AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C 20523

BIBLIOGRAPHIC INPUT SHEET

FOR AID USE ONLY
Batch 83

1. SUBJECT CLASSIFICATION

A. PRIMARY
Health
NH00-0000-G570

B. SECONDARY
Maternal and child health care--Asia

2. TITLE AND SUBTITLE
Report of the West Asia working party

3. AUTHOR(S)
(101) West Asia Working Party of the Int.Confederation of Midwives,Kuala Lumpur, Malaysia,1975; Int.Confederation of Midwives,London

4. DOCUMENT DATE	5. NUMBER OF PAGES	6. ARC NUMBER
1975	~~279p.~~ 280p.	ARC

7. REFERENCE ORGANIZATION NAME AND ADDRESS
ICM

8. SUPPLEMENTARY NOTES *(Sponsoring Organization, Publishers, Availability)*

9. ABSTRACT

10. CONTROL NUMBER
PN-AAF-534

11. PRICE OF DOCUMENT

12. DESCRIPTORS
Asia
Family planning
Gynecology
Health education
Medical education
Medical personnel
Midwife
Meetings
Obstetrics
Personnel development

13. PROJECT NUMBER

14. CONTRACT NUMBER
CSD-3411

15. TYPE OF DOCUMENT

AID 590-1 (4-74)

REPORT

OF THE

WEST ASIA WORKING PARTY

IN

MATERNAL CHILD HEALTH AND FAMILY PLANNING

KUALA LUMPUR, MALAYSIA

OCTOBER 17 - 25 1975

SPONSORED BY

USAID GRANT NO. CSD 3411

IN CO-OPERATION WITH THE JOINT STUDY GROUP

OF THE

INTERNATIONAL CONFEDERATION OF MIDWIVES

AND THE

INTERNATIONAL FEDERATION OF GYNAECOLOGY

AND OBSTETRICS

PRINTED FOR AND DISTRIBUTED BY THE

JOINT STUDY GROUP OF THE ICM/FIGO

NOTE

The views, consensus reports and recommendations expressed and published in this Report are those of the delegates of the Working Party and do not necessarily reflect the policies of any one person or country.

This Report has been prepared by the ICM for governments of the States in the region and for those who participated in the Working Party in Maternal and Child Health/Family Planning for Midwives and Obstetricians, which was held in Kuala Lumpur, Malaysia, October 17 - 25 1975.

All health personnel involved in Maternal and Child Health/Family Planning Services will find this Report useful.

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INTRODUCTION

The progress of a country depends greatly upon the quality of its citizens which are indirectly its wealth. The ingredient for a high quality of life for any person is "Positive Health" i.e. he must enjoy physical, emotional and social well-being. This can only come about if he is given total health care from his conception onwards. According to the UN Children's Act, every child has the right to expect to be given the best possible opportunities to develop into a quality citizen.

In many developing countries, overpopulation resulting in poor economic growth, inadequate health services (particularly in the rural areas) have deprived their citizens of their rights to develop into useful and quality citizens.

It is obvious that frequent pregnancies and large size families have detrimental effects on the health of a family, especially of the mothers and their babies.

The midwives, the acclaimed friends, teachers and confidants of the women they serve, would be the most suitable health personnel to have their role expanded so as to enable them to function in varied areas of the health fields such as family planning, nutrition, paediatrics and health education.

The International Confederation of Midwives in co-operation with the Joint Study Group of the International Federation of Gynaecology and Obstetrics and the International Confederation of Midwives is strongly recommending that every midwife of whatever category be appropriately prepared to enable her to function effectively in her expanding role.

This Working Party is in a small way supporting the International Women's Year by promoting the development of midwives, who are chiefly women to enable them to function more effectively in the delivery of family health care, thus participating in National Development.

BACKGROUND - AIM and OBJECTIVES

The International Confederation of Midwives, in co-operation with the Joint Study Group of the International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics (ICM/FIGO), held a Working Party in Kuala Lumpur, Malaysia, from October 17-25, 1975, for senior midwives and obstetricians from the West Asian Region.

Nine similar Working Parties were held in various parts of the World to assist nations to formulate health programmes which would meet the AIM of ICM and FIGO. This is "To continue the improvement of maternal and child care and the quality of maternal and child life through the inclusion of Family Planning smong the services provided by midwives of all categories in their expanding role".

