding (3).
No comments (8).

VI Follow-up Visits

Follow-up visits were made by the part-time Regional Field Director to Iran, Afghanistan, Pakistan and Turkey between 24th April and 30th May 1977.

Iran

The recommendations of the Working Party had been sent to the Minister of Health, but due to lack of communication neither the Midwifery Division nor the Midwifery Association had received copies. The organization of the Ministry was in a fluid state and it was not certain whether the Midwifery Division would continue to exist. This resulted in a general lack of co-operation between doctors and midwives, and in an unwillingness by the Midwifery Division to take responsibility for action. The Midwifery Association was too small to exert much influence, although its numbers were growing. The officials seen expressed personal approval of the recommendations but would not speak for the Ministry.

The midwifery training curricula were kept under review and were up-to-date.

There was a training programme for rural midwives. Those with good general education were trained for six months and then returned to their villages. They were supervised every month. It was official policy to replace TBAs by these trained workers, since TBAs were getting older and were not legally recognized. However, the midwives agreed to support the training of TBAs, although such a training programme had no official backing.

Recommendations regarding family planning were already put into practice as the legislation for midwives was very flexible. Midwives prescribed pills and inserted IUDs.

Termination of pregnancy up to 12 weeks was legal as was sterlization of either married partner over the age of 25 who had two or more children. Single persons aged over 30 could request abortion or sterilization.

Afghanistan

The recommendations of the Working Party had been received by the Ministry of Health and the Nursing Division had been made responsible for their implementation.

There was considerable enthusiasm for the training of TBAs, and a study programme in a selected area was being planned. Assistance was asked for, and eventually agreement was reached, to hold a Training Seminar for Trainers of TBAs in the Autumn of 1977.

Attempts were being made to set up either a Midwifery Association or a Council of Midwifery.

The nurse-midwife training curriculum comprised 3 years' nursing and on year of midwifery and was generally satisfactory, although further aspects of training ought to be included if the involvement of midwives was to increase. The biggest problem was the shortage of teachers.

There was an 18-month training programme for auxiliary midwives which covered all the areas recommended.

Midwifery personnel were still being sent to University of California, Santa Cruz for continuing Education.

There was no legislation on nursing or midwifery, although laws were being drafted.

Registration of births took place only in the capital, Kabul, but plans were being prepared to register births in Basic Health Centres and family planning clinics.

There were 8 MCH clinics in Kabul.

There were 37 family planning clinics in the country, 32 of which were

open full time, 5 for only two days weekly. Clinics were well equipped and well staffed. Midwives were allowed to prescribe pills and condoms and to insert IUDs. Contraception was becoming increasingly accepted, and a survey by sociologists into the attitudes of women towards child care, nutrition, health education and contraception was under way.

Transport was being provided for midwives to travel to rural areas.

Pakistan

The Nursing Adviser, Ministry of Health, had received copies of the Working report and she had sent this information to the Registrar of the Nursing Council which was also responsible for midwifery matters and included midwives as members. It was suggested that the title of the Council might be changed to make this more obvious, but this view met with little support. The Council was preparing to discuss the recommendations, and its Education Committee would consider extending the midwifery training curriculum to include more on nutrition, family planning, health education and paediatrics. It was subsequently noted that the training course had been lengthened by three months for this purpose.

The recommendations had also been discussed by the participants with officials of the Ministry, the Nursing Council and the Nurses Federation.

The recommendations had been generally well received and there was a great desire to see them implemented. Problems arose from (i) the political and economic state of the country and (ii) the fact that midwifery was considered subordinate to nursing and neither profession was highly esteemed socially, although the status of nurses was higher than that of midwives.

In general there was good co-operation between nurses, midwives and obstetrician/gynaecologists.

There were probably about 20,000 TBAs in the country.

Some lectures on family planning were being given to medical students.

Midwives were allowed to distribute pills and condoms and to insert IUDs. The acceptance of laparoscopic sterilization had increased.

Turkey

As Turkey had been the host country, there was strong official support for further action in implementing the recommendations. However, old policies and legislation needed to be changed before the midwife could fulfil a wider role. The Midwifery Association would need to be strengthened before it could play an influential part.

The official view is that there should be only one category of midwife for both urban and rural work.

The training course for rural midwives had been lengthened from 3 to 5 years and now included nutrition, health education, paediatrics and family planning.

Education of village midwives in family planning had high priority. It had begun in 4 regions in 1977 and would take effect in 4 more regions in 1978. Pills and IUDs were supplied free of charge.

Midwives inserted IUDs under the supervision of a doctor as the law required. Sterilization and abortion were allowed only on medical grounds.

Following the Working Party, a five-day seminar on curriculum development had been organized by the General Directorate of Professional Education at the Ministry of Health. In attendance were the participants at the Working Party, the President of the Turkish Midwives Association and some of the principals and teachers of the nursing and midwifery schools. The proceedings and results of the seminar are summarised as follows:

1. Current nursing and midwifery training programmes were reviewed. Some of the cultural subjects were shortened and combined with others. More emphasis was placed on the professional aspect.

   A draft curriculum was prepared and presented to the Professional Education Division of the Ministry of Health. This mainly covered the preventive aspects of midwifery.

   The time devoted in the curriculum to nutrition, maternal and child health, paediatrics, health education, family planning and preventive midwifery were extended in the light of the Working Party recommendations.

2. A report was prepared and given to the Ministry of Health dealing with the expanded role of midwives and the new Midwifery Law.

3. One of the participants and the President of the Turkish Midwives Association reported on the results of the Working Party. Copies of the Turkish translation of the interim report and group discussions were distributed.

4. The interest aroused by the Working Party had stimulated all midwives to participate in their national Midwives Association.

5. Turkish midwives felt the need to learn the English language in order to exchange ideas and attend training courses in English speaking countries.

6. Supervisory posts for midwives had been set up in two pilot cities by the efforts of the Manpower Division of the Ministry.

7. The number of TBAs was decreasing and they were being replaced by village midwives. Because TBAs were not legally recognized,

Ministry officials were against training them. They would prefer to see seminars in MCH, health information and family planning for the village women, using films and demonstrations.

8. The interim report of the Working Party, translated into Turkish, was to be distributed to all schools of midwifery and nursing.

VII Outcome, Proposals for Future Activities and Achievements

1. In 2 countries positive steps were being taken to implement recommendations.
2. Further follow-up visits would be called for to assess the progress of implementation and to provide advisory services as necessary.
3. In-country seminars would be valuable on:
   (a) MCH/FP training for senior midwives and health personnel involved in training.
   (b) Modification of basic curricula.

APPENDIX I

List of Participants

Delegates

Afghanistan

Mrs. Fahima Arsala
Director of Nursing
Jamuriat Hospital, Kabul

Dr. Mrs. Karima Rashidi
Zaishgah Maternity Hospital
Kabul

Miss Kamila Weiss
Director of Polyclinics
Zaishgah Maternity Hospital
Kabul

Iran

Mrs. Hamdam Ghaffari
Nurse-midwife
Family Planning Association of Iran
Tehran

Miss Talat Shahgoli
School of Midwifery
National University of Iran
Tehran

Dr. Houshang Vazir-Daftari
Assistant Professor of Obstetrics
Tehran

Kuwait

Miss Mariam A. Al-Raqem
Assistant Director, Nursing Service
New Maternity Hospital, Kuwait

Miss Fatima G.M. Ashour
Assistant Director, Nursing Service
Maternal and Child Welfare Service
Kuwait.

Pakistan

Dr. Mrs. Nazakat Begum
Assistant Professor of Gynaecology and Obstetrics
Bolan Medical College, Quetta, Baluchistan

Mrs. Sabira Nadir
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Government Lady Reading Hospital
Peshawar

Mrs. Akhtar Sultan
Nursing Instructor
Central Government Hospital
Rawalpindi

Turkey

Mrs. Emel Berkay
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Istanbul

Mrs. Muazzez Okay
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Zeynep Kamil College of Health
Uskudar
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Dr. Ali Naim User
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Zeynep Kamil Hospital
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Observers (all from Turkey)

Miss Fatma Acar
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Ms. Melehet Akgun
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Ms. Gulfidam Cosar
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Ms. Fevziye Yetiz
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Gaziantep

Resource Persons
Miss Mary Corcoran
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Contract Team
Kabul, Afghanistan

Miss Taricher Darheshem
Family Planning Association of Iran
Tehran

Miss Frainy Munshi
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Karachi, Pakistan

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World Health Organization
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Regional Adviser on Nursing
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Eastern Mediterranean
Alexandria, Egypt

University of California
Miss Anne Richter
Nurse-midwife Adviser
University of California Santa Cruz
Contract Team
Kabul, Afghanistan

International Confederation of Midwives Officials
Miss F. Margaret Hardy
Executive Secretary ICM
Assistant Administrator ICM/USAID
Project

Mrs. Suheda Ozgur
Local Part-time Regional Field
Director
ICM/USAID Project

Mr. Harry Smith
Financial Administrator
ICM/USAID Project

Mr. John Tomkinson
Chairman FIGO/ICM Joint Study
Group

Miss Julia Withington
Field Director
ICM/USAID Project

Other Speakers
Dr. Nezakat Akkerman
Maternal and Child Health
Department
Ministry of Health & Social Welfare
Ankara

Mr. Baki Durmaz
Divisional Director of Population Planning
Ministry of Health & Social Welfare
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Mrs. Aygun Demren
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Mrs. Gulsun Algul
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Dr. Sabiha Ozgur
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Ege University, Ankara

Dr. Vedat Yeginsu
Faculty of Commerce
University of Istanbul

Avukat Cetin Akcaglayan
Legal Adviser
Ministry of Health & Social Welfare
Ankara

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Obstetrician, Zeynep Kamil Hospital
Uskudar, Istanbul

APPENDIX II

List of Papers Presented

1.	The ICM/USAID Project	Miss Margaret Hardy Executive Secretary, ICM
2.	A Brief Report on Zeynep Kamil Health College	Mrs. Muazzez Okay Chief Assistant Director Zeynep Kamil Health College
3.	Family Health Care in Countries	
	a) Administration and Management	Dr. Nezakat Akkerman
	b) Training and Utilization of Personnel	Dr. Karima Rashidi
	c) Resources available: Supervision: Co-operation	Mrs. Akhtar Sultan
4.	Information, Education and Communication in Family Planning	Mr. Baki Durmaz Divisional Director of Population and Planning, Ministry of Health, Ankara

5. Current Participation of Midwives and Traditional Birth Attendants in Maternal and Child Health and Family Planning	Mrs. Talat Shahgoli – Iran Mrs. Sabira Nadir – Pakistan Miss Fatma Acar – Turkey Miss Kamila Weiss – Afghanistan Miss Mariam Al-Raqem – Kuwait
6. The Expanding Role and the Scope and Practice in the Field of Family Planning for all Categories of Midwives and Traditional Birth Attendants	Mrs. Aygun Demren Vice-President, Turkish Midwives Association. Mrs. Gulsun Algul MCH Department, Zeytinburnu, Istanbul
7. Curriculum Development in Maternal and Child Health and Family Planning Training	Mrs. Guney Cekirer Deputy Director, Professional Training Department Ministry of Health, Ankara
8. Integration of Family Planning, Nutrition, Paediatrics and Health Education in the Basic Midwifery Curriculum	
a) Family Planning	Dr. Ayse Tumay Cetinel
b) Nutrition	Prof. Dr. Orhan Koksal
c) Paediatrics	Prof. Dr. Sabiha Ozgur
d) Health Education	Miss F. Munshi
9. Integration of Family Planning with Social Welfare in Iran	Miss Farman-Farmaian (read by Mrs. Taricher Dhardeshem)
10. Family Planning in National Development	Dr. Vedat Yeginsu Faculty of Commerce University of Istanbul
11. Importance of Legislation Governing Midwifery Training and Practice	
a) Legal Adviser	Avukat Cetin Akcaglayan
b) Midwifery Association	Miss Hamdam Ghaffari
c) Obstetrician	Dr. Ertugrul Bayirli
12. Continuing Education in Family Planning	Mrs. Mary Corcoran Public Health Nurse Educator UCSC/USAID Contract Team Afghanistan

ANGLOPHONE MIDDLE EAST REGIONAL SEMINAR ON EXPANDED INVOLVEMENT OF THE MIDWIFE IN REPRODUCTIVE HEALTH, KHARTOUM, SUDAN, 12th – 18th NOVEMBER, 1977.

Participating countries: Egypt, Lebanon, Sudan, Syria.

Jordan had accepted an invitation to attend, but the delegates were prevented from travelling through a breakdown in their travel arrangements.

1. **Preliminary Visits, July–August 1977**
   Khartoum, Sudan
   The Under-Secretary of Health and the Director of the MCH/FP Project explained that the Ministry of Health was to conduct a National Seminar on Family Health from 12–15th November, and the suggested dates in November for the Regional Seminar would therefore be unacceptable. They suggested February 1978 as no other earlier date was practicable. This did not suit ICM and after much discussion it was agreed that the two projects should co-operate and operate jointly, with the National Seminar running from November 12–14 and the ICM Regional Seminar from November 12–18. On the 12th–14th the Regional Seminar participants would attend the National Seminar from 9 a.m. to 2 p.m. and their own meeting from 4.30–6.30. On the remaining days the Regional Seminar would operate on its own from 8.30 – 2.30. The objectives of both Seminars would be maintained, and each project would be responsible for its own expenses.

   At the time of the visit three Sudanese delegates to the Regional Seminar had been appointed, one obstetrician, one nurse-midwife and one public health nurse-midwife. Each country was now being invited to nominate two additional delegates, one obstetrician and one midwife.

   The objectives, preparations, organization and follow-up of the Seminar were discussed.

   The Assistant Director of Nursing was seen, but it was obvious that the Director of Nursing had not been informed of the Seminar.

   A local committee had been set up, a regional field director appointed, and the programme and the venue of the meeting finalized. The field director would return to Khartoum two weeks before the Regional Seminar.

   Observations

   1. ***Categories of midwives***
      Sister-midwives – with 12 years' general education, three years' nursing and one year midwifery at the Higher Nursing College. Some family planning training was included in the second year.

Staff midwives – with 9 years' general education, three years nursing in Nursing School and one year midwifery in the Midwifery School. The course included one week's orientation in family planning.

These two grades worked in maternity hospitals.

Health visitors – staff midwives with 18 months' health visitor training and four weeks' MCH/FP training. They staff all health centres and also function as trainees of district midwives.

Village midwives – village girls with some elementary education who are selected by their village community for one year's midwifery training. They return to work in health centres in their own area. Family planning was not yet included in their training.

TBAs – There was a plan to train TBAs, but no indication when training would start.

2. ***Family Planning***
Until 1975 family planning services were available only through the countrywide clinics of the FPA. This body was now engaged in training, I.E. & C. services, and cooperated closely with the Maternity Centred Family Planning Project of the Ministry of Health (MCFP/MOH).

MCFP/MOH did not have top priority and so had no budget. The scheme was started in 1975, funded by WHO/UNFPA. Services were available in five hospitals and three health centres in Khartoum. Slow progress was said to be due to lack of trained personnel because of lack of priority to family planning services. However, there was no population problem.

Midwives were mainly involved in motivation. All services were delivered by doctors. There were enough doctors at present in urban hospitals and health centres; two sister midwives working in hospitals inserted IUDs with the permission, and under the supervision of obstetricians.

Calls were paid on the USAID Mission Director to inform him of the programme of the visit and to report achievements. The programme of the Regional Seminar was discussed with him and the prospective Regional Field Director introduced.

Met Mrs. R. Azzizi, WHO Adviser in Family Health, who offered support and assistance.

Cairo/Egypt
At a meeting with Ministry of Health officials the increase in the number of delegates was explained. Two nominations had been made and the names of the others would be sent in later. Other administrative matters were settled and full approval given to the participation of the delegates in the joint meetings as arranged in Khartoum.

One delegate was seen and various aspects of the Seminar discussed with him. He would brief the other delegates.

The Director, Family Planning Directorate, Ministry of Health, had not been consulted about the Seminar by the Ministry. In view of her knowledge and experience she was invited to take part as a speaker and she accepted. She outlined the responsibilities of the Directorate as:

1. Co-operation with other Ministries (which was good except with the Ministry of Religion), and promoting family planning as an integral part of MCH services.
2. Education in I. E. & C. Training was being planned according to priorities. Doctors were not adequately trained, and this could harm an already weak programme. As there was no shortage of doctors, midwives should continue to function at present as motivators, but when all doctors had been trained, midwives could be trained in IUD insertion, pill prescription, etc. There were plans to train and utilize TBAs as motivators and distributors of conventional contraceptives. The Bangladesh Training of Dai Trainers Seminar was discussed and the guidelines for the Dai Trainers Manual, and a copy was asked for.
3. Delivery of services was undertaken by the MCH services through its clinics and was not a function of the Directorate.

The Head Mistress, a nurse-midwife, of the School of Nursing, Cairo University, explained the situation regarding midwives. There was only one category, the nurse-midwife, and the TBA. All midwives were nurses, but not all nurses were midwives. Midwifery training was an optional one-year postbasic course, but could only be taken after 2 years' practical nursing experience. Some family planning was included in the curriculum.

Some TBAs had received some training, but with little or no follow-up their performance could not be assessed. Most trained midwives preferred to work in urban areas. The few who operated in rural areas were not accepted because of their youth and lack of experience; rural women preferred TBAs. However, new government policy laid down that all newly qualified health personnel should work for two years in a rural community.

WHO officials were unhappy with the arrangements for the joint seminar and wanted the arrangements changed, but eventually the meeting ended amicably.

The USAID representative was informed of the arrangements and gave his approval to them. He and his staff were most helpful in every way.

Amman, Jordan

At interviews with Ministry officials, the reasons for the changes in arrangements regarding the joint seminars were explained, and the

composition of delegations confirmed. Two of the nominated delegates were already committed to an in-country family planning trainer's course, and talks were held to see if they could be released to attend the Seminar. The help of the USAID representative was also enlisted in this matter.

The Assistant Professor of Nutrition and Child Health, Faculty of Medicine, University of Jordan, accepted an invitation to speak at the Seminar, and the content of his presentation was discussed.

A courtesy call was paid on the Chief Nursing Officer to brief her about the Seminar. She was not a midwife but appeared to be interested. Copies of reports of past Working Parties were sent to her.

The Seminar was discussed with the USAID representative who agreed that the joint arrangements were the best in the circumstances.

Categories of midwives were:

1. *Nurse-midwives* – only four in the country. They had 12 years' general education, 3 years' nursing training and one year's midwifery education. Family planning was not included in the curriculum.
2. *Midwives* – 12 years' general education, 2¼ years' midwifery education. Again, no family planning was included.
3. *TBAs* – there were about 200 of them; some had been trained in the Maternity Hospital. There was no record of the number trained or any information about their practice.

The MCH/FP project was in a developmental stage and would be launched in 1978. A demonstration centre was to be built and personnel trained.

Damascus – Syria

At discussions with Ministry of Health officials, the arrangements for the Seminar and the nomination of delegates were discussed. None of the delegates was available for interview and briefing material was left to be passed on to them. A Syrian speaker was to be nominated.

It was said that TBAs had formerly been trained but this had now stopped; no reasons were given. Family planning services were provided in the main by the 10 clinics of the FPA. Additional services were provided through the MCH services. The government had to move cautiously because of religious sensitivities.

The Director of MCH services, a paediatrician, was disturbed at the lack of progress. There were too few health centres because of lack of midwives and 90% of deliveries were undertaken by TBAs. Health auxiliaries were to be trained to help the MCH midwives. Their 6-month course would equip them to deal with health education, immunization and general clinical MCH duties, but not with midwifery. However, the

Chief Nursing Officer saw no need to train a new category of worker. She said that there were enough midwives, but they were wrongly assigned and were to be found mostly in schools of nursing, general hospitals, etc. The government should take powers to direct them to the MCH services, and nurses should be encouraged to take up midwifery training to counteract the low intake of midwifery students. Also, TBAs should be trained and utilized.

The USAID representative gave some very useful background information on the position of family planning in Syria.

II Organization

As agreed during the preliminary visits, it was agreed that participants at the Regional Seminar should join in the proceedings of the National Seminar on Family Health which had already been arranged for November 12–14th. On those three days they joined the National Seminar for morning sessions and met independently in the afternoon.

III The Working Party

(a) ***Attendance:*** Those attending comprised:

(i) 15 delegates from Egypt (5); Lebananon (2); Sudan (5) and Syria (3).

(ii) 8 observers from Sudan.