The Objectives of the Working Party

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 obstetrics 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:

      i) Regulations
      ii) Curriculum modification
      iii) Define the broad areas of the new curriculum content which should be incorporated in the training of each category of midwifery personnel.
      iv) Post Basic Training/Continuing Education
      v) Seminars/Workshops

   c) Services:

      i) Working with TBAs.
      ii) Working with professional organisations

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

PREPARATION - PROGRAMME - PROCEDURE

OF THE WORKING PARTY

PREPARATION

Governments - Ministries of Health, Obstetric Societies, Midwifery Associations (where they exist), Planned Parenthood Federations, Family Planning Associations (National or otherwise), World Health Organisation, UNICEF and International Paediatric Association were all sent letters with enclosures relating to the history of the ICM/FIGO Joint Study Group and the AIM and Objectives of the Working Party.

Countries invited to the Working Party were requested to nominate three delegates - two senior midwives and one obstetrician. All their expenses were paid by the International Confederation of Midwives (ICM) through a grant from the United States Agency for International Development (USAID). Governments and International Organisations were invited to send observers if they wished, but at their own expense.

A Local Committee was formed to advise the Regional Field Director of local customs and culture and to work with her in the general preparation of the Working Party and assist in the management during its duration. Members of the local committee are senior officials from the Ministry of Health - Maternal Child Health/ Family Planning, Midwifery/Nursing Division, Midwifery School, National Family Planning Board, Obstetrical and Gynaecological Society and Department of OB/GYN University of Malaya.

Following the written communications, the Regional Field Directors visited the countries invited to participate and fully discussed the proposed Working Party. This personal contact stimulated the plan of action for the Working Party and the post Working Party action programmes.

The governments and delegates were asked to update their country reports on maternal and child health/family planning and where there were no previous reports they were requested to prepare one. The reports were useful in that it enabled the delegates to review their own country's situation, helped the project staff in their planning and further understanding of the many complexities in each country, as well as providing useful data for the new publication of the book "Maternity Care in the World".

Educational materials - books, posters, films, literature and documents relating to Maternal and Child Health/Family Planning (MCH/FP) and nutrition were sent from ICM headquarters to set up a library at the Working Party. The delegates were invited to take whatever materials they wanted. The delegates were asked to bring with them educational materials related to MCH/FP and nutrition as exhibits at the Working Party.

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

Continuous communication was maintained between the participating countries, delegates and the Regional Field Director. The magnificent co-operation of the local committee and the hard work put in by the local committee and the Regional Field Director contributed greatly to the success of the West Asia Working Party.

ORGANISATION - PROGRAMME - PROCEDURE

The design of this programme was to focus attention on the midwife as a key person in the FP field because of her unique position in the health team and to ensure that FP is included in the training curricula of all categories of midwives.

The AIM of the Joint Study Group of the ICM/FIGO and the objectives of the Working Party have been recorded earlier in this report as a background. The programme included various topics for discussion, presentation of papers and the submission of prepared country reports.

Delegates were divided into three groups, consideration was given to communication problems and group interactions. Group Chairmen and rapporteurs were elected by the delegates and they held office for the whole duration of the Working Party. Every plenary session had a Chairman and a rapporteur who were responsible to the Rapporteur General.

The Rapporteur General was appointed by the Regional Field Director, who acted as the Working Party overall Director. The Rapporteur General was assisted by a Co-Rapporteur.

A Reports Committee, made up of the three Group Chairmen, the Co-Rapporteur and the Rapporteur General who was Chairman, was formed. The Reports Committee was responsible for consolidating group reports into consensus reports, which included recommendations made by the delegates. The Reports Committee prepared the Final Report which was presented by the Rapporteur General on the last day of the Working Party. The Final Report was unanimously adopted.

WORKING PARTY

The Hon. Deputy Minister of Health, Encik Abu Bakar bin Umar, SDK, in his opening speech enumerated various problems which impede the progress of family health services in the majority of the participating countries. As these problems are closely related to midwifery practice and the midwives are key members of a multi-disciplinary health team in the delivery of total family health care, he advocated that midwives must be adequately prepared, given legislative protection and properly supervised so that they can practise effectively in their expanding role.

He stressed the importance of including family planning as an integral part of socio-economic development. As an example, he quoted a passage from the Prime Minister's opening address of the ILO/ECAFE Asian Symposium on Labour and Population Policies in Kuala Lumpur, July 27 1972 - "The neglect of reducing the population inflows is perhaps the greatest of demographic hazards of the 70s. It is therefore clear that neither the miracle of the green revolution nor the recent technological breakthrough has succeeded in removing the need for a population policy in Asia".

During the remaining seven days, the participants heard papers on various topics in Family Health Care, Family Planning and Family Planning in National Development. The delegates discussed the major topics very extensively. As they shared common problems and their needs are similar, the delegates seemed to have a unified approach in formulating their recommendations for the following:

1. The Expanding Role of Midwives

   This covers family planning education and service, maternal and child care - preventive and curative and Nutrition. Midwives need to be prepared for these specialised fields and given job satisfaction if they are to contribute effectively in their expanded role.

2. Integrated Programmes

   It was unanimously agreed that Family Planning should be fully incorporated with the Family Health Services and this should be done through an integrated approach and collaboration of all organisations concerned.

3. Traditional Birth Attendants (TBAs)

   All the delegates agreed that the TBAs have to be identified, given appropriate training and registered before given a licence to practise in their expanded role. It is important that they be assisted to function effectively through regular supervision.

4. Promotion of Family Planning

   All the delegates agreed that the delivery of family planning education and service should be the responsibility of all categories of midwives, including the TBAs.

Bangladesh, Nepal, Sri Lanka, Thailand and Malaysia were the participating countries. The participants were made up of seventeen delegates, and observers from Thailand, Malaysia, WHO and IPPF.

In his closing address, Dr. Raja Ahmad Noordin, then Ag. Director-General of Health, congratulated the delegates on their deliberations which resulted in the practical recommendations. He wished the delegates, especially the visitors, good luck with their follow-up action plans.

RECOMMENDATIONS

Preamble

The Working Party participants, even at the outset of their deliberations recognized:

1. The broad range of primary health care needs that exist at the community level.

2. That the midwife of all categories is usually the primary and continuing contact with the family unit, and therefore must be fully equipped through training, to manage a broad range of primary health care needs.

3. That a potential overload of midwife functions could arise.

I. General

The West Asia Working Party, in the light of the proposed expanded role of the midwife of all categories, strongly urges that governments conduct:-

a) Feasibility studies of such expanded roles before they are widely implemented.

b) That after implementation of the recommended expanded roles conduct task and functional analyses at appropriate intervals to assess the effectiveness with which the expanded roles are carried out and where tasks and functions need to be modified.

II. Specific

a) The Priorities and Problems in Family Health Services and in Family Planning Information, Education and Communication

1. 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.

2. Proper identification of problem areas.

3. The plan should be simple, practical and acceptable to the people.

4. Good co-ordination between all Government departments and voluntary organisations.

5. Planning of seminars should include all key personnel required by the planners - medical, administrators, midwives, economists and research staff.

6. Health education of existing personnel by in-service training and refresher courses.

7. Crash training programmes of new personnel.

8. 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.

9. Expand Basic Health Services in the rural areas by having more infra-structure, trained personnel and equipment.

10. Government should formulate national policies on food, nutrition, health and family planning.

b) <u>The Expanding Role of all Categories of Midwives and Traditional Birth Attendants in Family Planning Information, Education and Communication</u>

The Participants at Working Party recommend that:

1. 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.

2. That greater emphasis be given to health education and motivation in basic training curriculum. Health Education materials suitable to the community should be made available.

3. That all midwives be given regular refresher courses at least every five years including Health Education and Family Planning.

4. a) More elaborate procedures such as insertion of IUD and the management of material and paediatric emergencies e.g. giving of intravenous and manual removal of placenta should be included in the basis midwifery curriculum so as to enable them to function effectively in isolation where medical aid is not readily available.

   b) Midwives assigned to remote areas should be given special refresher courses in these procedures.

5. To improve the standard of patient care, promote efficiency of service and to ensure job satisfaction, there must be better liaison and two way communication between hospital and field service.

6. Limited curative medical care for minor ailments should be part of a midwife's function.

7. The reporting of all births, maternal and child deaths be a standard procedure for all midwives.

8. Immunization should be one of the essential functions of the midwife.

c) The Incorporation of Family Planning, Paediatrics and Nutrition in the Basic Midwifery Training Curriculum

The Working Party participants strongly recommend that Family Planning Paediatrics, and Nutrition be incorporated into the basic midwifery curriculum. It is therefore recommended that:

1. This should be implemented by modification or review of existing curricula, with emphasis on those aspects thought to be most important.