(iii) 2 resource persons; rapporteur-general and assistant rapporteur-general, all from Sudan. Chairman, Steering Committee (Sudan), and 4 committee members (3 from Sudan, 1 from ICM)

(iv) 1 representative from WHO (Alexandria) and 4 other representatives from FIGO/ICM

(b) ***Summary of Proceedings***

At the Opening Session addresses were given by the Director of the National Seminar and representatives of the Sudanese Family Planning Association, the Sudanese Society of Obstetrics and Gynaecology; the Sudanese Midwives Association and the ICM. Miss M. Hardy, Executive Secretary ICM and Assistant Administrator, ICM/USAID Project, described the work of ICM, the original ICM/USAID Project and the new Project now in operation. She stressed the importance of the role of the midwife and the need to train and utilize the TBA until such time as sufficient professional personnel were available.

The Opening Address was given by His Excellency, The Minister of Health, Sudan, who welcomed the participants and spoke of the President's great concern for maternal and child health, and his directive that they should 'ensure the availability of a midwife in every village'. As a result MCH had top priority in the National

Health Programme. There was a great shortage of midwives and about half a million children born each year would not have proper medical care. There was great need for education in avoiding the risk of too frequent pregnancies. He assured the Seminar that the recommendations would have full attention and consideration.

Later that day the participants were introduced, arrangements for the Seminar explained, and a paper was given by Mrs. B. Brohier, ICM, on *The Role of Chairman, Rapporteur and Members of a Discussion Group.* The groups met on Sunday morning to elect these officials, and in the evening country reports were presented.

Egypt

MCH centres had existed since 1927. There were now 225 centres in cities and about 2000 in rural areas. Personnel at city centres included one nurse-midwife and 8–12 auxiliary nurse-midwives. In rural centres there were 3 nurse-midwives or assistant midwives and also dayas who were used for motivation and assistance only. They were employed to compensate them for financial loss and to decrease their opposition to the new system. Comprehensive care was offered, including preventive measures and family planning and health education. There were problems of transport and of continuous inservice training and upgrading of workers.

Lebanon

The health personnel included about 500 midwives, 1440 nurses and 60 TBAs. Midwives practised in special hospitals, MCH centres, outpatient and private clinics, family planning centres and in the homes. The shortage of midwives was especially acute in rural areas, where many deliveries were undertaken by TBAs, although their practice was illegal. However, plans to train and licence some TBAs were being considered. There had been a decreasing number of students in the midwifery schools in recent years. A wider midwifery training was now being offered at the only school still in existence. This was a four-year course leading to a master's degree.

Syria

Most of the population lived in towns, but health coverage in some rural areas was not good and some deliveries were conducted by TBAs. Some TBAs had received some training and trained midwives assisted in this. MCH services began in 1941; they were a continuous process beginning with health education in schools. Midwives operated in centres and in the homes.

The work of health centres was hindered by shortage of midwives and other health workers, and by their lack of training, by shortage of drugs and equipment and by bad communications.

Family planning services were established in 1972 for health and socio-economic reasons.

Sudan

MCH services had top priority because of high maternal and infant mortality and morbidity but was limited by the usual constraints of finance, shortage and bad distribution of personnel, bad communications, low standards of education of the population, etc.

Maternity care consisted of pre-, intra- and postnatal care, maintenance of lactation and promotion of breast feeding, and family planning (including advice on infertility). Child care of: immediate care to the newborn, maintenance of normal growth and development through advice on nutrition and general health, immunizations, care of 0–5s and of the school child. Of 138 health centres only 26 were in rural areas. The 16 midwifery schools produced about 700 trained midwives annually. Postbasic training for health visitors and for nurse-midwives was also given. MCH/FP training was needed for health workers at village level.

On Monday morning the groups met to consider the first Discussion Topic – The Priorities and Problems in Reproductive Health Services in Developing Countries. Reports were prepared later and presented the following day. Also on Monday visits were paid to health centres.

The first subject on Tuesday was *The Present Involvement of all Categories of Midwives and TBAs in Reproductive Health and Family Planning.* Dr. Ahmed Mohsen, Egypt, reviewed the activities of midwifery personnel in this field in other parts of the world. In Egypt hospital deliveries were conducted by physicians, and domiciliary deliveries (about 70% of the total) by nurse-midwives or by trained or untrained TBAs. Midwives and TBAs were involved in family planning motivation but more use could be made of them. Midwives distributed supplies, including pills; IUDs were inserted only by doctors. Abortion and sterilization were not part of the family planning programme.

Miss Waddad Abu Nader, Lebanon, said that midwives in her country had a high social status and were well trained. Some TBAs had received training from the FPA, WHO, The American University of Beirut and government. They were responsible for about one-third of all deliveries, midwives for one-third and doctors for one-third. TBAs were often available when trained personnel were not; also their fees were low and they were willing to go to the patient, so that they were more acceptable. There was need to reconsider the practice of midwives and TBAs.

Miss Naila Mousa Diah, Syria, said that midwives were responsible for health education in schools, for all phases of maternal and child care, and for family planning and family health education. Health visitors worked in centres and were not allowed to conduct

domiciliary deliveries, but otherwise performed similar functions. They also supervised TBAs, who only conducted home deliveries. Family planning was now an important part of MCH care.

Miss Fatma Killa, Sudan, described the four categories of practising midwives in her country: (i) the nurse-midwives who worked in hospitals under the supervision of doctors; in family planning they functioned as motivators; (ii) health visitors who were nurse-midwives with an additional one year's training in MCH – they worked in clinics under the supervision of their tutors and gave MCH/FP services and health education; (iii) village midwives who had had nine months' training and worked in local communities and performed home deliveries; family planning was included in their training; (iv) TBAs, some of whom had just received a short two-month training course in hygiene, asepsis, and some knowledge of pregnancy, nutrition, child spacing and child care.

After this general survey, Dr. Osman Modawi, Director, Maternity Centred Family Planning Project, Sudan, spoke on *The Expanding Role and Scope of Practice of all Categories of Midwives and TBAs in Reproductive Health Services.* He described the problems hindering the spread of health care in developing countries and stressed the need for covering the requirements of the rural population by the use of community health workers and village midwives. Health care had to be adapted to the culture of each society, and the midwife was the most important link into the life of the family. Her role in health education, family planning and community health ought to be expanded.

Discussion of Topic No. 2 followed: The Expanding Involvement of all Categories of Midwives and TBAs in Reproductive Health. A consensus report was approved on Wednesday morning.

The next subject was *Family Planning, Paediatrics, Nutrition and Health Education as Integral components of the Curriculum of all Categories of Midwives and TBAs.*

Dr. Zein el Nayal, Senior Consultant in Obstetrics and Gynaecology, Omdurman, Sudan, spoke first of *Family Planning.* The Sudan FPA began work in 1965 and now had clinics in most large towns in the country; it ran training courses for different categories of medical personnel. As a result family planning was introduced into the curriculum of the Medical School, High Nursing College and Health Visitors School and latterly into courses for midwives and rural workers. Government was now committed to provide, as part of MCH services, free contraceptive advice and services, to train personnel and to use TBAs and rural health workers as motivators. Midwives were the obvious people to carry the message of family planning to the family, but lack of

training, fear of loss of income and the attitude of the rural population had to be overcome. They recognized their responsibilities to train and some courses had already been held for health visitors and midwives, but not yet for village midwives or TBAs. The general improvement in rural development and primary health care was already in hand. Three seminars had been sponsored to consider the problems, including the present meetings.

Dr. Mahmoud Mohammed Hassan, Senior Consultant Paediatrician, Ministry of Health, Sudan, discussed *Paediatrics.* He said that training courses for midwives and TBAs should include preventive, social and curative aspects of major health problems – endemic diseases, prenatal factors (maternal age, effect of drugs), maternal infections, natal factors (obstetric difficulties, birth injuries, etc.), postnatal factors (congenital malformations, infections, etc.). The most important role of the midwife lay in the promotion of breast feeding, proper nutrition, management of gastro-enterology, collection of statistics, and community and family health.

Nutrition was covered by Dr. George Wadsworth, WHO Consultant, Nutrition Unit, University of Khartoum. He said that dietary deficiency was probably most dangerous at the earliest stages of fetal life. The relationship between fetal development and maternal nutrition was not yet fully understood. He stressed the importance of breast feeding and of adequate nourishment of low birth weight babies.

The next speaker was Mrs. Awatif A. Osman, Director, College of Nursing, Khartoum, on the subject of *Curriculum Development.* She spoke of the need to re-examine the training of health personnel in the context of local needs and of the goal to be achieved. Clear educational objectives were required; the needs of the students had to be assessed and a curriculum devised accordingly and evaluated. Familiarity with modern teaching methods was essential.

This was followed by a paper entitled *Continuing Education in Reproductive Health,* by Mrs. Muazzez Okay, Chief Assistant Director, Zeynep Kamil Health College (Midwifery School), Istanbul, Turkey. She said that health care was a progressive art, and its practitioners (midwives included) needed to be kept up-to-date if they were to function adequately in MCH/FP. She discussed the principles affecting the choice of courses to be provided and the selection of candidates, and said that it was vital to promote the enthusiasm of the trainee. Courses should be available for all – from doctors to TBAs and should be held in both towns and rural areas, but the special needs of the TBA should be borne in mind.

A Panel Presentation on *Legislation Governing the Training and Practice of Midwives and TBAs* then took place. Prof. Dr. Mahmoud El-Minawi, Obstetrician spoke of the situation in *Egypt* and gave details of the midwifery training courses available and of the curricula. Mr. G.H. Faris, Advocate, Khartoum, discussed *Legal Aspects of Midwifery in Sudan*, and enumerated the laws governing the practice of the profession in that country.

Dr. Abba Mukhtar, Under Secretary, Ministry of Health, later spoke on *Administration and Organization of Maternal and Child Health Services.* He said that services had to be adapted to the needs of families and communities. They should be acceptable to the people, achieve desired objectives, be co-ordinated with the socio-economic programmes and be economically feasible. He listed the problems and constraints in providing such services and went on to describe the inception of organized MCH in Sudan and its planning and structure. Family planning was offered only as part of MCH services and had not yet spread to rural areas. Training was being developed but was still inadequate, while distribution of supplies was hindered by bad communications.

Discussion Topic No. 3 was dealt with on Thursday – The Incorporation of Family Planning, Paediatrics, Nutrition and Health Education in the Basic Midwifery Curriculum and the TBA Training Course.

On Friday. evaluation of the Seminar took place, follow-up action plans were submitted and the Interim Report discussed and accepted. The Closing Address was given by Dr. Abbas Mukhtar, and votes of thanks expressed by a delegate from each country.

IV Consensus Reports of Group Discussions

(a) *Topic 1. Priorities and Problems in Reproductive Health Services in Developing Countries.*

1. A National Multidisciplinary Body for Family Health Services should be created. The detils of its establishment should be left to each particular country. Its functions should be:
   - (i) Identifying problem areas in reproductive health within the context of the overall health and development programmes of the country.
   - (ii) Implementation, supervision and integration of the national programme of reproductive health.
   - (iii) Identification, training and supervision of all categories of personnel delivering reproductive health services with the objectives of raising the status and remuneration. This should include innovative programmes to meet the needs of maximum coverage especially in rural areas.

2. Health Education is considered an important tool in improving reproductive health. It should be included in the general educational programmes and other training programmes for community and social welfare organizations. Health education should include premarital counselling, reproductive health, child health, nutrition and family planning.

3. Continuous education programmes for all personnel involved in reproductive health services should be implemented, the courses being tailored according to the level of previous training and experience.

(b) ***Topic 2. The Expanded Involvement of all Categories of Midwives and TBAs in the Reproductive Health Services.***

1. Integration of MCH/FP in all basic curricula of all ca midwives and nurses. For those already graduate certificate training should take place in on-going in-cou training courses in addition to on the job and local training.

2. It is recommended that education, information and motivation for family planning and counselling should be considered as an important function of all categories of midwives and TBAs. It is also recommended that they should be trained in the emergency management of some of the serious obstetrical and paediatric problems.

3. In order to evaluate the role of TBAs, a national survey will be necessary. Thereafter a multi-disciplinary training programme should be organized in target areas with emphasis on information and education of the village communities in general.

(c) ***Topic 3. The Incorporation of Family Planning, Paediatrics, Nutrition and Health Education in the Basic Midwifery Curriculum and the Traditional Birth Attendants' Training Courses.***

1. The groups recommend the review of the curricula of midwifery training and assessment of how much family planning and health education, paediatrics, nutrition should be included in their basic programmes. The integration of family planning in the training programme of different levels of personnel working in midwifery is important for an efficient promotion of health of the mother and child.

2. In formulating the basic curricula for training courses consideration should be given to social, cultural and religious factors.

3. Continuous updating and training of the trainers of all categories working in the reproductive health service is necessary. Co-operation with international organizations in this respect is desirable.

V Country Follow-up Action Plans

Egypt

1. On our return to Cairo the information about the usefulness of this Seminar organized by ICM and FIGO will be given to the Ministry of Health.
2. Our activities and reactions to the Seminars will be discussed with the officials concerned with the health of the family. The feasibility of a local country seminar will be discussed with the Ministry of Health and all officials concerned with family health.
3. The final government decision and recommendation will be sent in the very near future to ICM.

Lebanon

1. To stress the teaching of Health Services in the school programme for midwives.
2. To organize in-country seminars, refresher courses and workshops for all midwives, particularly for those in the rural areas.

Syria

1. We shall report to the Ministry of Health and present the Interim Report and the Recommendations. The implementation will depend on the government.
2. We shall also talk to as many of our colleagues as possible about the Seminar.
3. We hope our government will invite ICM to organize a Seminar Workshop for midwives in Syria.

Sudan

1. It was a great privilege to hold the Seminar in our country and it has highlighted many of our problems.
2. The contents of the different resolutions and deliberations will be discussed with other Sudanese personnel concerned at different levels and conveyed to the top policy makers in the Ministry of Health for their implementation.

IV Recommendations

1. A National multidisciplinary body for Family Health Services should be created. The details of its establishment should be left to each particular country.

   Its functions should include:

   (a) Planning the identification of problem areas in Reproductive Health within the content of the overall health and development programmes of the country.

(b) Implementation, supervision and integration of the National Programme of Reproductive Health.
(c) Identification, training and supervision of all categories of personnel delivering Reproductive Health Services with the objective of improving their status and remuneration.
(d) The inclusion of innovative programmes to meet the needs of maximum coverage especially in rural areas.

2. Health Education be considered an important tool in improving Reproductive Health and be included in general educational and other training programmes for community and social welfare organizations. It should include:–
   (a) Pre-marital counselling
   (b) Reproductive Health
   (c) Child Health
   (d) Nutrition
   (e) Family Planning

3. Continuing education programmes be implemented for all personnel involved in the Reproductive Health Services. Such programmes should be tailored according to the level of previous training experience.

4. Maternal and Child Health/Family Planning be integrated into all basic curricula for all categories of midwives and nurses. For the personnel already graduated, continuous in-country training courses should be arranged in addition to the job and ad hoc training.

5. Education, Information and Motivation for Family Planning and counselling be considered as an important function of all categories of midwives and TBAs. In addition they should be trained in the management of some of the first-aids of obstetrical and paediatric emergencies.

6. There is a a need for a national survey to evaluate the role of TBAs. Thereafter multi-disciplinary training programmes should be organised in target areas with emphasis on information and education of the village communities in general.

7. The curricula of midwifery training be reviewed and an assessment made of how much family planning, health education, paediatrics and nutrition be included in their basic programmes.

8. Consideration be given to social, cultural and religious factors in formulating the basic curricula for training courses.

9. Continuous updating and training of the trainers of all categories working in the Reproductive Health Services is necessary. Co-operation with international organizations in this respect is desirable.

VII Analysis of Evaluation Questionnaires

(a) ***Technical Aspects***

Q. Is this the first time you have been out of your country?
A. Yes – 3; No – 11; Abstained – 1.

Q. Have you attended an international meeting before?
A. Yes – 9; No – 6. (Details were given by those answering 'yes').

Q. Were you eager to attend this Seminar?
A. Very eager – 12; fairly eager – 3.

Q. Are you pleased that you attended this Seminar?
A. Very pleased – 12; fairly pleased – 3.

(b) ***Objectives of the Seminar***

Q. Were the objectives adequately met in the time allowed?

1. To exchange information on the present situation of Reproductive Health Services (RHS) in the countries represented here.
   A. Yes – 14; No – 1; Abstained – 1.
2. To exchange information on training and functions of all categories of midwives and TBAs.
   A. Yes – 15; (no other answers given).
3. To identify common problems in RHS, especially in rural communities such as obstetric and paediatric emergencies; the underserved or unserved areas in RHS such as family planning, nutrition, paediatrics and health education, particularly in rural communities.
   A. Yes – 13; No – 1; Abstained – 1.
4. To consider how the functions of all categories of midwives and TBAs can be expanded so as to assist in solving problems and in contributing towards the underserved or unserved areas.
   A. Yes – 14; No – 1.
5. To suggest actions which are necessary to promote the expanded involvement of midwifery personnel and TBAs and their motivation.
   A. Yes – 12; No – 2; Abstained – 1.
6. To plan an appropriate follow-up action programme for each country in order to ensure the implementation of the recommendations.
   A. Yes – 6; No – 7; Abstained – 2.

Q. Of what value to you were the various presentations?

1. Reproductive Health Services in Developing Countries.
   A. Very useful – 9; Fairly useful – 5; Abstained – 1.

2. To what Extent are the Midwives and TBAs involved in RHS?
   A. Very useful – 8; Fairly useful – 4; Of little use – 2; Abstained – 1.
3. The Expanding Involvement and Scope of Practice of all Categories of Midwives and TBAs in RHS.
   A. Very useful – 10; Fairly useful – 3; Abstained – 2.
4. Family Planning, Paediatrics, Nutrition and Health Education as Integral Components of the Curricula of all Categories of Midwives and TBAs.
   A. Very useful – 13; Fairly useful – 1; Abstained – 1.
5. Curriculum Development.
   A. Very useful – 5; Fairly useful – 8; Of little use – 1; Abstained – 1.
6. Continuing Education in Reproductive Health.
   A. Very useful – 7; Fairly useful – 6; Of little use – 1; Abstained – 1.
7. Legislation governing the Training and Practice of Midwives and TBAs.
   A. Very useful – 2; Fairly useful – 10; Of little use – 2; Abstained – 1.
8. Administration and Supervision.
   A. Very useful – 4; Fairly useful – 8; Of little use – 2; Abstained – 1.

Q. Of the objectives (1–6 above), which were most satisfactorily achieved?

1. Which objective was not adequately achieved?
   A. No.1 – 2; No.6 – 8. Abstained – 5.
2. Which objective was most satisfactorily achieved?
   A. No.1 – 7; No.4 – 5; No.5 – 1. Abstained 2.
3. If you could have had a further two days to work on one objective which one would you choose?
   A. No.2 – 4; No.3 – 1; No.4 – 2; No.5 – 6; No.6 – 1. Abstained – 1.
4. On which of the six objectives did you participate most in the discussions?
   A. No.2 – 1; No.3 – 2; No.4 – 4; No.5 – 5. Abstained – 3.

Q. Was adequate time given for discussion of major issues?

1. The priorities and problems in RHS in developing countries.
   A. Adequate – 11; Too little – 3; Abstained – 1.

2. The expanded involvement and functions of all categories of midwives and TBAs.
   A. Adequate – 11; Too little – 3; Abstained – 1.
3. The incorporation of family planning, paediatrics, nutrition and health education in the basic midwifery curriculum and the TBAs' training course.
   A. Adequate – 10; Too little – 4; Abstained – 1.

Q. How relevant to your country were the conclusions and recommendations?

1. How many reflect a need for a change in your programme?
   A. All – 2; More than half – 8; Less than half – 3; Abstained – 2.
2. How many will be acceptable to your colleagues at home?
   A. All – 4; More than half – 1; Less than half – 4: Abstained – 6.
3. How many were already fully implemented in your country?
   A. All – 1; More than half – 9; Less than half – 3; Abstained – 2.

(c) ***General Comments***

Q. Which specific feature of this Seminar pleased you most?

A. Group discussions – 3; Exchange of information – 7; Recommendation No.1 – 1; Expanding the involvement of the TBA in the rural health service until there are more trained midwives – 2; No comment – 2.

Q. Have you any other comments to make?

A. 1. Very well organized Seminar and very interesting topics. Time was short for discussions.
2. Bringing together doctors of different disciplines and midwives of different standards to discuss a genuine problem.
3. Thank you.
4. A proper and continuous follow-up from the ICM to this subject – the involvement of the TBAs.
5. As a result of language difficulty some delegates were unable to express themselves properly.
6. Inclusion of more midwives in ICM.
7. Not enough time for discussion. I would like to have a follow-up for this Seminar.
8. Six had no other comments.

VIII Hand-outs

At the meeting the following papers were circulated:

1. Paper on The Egyptian Reproductive Health Programme by Professor M.F. El-Minawi, Professor of Obstetrics and Gynaecology, Faculty of Medicine, Cairo University, Egypt.