2. Where applicable and available, medical personnel, especially obstetricians and paediatricians as well as health educators and nutritionists, should be involved in instruction.

3. Health education and motivation must have a high priority in the training curricula of all categories of midwifery personnel and TBAs.

4. 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 post-basic training for midwives.

5. The training of midwives in paediatrics should prepare them to provide care for the child from birth through school age. This should include:-

   a) Infant feeding and the importance of breast milk.

   b) Management of low birth weight babies.

   c) The ability to detect certain abnormalities and genital problems.

   d) Communicable diseases and immunization.

   e) Interaction of infection and infestation with nutrition.

   f) Assessment of growth and development.

   g) Recognition of the "well-baby"; recognition of departures from the normal and recognition of critical signs such as dehydration and fever.

   h) The ability to treat simple minor ailments.

1. It is recommended that nutrition be identified as an expanded area in the training curriculum, under the following headings:-

a) Nutrition and home economists should be invited to participate as instructors, with consideration for local dietary patterns, eating habits, local taboos, cooking practices, etc.

b) Emphasis on nutrition for the pregnant, post-partum, and lactating mother.

c) Emphasis be given to feeding, and to the correct diet on weaning from the breast, and the importance of mixed feeding.

2. That the training syllabus be reviewed every three years after appropriate discussion with personnel at all levels.

3. Refresher courses for midwives should be held at least every five years, including new advances in family planning methods.

4. Instructors and supervisors should establish a good follow-up system to ascertain whether what was taught during the training period is being practised in the field.

5. In view of the responsibilities undertaken in their expanding roles, all midwives should have a more attractive salary and career structure.

6. Since auxiliary midwives are now expected to play a more important role in the delivery of health services, and their training is to be expanded and upgraded, it is therefore recommended that the entry requirements be raised according to their own country's educational criteria.

7. Tutors must be specially prepared for these expanded areas in the midwifery curriculum - family planning, paediatrics and nutrition.

d) <u>The Delivery of Family Planning Education and Service is the Responsibility of all Midwives</u>

The participants at the Working Party recommend 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 standard of service including continuous availability of supplies.

EVALUATION

All the participants - delegates, observers and resource persons worked very hard and seriously to solve their common problems. They displayed great concern for their countries' problems and determination to overcome as much of these as possible. This was clearly shown in the countries' plan for follow-up action.

The participants were well rewarded for their enthusiasm and hard work by social activities. A Welcome Dinner was hosted by the Hon. Deputy of Health, Encik Abu Bakar bin Umar, SDK. The Nurses' Association staged a cultural show one evening. The highlight of the evening was "The Nutritional Wedding".

A G E N D A

THURSDAY **OCT 16**	**ARRIVAL** **REGISTRATION**
FRIDAY **OCT 17** **9.0 a.m. - 10.00 a.m.**	OPENING CEREMONY - Anggerik Room CHAIRMAN: Dr. Thomas Ng, AM, MBBS, FRCOG. Chairman, Local Organising Committee, Senior Consultant Obstetrics & Gynaecology Maternity Hospital, Kuala Lumpur, Ministry of Health, Malaysia. WELCOME ADDRESS Dr. Thomas Ng. OPENING SPEECH Y.B. Encik Abu Bakar bin Umar SDK The Honourable, Deputy Minister of Health, Malaysia.
10.00 a.m. - 10.30 a.m.	RECEPTION
11.00 a.m. - 12.00 noon	CHAIRMAN: Mrs. B. Brohier, SRN, SCM, HV, Regional Field Director, International Confederation of Midwives (ICM) 1. Self Introduction of Participants, Resource Persons and ICM officials. 2. AIM and objectives of the Working Party 3. Working Programme 4. Working Party Procedures 5. Grouping of Participants
12.00 noon - 1.00 p.m.	PAPER 1 THE ROLE OF CHAIRMAN, RAPPORTEUR AND PARTICIPANT SPEAKER: Encik Abu Kassim b. Hj. Mohamed, KMN Director, National Productivity Center, Ministry of Trade & Industry, Malaysia.
1.00 p.m. - 2.30 p.m.	LUNCH

2.30 p.m. - 3.00 p.m.	CHAIRMAN: Mrs. B. Brohier PAPER II THE ICM/US-AID PROJECT SEPAKER: Miss Margaret Hardy, SRN, SCM, MTD, DN Executive Secretary, ICM, Secretary, ICM/FIGO JOINT STUDY GROUP
3.00 p.m. - 3.10 p.m.	DISCUSSION
3.10 p.m. - 3.40 p.m.	Groups meet to elect Group Chairman and Rapporteurs for the week
3.40 p.m. - 5.0 p.m.	FILMS - Raya Room
8.00 p.m.	Welcome Dinner
SATURDAY OCT 18 8.30 a.m. - 10.00 a.m.	CHAIRMAN: Dr. Bruce Faris MBCH.B, FRCS(ED), FRACS, FRCOG. Medical Superintendent, St. Helen's Women's Hospital, Auckland, New Zealand.
	RAPPORTEUR: Mrs. G.M. Paranjothy, SRN, SCM, HV&SN, Public Health Matron, Maternal & Child Health Unit, Ministry of Health, Malaysia.
	COUNTRY REPORTS
	DISCUSSION
10.00 a.m. - 10.30 a.m.	COFFEE BREAK
10.30 a.m. - 12.00 noon	CHAIRMAN: Y.B. Senator Rafidah Aziz. AMN, MA, Lecturer, Faculty of Economics, University of Malaya.
	RAPPORTEUR: Ms Rita Raj Hashim BA(P/Sc.) Evaluation Officer, Federation of Family Planning Associations, Malaysia.
	PAPER III
	FAMILY HEALTH CARE IN DEVELOPING COUNTRIES
	SPEAKER: Dr. Frank N. Beckles, MD, Director, National Center for Family Planning, Health Services and Mental Health Administration, Dept. of Health, Education and Welfare, U.S.A.

11.0 a.m. - 11.15 a.m.	DISCUSSION
11.15 a.m. - 11.45 a.m.	PAPER IV FAMILY HEALTH SERVICES IN MALAYSIA SPEAKER: Dr. Raja Ahmad Noordin Raja Shahbudin JSM, AMN, BCK, MBBS, MPH, DPH. Director of Health Services, Ministry of Health, Malaysia.
11.45 a.m. - 12.00 noon	DISCUSSION
12.00 noon - 12.30 p.m.	CHAIRMAN: Dr. Norlaily Datuk Abu Bakar MBBs, MSc. (Med.Demog) London. Health Officer in charge Family Planning, Maternal & Child Health Unit, Ministry of Health, Malaysia. RAPPORTEUR: Dr. P. H. Amarasinghe MBBS(Cey), MRCOG (Gt.Brit.) Gynaecologist, South Colombo Hospital, Colombo, Sri Lanka. PAPER V FAMILY PLANNING INFORMATION EDUCATION & COMMUNICATION SPEAKER: Mr. Robert Blake UNESCO Regional Communication Adviser UNDP, Malaysia.
12.30 p.m. - 12.45 p.m.	DISCUSSION
12.45 p.m. - 2.00 p.m.	LUNCH
2.00 p.m. - 4.00 p.m.	Group Discussion No 1 Topic: THE PRIORITIES AND PROBLEMS IN FAMILY HEALT SERVICES AND IN FAMILY PLANNING INFORMATION EDUCATION AND COMMUNICATION.
4.00 p.m. - 6.00 p.m.	Group Chairman and Rapporteurs prepare Group Reports on Discussion No. 1
SUNDAY OCT 19	SOCIAL PROGRAMME

MONDAY OCT 20 8.30 a.m. - 10.00 a.m.	CHAIRMAN: Mrs. B. Brohier Presentation of Group Reports on Discussion No 1 by Chairman of each Group. Brief discussion, recommendations and acceptance of consensus report.
10.00 a.m. - 10.30 a.m.	COFFEE BREAK
10.30 a.m. - 12.00 noon	CHAIRMAN: Datuk Dr. Ariffin bin Ngah Marzuki AM, PSD, DPMT, DPMK, MBBS, FROCG, FICS. Senior Consultant, Obstetrics & Gynaecology, Maternity Hospital, Kuala Lumpur, Malaysia. RAPPORTEUR: Miss Margaret Hardy
10.30 a.m. - 11.15 a.m.	PAPER VI THE EXTENT TO WHICH MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS ARE INVOLVED IN MATERNAL & CHILD HEALTH/FAMILY PLANNING SERVICES SPEAKERS: Dr. P.H. Amarasinghe MBBS(Cey.), MRCOG (Gt.Brit.) SRI LANKA Puan Mahelan bte. Abdul Manap SRN, SCM, HV, SN. MALAYSIA Mrs. Mohan Tamrakar CNM, NEPAL Miss Lamom Srichandrabhad THAILAND
11.15 a.m. - 11.30 a.m.	DISCUSSION
11.30 a.m. - 12.00 noon	PAPER VII THE EXPANDING ROLE AND SCOPE OF PRACTICE OF ALL CATEGORIES OF MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN THE FIELD OF FAMILY PLANNING. SPEAKER: 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.
12.00 noon - 12.15 p.m.	DISCUSSION
12.15 p.m. - 2.00 p.m.	LUNCH