2. Paper on Teaching of Family Health in the Health Profession Institutions by Dr. Hamid Rushwan, Dept. of Obstetrics and Gynaecology, Faculty of Medicine, University of Khartoum and Dr. Awatif Osman, Director, Khartoum Nursing College.
3. Paper on The History of the Egyptian Midwifery and Nursing by Mrs. Naemet Abou El Saoud, Director of Cairo University School of Nursing.
4. The Activities of the Egyptian Nurses Association which has recently been turned into a Syndicate by The Headmistress, Kasr El Einy School of Nursing.

IX Follow-up Visits, February/March 1978

Sudan

(a) ***Meetings with officials***

The Under-Secretary and heads of various sections of the Ministry of Health were seen. The recommendations were slowly being implemented by the Ministry and by the training institutions. The Maternity Centred Family Planning Project (MCFP) was organizing a mini-workshop on The Inclusions of Maternity Centred Family Planning in all Curricula. The participants at the Seminar would arrange this, act as speakers, resource persons, etc. Training of trainers for MCFP had begun with a 12-week course for 15 students, and more courses would follow. Training of TBAs was being planned and the pilot programme in Blue Nile Province was progressing well although there were few participants at present.

The Rapporteur-General, who was senior lecturer in obstetrics and gynaecology at the University of Khartoum, thought the final recommendations excellent. The suggestions for expanding the involvement of the midwife in reproductive health had stimulated the participants to improve the standards of teaching and delivery of services. This was an immediate result of the seminar. Actual implementation of the recommendations would need time and effort.

(b) ***Meetings with delegates***

The two obstetric delegates said that they had taken every opportunity to stress the role of the TBA and the possibilities of training them.

The Matron, Soba Hospital, University of Khartoum, spoke of family planning sessions held at the hospital. Refresher courses were being given to nurse-midwives. The Midwifery Tutor, Nursing College, Ministry of Education, said that the Midwifery Institute was planning to recruit midwifery graduates as teachers to improve standards of training. The curriculum was being revised to include field training.

The Student Health Visitor at the Omdurman School would do her best to promote the expanded involvement of midwives in reproductive health when she returned to Southern Sudan after completion of her training. She would be involved in midwifery training there.

Opportunity was taken to discuss the new USAID/ICM project for the training of trainers of rural health workers and interest was expressed. The project might fit in well with the national health development policy.

A report was made to the USAID representative on progress in implementing the recommendations of the Seminar.

Egypt

Meetings with officials and delegates

The USAID Population Officer was interested to hear of developments in the Sudan and asked that the Director of Nursing and Midwifery, Ministry of Health, be kept informed.

Government officials and delegates reported that the first recommendations of the Seminar had been implemented by the High Council of Maternal and Child Health and the High Council of Population. Integration of MCH and family planning was already included in the 5-year plan. The Council for Human Resources was responsible for health education in schools and technical schools and for family planning I.E.& C. The General Nursing School was conducting 3-month midwifery courses, but these were inadequate. There was a shortage of nurses with midwifery training; only about half of the 3,000 nurses were qualified in midwifery.

The government planned to have nurse-midwives working in MCH/FP centres, so that assistance would be needed in training of trainers and in the provision of teaching materials and equipment. There were said to be no TBAs (although others said that there were some working in rural areas).

On-going projects were: evaluation of secondary school programmes; promotion of refresher courses in public health; review and evaluation of one-year obstetrics and gynaecology nurses' diploma courses. There would be co-operation with international organizations in all training programmes for all categories of health workers in reproductive health.

The new ICM/USAID project was discussed and the group thought that ICM could assist in the training of trainers of assistant midwives. A training seminar in Egypt was suggested.

A visit was paid to a MCH clinic and also to the FPA model MCH/FP centre, to which midwives, nurse-midwives and students were assigned for practical training. It ran refresher courses for its staff

every six months. They were very interested in the new ICM/ USAID project.

Lebanon

The delegates had presented the recommendations to the Ministry of Health, the Ministry of Social Welfare and to the Directors of the French School of Nursing and Midwifery.

A government official emphasized the shortage of trained midwives. The profession was poorly paid and did not attract recruits. The government had done little to promote interest.

The practice of TBAs was illegal, but they were allowed to operate because of the shortage of trained personnel. They were largely illiterate and their practice often dangerous. The government had planned to train and utilize them but no funds were available. Government was planning to improve and develop MCH services including the training of personnel. Assistance in training would be welcomed.

The National School of Nursing ran two courses – a 4-year course for entrants with 10 years' education and a 3-year course for those with 12 years' general education. Public Health and MCH were already in the curricula and family planning was being introduced.

The President of the Midwives Association said that the political situation had prevented any implementation of the recommendations, although they would like to train TBAs. She was interested in having assistance from ICM through their new project.

The Director of the Nursing/Midwifery School at the French University had already implemented some of the recommendations, including the addition of family planning to the curriculum. The University would use the recommendations as guidelines in developing their new 2-year midwifery course.

The FPA conducted short family planning training courses for TBAs to equip them as motivators and distributors of simple contraceptive methods. They also conducted training and refresher courses for nurses and midwives. Both nurses and midwives inserted IUDs. The Association had 18 family health clinics and worked closely with the Ministry of Social Welfare in promoting family health. They planned to co-operate with the French University School of Nursing and Midwifery in their training programmes.

Jordan

Although the delegates had been unable to attend the Seminar, government officials had received the report and recommendations; comments on them were as follows:

1. A MCH/FP /Family Health project was due to begin shortly and personnel were being trained.
2. Family planning education was conducted in all 51 MCH centres. Services were available on request, because family planning *per se* was not officially recognized, but was accepted as a health measure.
3. Premarital medical checks were carried out.
4. Primary health care was a top priority; there was already a good nutrition programme.
5. There were training programmes for all MCH/FP personnel.
6. Health education was already included in medical, nursing and midwifery curricula.

TBAs had been trained and utilized. This had been stopped temporarily, but government planned to resume training and to register and license them. The midwifery curriculum compared favourably with the recommendations. The government was prepared to co-operate with any international organization to promote high standards of care in the reproductive services. They were interested in the new ICM/USAID project and asked for more information.

The School of Nursing and Midwifery had two midwifery training programmes – a basic two-year programme following 9 years' general education and a one-year postbasic course for trained nurses. The curriculum was revised annually and they would use the recommendations as guidelines for future revisions.

The FPA was promoting family planning as a health measure, not a means of birth control. There were 14 clinics in Jordan. The Ministry of Health had integrated family planning into health programmes. The Women's Union Association had organized short family planning training courses for their members and other women. I.E & C. was carried out via the media. They planned to develop family planning motivation, to work with the voluntary organizations and to participate in the Year of the Child.

The chosen delegates expressed continued interest and hoped that the new project might be applied in Jordan. The obstetric delegate had prepared four suggestions for consideration.

1. Upgrading of professional personnel by seminars and workshops.
2. Provision of incentives – pay, promotion and employment in MCH centres.
3. Supervision of TBAs through annual renewal of licences.
4. Make available necessary obstetric equipment.

Syria

The USAID representative was pleased with the recommendations and advised discussion of health problems with Ministry officials.

The Minister of Health suggested forming a committee to discuss the recommendations and to suggest implementation of those that were relevant. The new project was described and he promised to discuss this and all other matters with his assistants.

The Assistant Minister of Health – Director of General Training – said that:

1. Family planning would be offered as an integral part of MCH services.
2. There was a plan to provide every province with a training centre for MCH.
3. There were still a great number of TBAs in rural areas, and even some in towns.
4. Training – short and long MCH/FP training courses were given by WHO in Alexandria, Egypt.
   - government was planning to develop a training course for TBAs.
   - family planning would be included in the nursing and midwifery curricula.
   - a one-year course for assistant nurses was being planned, with MCH/FP as a major part of the curriculum.

   The existing midwifery programme was postbasic to nursing training. There were plans to revise this to emphasize family health aspects. A single certificate 2-year midwifery training course was proposed.

Visits were paid to:

1. MCH/FP Training centre. At present they gave practical training to medical students and to student nurses and midwives.
   Proposed activities included courses for health visitors (already prepared), auxiliary public health nurses and technical (assistant) midwives.
2. Nursing/Midwifery School (Ministry of Health). The Director had not received the recommendations although two of the delegates were members of staff. He promised to study them and to implement those that were relevant.
3. Syrian FPA. They had 8 clinics, 3 in Damascus and 5 in the provinces, and hoped to open 6 more next year. They conducted family planning training courses for medical, nursing and midwifery students. There were annual refresher courses for

Association staff. I.E. & C. activities were carried out. One clinic visited was very well attended and the staff overworked.

4. Assistant Director, Women's Union Association. They actively assisted the FPA in educational programmes, including literacy classes, health education and nursing classes.
5. The President, Syrian Nursing/Midwifery Association. She had been involved in the training of TBAs before the programme ended but was now strongly against their training and utilization because she wanted to stimulate government to recognize the need for more professional midwives.

The delegates had presented the report to the Ministry of Health but said that the recommendations had arrived late and they had been unable to discuss them with officials.

APPENDIX I

List of Participants

Delegates

Egypt

Dr. Mahmoud El Minawi MD,
Professor
Obstetrics/Gynaecology,
Faculty of Medicine,
University of Cairo,
Cairo.

Dr. Ahmed Abdel Wahab Mohsen,
Director-General of Health,
Dakahlia Medical Zone,
Mansoura.

Mrs. Naemat Abou El Saoud,
Nurse-Midwife
Director,
Kaser El Eini Secondary Nursing School,
Cairo.

Mrs. Farida Abou Metwali,
Nurse-Midwife,
Inspector,
Maternal and Child Health,
Fayoum Governorate,
Fayoum.

Mrs. Soad Embaby,
Nurse-Midwife,
Nursing Administrator,
Nursing Division,
Ministry of Health,
Cairo.

Lebanon

Miss Rose Bassile,
Midwife,
Supervisor,
School of Midwifery,
Faculty of Medicine,
University of Beirut,
Beirut.

Miss Wadad Abi Nader,
Midwife,
Social Counsellor,
Ministry of Social Welfare,
Beirut.

Sudan

Dr. Fadil Saeed,
Obstetrician/Gynaecologist,
Medical Office In Charge,
Maternity Centred Family Planning Project,
Omdurman Hospital,
Omdurman.

Dr. Zein El Nayal,
Senior Consultant,
Obstetrician/Gynaecologist,
Omdurman.

Miss Kaltoum El Agab,
Nurse-Midwife,
Matron,
Soba University Hospital,
Soba,
Khartoum.

Miss Fatma Killa,
Nurse-Midwife,
Midwifery Tutor,
College of Nursing,
Ministry of Education,
Khartoum.

Mrs. Elizabeth Ibrahim,
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Health Visitor,
Maternal and Child Health Dept.
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Syria

Miss Najla Moussa Diah,
Nurse-Midwife,
Nursing Instructor,
School of Nursing.
Ministry of Health,
Damascus.

Mrs. Zakieh Kurdi,
Nurse-Midwife,
Watani Maternity Hospital,
Aleppo Health Dept.,
Aleppo.

Miss Ibtissan Yahya Saada,
Nurse-Midwife,
Nursing Instructor,
School of Nursing,
Ministry of Health,
Damascus.

Observers

Sudan

Dr. Hassan Wahibi,
Obstetrician/Gynaecologist,
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Dr. Zuheir Ali Nour,
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Dr. Ibrahim El Amin,
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Dr. Mohamed Hassan Baldo,
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Miss Fatma Saleh,
Nurse-Midwife,
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Soba,
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Mrs. Sakina Abdel Gani,
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Reports Committee
Dr. Hamid Rushwan,
Miss Atiyat Abdel Ghafar,
Miss Rose Essile
Prof. Dr. Mahmoud El Minawi
Dr. Ahmed Abdel Wahab Mohsen
Miss Margaret Hardy
Mrs. Belinda Brohier.

APPENDIX II

List of Papers Presented

1.	The ICM/USAID Project	Miss F. Margaret Hardy Executive Secretary, ICM Assistant Administrator, ICM/USAID Project
2.	The Present Involvement of all Categories of Midwives and Traditional Birth Attendants in Reproductive Health and Family Planning	Dr. Ahmed Mohsen, Egypt Miss Waddad Abu Nader, Lebanon Miss Najla Mousa Diah, Syria Miss Fatma Keilla, Sudan
3.	The Expanding Role and Scope of Practice of all Categories of Midwives and Traditional Birth Attendants in Reproductive Health Service	Dr. Osman Modawi Director, Maternity Centred Family Planning Project, Ministry of Health, Sudan
4.	Family Planning as an Integral Component of the Curricula of all Categories of Midwives and Traditional Birth Attendants	Dr. Zein El Nayal Senior Consultant in Obst. & Gyn. Sudan F.P.A.
5.	Paediatrics: An Integral Component of the Curricula of all Categories of Midwives and Traditional Birth Attendants	Dr. Mahmoud Mohammed Hassan Senior Consultant Paediatrician Ministry of Health, Sudan
6.	Nutrition as Integral Component of the Curricula of all Categories of Midwives	Dr. George R. Wadsworth WHO Consultant, Nutrition Unit, Khartoum University, Sudan

7.	Expanded Involvement of the Midwife in Reproductive Health Care – Curriculum Development	Mrs. Awatif A. Osman Director, College of Nursing, Khartoum
8.	Continuing Education in Reproductive Health	Mrs. Muazzez Okay Chief Assistant Director Zeynep Kamil Health College (Midwifery School), Uskudar, Istanbul, Turkey
9.	Legislation Governing Midwifery Training and Practice in Egypt	Prof. Dr. Mahmoud El-Minawi Dr. Ahmed Mohsen Mrs. Naemat Abo-El-Saoud, University of Cairo, Egypt
10.	Legal Aspects of Midwifery in Sudan	Advocate G. H. Faris Khartoum
11.	Administration and Organization of Maternal and Child Health Services	Dr. Abbas Mukhtar Under-Secretary of Health, Khartoum, Sudan

ANGLOPHONE WEST AFRICAN INTER-REGIONAL SEMINAR ON HEALTH TRAINING, FREETOWN, SIERRA LEONE, 7th – 25th JUNE 1976.

Participating countries: The Gambia, Ghana, Liberia, Nigeria and Sierra Leone

Project Director: Miss Barbara Pattersen, ICM.

I Rationale

1. Many midwives, nurses and other health personnel in the field lack:
   (a) previous adequate training in family health;
   (b) knowledge of the demographic picture and its significance to the various countries;
2. The need to give information, motivation, education and assistance to doctors, midwives and nurses, because of their day-to-day influence and association with patients.
3. Because of the shortage of medical personnel, it is practical to harness the potential of midwives and nurses in the direct delivery of family health services in their expanded role. An immediate requirement, therefore, is to train midwives and other members of the health team responsible for providing MCH services. The aim of this three-week course was to achieve these objectives and to allow persons undergoing training to act as organizers of training programmes in their own countries.

The members of the health team having a role to play in this service are:

1. Members of all categories engaged in hospital and community work.
2. Medical officers engaged in hospital and community practice.
3. Public health nurses, health inspectors and field workers.
4. Auxiliary nursing and medical personnel.
5. Health centre midwives and nurses.
6. TBAs.

It is impossible to train all categories simultaneously because of:

1. Differences in roles and needs of the persons to be trained.
2. The numbers involved.
3. The coverage of clinics, hospitals and community during training.

Priority will be given to:

1. Midwives in the capacity of supervisors, senior members of staff,

and those who have received training in family health because of their influence on other categories of the team, and the need to use their training to national and regional benefit.

2. Medical officers with or without family health training because of their role as leaders of the team as well as their influence on staff and patients.
3. Field workers and health centre midwives and nurses because of their role in the delivery service.

It is accepted that some midwives have had some training in family health, but in view of their expanded role and the emphasis on maternal and family health, there is need to utilize those already trained and to train others who have not had any experience in the subject.

II Overall Objectives

At the end of the training course all participants with responsibilities in the delivery of maternal and family health services will be equipped to function more effectively in this particular field and will be able to train others in their local setting.

III Contributory Objectives

At the end of the course the participants will have:

1. Knowledge of fundamental population principles and their significance.
2. Awareness of the importance of family health to West Africa in terms of available resources and quality of life.
3. Knowledge of the objectives of family health.
4. In-depth knowledge of contraceptives – technology and methodology.
5. Awareness of the participants' role and responsibilities in family planning and effective counselling.
6. Knowledge of the importance of statistics in maternal and family health.
7. Knowledge of management principles with special emphasis on the role of leadership and planning.
8. The importance of evaluation.

IV Preliminary Visits, March/April 1976

(a) *Objects of the visits*

1. To ensure from the Ministry of Health that Sierra Leone would be the host centre.

2. To meet other Ministry of Health personnel, executive members of the Sierra Leone Midwives Association and the planning committee to discuss the programme in detail.
3. To make necessary arrangements for the Seminar and to discuss financial problems.
4. To meet nominated participants from Sierra Leone, Liberia and The Gambia.

(b) *Activities*

1. **Sierra Leone**
   (i) It appeared that, although no official reply had been received, Sierra Leone was undoubtedly intending to act as host to the Seminar.
   (ii) It was agreed that the inclusion of two doctors from the Obstetric unit as participants would be desirable.
   (iii) The draft programme was discussed. The need for more discussion sessions rather than lectures was stressed. The division between theoretical and practical sessions was agreed.
   (iv) Accommodation for the meeting and for the participants was arranged.
   (v) Visited clinics that would be used for practical sessions.
   (vi) Members of the Sierra Leone Midwives Association were informed of progress; they promised their support.
   (vii) Visits were paid to the British High Commissioner's Office, to Mrs. Comfort Akrofi, WHO Nursing Educator, to the PPA and WHO offices.
   (viii) It was learned that a three-week training course was in operation for TBAs and 30 were in training. Three nursing sisters were responsible for training; nutrition and family health were included. Financial assistance for training was asked for.
2. **Liberia**
   (i) Discussions at the Ministry of Health and Social Welfare centred on criteria for selection of delegates. The delegates were seen and briefed. Neither had ever been outside Liberia and they were very enthusiastic at the prospect of attending the meeting.
   (ii) Visited the FPA. Much progress had been made in the acceptance of family planning in the past year.
   (iii) Had discussions with Mrs. Bermadia, midwife in the Family Health Division, Ministry of Health, and responsible for training TBAs. She described changes in nursing and midwifery then taking place in Liberia.

3. **The Gambia**
   (i) Two of the three delegates were seen and briefed.
   (ii) Visited the School of Nursing and met Chief Nursing Officers for Sierra Leone and Ghana who were on an official visit to arrange exchange programmes. A lively discussion took place between them and trained and student nurses, which revealed good prospects for inter-regional co-operation in family health.

4. **General**
   (i) Regional reciprocity in health matters had been fostered by the Anglophone West African Working Party in Ghana in 1972.
   (ii) The response to the Family Health Training Seminar was encouraging despite lack of government policy on family planning in some countries.
   (iii) It was hoped that 24 participants would attend the Seminar, including the two MCH doctors from Sierra Leone.

V Objectives of the Seminar

(a) To provide training in Family Health.

(b) To prepare health personnel who contribute positively to national health and family welfare.

(c) To further stimulate an awareness of their expanding role as members of the health team.

(d) To develop the skills in communication, supervision, counselling and administration.

(e) To enable participants to act as trainers and organize training courses in their own countries.

(f) To further recognize the need for good inter-personal relationships.

(g) To develop practical skills through clinical sessions for the direct delivery of Family Health and Welfare services.

VI The Seminar

(a) ***Attendance.*** Those attending comprised:
25 participants from The Gambia (3); Ghana (3) (1 supported by Ghana Medical School); Liberia (2); Nigeria (2); Sierra Leone (15).

(b) ***Summary of proceedings***

1. The Opening Address was given by the Hon. Mr. J.C.O. Hudson Taylor, Minister of Health, and the Keynote Address, on *The Role of the Mid-wife in the Community in Developing Countries,* by Mr. Charles H[illegible]ling, FRCOG, Specialist Consultant in charge, Princess Chr[illegible]ian Maternity Hospital, Freetown, Sierra Leone.

2. The working programme consisted of Group Discussions, Lectures, Programme Planning, Role Playing, Clinical Sessions and Field Trips, Film Shows, Post-Training Assignments and Evaluation.

Group Discussions centred on two topics:
(i) It is widely recommended that TBAs should be accepted as members of the health team,
(ii) It has been argued that adequate nutrition contributes to the good health of the family,
and led to an exchange of information and expression of the views of the participants.

Lectures took on average one hour, with an extra 15 minutes for questions. Lectures on contraceptive methods and on administration and management were given 2½ and 3 hours respectively. A full list of lectures and speakers is given in Appendix II.