2.00 p.m. - 4.00 p.m.	Group Discussion No II Topics: 1. THE EXPANDING ROLE OF ALL CATEGORIES OF MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN FAMILY PLANNING INFORMATION EDUCATION AND COMMUNICATION 2. THE TRADITIONAL BIRTH ATTENDANTS AS MEMBERS OF THE HEALTH TEAM
4.00 p.m. - 6.0 p.m.	Group Chairmen and Rapporteurs prepare Group Reports on Discussion No II
TUESDAY OCT 21	
8.30 a.m. - 10.00 a.m.	CHAIRMAN: Mrs. B. Brohier Presentation of Group Reports on Discussion No II by Chairman of each Group. Brief discussion, recommendations and acceptance of consensus report.
10.00 a.m. - 10.30 a.m.	COFFEE BREAK
10.30 a.m. - 12.30 p.m.	CHAIRMAN: Prof. S.S. Ratnam MBBS(Cey), FRCS, FRCSE, FRCSG, FACS, FICS, FRCOG, MD, AM. Prof. & Head, Dept. of Obstetrics & Gynaecology, University of Singapore. RAPPORTEUR: Miss Helen Nathaniel SRN, SCM, HV.SN Family Planning Instructor, Regional Training Centre, Ministry of Health, Malaysia. PAPER VIII INTEGRATION OF FAMILY PLANNING, PAEDIATRICS AND NUTRITION WITH THE MIDWIFERY TRAINING PROGRAMME OF ALL CATEGORIES OF MIDWIVES.
10.30 a.m. - 11.00 a.m.	A. FAMILY PLANNING SPEAKER: Dr. Norlaily Datuk Abu Bakar
	B. PAEDIATRICS
11.00 a.m. - 11.30 a.m.	SPEAKER: Prof. Prasong Tuchinda MD, DTM&H(Eng.) Prof & Head, Dept. of Paediatrics University of Mahidol, Bangkok, Thailand.

11.30 a.m. - 12.00 noon	C. NUTRITION SPEAKER: Dr. Virginia Guzman MD, MPH, Professor, Maternal & Child Health, Chairman, Community Health University of Philippines.
12.00 noon - 12.30 p.m.	DISCUSSION
12.30 p.m. - 2.00 p.m.	LUNCH
2.00 p.m. - 4.00 p.m.	CHAIRMAN: Prof. Prasong Tuchinda RAPPORTEUR: Dr. Shamsun Nahar
	PAPER IX
	FAMILY PLANNING TRAINING PROGRAMMES IN MALAYSIA
2.00 p.m. - 2.30 p.m.	A. FOR SUPERVISORS SPEAKER: Dr. Loh Sow Khin MBBS, MPH, Director, Training, Education & Medical Research Division, National Family Planning Board, Malaysia.
WEDNESDAY OCT 22 8.30 a.m. - 9.00 a.m.	CHAIRMAN: Dr. J. Varughese MBBS, MPH, DPH Director, Public Health Institute, Ministry of Health, Malaysia.
	RAPPORTEUR: Encik M.S. Murthy PPN, SRN, STD Assistant Principal Matron (Training), Ministry of Health, Malaysia.
	PAPER X
	PLANNING OF FAMILY PLANNING TRAINING PROGRAMME - OBJECTIVES, NEEDS AND CURRICULUM DEVELOPMENT
	SPEAKER: Dr. G. R. Amritmahal Ph.D. Adviser on Training, National Family Planning Co-ordinating Board, Jakarta, Indonesia.
9.00 a.m. - 9.15 a.m.	DISUCCSION
9.15 a.m. - 9.45 a.m.	PAPER XI
	CONTINUING EDUCATION IN FAMILY PLANNING
	SPEAKER: Miss Mazel Lindo CNM, MS. Downstate Medical Center, New York, U.S.A.