Programme Planning. The community was responding poorly to family planning. The community leader discussed the problem with the nurse-midwife superintendent of MCH/FP services and invited her to work out an educational programme for the promotion of family planning. Nursing, midwifery and auxiliary health personnel had to be involved.

Role Playing. Two types were chosen:
(i) Showing how a midwife counselled and assisted a very worried and extremely anxious client at a Family Health Clinic.
(ii) Showing how a midwife counselled a very difficult and aggressive client who had had six children and was desperate to have help at the Family Health Clinic.

Field Trip. This took the participants to Port Lokko in the Northern Province. A programme was planned by the Medical Officer and District Officer which included a conducted tour of the Maforki Self Help Projects, the Mange Burch Bridge – a modern bridge built by Chinese engineers – and the Planned Parenthood Clinic where participants saw the staff at work and had the opportunity of meeting a good number of clients and answering questions put to them.

Film Shows. The following films were shown:
(i) The Future of us all.
(ii) Techniques of Contraception.
(iii) Human Reproduction.
(iv) Avenues to Change.

They were borrowed from International Audio-Visual Resource Service through the auspices of IPPF, London.

Post-Training Assignments. As the participants' area of practice varied, different post-training assignments were allocated. The participants were expected to send a report to the Project Director in London, on one of the six areas listed, during the three months following the Seminar. The six areas were:

(i) The number of family planning acceptors recruited through your efforts.

(ii) The number of educational classes organized and conducted - where and for whom.

(iii) Promote the inclusion of family planning in the basic midwifery curriculum.

(iv) If already working in MCH/FP clinics, what actions have you promoted or recommended to improve service, clinic attendance and continued practice of family planning.

(v) If you are a nurse-midwife working in a hospital which has no family planning clinic, what have you done to bring family education and/or service into the hospital.

(vi) What measures you have adopted to ensure that members of your clinical staff understand the important need of family planning information, education and communication and extend this through face-to-face motivation in the clinics and during home visits.

VII Analysis of Evaluation Questionnaires

Q. Was the curriculum well developed?

A. Well developed – 18; fairly well developed – 7.

Q. What did you think of the curriculum content?

A. Socio-economic and health aspects of family planning. Good – 25.
Contraceptive techniques. Good – 21; Fair – 4.
I.E. & C. Good – 25.
Administration and Management. Good – 25.

Q. Were the Role Playing and Programme Planning sessions helpful?

A. Yes – 25.

Q. Has this training prepared you for your future work?

A. To work independently – 17; under supervision – 8.

Q. Has this training provided you with sufficient knowledge to function as a trainer?

A. Of professional midwives – Yes – 1; No – 2.
Of TBAs – Yes – 9.
Of both – Yes – 12.

General comments (numbers making the comments in brackets)
Congratulations and thank you (8).
Feel the need for more practical experience with IUDs (1 suggests 3 weeks) (7).
Well organized seminar (5).
Will help to improve future work (4).
Stimulating experience to meet colleagues from other countries (3).
Too hectic; day very long and tiring (3).
Since programme was supposed to be on Family Health, the whole family should have been included (also nutrition, prenatal care, etc.) (2).
Time too short and should not be done in the rainy season (1).
Needed more time for questions and answers (1).
Needed more time for role playing and programme planning (1).
Could have been done in a shorter time (1).
Got little knowledge of family planning (1).
One free afternoon a week should be given (1).
Would have liked a model for each participant to take home for practice (1).
Have another seminar in Sierra Leone between January and April (1).
Transport facilities should be provided to be able to reach people (1).
Family planning should be included in the hospital set-up (1).

VIII Comments on Post-Training Achievements

Nineteen reports were received. Comments on 18 of these are as follows:

1. Has the right aptitude and much dedication.
2. Has right approach but does not have the co-operation of the obstetrician she works with. She has tried hard to promote FP education but progress is not very encouraging as there still seem to be barriers to FP acceptance. FP service is also not readily available.
3. Her IUD clients have no complaints.
4. Has conducted educational classes for 63 prenatal clients and 18 husbands.
5. In her capacity as private practising midwife she has done much and will do more.
6. She suggested the promotion of FP clinics and education within the hospital.
7. Government taken over FP training/work. Pupils taught.
8. Conducted educational classes for hospital staff to prepare them to be FP motivators. Feels very strongly about wastage of FP trained personnel.

9. Promotion of MCH/FP education is given top priority by her.
10. Is taking every opportunity to deliver FP service.
11. Is trying to get FP organized in the hospital.
12. Recommends that additional FP clinics should be organized.
13. Her main responsibility is supervision, but she conducts motivation of difficult cases as well.
14. Post-training assignment commenced 6 months after the Seminar, but she was seriously ill soon after the training. Good achievement so far.
15. She took every opportunity to promote FP and I. E. & C.
16. She has requested a FP clinic to be attached to the hospital in order to provide clinical practice for the students (enrolled nurses/ midwives). She has recommended integration of family planning as an integral part of the midwifery curriculum.
17. Makes valuable contribution in the area of training in FP services. During mid 1976–early 1977 conducted two training courses for periods of four and ten weeks respectively. The participants comprise all the members of the health team in numbers of 12 and 13 in each group. The training of TBAs continues, as well as of their trainers. Assists in the preparation of manuals for TBAs and the Trainers of TBAs.
18. Letter of 26/8/77 in response to Project Director's second reminder revealed nothing with regard to post-training assignment. Letter of 5/9/77 requests that participant informs HQ as soon as some achievement is made towards the post-training assignment.

APPENDIX I

List of Participants

Sierra Leone

Mrs. Edna Carew
c/o 32 Pademba Road
Freetown

Mrs. Sylvia Bassie
c/o The Government Hospital
Kenema, Eastern Province

Mrs. Adama Dimoh
c/o P.C.M. Hospital
Fourah Bay Road
Freetown

Mrs. Sarah Keister
c/o Government Hospital
BO – Southern Province

Mrs. Lois Fallah
c/o Government Hospital
Magburaka – Northern Province

Mrs. Eunice Randall
c/o Koidu Government Hospital
Kono-Eastern Province

Mrs. Nora Bell
c/o Government Hospital
Makeni, Northern Province

Miss Laura Lewis
c/o Lumley Health Centre
Freetown

Mrs. Euphemia Macauley
21 Guy Street
Freetown

Mrs. Ethel Smith
4 Malta Street
Freetown

Mrs. Jestina Stanley
49 Naimbana Street
Freetown

Mrs. Sarah Kamara
1, Williams Street
Freetown

Mrs. Iona Shanu-Wilson
c/o 53 St. John Street
Freetown

Miss Lois Vincent
c/o 34 Macauley Street
Murray Town
Near Freetown

Mrs. Sarian Aboko-Cole
c/o Lake Street
Freetown

Ghana

Mrs. Victoria Abbeyguaye
Midwifery Training School
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Atisie, – Mpreso

Mrs. Lucy Osei-Kofi
Midwifery Training School
P.O. Box 81
Accra

Mrs. Mavis Beatrice Amonoo-Acquah
c/o Ghana Medical School
Accra

Liberia

Mrs. Dorothy Cooper
Gbarnga Bong
Country Monrovia
c/o Emson Realy
Box 31

Mrs. Annie Johnson
Lower Buchanan
Grand Bassa Co.
c/o Liberia Government Hospital
Bassa

The Gambia

Mrs. Bertha H. M'Boge
M.C.H. Project
Ministry of Health
Banjul

Mrs. Awa Jallow
c/o Family Planning Association
Banjul

Miss Olga S. Roberts
33 Grand Street
P.O.Box 162
Banjul

Nigeria

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153 Tolunboh Street
Lagos

Mrs. Florence Bade Falodun
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Rumens Road
Ikoyi – Lagos

APPENDIX II

Lecture Headings and Content Breakdown as per speaker

LECTURES	CONTENT BREAKDOWN
1. The importance of Family Health Services in the Community DR. MOIRA BROWNE	Housing, educational facilities, environmental hygiene, family planning, primary health care, occupational health care and psychiatric care.
2. The Socio-Economic and Cultural factors that influence family health. MR. EDWOW HYDE	Housing, education, customs, beliefs, myths, poverty, superstition, unemployment, unplanned families and fear.
3. Religious beliefs and attitudes towards family planning REV. LESLIE SHYLLON	Misconception of religious teachings, establish "No religion is anti family planning". The purpose of marriage and procreation. Parental responsibility.
4. Contraceptive Technology. DR. MARJORIE NICOL	History, overview of methods, recent advances, advangages, disadvantages, effectivity, use, abuse, contra-indications, side-effects, effects of hormones on lactation and nutrition and the place of contraceptives in and outside marriage. Problems of abortion and sterilization.
5. The Traditional Birth Attendant in Maternal and Child Health and Family Planning. DR. BELMONT-WILLIAMS	The TBA's status in her Community, her present role and functions. Expansion of her functions and her involvement as a valuable member of the health team. Special emphasis should be placed on training, supervision and her specific tasks.
6. Demographic considerations the planning of a Family Health Service DR. OKERE	Historic background, vital statistics, migration – external, internal (rural/urban drift). Problems which ensue.

7.	The training of the Midwife for Family Health and Welfare MRS. C. AKROFI	Tasks, training needs, and objectives, knowledge and skills required to perform tasks. Evaluation. Continuing education.
8.	Problems of contraceptive methods DR. D. JARRET	Physiological problems with hormonal contraceptives; effects of prolonged or uninterrupted use of oral pills or injections; rejection of foreign body for example – IUD and its effect on the uterus. Social, Psychological and emotional aspects of abortion and sterlization.
9.	Management of Gynaecological disorders. DR. G. B. FRASER	Vaginal discharges, erosions, positive PAP smear, pelvic masses, polyps, warts, pelvic inflammatory diseases. Referred cases.
10.	Preventive Medicine in developing countries DR. G. D. CAGE	Scourges of the past/present health standards. Family planning, maternal child health care, Environmental health care, control of communicable diseases and health education. Modification of health programmes to meet urgent needs.
11.	Screening techniques DR. A. AUBEE	Normal and abnormal conditions. Guidelines for referring cases.
12.	Principles and techniques of Health Education MR. S. K. LEWIS	Human behaviour, its relationship to inter-personal rapport. Message, language, target audience, cultural factors affecting response to Health Education. Educational aids and mass media.
13.	Utilization of local foods. MRS. ARYATTA	Comparison of local and imported foods in terms of nutritional values and costs. List of available local foods, promotion of home gardens and advice on practical crops for domestic growing. Preservation of foods – bottling, drying, smoking and so forth.
14.	Modern concept in Paediatrics DR. TAGI	Feeding, growth and development (physical and emotional).

15.	Nutrition of the pre-school child. MRS. S. C. YILLA	Nutrients necessary for the promotion of physical and mental growth. Malnutrition or sub-nutrition and its relationship to retardation and diseases.
16.	Inter-personal communication and motivation. MR. JOSEPH FINDLAY	Human relations; general attitudes to self, colleagues, staff and client. Working singly, in groups and concept of teamwork. Principles and techniques of interviewing and counselling. The midwife or the nurse as an agent of change.
17.	Data collection and statistics MR. CARR	Purpose of data collection. Procedure – simple and meaningful. Collected data as material for research.
18.	Parenthood in relation to family planning DR. J. C. O. VINCENT	Purpose of marriage, parenthood, husband/wife relationship, parent/child relationship. Definition of responsible parenthood; husband's responsibility to wife and vice versa. Parents' responsibility to their children.
19.	Cultural clashes in Family Planning. DR. T. KARYBO	Patriarchal society "To have a son is a must" and he is the dominant factor. Influence of society, family and community elders. Concept of large families as a means of "wealth" for the future. Family Planning is sex related therefore taboo for open discussion; "Provision from God" hence large families. "It is a woman's duty to mother and care for children."
20.	Heredity diseases in Family Health. DR. ELEADY COLE	Effects on individuals, family, community, and country. Role of family planning in the reduction of hereditary diseases.
21.	Sickle cell disease DR. KNOX MACAULEY	Relate this in terms of Family Planning and Health.

22.	**Social welfare work in Family Health** **MRS. NJGE**	Housing, schools, community centres; programmes for out of school youths such as leadership training, preparation for adulthood, causes of juvenile deliquency. Adult education and family health education.
23.	**Administration and Management** **MISS BARBARA PATTERSON**	Management Principles; role of supervisor and follow-up; assessment of programme/organisational needs; stating objectives. Resource identification and utilization (human, financial, material, organisational, institutional or communal) Use of results of assessment (evaluation)
24.	**Clinical Sessions**	A) Knowledge of human reproductive systems — organs & functions, related physical and emotional developments. Fertility, infertility and sub-fertility. Human Sexuality. B) Clinic Procedures: Physical examination of breasts (for teaching clients) abdomen, pelvis, legs, PAP Smear (taking) IUD insertion, removal and recognition of pelvic contra-indications for IUD insertion. Management of gynaecological disorders.
25	**Clinical session contd.**	Referrals — what type of cases: Tubal ligation, V.D., sub-fertility/infertility, abortion. Procedures for referrals where to refer cases to i.e. what agencies are available.

WEST ASIA INTER-REGIONAL SEMINAR ON FAMILY PLANNING INFORMATION, EDUCATION AND COMMUNICATION TRAINING FOR MIDWIVES, DACCA, BANGLADESH, 20th – 30th NOVEMBER 1976.

Participating Countries: Bangladesh, Nepal, Sri Lanka.

Field Director: Mrs. B. Brohier, ICM.

I. Rationale

Practically all the countries which participated in the East and West Asia Working Parties have national family planning programmes with the built-in support of organized information, education and communication (I.E. & C.) programmes which utilize the various mass media channels such as radio, T/V, magazines, newspaper and so on.

National family planning administrators have recognized the need for specially trained I.E. & C. personnel for the national I.E. & C. programmes.

I.E. & C. through the mass media provides the masses with information and education but it has a very limited influence on attitude change e.g. mass family planning I.E. & C. programme of a country brought awareness and knowledge to about 95% of the eligible population but only 35% of these accepted to practise family planning.

It has been accepted that face-face contact is the most effective method of information, education and communication; hence the development of a category of family planning workers – the "family planning motivators".

The midwives, due to the nature of their work come in constant face-face contact with their clients and the people they serve in the community. It is not surprising, that they are classified as the mothers' friends, teachers and counsellors. These assets qualify them as the most appropriate agents to promote family planning I.E. & C. and to deliver family planning services.

Their family planning training is mainly oriented to the clinical aspects and very little emphasis on I.E. & C. Consequently the family planning trained midwives emerge as expert clinicians but weak educators. Thus their potentials as educators are not fully utilized and in addition they will not be able to assist, advise family planning motivators and clinical staff and/or organize appropriate I.E. & C. programmes at the clinic, home or community level.

The proposed two weeks Inter-Regional Seminar on Family Planning I.E. & C. Training for Midwives would bring into being a core of

I.E. & C. trained midwives within the West Asia Working Party Region. The participants on their return would promote similar training courses for their colleagues, function more effectively as family planning educators and supervisors of family planning motivators.

II. Objectives

The training programme will provide the participants with:-

1. The philosophy of family planning.
2. A comprehensive knowledge of Family Planning Information, Education and Communication (I.E. & C.) which will enable them to identify their role as family planning educators.
3. The ability to promote a positive rapport with their clients which will help in the motivation of their clients.
4. The ability to plan and organize simple educational programmes at the clinical, home and community level.
5. The ability to prepare simple educational aids with available resources; to make correct selection of educational aids and to use these objectively.
6. The ability to understand the importance of sustained educational or motivational programmes i.e. to evaluate educational programmes with the view of stepping up effectively, identifying areas of weakness and to introduce re-inforcement of the programme concerned.
7. The ability to understand the purpose of evaluation, the importance of feedback and how to utilize the result of evaluation for the promotion of a more effective programme.
8. The ability to assist and advise clinical and field personnel in family planning I.E. & C.
9. The ability to conduct basic family planning I.E. & C. training for midwives, traditional birth attendants and health auxiliaries.
10. The ability to appreciate the various barriers to family planning acceptance and to utilize these as basis to develop motivational approaches.

III. Preliminary Visits, August/September 1976

(a) *Nepal*

1. *USAID Population Officer*

   The purpose of the visit was discussed and the Inter-Regional Seminar explained. He talked of the activities of the MCH/FP project and said that AID would probably sponsor midwives for further training at Downstate.

2. *Ministry of Health*

   The selection of participants was discussed with the Director-General of Health and with the Director of Training and the Chief Nursing Aministrator (CNA). The programme of the Seminar was discussed with the heads of the MCH/FP Project.

The CNA proposed to hold four Seminars in 1977 for midwives and public health nurses and asked for advice and guidance on programme planning. Dr. Thapa asked if a Seminar could also be arranged for auxiliary nurse-midwives operating in the districts.

The Berkeley training project for trainers for village health workers was discussed and it was suggested that trainers of MCH/FP midwives might join the training programme.

(b) ***Bangladesh***

1. A WHO national seminar on MCH/FP had been arranged to coincide with the Inter-Regional Seminar. Although it was suggested that these might be combined it became obvious that the objectives and participants were so different that it was better for the two meetings to stay separate.
2. A local organizing committee was formed and its functions agreed.
3. All arrangements for the Seminar were finalized as far as possible.
4. Discussed with the UNFPA representative the problems encountered by WHO's Family Adviser in revising the training programme for family welfare visitors. Help was asked for and promised when the reporter returned to attend the Seminar.
5. The formation of a midwifery branch within the Nurses Association had not progressed because of mutual opposition between nurse-midwives and lady health visitors. The position was discussed and it was hoped that the lady health visitors would understand the situation and agree to help to form a group.

(c) ***Sri Lanka***

1. Discussions about the selection of participants showed that this time appropriate choices had been made.
2. The Family Health Bureau offered assistance in the project, and some areas where help was needed were listed.
3. The status of midwives was extensively discussed and the need for the formation of a professional Association stressed.

IV. The Seminar

This Seminar was primarily planned for midwives (LHVs) and nurse-midwives who were trainers of MCH/FP personnel, auxiliary midwives (FWVs) and other personnel to equip them with better knowledge and skills in Family Planning Information, Education and Communication (I.E. & C.) so that they could impart what they had learned to their students. Unfortunately not all the delegates were trainers, but it was observed that some of the non-trainer delegates also benefited from the Seminar.

(a) ***Attendance***

The total number of participants was 17, made up of four from Nepal, five from Sri Lanka, and five delegates and three observers from Bangladesh.

Of the four Nepalese delegates, one was from the national FP/MCH Project, slightly involved in the training of MCH/FP workers. The remaining three worked in hospitals – maternity and general – where there were some family planning education programmes. Two of the three could hardly understand English, so that the Seminar was of little benefit to them. In addition, they arrived late – three by two days and one by three days. Those who had some command of English did not have much problem in absorbing the missing lectures.

The Sri Lanka delegates arrived one day late. Although they were not MCH/FP trainers, they worked in FP clinics in the hospitals and health centres and were actively involved in education and motivation. The Seminar helped them to improve their techniques of interviewing, counselling and communication.

The Bangladeshi delegates were nurse-midwives and lady health visitors, (midwives), who were trainers of the family welfare visitors (auxiliary midwives). The majority of them understood English, but had difficulty in expressing themselves because of lack of practice.

The Bangladeshi observers were Principals of Training Schools for FWVs.

(b) ***Summary of Proceedings***

1. ***Opening Session***

Government officials from the various Ministries, representatives of International Organizations, USAID, Voluntary Organizations, Nursing Council and Nursing Association were invited.

Dr. Shamsun Nahar, Chairman of the local organizing committee, chaired this session and delivered the Welcome Address.

Dr. Mohd. Ibrahim, Adviser (Minister) Population Control/ Family Planning Division, Bangladesh, gave the Opening Address, stressing the important role the midwives (LHVs/FWVs) played in the national health programme: primary health care, MCH and family planning. He pointed out the importance of good training for all midwives to enable them to deliver health services inclusive of MCH and family planning to the rural women and their families. He strongly emphasized the importance of nutrition and child spacing in maternal and child care.

The midwives, he said, had much to contribute to the health programme, particularly in the field of maternal and child health and family planning. This Seminar could help them to work more efficiently and effectively. He thanked ICM for organizing the Seminar and declared it open.

Mrs. Belinda Brohier, Field Director, ICM, spoke briefly on the ICM/USAID Project.

2. ***Training Methodology***

i. ***Pre-training questionnaires.***

The object of this exercise was to assess the delegates concept of FP I.E. & C., their participation in such programmes, their views on mass I.E. & C. and the promotion of family planning as one of the most important functions carried out by midwives.

The questions asked were:

1. What do you understand by family planning I.E. & C.?
   Ans. 10 understood very well, 4 fairly well; 1 did not understand the question.
2. Do you agree that the promotion of family planning I.E. & C. should be one of the most important functions carried out by midwives?
   Ans. All 15 agreed – yes.
3. Do you think that mass family planning information, education and communication programmes have much influence on the changing of attitudes?
   Ans. 6 thought they had and 9 thought not.
4. Have you been responsible for planning and conducting education programmes at the clinic, home or community? If you have, were you satisfied with your performance and achievements? It not, please explain your reasons briefly.
   Ans. 13 had been and 2 had not been responsible for planning such programmes.
   8 were satisfield with their achievements and 3 were not.

Reasons for dissatisfaction

1. Problem of no medical and clinical supplies; irregular contraceptive supplies; family planning workers could not differentiate between eligible and non-eligible women; people were so poor and needed medical help very much.
2. Follow-up of motivation was very necessary because the village people were so poor; they were very interested in the educational programme of MCH/FP but did not accept the practice after they got home.

3. Educational programmes were not successful because of poor communications (transport); poor co-operation among clinic staff; the motivators were not sufficiently trained and often gave the wrong information to clients; the clients became confused if outsiders (from Dacca) tried to give them correct information and education.

ii ***Presentation of papers***

Speakers spoke to their papers rather than delivering them as straight lectures. Important points were highlighted. The participants (delegates and observers) were requested to ask questions and the issues were discussed by the speakers and participants. After each session, the relevant subject paper was distributed.

iii ***Learning exercises***

Group discussion, role playing and simple project planning were exercises which provided the trainees with the opportunity to put into practice the knowledge they had gained from the various lectures and the skills they had acquired. Learning by doing has been proved to be a more effective method of learning.

Role playing is an exercise which helps the trainees to interpret what they have learned and demonstrate their understanding of the knowledge and skills they have acquired, such as the art of interviewing, counselling and communicating, and the importance of inter-personal relationships between client and worker, the importance of feedback for programme evaluation and the need for systematic follow-up services.

The participants were divided into three groups each of which elected its own Chairman and Rapporteur who were responsible for finalizing group reports. The Chairman presented the reports of the exercises to the other two groups and the resource persons for comment.

The experience of being group chairman and rapporteur provided the trainees with the opportunity to develop as leaders, decision makers and public speakers. In addition they gained confidence in themselves. Eighteen hours were given for these exercises.

Comments: The delegates had had no previous experience of such exercises so they had some difficulty during the first group discussion.

The Field Director, ICM, provided guidance and assistance by demonstrating the steps to be taken in the preparation of the

subject to be discussed, how the report was prepared, and the actual presentation of the report.

The first discussion report was rather disjointed, the presentation poor, the delegates highly nervous. The second and subsequent presentations were markedly improved and the delegates encouraged to keep on improving. Their confidence in themselves was gradually growing.

Project planning proved to be extremely difficult for them as they had no opportunity to experience this kind of exercise. To overcome the problem, The Director, Service Delivery and Training, Population Control/Family Planning Directorate, who had been invited to observe the presentation of the planned projects, and the Field Director, ICM, assisted the delegates by demonstrating the step by step measures taken to plan the requested project. The demonstration was given in the form of role playing by two delegates with comments and support from their colleagues. The outcome of this exercise was not as good as expected, but it was felt that the delegates had obtained some benefit.

iv ***Field practice***

Thirteen hours had been allocated for the following:

1. Promotion of MCH/FP I.E. & C. during home visiting.
2. Group talks on MCH/FP in postnatal clinics.
3. Delivery of an educational talk at the community level on MCH/FP, breast feeding, the importance of continual contraceptive use.

However, field practice was in the event not given because:

1. There were language problems, the foreign delegates could not communicate with the Bengali village women.
2. The Bengali delegates were not able to interpret successfully as they were not sufficiently fluent in English to do so. Thus there would have been a tremendous breakdown in client/worker communication.
3. The village women were not used to large numbers of foreign visitors and could have reacted apprehensively.
4. The time allocated would not have been gainfully utilized.

After considering the above, it was decided to write off the actual field practice and use the time available by conducting field practice in the form of classroom exercises, which proved satisfactory. Most of the delegates had had some experience in field practice, some more than others, but they needed the knowledge and skills to conduct their field practice more effectively – shown by more acceptors of

MCH/FP, and eventually better health care and services for the rural population.

The classroom exercises in field practice demonstrated the correct approach to clients, the techniques of conducting home visiting, the techniques of effective I.E. & C. through face-to-face contact, the importance of empathy and respect and of identifying themselves with their clients.

Comments: Despite the reasons given for cancelling field practice, some of the foreign delegates were disappointed as they could not appreciate the difficulties which they would encounter during their interviews with their clients, such as breakdown of face-to-face communication between themselves and the Bengali village women. At the end of the Seminar they visited a rural health centre and on the way they were shown a couple of villages.

V. Recommendations

The delegates and observers made the recommendations. The Chairman and Co-Chairman, Local Organising Committee and the Field Director, (International Confederation of Midwives) assisted in the working of the recommendations as their English is not sufficient in these areas.

The group recommended that:–

1. The contents of the various training curricula be fully implemented i.e. discussions, role playing and project planning such as preparation of group talks, techniques of face-to-face communication. The Sister Tutors and Trainers should assist and guide the students by demonstrating to the students how the various exercises can be developed and conducted. These demonstrations should be done before the students go out for field practice.
2. Subject papers should be distributed to the students prior to the actual session. This will help them to benefit from the lectures and participate more actively during the post lecture discussions.
3. All training schools should be supplied with equipment and facilities for the preparation of lecture papers for distribution to the students. Clerical staff and office attendants should be employed and trained to manage the office equipment efficiently for example duplicating machines, and typewriters; and maintain the equipment in good condition. Spare parts should always be available.
4. All International Seminars, Conferences and Congresses are usually conducted in English. Technical books and reference books are mostly in English. The students lose very valuable knowledge because they cannot use them. Nurses, Lady Health Visitors and Family Welfare Visitors (Midwives/Auxiliary midwives) should all

be encouraged to practise speaking English.

5. Lady Health Visitors (LHVs) and Family Welfare Visitors (FWVs)/ Midwives should be kept up-to-date with modern advances in midwifery and health sciences particularly in the field of MCH/FP. These can be provided in the form of refresher courses, in-country training seminars similar to the one we are attending or the LHVs and FWVs be given the opportunity to attend such seminars overseas.
6. To enable the Bangladesh LHVs/FWVs (Midwives/Auxiliary Midwives) to function effectively and efficiently, hospitals, health centres, and rural clinics should be adequately and continuously supplied with the necessary commodities such as clinical equipment, medical supplies, drugs, dressings and contraceptives. Government (Population Control/Family Planning Division) should provide these essentials if the PC/FP Programme is to succeed.
7. Educational and motivational services should be complemented with parallel clinical services, as they are inter-dependent. Neither can be effective without the other. Some incentives must be promoted to attract young doctors to offer part-time services. They will be happy to gain family planning experience if suitable remuneration is given.
8. The Bangladesh delegates recommended that practical field training should be conducted in the rural areas nearer the training schools. The government should equip these rural clinics as demonstration training centres for rural field practice.
9. a. LHVs/FWVs (Midwives/Auxiliary Midwives) should be well trained i.e. be well equipped with the knowledge and skills for the work they are expected to do.
   b. There should be continuous supervision to help the field staff improve their standard and the standard of the services provided by them.
   c. Supervisors must be trained if supervision is to be effective.
10. Feedback from the field staff should be utilized for programme changes, evaluation and/or improvement.
11. The LHVs/FWVs (Midwives/Auxiliary Midwives) in Bangladesh must unite and form professional midwifery associations and elevate their status in society. They can request government to recognise their contribution to the nation and provide them with a working scheme like other government officers i.e. salary scale, grading and promotional opportunities.

VI. Analysis of Evaluation Questionnaire

Two of the Nepalese delegates could not understand the questionnaire and therefore could not give answers, even after their colleagues had explained the questions in Nepali.

The following analysis is of answers by 12 delegates and 3 observers.
N.B. Please indicate your answer with "X" in the appropriate space.

I. Was the curriculum	a. Well developed	12	
	b. Fairly well developed	2	14/15
	c. Poorly developed		

If your answer is 'c', please give your comments and suggestions:
one unanswered.

II Curriculum Content

1. Family Planning I One unanswered Seven late arrivals	a. Good	7	
	b. Fair		7/15
	c. Poor		
2. Family Planning II Three late arrivals	a. Good	12	
	b. Fair		12/15
	c. Poor		
3. Problems in FP Communication Three late arrivals	a. Good	11	
	b. Fair	1	12/15
	c. Poor		
4. Role of MCH/FP Trainers 3 blanks - late arrivals	a. Good	11	
	b. Fair	1	12/15
	c. Poor		
5. Infertility & Sub-fertility 4 blanks - 3 late arrivals 1 unanswered	a. Good	11	
	b. Fair		11/15
	c. Poor		
6. Early detection of Cancer as part of MCH/FP Service 3 blanks - late arrivals	a. Good	10	
	b. Fair	2	12/15
	c. Poor		
7. Techniques of Contraception I 1 blank - late arrival	a. Good	14	
	b. Fair		14/15
	c. Poor		
8. Techniques of Contraception II 1 blank - late arrival	a. Good	13	
	b. Fair	1	14/15
	c. Poor		
9. Simple endocrinology 1 blank - late arrival	a. Good	6	
	b. Fair	7	14/15
	c. Poor	1	

10. Psychological, Socio-Cultural and legal implications of abortion and sterilization. 1 blank - late arrival	a. Good b. Fair c. Poor	9 5 	14/15
11. Information, Education and Communication 1 blank - late arrival	a. Good b. Fair c. Poor	13 1 	14/15
12. Principles and techniques of learning and teaching. 1 blank - late arrival	a. Good b. Fair c. Poor	14 	14/15
13. Principles of planning and organising educational programmes	a. Good b. Fair c. Poor	10 4 1	15/15
14. The Midwives as MCH/FP motivators	a. Good b. Fair c. Poor	13 2 	15/15
15. Audio visual aids	a. Good b. Fair c. Poor	7 8 	15/15
16. Human relations	a. Good b. Fair c. Poor	12 3 	15/15
17. Principles of interviewing and counselling	a. Good b. Fair c. Poor	13 2 	15/15
18. Barriers to family planning acceptance	a. Good b. Fair c. Poor	13 2 	15/15
19. Importance of follow-up of contraceptive users and system of follow-up services.	a. Good b. Fair c. Poor	15 	15/15
20. Integration of family planning and pre-natal education	a. Good b. Fair c. Poor	12 3 	15/15
21. Evaluation and Importance of feedback for programme improvement	a. Good b. Fair c. Poor	15 	15/15

If your answer to any of the above is 'poor', please give your suggestions and comments.

III	Do you find the sessions on Discussion, Role playing and Project planning	a. Helpful	15	15/15
		b. Fairly helpful		
		c. Not helpful		

If your answer is fairly helpful or not helpful, please give your comments:

No comments for 'b'.

IV	Have you benefited from the field practice exercises	a. Yes	7	15/15
		b. Slightly	7	
		c. Not at all	1	

If your answer is b or c, please explain your reason briefly but clearly:

V	Has this training prepared you to work as a family planning educator.	a. Independently	14	15/15
		b. Under supervision	1	

VI	Do you feel this training has provided you with sufficient knowledge and skills to plan and conduct family planning training courses for:		Yes	No	
		a. Professional Midwives	5		15/15
		b. TBAs			
		c. Both	10		

If your answer is No, please give your reasons:

Direct comments as quoted by the participants in response to the questions:–

Q IV

1. I prefer to visit the field and communicate with the clients in in their houses and to visit the family planning clinic in the village.
2. I gained experience in role playing No. 11 only as actual field practice is not possible because of language problem. Discussions and presentation of Project No. 1 helped me in this practice.
3. The reason for slight benefit from the exercise is this - that the participants were not actually taken to any practice area; only theoretical discussions were there and as such I have not benefited from the field practice exercises.
4. I would have been happier if I got the opportunity to visit the village mothers in the field also.
5. As I am working in the hospital as a nurse/midwife, I do not have the privilege for field practice at all.
6. It would have been better if we did one or two home visits as some

of us are working in the hospitals and it would enable us to understand their home conditions.

7. I did not have the opportunity of visiting field and did not have communication with the community.

General Comment from one participant:
In relation to time, some topics such as endocrinology, contraception need not be included and more time given for I.E. & C. and human relations.

VII Post-training Assignment

The purpose of the post-training assignment was to follow-up the participants' activities during the first three months after they had completed the training. Each was asked to submit a report of her activities to The Project Director, ICM, London as soon after 4th March 1977 as possible. The report should include at least one of the following:

(a) Number of family planning acceptors recruited through your efforts.

(b) Number of educational classes/programmes organized and conducted by you – where and for what type of audience.

(c) What kind of educational programme have you introduced in maternity hospitals?

(d) Your involvement in re-organizing or organizing follow-up services for your family planning clients.

(e) What efforts you have made to ensure that your staff fully understand the importance of family planning information, education and communication and to implement this service through face-to-face motivation in the clinics, homes and in the community, such as in women's clubs and in industry.

Participants were asked to give reasons if they had difficulty in fulfilling their assignment.

VIII Certificate of Attendance

At the Closing Session the Joint Secretary, Population Control/Family Planning (PCFP) Division, Bangladesh, and the Field Director, ICM/USAID Project, presented certificates of attendance to the participants. These were signed by the Secretary, PCFP Division, Bangladesh, and the Project Director, ICM/USAID Project, ICM, London.

IX Closing Session

The Co-chairman, local organizing committee, Dr. Rezia Laila Akbar took the chair. Guests who had been invited to the opening session were again invited.

One delegate from each of the participating countries gave a vote of thanks. They reviewed what they had learned and the benefits they had acquired in the form of knowledge and skills in the art of teaching by demonstrations, the correct approach to face-to-face communication, the importance of inter-personal relationships and the techniques of MCH/FP I.E. & C.

The Director, Service Delivery and Training, said that after Margaret Sanger, leaders in family planning/population control had always been medical doctors, demographers, economists, administrators, social scientists, journalists and so on. The ICM, represented by Mrs. Brohier, was the Margaret Sanger of today, and the future leaders in this field could well be the midwives.

X General Comments

) This was the first time the delegates had experienced this type of training seminar.

(b) They were thrilled with their new exposure which they claimed had helped them tremendously, especially in their role as health educators and particularly in face-to-face communication.

(c) The observers – medical doctors and principals of FWVs training schools – at first thought it was not necessary for them to attend this Seminar as they would learn nothing new. They soon changed their minds, became extremely interested, participated actively, made recommendations and wanted to know how the curriculum was developed. Relevant materials were given to them. They said they would like to adopt this training methodology in their schools One of the observers had recently returned from Connecticut. USA, after attending a seminar on Planning of FP Programmes. The change in this observer was so pronounced that the Field Director felt gratified.

(d) Government officials, representatives of UNFPA and USAID, and most of the speakers were impressed with the delegates' reaction to the Seminar.

(e) The Family Health Adviser, WHO, attended a few sessions and participated as well. The ICM and WHO personnel worked in close co-operation during the Seminar.

XI Conclusions

The Chairman and Co-Chairman of the local organizing committee and their staff gave the Field Director, ICM, organizer of the Seminar, full co-operation and advice, particularly on local traditions and protocol. Much of the success of the Seminar was gained through the advice and assistance received from this committee.

Government support was maximal, as was the participation of their officials.

The Field Director, ICM, together with the Chairman and Co-Chairman of the local organizing committee called on the Adviser (Minister), Secretary, Director-General and the Directors of the various departments (related to the Seminar) of the Population Control/Family Planning Division to present the Seminar Report, emphasize the need for follow-up of the Seminar by the government, and to discuss the recommendations with Ministry personnel and ask the government to study them and to implement them according to their priorities, in particular those made by the Bangladesh group.

This Report was compiled with the co-operation and assistance of the Chairman and Co-Chairman of the local organizing committee.

On behalf of the Executive Secretary, ICM, and the ICM/USAID Project Director, the Field Director expressed her sincere appreciation for all the assistance, advice and co-operation which was extended to her. She thanked the government for hosting the Seminar, its various officials, the USAID Population Officer, the speakers, members of the local organizing committee, the seminar secretariat staff and numerous other helpers for their support and assistance. Not least, she thanked the delegates who had worked incessantly for 10 days, which had reflected their keen desire to learn in spite of the handicaps already mentioned.

XII Comments on Post-Training Assignment Reports

Reports from 8 trainers had been received to date:

1. Awarded scholarship at Downstate Medical College.
2. Very dedicated worker. Good potential.
3. The participant is involved in the teaching as she is Matron of the hospital.
4. Before the training she did not involve herself in family planning.
5. Transferred to rural health training centre immediately after returning from the Seminar.
6. Had conducted 52 education classes for FWVs.
7. Transferred to a newly organized training institute soon after return from the Seminar. Due to lack of transport, clinical equipment, etc., field work and services have not yet been established. In the meantime she is confined to classroom teaching of FWVs.
8. Transferred to new MCH centre with weekly family planning sessions.

APPENDIX I

List of Participants

Delegates

Nepal

Mrs. Chandra Shrestha
Senior Public Health Nurse
National Family Planning Project
Kathmandu

Miss Nani Maiya Shrestha
Nurse-midwife
Senior Sister, Bir Hospital
Kathmandu

Miss Gopi Udai
Nurse-midwife
Koshi Zonal Hospital
Biratnagar

Sri Lanka

Mrs. M.S. Martin
Nurse-midwife, FP Motivator
Base Hospital
Negombo

Mrs. P. Mahawela
Nurse-midwife, FP Motivator
General Hospital
Kandy

Mrs. D.S. Jayasuriya
Nurse-midwife
c/o Medical Officer of Health
Moratuwa

Mrs. M.G.S. Fornanda
Nurse-midwife
c/o Medical Officer of Health
Four Gravets, Galle

Mrs. M.L. Weerakoon
Nurse-midwife
c/o Medical Officer of Health
Kalonnawa

Bangladesh

Mrs. Zebunnessa Khanum
c/o Principal
FWV Training Institute
Khulna

Mrs. Lutfunnessa
Lady Health Visitor
FWV Training Institute
Kalibari
Barisal

Mrs. Shahera Khatun Tulu
Nurse-midwife
Field Trainer
FWV Training Institute
Rajshahi

Mrs. Surobala Sarkar
Nurse-midwife
Field Trainer
MCH Training Institute
Dacca

Mrs. Smriti Kona San
Nurse-midwife
Field Trainer
FWV Training Institute
Chittagong

Observers

Dr. Sadequl Haq
Principal
Training-cum-Research Institute
Rajshahi

Dr. Amiya Chowdhury
Principal
Training-cum-Research Institute
Chittagong

Dr. Ashfaque Ahmed
Principal
Training-cum-Research Institute
Khulna

Members of Local Organizing Committee/Resource Persons

Dr. Shamsum Nahar, (Chairman)
Superintendent
MCH Training Institute, Dacca
Population Control/Family Planning Directorate
Bangladesh

Dr. Rezia Laila Akbar, (Co-Chairman)
Superintendent
Maternity and Child Welfare Services
Population Control/Family Planning Directorate
Bangladesh

Mrs. Salma Begum
FWV Training Co-ordinator
Population Control/Family Planning Directorate
Bangladesh

Mrs. Khawla Khatun
Nurse-midwife
Field Trainer
MCH Training Institute, Dacca
Population Control/Family Planning Directorate
Bangladesh

Mrs. Awlia Begum
Nurse-midwife
Sister Tutor
MCH Training Institute, Dacca
Population Control/Family Planning Directorate
Bangladesh

Mrs. Begum Jahanara
Nurse-midwife
Sister Tutor
MCH Training Institute
Population Control/Family Planning Directorate
Bangladesh

Mrs. Kulsum Ara Begum
Lady Health Visitor
Training-cum-Research Institute
Azimpur, Dacca

Mrs. Belinda Brohier
Field Director,
ICM, London

APPENDIX II

List of Papers Presented

1.	Family Planning	Dr. M.A. Sattar Secretary, PCFP Division
2.	Family Planning	Col. (Dr.) Hashmat Ali Director General, PCFP Directorate
3.	Problems in Family Planning Communication	Mr. Shawkat Ali Deputy Commissioner, Dacca
4.	Role of MCH/FP Trainers	Dr. Shamsun Nahar Superintendent, MCH Training Institute, Dacca
5.	Infertility and sub-Fertility in Relation to Family Planning	Dr. T.R. Chowdhury Assistant Director, PCFP Directorate

6.	Early Detection of Cancer – a Part of MCH Services	Dr. Syeda Firoza Begum Professor of Obst. & Gyn. Dacca Medical College
7.	Techniques of Contraception	Dr. Nargis Aktar Deputy Director, PCFP Directorate
8.	Techniques of Contraception	Dr. Halila Hanun Medical Officer, Family Planning Model Clinic, Mahamedpur
9.	Simple Endocrinology	Dr. Ishaque Associate Professor, Dacca Medical College
10.	Psychological, Sociological and Legal Implications of Terminal Contraception and Menstrual Regulation	Dr. Atiqur Rahman Deputy Director, PCFP Directorate
11.	Information, Education and Communication	Dr. Jahana Rabbi Director I.E.M., PCFP Directorate
12.	Principles and Techniques of Learning and Teaching	Mr. Najmul Huq Population Programme Officer, Directorate of Labour
13.	Principles of Planning and Organizing Educational Programmes at Clinic, Community and Home Levels	Mrs. Rezia Khatun Division Inspectress, MCH/FP Services
14.	The Midwives as MCH/FP Educators and Motivators	Mrs. Shazadi Haroon Principal, College of Nursing
15.	Audio-visual Aids	Mr. Nazrul Islam Health Education Officer, Ministry of Health
16.	Human Relations	Mrs. R.N. Huq Medical Social Organizer, PCFP Directorate
17.	Principles and Techniques of Interviewing and Counselling	Mrs. Syeda Naymunnessa Assistant Director I.E.M., PCFP Directorate
18.	Barriers to FP Acceptance	Mrs. Jahanara Begum Assistant Director, I.E.M., PCFP Directorate
19.	Importance of Follow-up of Contraceptive Users. Simple System of Follow-up Service	Dr. Shafique Rahman Director, Service Delivery, PCFP Directorate

20.	Integration of Family Planning, Prenatal, Natal and Postnatal Education	Dr. Rezia Laila Akbar Superintendent, MCH/FP Services
21.	Evaluation and Importance of Feedback for Programme Improvement	Dr. Waliullah Director, Training, Education, Supervision and Planning, PCFP Directorate

APPENDIX III

Curriculum Plan

Tasks	Knowledge required	Skills to be acquired
1. To inform clients of the philosophy of family planning.	Comprehensive concept of family planning; the various aspects such as health; economic, psychological and sociological.	The ability to: Present this knowledge in the simple language of the clients.
2. a) To give correct information on infertility and sub-fertility. b) To assist sub-fertile couples for treatment	Difference between infertility and sub-fertility. Type of treatment available for sub-fertile couples and % of success. Why should education and service for these two conditions be included in MCH/FP services.	Explain the difference between the two.
3. To assist clients to select the contraceptives most suitable to them.	Techniques of contraception; side-effects and their management; the psychological, sociological and legal implications of abortion and sterilization. Simple endocrinology.	Give simple and clear explanation to help clients to understand the reasons behind the advice; and the importance of correct and continued practice.
4. To provide clients with correct answers on side-effects.	As above.	Discuss side-effects truthfully but with assurance that the known side-effects have not been found harmful; they can be treated and they are short-term effects; dispel unnecessary anxiety with reassurance.

Tasks	Knowledge required	Skills to be acquired
5. Create a positive rapport with clients, colleagues and other members of the health team.	Human behaviour patterns. Inter-personal relationship; team spirit and group dynamics.	Identify with clients, provide privacy during interview, listen objectively, respect clients' need for confidence at all times; assist and advise accordingly.
6. Conduct family planning information, education and communication in the clinic, home and in the community.	Comprehensive knowledge of information, education and communication (I.E. & C) i.e. meaning and the difference between information and education. Types of I.E. & C.; and the effects of each in terms of attitude change. Use of audio visual aids (AVAS). Importance of correct selection, proper use of educational aids.	Plan educational programmes, to meet the objectives of the programme. Use AVAS effectively, operate film and slide projectors efficiently, maintain AVA equipment and material in good order. Conduct educational programmes face-face motivation, group talks and mass meetings.
7. Train midwives and other health aids in simple family planning I.E.C. Such as face-face motivation and group talks.	Principles and techniques of learning and teaching, principles of planning and organizing educational programmes such as face-face motivation, group talks and mass meetings. Management and maintenance of film and slide projectors and other AVA equipment. Development of simple educational aids with available resources.	Plan and conduct simple training courses midwives and other health aids. Produce simple educational aids by using magazine cut-outs, dolls, etc.

Tasks	Knowledge required	Skills to be acquired
8. To motivate clients to accept family planning practice.	Benefits of family planning in relation to health, sociology and economy. Barriers to acceptance of contraceptive practice misconceptions, myths, religion, culture and fear. Techniques of overcoming the barriers. Simple demography.	Utilize knowledge gainfully by applying relevant aspects to the situation on hand – i.e. correct misconceptions, dispel myths, explain religion and family planning, explain social progress and its effects on culture. Explain the socio-economic implications of rapid population increase in the context of family sizes against family income and family welfare.
9. Promotion of continued contraceptive practice until a pregnancy is desired.	Why is continued practice important? Discontinued use is not always the clients' fault. How to minimize this. The effects of irregular use of contraceptives on the clients themselves, their families and their country's development.	Convince clients that continued family planning practice is important until a pregnancy is desired. Stress the hazards of unplanned pregnancies. Plan and organize a systematic follow-up service where defaulters can easily be identified and clients reached before they become burdened with unwanted pregnancies.
10. Evaluation of programme achievements.	Purpose of evaluation, importance of feedback information. How to collect and record data for evaluation. How to plan and organize programme evaluation. How to analyse evaluation, and to use feedback information and evaluation report for programme improvement.	Plan and organize programme evaluation. Supervise record keeping and data collection, interpret feedback information and utilize it accordingly. Analyse evaluation, use the result for programme improvement.

APPENDIX IV

Basis for developing the Curriculum

Objectives	Tasks to be Performed	Knowledge needed for the performance of tasks	Skills necessary for tasks performance
1. To provide Senior public Health Nurse/ midwives, midwifery educators and Community health (nursing/ midwifery) educators with family planning training 2. To prepare senior public health nurse/ midwives as family planning instructors for health auxiliaries such as the traditional birth attendants (TBA's)	1. To assist and supervise midwives particularly in family planning services. 2. To ensure family services are of a high standard, clients are correctly instructed in the techniques of contraception. 3. To ensure clients continued practice of family planning. 4. To teach family planning to midwives, health auxiliaries including TBA's.	1. **Family Planning** a. History and progress to date. b. Comprehensive concept of family planning its relationship to psychology, sociology, economy and health 2. **Demography** a. World Population Growth b. Population distribution c. Vital Statistics 3. **Anatomy and Physiology of human reproduction** a. Male and female b. Physiology of menstruation, conception and pregnancy c. Gynaecological disorders and simple treatment of the same. d. Cytology and Pap Smears. e. Sub-fertility and Infertility	1. Ability to utilize knowledge to assist staff to overcome their problems in motivation for acceptance of family planning. Ability to impart knowledge effectively to various levels of Trainees m/ws and health aids. Ability to develop a modified presentation appropriate to the target trainees' comprehension. Ability to assist clinical staff in this area – in their day to day functions. Ability to teach in the language of the trainees. Supervision and teaching of treatment of Gynaecological Disorders.

Objectives	Tasks to be Performed	Knowledge needed for the performance of tasks	Skills necessary for tasks performance
		4. **Techniques of Contraception** a. Various contraceptive methods. b. Effectivity; contra-indications c. Side-effects and their management. d. Problems associated with abortion and permanent methods of contraception.	Ability to take PAP Smear and demonstrate procedure, counselling clients on choice of suitable methods. Teaching trainees to counsel and demonstrate technique.
		5. **Information, Education & Communication (IE&C)** a. Correct definition b. Principles of Health Education c. Types of IE &C programmes – Mass, Group, Individual d. Types of Media available e. Development of simple audio visual aids (AVAS) f. Selection and utilization of AVAS. g. Management of film and slide projectors h. Principles and techniques of interviewing and counselling	A. Ability to:– Assist and supervise clinical staff in daily work – client counselling, motivation, use of AVAS B. Conduct and Plan training courses for the different category of trainees – TBA's and Health Aids. C. Identify training objectives, trainees' needs for tasks and the skills required for tasks performance. D. Develop curriculum accordingly.

Objectives	Tasks to be Performed	Knowledge needed for the performance of tasks	Skills necessary for tasks performance
		i. Problems in IE&C. j. Curriculum Development. 6. **Supervision** a. Definition b. Difference between new and old concept. c. Principles and techniques of supervision. 7. **Administration** a. Principles and techniques of administration b. Basic knowledge of accounting such as simple book-keeping c. Principles of evaluation d. Data collection and utilization of data for evaluation. e. Reporting.	Ability to:– a. Function in the context of modern concept of supervision. b. Promote good job relations. c. Promote good job organization and methods. d. To conduct good job instruction The ability to:– Assist members of staff to appreciate the relationship between job input and output. Keep simple book-keeping; supervise and teach in this area. Organise systematic data collection; maintain accurate records; utilize collected data for evaluation. Utilize result of evaluation for the improvement of clinic management and the standard of service.

APPENDIX V

Course Content

Course Content	Breakdown of Content
1. Family Planning (1 hour)	Brief history, progress international, and national, various aspects of F.P. such as health, socio-economic, psychological and sociological.
1A. Family Planning (1 hour)	Family Planning as a human right (mother and child). How to convey this concept to the illiterate masses who need to practise family planning but who have not done so for various reasons. Simple demography.
2. Techniques of Contraception (2 hours)	Conventional; modern and natural techniques, various types; advantages and disadvantages; effectiveness of each type; side-effects and management of harmful rumours. Emphasis on effects of hormonal contraceptives on breastfeeding and measures to assure contraceptive users that it is possible to breastfeed their babies and use hormonal contraceptives at the same time.
2A. Techniques of Contraception – Terminal Methods and M.R. (2 hours)	Menstrual Regulation and female and male sterilization. Possible failures complications in terminal methods and % of method failure or % of effectivity.
3. Endocrinology (1 hour)	Simple endocrinology related to hormonal contraceptives.
4. Infertility and sub-fertility (1 hour)	Definition of infertility and sub-fertility. Causes; treatment of sub-fertility. Prognosis. Why infertility and sub-fertility services should be an integral part of MCH/FP services.
5. Early detection of cancer as part of family planning service	How to detect early cancer; and where is this easily carried out; Suspicious cases – early referral. Signs of tissue changes – especially in cervical area, breast. Symptoms.

Course Content	Breakdown of Content
6. Psychological, socio-cultural and legal implications of terminal methods and menstrual regulation	Why hesitancy in accepting terminal methods: Need to understand psychological reaction to the method. How to reassure clients by explaining rather than dispelling their fears and doubts. Dangers of illegal abortion –what is the law governing abortion. The justification of menstrual regulation. What criteria should there be for male and female sterilizations.
7. Information, Education and Communication (1 hour)	Definition of each of the components, and identify how they differ. The different types of communication which can be utilized successfully for the promotion of information and education. Factors which influence communication. The process of communication.
8. Problems in Family Planning Communication (½ hour)	Family Planning personnel, especially those who operate at the grassroot level must know everything about the goods they are promoting – importance of training field staff – MCH/FP personnel for the tasks they are expected to do. Importance of supervision for service improvement. Continuous supervision and feedback of information gathered.
9. Role of MCH/FP Trainers (½ hour)	Responsible to build curriculum on the basis of students' needs for tasks to be done – identify tasks to be performed and the skills to be developed for the performance of the tasks. Trainers must know and experience the problems which confront the field staff. Without this knowledge it would be impossible for the trainers to have a full comprehension of the problems and therefore be able to help their students to face and overcome the problems.
10. Principles and techniques of learning and teaching (1 hour)	Purpose of learning; correlation of learning experience with objectives for learning. Types of learning experiences. Defects in the teaching of family planning I.E. & C. Measures to overcome or modify these defects.

Course Content	Breakdown of Content
11. Principles of planning and organizing educational programmes at clinic community and home level.	Objectives of the programme; procedures in planning and organizing at the stated levels. Factors which would contribute to the success of the programmes. Such as tailoring educational programmes, educational materials to the target audiences' level of comprehension.
12. Audio Visual Aids (1 hour)	Purpose of AVAs – The various types, their effectiveness. How to select the appropriate ones for maximum results. Suitability of AVAs in different situations. Misuse or improper use or AVAs or VAs. How to prepare simple VAs with available resources. Maintenance of AVA equipment.
13. Human relations (1 hour)	Human behaviour – people as individuals. Attitude to self and to the job one is doing, to one's colleagues, and to the clients. What is inter-personal relationship. Causes of breakdown in inter-personal relationship; its effects on job, team spirit and personal emotional disturbance.
14. Principles of interviewing and counselling (1 hour)	How interviewing is different to counselling. Techniques of interviewing, and counselling. Importance of maintaining good rapport between clients and worker. Human beings need to have their confidences honoured and they need to be respected as a person and not as a piece of article.
15. Importance of follow-up of contraceptive users. A simple system of follow-up service (1 hour)	Why should there be a follow-up service. Stress the profit and loss aspect of irregular contraceptive practice – to the users and the family planning programme. Possible causes of defaulting, methods of identifying reasons for defaulting, importance of establishing clients' addresses where there are no postal services, some kind of identification of clients' house, after they have accepted family planning practice, so that follow-up service would be possible.

Course Content	Breakdown of Content
16. Integration of Family Planning, Pre-natal, Natal and Post-natal education.	Advantages – in what way. How can this be achieved – guidelines for the preparation of such a programme.
17. Barriers to family planning acceptance (1 hour)	Various barriers – psychological, tradition, fears and rumours. Causes of these barriers. How can they be overcome or reduced so as to make motivation easier.
18. The Midwives as MCH/FP educators and motivators	Relationship between midwives and the community, the women they serve, their status in the community. The nature of their work qualifies them for this role. They must recognise their role, responsibility to their clients and their government. Reason why they have been identified as the most suitable to promote health education. They should recognise problems and be responsible to feedback information gathered which are detrimental to their programme effectivity. Importance of follow-up of education and motivation until acceptance is achieved.
19. Evaluation and importance of feedback for programme improvement.	What is evaluation, why it is necessary, who should be responsible at the various levels? How to utilise information gathered or result of evaluation to improve programme. What is feedback? How to develop a simple system to feedback, importance of continuing feedback.

WORKSHOP ON TRAINING OF TRAINERS/ SUPERVISORS OF TBAs, COMILLA, BANGLADESH 9th MAY – 4th JUNE, 1977

Participants: 24 Bangladeshi Family Welfare Visitors (Auxiliary Nurse-midwives)

Venue: Family Welfare Visitors Training Institute, Comilla

Medium of Instruction: Bengali and English

I Rationale

The training and utilization of the traditional birth attendants (TBAs) have been widely recognized as important, necessary and should be carried out.

It is not difficult to identify the TBAs, and train them. Training programmes can be easily planned and implemented. Their trainers/supervisors too are easily found among the nurses, midwives, auxiliary midwives or auxiliary nurses.

For the TBAs to be utilized successfully, they must first be fully accepted as members of the health team by their professional and paramedical colleagues.

One of the various obstacles to the training and utilization of the TBAs is professional jealousy generated by the nurses and/or midwives. This is disguised by the 'desire' of the professional nurses and midwives to provide a high standard of health care. Then some people who cry out for the best are not fully aware that, but for the TBAs' contribution to the health services, the vast majority of the rural populati.. would be completely without any health care.

If this seminar on the Training of Trainers for TBAs is to be successful, special consideration must be given to the selection of delegates, such as attitude towards the objective of the seminar, and the TBAs.

It is therefore essential that the motivation of the selected delegates towards TBAs as members of the health team must be strengthened during the seminar. This would help to ensure a higher degree of acceptance and continued congeniality between the professionals, paramedicals and TBAs.

II The Field Assignment

The total field assignment in Bangladesh lasted from 25th April to 12th June 1977. Field Director: Mrs. B. Brohier.

Purpose of the assignment

To conduct a 4-week Workshop on Training of Trainers/Supervisors

of TBAs with the following objectives:

1. To motivate midwives to recognize the TBA's contribution to rural health services, especially in areas where there are no organized government services.
2. To train midwives to teach and supervise TBAs and other MCH/FP auxiliaries in reproductive health care.
3. To teach midwives to plan and develop a reproductive health training curriculum for Bengali TBAs (dais).
4. To teach midwives:
   (a) the principles of evaluation;
   (b) methods of simple evaluation;
   (c) to use the results of evaluation as guidelines for programme change and/or improvement;
   (d) the techniques of effective teaching and supervision.

III Preliminary Meetings

Preliminary meetings were held with:

(a) Dr. M.A. Sattar, Secretary, Population Control/Family Planning (PCFP) Secretariat.

(b) Dr. Shafiqur Rahman, Director, Training and Service Delivery, PCFP Directorate.

(c) Dr. T.R. Chowdhury, Deputy Director, Training, PCFP Directorate.

(d) Mrs. Salma Begum, Assistant Director, Training, PCFP Directorate.

Dr. Sattar explained the government's plan to involve TBAs (dais) as semi-voluntary MCH auxiliaries.

Dr. Shafiqur Rahman and Dr. T.R. Chowdhury were very impressed with the materials prepared for the Workshop, such as the Rationale for the Workshop, the basis for developing the Training Curriculum, the Curriculum and the breakdown of its contents.

They expressed the need for a Manual for the TBAs' Trainer and requested the Workshop to prepare a guideline for developing the Manual.

The Field Director agreed to develop a draft Dai Trainers Manual, thus adding one more objective for the Workshop.

IV Field Director's Counterpart

Mrs. Salma Begum was appointed counterpart to the Field Director and was specifically asked to learn 'Curriculum Development'. The Field Director was pleased to report that, by the end of the Workshop, Mrs. Salma Begum had satisfactorily acquired the knowledge and developed the skill for curriculum development.

V Revised Objectives for the Workshop

As a result of the request reported above, the objectives were revised as follows:

1. To train Trainers/Supervisors of Dais
2. To develop guidelines for a Dai Trainers' Manual.

VI The Workshop – Analysis of Programme

(a) ***Lectures***

These were conducted as lecture/discussions supported by examples and demonstrations. The participants enjoyed the sessions because they could compare their new knowledge with their experiences. They tried this technique of instruction in their training practice.

(b) ***Group Work***

This method of learning was completely new to the participants. They found it extremely difficult at first as they were not used to thinking and expressing their thoughts methodically in the form of written reports. Several days of group work exercises, and their willingness to work hard and to learn, made the participants appreciate the value of group work. Their interest was stimulated and they began to enjoy the sessions and to benefit from them.

(c) ***Teaching practice***

Initially this was conducted in the form of role playing with fellow participants as dai trainees. This was an exercise for developing the technique of simple but clear teaching, i.e. in the language of the dais.

Like health personnel everywhere, FWVs find it difficult not to use technical terms in their teaching of dais.

As this is a very important aspect of dai teaching, much time was spent in getting the participants to use colloquial terms. The participants themselves appreciated the need for lay words and really worked hard to overcome the problem. By the time they had dais as their trainees they were much better, although not completely 'cured'.

Thirty dais were able to come as trainees for the participants' teaching practice. Most of them had been involved as family planning motivators but had had no training in MCH care They were knowledgeable in general matters and keen to have training in maternal and child care and family planning.

The participants conducted their teaching practice satisfactorily by demonstrations and teaching aids. The dais participated actively by asking and answering questions and by relating the problems

they encountered in maternity care and family planning. The participants were assisted in helping dais to overcome the problems.

Each participant had the opportunity to teach two subjects.

(d) ***Home Visiting***

This was organized to identify practising dais who had not been registered or who had not been known to be practising; to find out if 'grannies' or relatives who had delivered babies would like to have training; and to establish why there is no demand for or contact with dais until delivery time.

If dais are to function effectively as MCH/FP auxiliaries, they must have access to all childbearing women pre-, intra- and postnatally. It is therefore necessary to find out why there has been little contact between expectant mothers and dais in order to develop measures to promote the need for contacting dais during pregnancy.

The majority of women contacted said that they did not disclose their pregnancies even to their nearest relatives because they were very shy to discuss their condition until the signs of pregnancy could no longer be concealed.

Of the twelve dais contacted during the home visiting, two had had training and the remaining ten would like to have training.

It was not possible to observe a dai during a home delivery as none of them had a confinement at the time.

(e) ***Post-training questionnaires***

These were conducted orally, firstly because the participants could speak better than they could write, and secondly because it would have taken time to translate their answers into English. On the spot translation of verbal answers was easier, because the participants could understand English fairly well although they could speak very little.

1. **What are the principles of curriculum development**

   Each participant contributed to part of the question until it was fully and satisfactorily answered. Thus all the participants were involved and their achievements evaluated.

2. **Describe the contents of the curriculum for reproductive health training of dais.**

   The participants identified the major contents of the curriculum, i.e. basic midwifery, maternal and child care and family planning. They then discussed the sub-topics of each major topic. Each participant had to discuss one sub-topic, enumerating the knowledge required and the skills to be developed.

3. **Demonstrate teaching of dais**

   One participant was asked to conduct a session of 10 minutes. This was to assess teaching technique and ability.

4. **Discuss supervision**
   All the participants had the opportunity to contribute to this question.

The participants answered the questions to the satisfaction of the Workshop Directors. They had done better than expected. They thanked the ICM/USAID Project for conducting the Workshop and promised to start TBA training as soon as possible.

VII Analysis of Evaluation Questionnaires

(a) ***Technical aspects***

Q. Have you attended a Seminar before?
A. Yes – 11; No – 13.

Q. Were you eager to attend this Seminar?
A. Very eager – 20; fairly eager – 4.

Q. Were you pleased that you attended this Seminar?
A. Very pleased – 24.

(b) ***Seminar objectives***

In answer to a question whether or not the objectives (1–4 above) of the seminar had been met, all participants answered yes except that two did not answer question 4 a, c and d and one did not answer question 4 b.

Q. Which objective did you think most important before the Seminar began?
A. No.1 – 2; No.2 – 9; No.4a – 1; No.4d – 12.

Q. Which objective had been most satisfactorily met?
A. No.2 – 4; No.3 – 9; No.4a – 6; No.4b – 2; No.4d – 1.

Q. Which objective would you have liked to spend more time on if possible?
A. No.1 – 2; No.2 – 1; No.3 – 1; No.4a – 1; No.4b – 2; No.4d – 14.

Q. Which of the above four objectives did you enjoy discussing?
A. No.1 – 2; No.2 – 1; No.4a – 14; No.4b – 1; No.4c – 3.

In these last four questions, two did not answer the second and three did not answer the third and fourth.

(c) ***Lectures***

Q. Which lecture did you find the most useful?
A. 1. Traditional health practitioners, in particular TBAs.
   Very useful – 22; fairly useful – 2.
   2. Principles of curriculum development.
   Very useful – 24.
   3. Principles and techniques of communication.
   Very useful – 24.

4. Principles and techniques of teaching.
   Very useful – 24.
5. Educational aids.
   Very useful – 22; fairly useful 2.
6. Principles and techniques of supervision.
   Very useful – 24.
7. Evaluation – purpose and methods.
   Very useful – 24.

(d) ***General***

Q. Which specific aspect of the Seminar did you like most?

A. Teaching practice – 10; teaching techniques – 10; group discussions – 2; other comments not relevant – 2.

(e) ***Other Comments***

1. Eight participants would like similar Workshops more often.
2. Three felt that the Workshop would help to improve their performance if the recommendations were implemented.
3. Three would like refresher courses to be conducted in a similar way to the Workshop.
4. One felt that the duration of the Workshop had been too short.

VIII Dai Trainers' Manual

This was developed from the dais' curriculum developed during the Workshop. It is in English and demonstrates the actual teaching method of each subject using simple words and teaching aids. If approved, the draft would be translated into Bengali.

IX Recommendations

1. Training of dais should start as soon as possible, before the participants lose interest.
2. Dai trainers should be supervised through follow-up of their training.
3. If dais are to be health educators they should be able to be examples of good health. To be so, they need to have the means to provide themselves with the basic necessities of life, food and clean clothes. The dais are so extremely poor themselves, they are certainly not pictures of healthy women. It is therefore recommended that dais be given some remuneration regularly in order to do their work effectively.
4. If the training and utilization of dais are to be effective, there must be regular supervision of the dai supervisors.

X Post-Workshop Discussions

Dr. M.A. Sattar
Col. (Dr.) Hasmat Ali, Director-General, PCFP Directorate
Dr. Shafiqur Rahman
Dr. T.R. Chowdhury

Mrs. Selma Begum and the Field Director presented the Workshop Report and we discussed the draft Manual. They were impressed and commented on the success of the Workshop and informed the Field Director that the Training Committee would study the draft Manual before translating it into Bengali.

Dr. Chowdhury mentioned that he would like, if possible at a later date, to have the services of the Field Director to conduct Workshops on the Training of FWVs Trainers, Curriculum Development and Management of the FWVs' Training School. The Field Director said that the ICM/USAID Project might be able to help provided that the programmes concerned were not duplicated projects – i.e. similar to projects sponsored by other bodies. She also pointed out that the ICM/USAID Project did not have the funds available to support the kind of programme Dr. Chowdhury had outlined. Dr. Chowdhury said that the funds were available; it was the 'know-how' that they lacked.

USAID Population Officer

A copy of the Report was given to him and Dr. Chowdhury's proposal discussed.

UNFPA Representative

Dr. A.P. Satterthwaite was most interested in the Workshop, especially in its preparation, because she had wanted a similar training procedure for the FWVs' training but had not been able to get the Training Unit to prepare one. She was very happy to receive a copy of the Workshop Report and to hear of Mrs. Selma Begum's achievements.

ILO Representative

Mr. Ian Howie was very interested in the Workshop because he wanted to introduce TBA training in the Women's Co-operative Programme. He asked for a copy of the draft Manual.

XI Follow-up Visits, May 1978

On the advice of the USAID Population Officer, meetings were first held with the WHO Family Health Adviser and the Assistance Population Officer, UNICEF, for Health, Nutrition and Family Planning. Both of these bodies had allocated funds for the initiation of a project to train 144 dais under the government five-year plan, but the programme had not begun and the reasons for the delay were not understood. A training strategy document had been drawn up allowing for the training of 600 FWVs and the eventual training of 65,000 TBAs.

Details and costs of the scheme had been worked out and suggestions for funding made.

Meeting with the Director-General, PCFP Directorate and Deputy Director Training

When asked why the training course had been delayed when there were 24 trainees available, he said that those who had been trained were to be given the status of trainer-supervisor, but this had not yet been done. It was suggested that they should be persuaded to function as trainer-supervisors while waiting for the posts to be created. Also, some of the 24 had since been assigned to areas where they would not be able to function as trainers. Assignment was the responsibility of a different department.

The Joint Secretary, Population Control/FP Division, gave an assurance that approval would be given to practical suggestions for implementing the training of the 144 TBAs. He suggested that the reporter might return to evaluate performance once the scheme was under way.

Meeting with the senior staff, Training Division, PCFP Directorate

As 18 of the 24 trainers were working in rural clinics, it was decided that the programme should begin with 18 centres and 18 trainers, with more to be added later if the situation changed. The programme could start in mid-July 1978. The projected number of TBAs to be trained would therefore be reduced to 108 and of new trainers to 216 (making available 234 trainers in all). More trainers would be accommodated if possible, but if one waited for the full scheme to be implemented, nothing would ever happen.

The method of selection of TBAs and FWVs for training was discussed and agreed. A minimum training period of two weeks for trainers was accepted.

The Dai Training Manual had been translated into Bengali and was being printed. UNICEF would provide the funds. Sufficient other teaching aids were available for the first course. UNICEF would provide 144 basic delivery kits.

It was requested that PCFP inform ICM when the programme had been launched. As the Director-General, PCFP, would be out of the country for some weeks, deputies were appointed to make sure that the programme would be ready to begin in mid-July.

The outcome of these talks was reported to the USAID Population Officer.

APPENDIX I

List of Participants

Mrs. Anowara Khatun
FWV
Mobile Team Headquarters
Dacca

Mrs. Hasina Banu
FWV
Welfare Clinic, Palash Bari
District Ranjpur

Mrs. Momena Begum
FWV
Diabetic Association
Dacca

Mrs. Sofia Khatun
Buruj Bagar Rural Health Centre
Jessore

Mrs. Khaleda Begum
Thana PCFP Office
Narayanganj, Dacca

Mrs. Dipti Rani Chakraborty
T.F.P.O. Bakarganj
Barisal

Mrs. Yeakutun Nessa
Thana Family Planning Office
Barura, District Comilla

Mrs. Sufia Akhter Khonom
Thana Family Planning Office,
Murad Narar, Comilla

Mrs. Suraiya Begum
Marinda Maternity and Child Welfare Centre
Dacca

Mrs. Rabia Khatoon
Fulbaria Zonal Clinic
District Mymensingh

Mrs. Jahan Ara Begum
Begumganj Zonal Clinic
District Naokhali

Mrs. Sultana Rezia
Pangpur Medical College Zonal Clinic

Mrs. Mahbuba Begum
MCH Training Institute
Rajshahi

Mrs. Arzumand Banu Begum
NEW Centre
Comilla

Mrs. Tahuran Nessa Begum
Midford Hospital Family Planning Clinic
Dacca

Mrs. Rabeya Begum
Urban Clinic
Tangail

Ms. Rupuia Khatun
Nazirpur, Barisal

Mrs. Marjiana Begum
Gabtail Rural Health Centre
Bagura

Mrs. Mannujan Khanam
Manikganj P.S. and District Dacca

Miss Fazilatan Nessa
T.P.C. and F.P.
Fatullah, Dacca

Mrs. Sumitra Rani Saha
TCRI
Khulna

Mrs. Aminun Ara Begum
Urban Clinic
Barisal

Mrs. Hafiza Khanam
Urban Clinic
Barisal

Mrs. Amina Begum
Bhandaria Family Planning Clinic
Barisal

APPENDIX II

Basis for developing the curriculum for the Trainers/Supervisors of Traditional Birth Attendants (TBAs)

Trainers' Tasks	Knowledge required	Skills to be developed
Accept TBAs as contributing members of the health team. (This is a passive task which is very important to the whole programme).	The role of the TBAs – their involvement in the community, such as health, social, cultural and traditional activities. The influence they have in the community and the status they enjoy. How their services benefit or endanger the health and lives of the people they serve. Why is there a need to identify, train and utilise them more effectively and widely? Human relationships.	The understanding of the social, cultural, traditional, psychological and health needs of the communities served by the TBAs. Ability to identify with the trainees. Ability to exercise good inter-personal relationships.
To train TBAs in Reproductive Health Care.	General nursing and/or midwifery, maternal child health, family planning, nutrition, paediatrics, health education. Domiciliary nursing and midwifery. Clinical Administration Principles and techniques of face to face communication. Principles and techniques of teaching educational aids.	Ability to assess the amount of knowledge required by the trainees to perform their tasks. Ability to teach by demonstration, guide and assist the trainees in their practical work. The art of communication from person to person clearly, simply and in the language of the trainees. The art of teaching by demonstration, utilisation of visual aids. The art of teaching by clear and simple verbal instruction.

Trainers' Tasks	Knowledge required	Skills to be developed
To supervise trainees during training and at work.	Principles and techniques of supervision. The role of the supervisor and the supervisee. Problems in supervision.	The art of understanding supervisees' problems, especially in terms of working relationships. The art of giving clear and specific instructions in order to ensure positive understanding and good implementation. The art of methodical planning and organisation of working programmes. The art of keeping an open mind and of receiving suggestions.
To develop a reproductive health training curriculum for TBAs.	Principles of curriculum development. The kinds of syllabus required to provide the knowledge for the tasks to be performed.	The ability to construct a working agenda which has the course contents arranged according to their priority. The ability to obtain maximum benefit from field practice.
To evaluate trainees' achievement from the training.	Principles of evaluation. Preparation of appropriate questionnaires. How to analyse the questionnaires. How to determine whether the trainees have done well or otherwise.	The ability to study the result of the analysis and use it gainfully, such as improvement in the curricula, etc. The ability to observe the trainees during the training, note their participation and assess their achievement and their aptitude for further improvement.

APPENDIX III

Breakdown of Curriculum

1.	Duration of training – 4 weeks	124 hours
2.	Curriculum Content –	
	a) Opening Session and Orientation	4
	b) Theory	
	(i) Lecture	8
	(ii) Group Work	68
		80
	c) Practical Work	44
		124

APPENDIX IV

Curriculum Content

Lecture	1 hour	Traditional Health Practitioners; in particular the Traditional Birth Attendants.
Lecture	1 hour	Principles of curriculum development.
Group work	3 hours	Establish the basis for developing a training curriculum for family planning motivators.
Presentation of group reports	1 hour	Reports, discussion and acceptance of consensus report as recommendations.
Lecture	1 hour	Principles and techniques of communication.
Lecture	1 hour	Principles and techniques of teaching.
Lecture/ demonstration	2 hours	Educational aids.
Group wok	3 hours	Prepare a guideline for teaching home economics to members of a village women's club.
Presentation of group reports	1 hour	Reports, discussions and acceptance of consensus report as recommendations.

Lecture	1 hour	Principles and techniques of supervision.
Lecture	1 hour	Evaluation – purpose and methods.
Group work	3 hours	Supervision of traditional birth attendants.
Presentation of group reports	1 hour	Reports, discussions and acceptance of consensus reports as recommendations.
Group work	3 hours	Basis for developing a reproductive health care training curriculum for traditional birth attendants.
Presentation of group reports	1 hour	Reports, discussions and acceptance of consensus report as recommendations.
Group work	4 hours	Planning of a syllabus for reproductive health care training curriculum for traditional birth attendants.
Presentation of group reports	2 hours	Reports, discussions and acceptance of consensus report as recommendations.
Group work – breakdown of course content	3 hours	Basic nursing.
Presentation of group reports	1 hour	Reports, discussions and acceptance of consensus report as recommendations.
Group work	8 hours	Midwifery.
Presentation of group reports	2 hours	Reports, discussions and acceptance of consensus report as recommendation.
Group work	10 hours	MCH/FP
Presentation of group reports	2 hours	Reports, discussions and acceptance of consensus report as recommendation.
Group work	6 hours	Development of simple teaching aids (one per delegate).
Presentation of production	2 hours	Discussion and comments
Practical work	55 hours	Teaching Supervision Motivation.
Evaluation activities	½ hour ½ hour	Evaluation of the Training Course. Post Training Questionnaire.

APPENDIX V

Course Content

Course Content	Time	Breakdown
Traditional Health Practitioners; in particular the Traditional Birth Attendants (TBAs)	1 hour	Brief history; categories besides TBAs. Role of TBAs – their involvement in the community such as health, social, cultural and traditional activities. The influence they have in the community; their status. How their services benefit or endanger the health and lives of the people they serve. Why is it necessary to identify, train and use them more effectively and extensively? Relationship between the TBAs and members of the health team, especially the midwives.
Principles of curriculum development	1 hour	Basic information required before commencing – such as identifying tasks to be performed. How to utilise available information to develop an appropriate syllabus for a particular curriculum.
Principles and techniques of communication	1 hour	Simple definition; types; methods; emphasis on face to face communication between – 1. Trainer/Trainee 2. Supervisor/Supervisee 3. TBAs/Clients 4. TBAs/Health Personnel Above as two-way communication and importance of maintaining an open channel of communication at all levels. How to communicate effectively, especially at grass roots level.
Principles and techniques of teaching	1 hour	Objective of teaching; role of teacher/instructor; importance of educational aids; relationship between trainees' background knowledge and the success of a teaching programme. Emphasise "learning by doing".

Course Content	Time	Breakdown
Educational Aids	3 hours	Purpose – maximum gainful utilisation. Importance of correct selection. Place of professionally prepared aids in TBA training. Advantages of simply prepared aid. Development of simple aids from available resources.
Principles and techniques of supervision	1 hour	Definition – purpose Role of supervisor and supervisee. Supervisory skills. Human relationships.
Evaluation	1 hour	Objective; principles of developing questionnaires (oral as well). How to analyse result of evaluation and to obtain maximum benefit from the result.
Establish the basis for developing training curriculum for family planning motivators.	1 hour	**Group work – guidelines** Preparation of step by step development of a curriculum such as:– 1. Determine the tasks to be carried out by the trainees. 2. What knowledge they will require in in order to perform their tasks effectively. 3. What skills they must acquire in order to do the tasks expected of them.
Prepare guideline for teaching home economics to members of village women's clubs	3 hours	**Group work – guidelines** 1. Define "home economics" 2. Determine time required. 3. Appraise the make-up of the village women, such as – Background – social, cultural and educational 4. Plan programme accordingly. 5. Determine the teaching methods to be adopted.

Course Content	Time	Breakdown
Supervision of the traditional birth attendants	3 hours	**Group work – guidelines** 1. Define a supervisor – old and modern concept. 2. Qualities of good supervisors. 3. Problems in supervision – methods of preventing the same. 4. Procedure for maintaining continued supervision without involving too much expense.
Development of a reproductive health care training curriculum for traditional birth attendants	48 hours	**Group work – guidelines** 1. Study the functions the TBAs are expected to carry out. 2. Identify the various kinds of knowledge they must acquire in order to carry out their tasks. 3. Enumerate the skills they will have to learn in order to do their jobs effectively. 4. Determine the period of training necessary, taking the TBAs' background into consideration. 5. Develop the curriculum as follows:– a) Content of syllabus b) Methodology c) Breakdown of content d) Evaluation
Teaching practice	50 hours	Classroom – audience – delegates Field – TBAs as trainees, if possible.
Practical Supervision	5 hours	Clinical and Field

WORKSHOP ON TRAINING OF TRAINERS AND SUPERVISORS OF RURAL HEALTH WORKERS, KABUL, AFGHANISTAN, 7th JANUARY-2nd FEBRUARY 1978.

Field Director: Mrs. B. Brohier.

Participants: 19 Afghani midwives and nurses as follows:
4 nurse-midwives – three were nurse-midwives' teachers and one a teacher of auxiliary nurse-midwives.
6 midwives
2 nurses
5 auxiliary nurse-midwives
2 auxiliary nurses.

I. Rationale

Afghanistan had developed a dai programme, and training of dais was part of it. In view of this, the Nursing President, Nursing Presidency, Ministry of Health, suggested (and the reporter agreed) that the aim of the Workshop should be slightly broadened, i.e. instead of training of trainers of dais and rural health workers, the Workshop would be for the training of trainers and supervisors of all categories of paramedical personnel in Maternal and Child Health and Family Planning services, especially in rural areas.

II. Objectives

To train the participants to:

1. Identify major health problems of mothers and children in Afghanistan.
2. Define the role that the dais of Afghanistan have in improving Maternal and Child Health.
3. Participate in a training programme for rural MCH workers, including implementation and evaluation of the programme, primarily at the local levels.
4. Explain the major purpose and methods of supervision, especially related to rural health workers.

III. Preliminary visits, August 1977

(a) ***Purpose of visit***

To clarify if the Training Seminar requested by the Ministry of Health was the same as the ICM offer of a Training Seminar for the Trainers of Rural Health Workers. The Ministry seemed to have misunderstood the ICM offer, and asked them to conduct a four-

week National Seminar (24th September – 22nd October 1977) to explore various ways of expanding the midwife's role.

(b) ***Meeting with Director of Nursing, Ministry of Health***
It was explained that a Seminar such as they had proposed was not possible under the new Project, and after discussion she agreed to accept the ICM proposal. There was already a programme for dai training and the reporter was advised to meet representatives of the agencies concerned. Dates were discussed, but decisions were left to a later meeting.

(c) ***Meeting with TBA Training Project Officials***
The dai training course was discussed and reasons given why a meeting in January 1978 would be advisable; the date was later confirmed as 7th January – 2nd February. Details for the preparation of the Seminar were worked out with a local committee for implementation by that committee.

(d) ***Meeting with Deputy Minister of Health***
It appeared that Afghanistan had not been able to implement the recommendations of the Cento Countries Working Party regarding the expanded role of the midwives. Midwives were not trained for these functions. Training was needed and the country would need technical or financial assistance for this. It was suggested that the Ministry of Health should approach ICM.

(e) ***Meeting with Director-General, Public Health, Ministry of Public Health***
He talked at length about the need for ICM to provide assistance to countries such as Afghanistan. It turned out that he was angling for invitations to participate in the Middle East Inter-Regional Seminar, Khartoum, but it was pointed out that a country was never asked to participate twice unless they could do so at their own expense. It appeared that a wrong choice of delegates had been made for the Cento Countries Working Party.

(f) The USAID representative was most helpful at all times.

IV. The Workshop

(a) ***Attendance:*** Those attending comprised:
19 delegates from Afghanistan, as listed above.
1 auxiliary nurse-midwife student as observer.
9 speakers
6 co-ordinators
2 resource persons
2 ICM officials

(b) ***Organization***

1. A local committee was set up; the names of its members are given in Appendix I.
2. The venue of the Workshop was the Nursing Training Center, Kabul.
3. The language of the Workshop was Dari.
4. Training methodology consisted of Lecture/discussions (speakers were asked not to give straight lectures), discussions, groupwork, role playing, demonstrations, observation, practice, pre- and post-training questionnaires.

(c) ***Synopsis of proceedings***

At the Opening Session Mrs. Mariam Shanawaz, Nursing President, welcomed the Minister of Public Health, the guests and participants, and introduced the ICM officials.

Professor D. Omer, Minister of Public Health, welcomed all present and spoke briefly on the general health programme of Afghanistan with its emphasis on MCH care. Primary health services had been brought to a wider range of population through the training of rural health personnel, including dais, and he hoped that the Workshop would further stimulate this process. He spoke of plans to provide basic health centres in every district so as to give Maternal and Child care to the growing population, and to reduce morbidity and mortality.

Mrs. Belinda Brohier, Field Director, ICM, then gave an account of the origins and work of the FIGO/ICM Joint Study Group and described the new ICM/USAID Project. This was followed by an explanation of the programme and the organization of the Workshop, and introduction of the participants.

Week 1

1. ***Specific objectives***

At the end of the first week each participant will:

i. know about the seven year health plan (MCH) of Afghanistan.
ii. know about the development and status of the dai programme.
iii. be able to use the Basic Health Centre Manual.
iv. be able to state the essentials of prenatal care, labour and delivery, and postpartum care.
v. know the high risk assessment of mothers and children.
vi. have visited at least one health centre.
vii. be able to state the essentials of premature, infant and child care.
viii. know about family planning, including anatomy and physiology, and infertility.
ix. know the essentials of teaching about health education to the family.

2. ***Pre-training questionnaire***

i. What are the maternal/child health services?
ii. Do you know anything about the dai training programme?
iii. What is your opinion about dais? Are they old, backward, stupid, no longer used? (Circle any true answer).
iv. Who will receive the benefit when dais are trained?
v. Have you read the new health manual?
vi. Write three important points of auxiliary nurse-midwife's work.
vii. Why is maternity care important? Give a brief answer.
viii. What are the three signs of a pregnant woman at risk?
ix. What are four signs of high risk in children under 5 years of age?
x. Why do you think it is important to visit a Basic Health Centre during this week?
xi. What is the benefit of using a method of family planning?
xii. What are three different methods of family planning which are available and used in Afghanistan?
xiii. Do you include health education talks or lessons in your clinic?

The week opened with a talk by Dr. Mujaddedi Aziz Ashraf, Director, Basic Health Services, on The Maternal and Child Health Programme in Afghanistan: The Seven Year Plan for MCH Services. His main points were:

i. MCH care in basic health centres.
ii. The need for rural health services because 85% of the population lived in rural areas.
iii. The need to recruit rural health workers or dais from the village where they would work.
iv. The need to use paramedicals as rural health workers in the villages.
v. The justification for training dais as rural MCH workers were (a) they assisted rural mothers at delivery, (b) lack of trained professional nurses and midwives, especially in rural areas, (c) they could be used as family planning workers.
vi. The Minstry of Public Health planned to have dais and rural health workers working with auxiliary nurse-midwives in the districts.
vii. The dai programme, and the importance of keeping the public informed of it and of the various government health programmes.
viii. Midwives and auxiliary nurse-midwives should be prepared to work in rural areas.

A discussion followed on *The Problems with Dais.* Speakers talked from personal experience of how the relationship between midwives and dais had improved following the setting up of the dai programme. It was agreed that dais should be used in health education, preventive MCH care, and should know how to take histories and which cases to refer. The type of training course suitable for dais was also discussed.

The Development and Current Status of the Dai Programme was then described by Dr. Younas Hassan, Medical Officer, Director of Basic Health Services. He gave the reasons why the Ministry of Public Health had promoted the dai programme, discussed the content of the curriculum, the number of courses held so far, the result of training, and the place of follow-up and supervision.

The first day closed with a panel presentation on The MCH Personnel. Ms. Jamila Farhadi, Assistant Director, Nurse-midwifery School, Zaishgah Hospital, spoke of the training, functions and responsibilities of nurse-midwives at that hospital, Ms. Habiba Habib, Director, Auxiliary Midwifery School, spoke of the training and functions of auxiliary nurse-midwives in the MCH services and Ms. Roqya Kakar, nurse-midwife, Basic Health Services, explained the activities of basic health centres and the functions and responsibilities of the auxiliary nurse-midwives who worked in them. Ms. Kamila Weiss, Assistant Director, MCH clinics, reviewed the services offered at MCH clinics and the role of the nurse-midwives and auxiliary nurse-midwives employed in them.

On Monday morning Ms. Guljan Jalal, Assistant Director, Nursing Training Centre, introduced the participants to the various MCH educational materials and said where they could be obtained, discussed health education classes in MCH clinics and showed how to select appropriate materials for educational talks and how to use them effectively. She then conducted the participants round the Nursing Training Centre and introduced them to its facilities, in particular the library.

Ms. Roqya Kakar introduced the new health training manual and went through its various sections. The participants them split into four groups to consider the manual further and found that it was simple to use.

The afternoon was devoted to consideration of *Essentials of Prenatal, Natal and Postnatal Care: Emphasis on High Risk Pregnancies* and opened with a paper by Ms. Hawar Aziz, Director of Zaishgah Polyclinic. She outlined the objectives of maternity care and listed the factors producing high risk.

On Tuesday a visit was paid to Shewaki Health Centre – a MCH training centre for nurses and midwives. The various activities of the centre were inspected and afterwards a discussion was led by the Director. Emphasis was on treatment of sick children, but with education of the mothers they were hoping to develop well-baby clinics. The preventive aspect was beginning to be understood. Those participants working in Basic Health Centres said that they could not offer comparable services because they lacked drugs and equipment.

Later a talk on *Essentials of Child Care: Emphasis on Assessment of High Risk in Children from 0-5 Years* was given by Ms. Guljan Jalal, who listed the main constituents of care and the conditions indicating risk.

The next day the subject turned to *Family Planning, Health Education and Family Health.* Ms. Afifa Yousefi, General Director, Afghan Family Guidance Association, spoke of *Family Planning* and outlined the reasons for it, the anatomy and physiology of reproduction, and the methods available together with side-effects, contraindications, etc. She noted that male sterilization was not accepted by Afghan men and abortion was illegal. Demonstrations were given after the description of each method.

Mr. A.K. Azizi, Public Nurse, Nursing Presidency, Ministry of Public Health, spoke on *Health Education.* He distinguished between education and propaganda and went on to discuss the need for health education, its objectives, and the areas in which it could be applied. Of these nutrition, hygiene and MCH/FP and preventive aspects were among the most important. The principles on which health education was based included communication, understanding, participation, motivation and reinforcement.

Mr. Azizi went on to discuss *Family Health Care.* After defining the family and its needs he stated the objectives of family health care – to maintain good health by nutrition education, immunizations and MCH services. He showed how these various components could be satisfied by care and teaching during attendance at MCH clinics and during home visiting. The need for family planning was stressed.

Week 2

1. *Specific objectives*

   At the end of the second week each participant will be able to:

   i. collect ideas about the dai.
   ii. do brainstorming with a group.
   iii. demonstrate practical work to students.
   iv. explain principles of good technique in communication.
   v. work in a group on training events.
   vi. make work objectives.
   vii. prepare a training event.
   viii. give and receive feedback, conduct simple evaluation of local programmes and the performance of personnel.
   ix. use visual aids.
   x. plan a learning situation at her place of work, i.e. in-service.

2. *Pre-training questionnaires*

   i. Does a teacher need to know the objectives for teaching to be effective?

ii. For teaching to be effective, does the teacher need to use educational aids?
iii. Is special planning necessary for the preparation of a dai training course?
iv. Feedback is (a) reporting back information; (b) reporting activities; (c) makes people upset; (d) gossiping. Circle true answer.
v. Problems can be solved if they are discussed in a group. Yes or no.
vi. If we want to identify MCH problems, the best way to do this is by discussion. Yes or no.
vii. Can attitudes be changed through health education?
viii. Can attitudes be changed through legislation?
ix. Do you give demonstrations with your health talks?
x. Our problems cannot be solved by discussion. Yes or no.
xi. Dais are too old to learn anything new. Yes or no.

Week 2 began with three talks on aspects of teaching. Ms. Guljan Jalal spoke on *Training Methodology*, Ms. Asifa Aminzada, teacher, auxiliary nurse-midwives school, on *Role Playing as a Teaching Method* and Ms. Saida Noel, Director, Nursing School, Zaishgah Hospital, gave a *Demonstration of a Method of Teaching*.

Ms. Guljan said that good methods needed to be backed up by a good qualities in the teacher and a good teaching environment. She described different teaching methods and teaching aids. The other two speakers each presented their subject in the form of a lecture/discussion followed by a demonstration to illustrate their theme, which in turn provoked further discussion.

Principles and Techniques of Communication were dealt with by Mr. Azizullah Haidari, Director of Nursing Services Administration, and assisting with Nursing Education, Nursing Presidency, Ministry of Public Health. He began with a demonstration of ineffective communication between instructor and student, which was followed by discussion. He then went on to discuss the principles of communication and the various methods and techniques available. Afterwards the participants split into four groups to work on Planning of Training Events – how to set objectives, how to develop a teaching plan, how to implement teaching and how to evaluate. Each group was given one specific topic.

The next day was given over to consideration of educational aids. Ms. Guljan Jalal introduced the subject, described the various visual aids available, and how to select and use them. After films had been shown the groups met and each participant prepared a visual aid and demonstrated its use in practice. Discussion and comments followed each presentation.

On the Monday further talks were given. Ms. Habiba Habib spoke on *Evaluation* – which she defined as a way of finding out how well the

student had learned and how well the teacher had taught. Evaluation could be performed by examinations, and she described the objectives and methods of examination and illustrated her points by discussing evaluation of dai training and of the trainer.

Ms. Guljan Jalal described the *Principles and Importance of Feedback*, which was another means of evaluation.

Group work on planning training events continued in the afternoon.

On Tuesday Ms. A. Richter, UCSC Adviser, auxiliary nurse-midwife programme, spoke on *Developing Attitudes to Learning in the Context of the Training of Dais.* She stressed the need to create working relationships, find out what the problem was, encourage by praise and participation, teach only as much as the student could learn, and correct mistakes without causing embarrassment.

This was followed by a lecture/discussion presented by Dr. J.W. Le Sar, Medical Officer, MSH Team. He covered the general principles of curriculum development and the application of them to the development of the dai curriculum; how the six phases of the development of the dai curriculum were planned and implemented; and the pros and cons of training methods. He demonstrated one method of teaching dais by role playing by two dai trainers, and stressed the importance of summarizing after each lesson.

The groups then reported on their work in planning training events. Group A had chosen pelvic assessment, fetal position/presentation and management of breech delivery; Group B had chosen diagnosis and treatment of dehydration; Group C nutrition of mothers and children 0-5 years, and Group D the need for dais and rural health workers. Each group described how they had planned the teaching and followed with a practical demonstration using lecture/discussions and visual aids.

On Wednesday the group work assignment was changed as it was realized that not all participants would be involved in dai training. The discussions were therefore widened to 'Development and Implementation of In-service Training courses for:

dais by the auxiliary nurse-midwives
MCH workers by MCH midwives
family planning counsellors by family planning midwives
auxiliary nurse-midwife teachers } by nurse-midwife teachers.
nurse-midwife teachers

Reports from the groups were presented the next day under the headings: objectives of training; tasks to be done; curriculum content; training methods; evaluation.

Week 3

1. ***Specific objectives***

   At the end of the third week each participant will:

   i. know the principles of supervision.
   ii. have observed at least one supervisor at work.
   iii. will be able to describe approaches to problem solving.
   iv. describe the role of supervision in developing a dai programme.
   v. be able to state different methods of supervision.
   vi. know the essentials of evaluation of a programme.

2. ***Pre-training questionnaires***

   i. Dais are (a) village doctors; (b) untrained midwives; (c) auxiliary midwives. Give one answer only.
   ii. Dais practise in (a) hospitals; (b) villages; (c) cities. Give one answer only.
   iii. There are many dais in the developing coutries because the village mothers do not like other people to care for them. True or false?
   iv. Name three jobs the dais do.
   v. Which of the following do you think would be the most suitable place for dais to work in? (a) polyclinics; (b) in modern hospitals; (c) in the homes.
   vi. Who should supervise the dais? (a) The President of a hospital; (b) the doctor; (c) the Nursing President; (d) the student midwives; (e) the midwives; (f) the auxiliary midwives.
   vii. What are the qualities of a good supervisor? (a) She should be like a policewoman; (b) she must always be ready to find fault; (c) she must always punish her staff if they make mistakes or do not do their job well; she should be an adviser, teacher and friend.
   viii. Give three ways dais can help to introduce modern medicine to the village community.

Week 3 concentrated on Supervision and Problem Solving. Ms. Kamila Weiss, Assistant Director, MCH Clinics, led a session entitled *Brainstorms on Supervision.* Each participant had to give her own understanding of 'Supervision'; all the views were recorded and then discussed. The object was to encourage the participants to think and to accept criticism gracefully. Ms. Jamila Farhadi then spoke on *Supervision* and defined its meaning and concepts and described its techniques. She went on to describe the qualities and responsibilities of a good supervisor. Ms. Habiba, Director, Nursing Training Centre, discussed *Interpersonal Relationships* and listed the factors which promoted good relationships.

On Sunday Mr. A.K. Azizi spoke on *Problem Solving* and this then formed the subject for group work for the remainder of the day.

On Monday the groups discussed 'How to Carry out effective Super-

vision of (a) MCH workers, (b) dais, and prepared a consensus report. Their main points were:

i. Supervision, to be effective, must be carried through from Minister of Public health down to Basic Health Centres.
ii. Auxiliary nurse-midwives, midwives, sanitarians and/or vaccinators could supervise dais and village health workers. Usually midwives or auxiliary nurse-midwives supervised dais and female village health workers.
iii. Supervisors should be mature and interested and know their own jobs well, as well as those of the people they supervised. Good relationships were vital and supervisors should be understanding, kind and helpful.
iv. Effective supervision should be planned and regular. It should be continuous and be carried out in all situations. Credit should be given where due and the reasons for poor performance discovered.

On Tuesday and Wednesday there was field experience in Zaishgah Maternity Hospital where the participants were able to observe supervision of the auxiliary nurse-midwife students' clinical practice in Obstetric, Maternity, MCH and Family Planning Departments. Experiences were discussed and a report prepared. Routine postnatal examination was not provided at the hospital and was only given to women who complained. The participants seemed not to notice this omission and opportunity was taken to stress the importance of the routine postnatal examination, and the Field Director also made this point to the Director of the clinic. During discussion on supervision of students it was pointed out that supervision was not only of performance, but should include the giving of opportunities for students to learn.

Week 4

1. ***Specific objectives***

   At the end of the fourth week each participant will:

   i. be able to prepare a plan to help their work with dais in their jobs.
   ii. have observed different methods of teaching that health workers use in clinics and in hospitals.
   iii. be able to teach a subject on maternal and child health in a clinical setting.

2. ***Pre-training questionnaires***

   i. Is it necessary for dais to continue their job?
   If 'yes', can they do this without training? Give reasons for your answer.
   ii. Name six activities of prenatal clinics.
   iii. If you want in help in dai training, what subjects do you want to teach?

iv. When mothers bring their children for vaccination, what kind of instructions do you give them?
v. Should MCH and family planning education be taught at the same time or at different times? Give reasons for your answer.
vi. Do you know what feedback is? If so, give examples.

In week 4 the question of dai training was discussed. The first speaker was Ms. Marie Moseni, Nurse Co-ordinator, MSH Team, who dealt with *Recruitment, Location, Training and Utilization of Dais.* Recruitment was necessary because of the preponderance of rural population, shortage of professional personnel, and the fact that dais were already practising and their practice could be improved with training. Location was carried out by the nurse-midwife and female village health worker calling on the village leader to discuss the programme; if then there is no opposition from the leader, the villagers are informed and practising dais invited to meet the team to discuss training. Those who volunteer are tested, and those qualifying are given appointments for training. Training was in hand; 72 dais were already trained and the government planned to train 3,500 in five years. Refresher courses would also be provided. Training would be conducted by the Directorate of Basic Health Services. In utilization, the functions of the trained dai would be to promote better material and MCH/FP services, to help reduce maternal and infant morbidity and mortality by safe practice and early detection of abnormal cases, and in health education, family planning and detection of illness and referral for medical care.

The remainder of the day was devoted to group work when the subject was role playing in the teaching of dais in a clinical setting.

On Sunday the participants returned to the same clinics they had attended the previous week for further field practice, and reports on this activity were then presented.

On Monday the participants prepared post-Workshop action plans and presented these for discussion. Those that were not practical were returned for modification and help was given in the revision.

On Tuesday field visits were paid to the Kabul water purification plant and to the vaccine supply department. Reports were prepared and presented on these two visits.

On Wednesday Ms. Roqya Kakar introduced the Dai's Home Visiting Card and explained its use. Cards were given to each participant.

An evaluation questionnaire covering the entire Workshop was then completed.

On Thursday Dr. Mohd. Asaf Gharwal, President, Curative Medicine, Ministry of Public Health, gave the Closing Address, votes of thanks were given and certificates of attendance presented.

V Analysis of Evaluation Questionnaires

Q. Do you think there should be more Workshops like this one?

A. All the participants would like future seminars for midwives to be conducted in the same way as this Workshop because they had never learned so much before.

Q. Which subject(s) did you find most helpful and interesting?

A. All found the subjects most helpful and interesting.

Q. Which subject(s) would you recommend for future Workshops?

A. They recommended that all the subjects should remain for future Workshops.

Q. Please give your frank comments on the Workshop.

A. i. The majority said that no Workshop should be organized during the winter, but if it had to be, it should be held in a warmer place.

ii. One participant said that there should be only morning sessions.

iii. One participant said that the post-training tests gave her a headache.

VI Comments

The Workshop was the first of its kind ever organized for midwives of Afghanistan (the participants as well as the co-ordinators).

The co-ordinators claimed that, although they were fortunate enough to have had training abroad, they had not utilized their knowledge and skills as they did during the Workshop. This experience had given them confidence and they felt certain that they would function better in their specified fields.

The participants' desire to learn and the interest they had in the Workshop motivated them to work extremely hard and maintain their interest right through the Workshop.

The auxiliary nurse-midwife student who attended as an observer participated fully. She was very intelligent and had the right aptitude for a good teacher.

VII Post-Workshop Assignments

The participants submitted their proposed post-Workshop activities and hoped to implement them on their return.

The Nursing President, Nursing Presidency, Ministry of Public Health, sent a circular letter to the heads of the various departments associated with the participants asking them to assist the participants in putting their post-Workshop plans into effect, as ICM expected to receive the reports from the participants three months after their return.

VIII Conclusion

The Workshop would not have been successful without the support, co-operation assistance and guidance from:
The Ministry of Public Health
The Nursing President and members of the Presidency
The Director and Staff of the Nursing Training Centre
The Chief, Health and Family Planning Division, USAID, Kabul
The Members of the Management Sciences for Health Team .
Advisers for the auxiliary nurse-midwife programme
The University of California, Santa Cruz.

APPENDIX I

List of Participants

Delegates

Ms. Aqela Eqbal,
Nurse-Midwife, Teacher,
Auxiliary Nurse-Midwife School,
Khir Khana Mena

Ms. Khadija Sultan,
Midwife,
Central Maternal Child Health Clinic,
Kabul

Ms. Rahima Rahimi,
Nurse-Midwife,
Central Maternal Child Health Clinic,
Kabul

Ms. Marghalay Mangal,
Nurse-Midwife, Teacher,
Nursing Midwifery School,
Zaishgha

Ms. Aaisha,
Auxiliary Nurse, Head Nurse,
Maternity Hospital,
Herat

Ms. Mahdya,
Nurse-Midwife, Teacher,
Nursing Midwifery School,
Nangrhar

Ms. Mastura,
Assistant Nurse
Basic Health Center (Senati),
Baghlam

Ms. Parigul.
Assistant Nurse-Midwife,
Basic Health Center,
Nahrin

Ms. Mobeena,
Assistant Nurse-Midwife,
Basic Health Center,
Khulm

Ms. Maliha,
Nurse, Teacher,
Nursing School,
Masturat

Ms. Sameha,
Assistant Nurse-Midwife,
Basic Health Center,
Sangcharak

Ms. Marian,
Midwife,
Family Planning Clinic
Zaerhga,
Kandahar

Ms. Nooria,
Midwife, Teacher,
Nursing Midwifery School,
Kandahar

Ms. Rahima Naoroz,
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Mr. Noorulla,
Male Nurse,
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Ms. Belinda Brohier
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EPILOGUE

As will be seen from the list of activities recorded in the introduction to this Report, several seminars were being planned to take place during the second half of 1978 and 1979.

It is the intention to issue further reports annually, to record the activities under the ICM/USAID Project during the previous twelve months, and to up-date where necessary, the results stemming from Working Parties and Seminars which have already taken place.