9.45 a.m. - 10.00 a.m.	DISCUSSION
10.00 a.m. - 10.30 a.m.	COFFEE BREAK
10.30 a.m. - 11.30 a.m.	CHAIRMAN: Dr. Raj Karim MBBS, DPH(London) Health Officer in charge Maternal & Child Health, Maternal & Child Health Unit, Ministry of Health, Malaysia. PANEL PRESENTATION: LEGISLATION GOVERNING THE TRAINING AND PRACTICE OF MIDWIVES PANEL MEMBERS 1. Puan Ranita Hussein LLB(S'pore) Legal Adviser, Prime Minister's Dept. Malaysia. 2. Puan Rosina Hj. Abd. Karim, AMN, PPN, SRN, SCM, HV.SN, Principal Matron, Ministry of Health, Malaysia. 3. Dr. Savitri Gurung, Senior Obstetrician/Gynaecologist, Bir Hospital, Katlmandu, Nepal. 4. Prof. S.S. Ratnam.
11.30 a.m. - 12.00 noon	DISCUSSION
12.00 noon - 2.00 p.m.	LUNCH
2.00 p.m. - 4.00 p.m.	Group Discussion No III Topic: THE INCORPORATION OF FAMILY PLANNING PAEDIATRICS AND NUTRITION IN THE BASIC MIDWIFERY CURRICULUM
4.00 p.m. - 6.00 p.m.	Group Chairmen and Rapporteurs prepare Group Reports on Discussion No III
THURSDAY **OCT 23**	
9.00 a.m. - 10.30 a.m.	CHAIRMAN: Mrs. B. Brohier Presentation of Group Reports on Discussion No III by Chairman of each Group Brief discussion, recommendations and acceptance of consensus report
10.30 a.m. - 11.00 a.m.	COFFEE BREAK

11.00 a.m. - 11.30 a.m.	CHAIRMAN: Dr. Shamsuddin bin Abd. Rahman AM, MBBS, MRCOG. Director General, National Family Planning Board, Malaysia and Senior Consultant Obstetrics & Gynaecology, Maternity Hospital, Kuala Lumpur, Malaysia. RAPPORTEUR: Miss Mazel Lindo PAPER XII FAMILY PLANNING IN NATIONAL DEVELOPMENT SPEAKER: Dr. Rita Thapa, MBBS, MPH Senior Public Health Administrator, Chief, Community Health and Integrated Health, Service, Directorate of Health, Ministry of Public Health, Nepal.
11.30 a.m. - 11.40 a.m.	DISCUSSION
11.40 a.m. - 12.40 p.m.	Group Discussion No IV Topic: FAMILY PLANNING EDUCATION AND SERVICE IS THE RESPONSIBILITY OF ALL MIDWIVES
12.40 p.m. - 2.00 p.m.	LUNCH
2.00 p.m. - 3.00 p.m.	Group Discussion (Cont.)
3.00 p.m. - 5.00 p.m.	Group Chairmen and Rapporteurs prepare Group Reports on Discussion No IV
Evening 8.00 p.m.	DINNER
FRIDAY OCT 24 8.00 a.m. - 9.30 a.m.	CHAIRMAN: Mrs. B. Brohier Presentation of Group Reports on Discussion No IV by Chairman of each Group Brief discussion, recommendations and acceptance of consensus report
9.30 a.m. - 10.00 a.m.	Evaluation
10.00 a.m. - 11.00 a.m.	Countries prepare plans for national follow-up action programme
11.00 a.m. - 1.45 p.m.	LUNCH

1.45 p.m. - 2.30 p.m.	Presentation of Report Discussion and acceptance of Final Report
2.30 p.m.	CLOSING SESSION CHAIRMAN: Dr. Thomas Ng CLOSING ADDRESS: Dr. Raja Ahmad Noordin Raja Shahbudin JSM, AMN, BCK, MBBS, MPH, DPH. Ag. Director General of Health, Ministry of Health, Malaysia.
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FOREWORD

The continuing improvement of family health care is a universal goal. The betterment of maternal and child life through the inclusion of family planning is an area in which midwives of all categories could and should have an important role.

There is a world wide shortage of family health care personnel undoubtedly. Doctors cannot personally provide all of the services needed and must therefore have the willingness and leadership to direct others in providing some of these services. It behoves hospitals and doctors, practising and academics, to change the pattern of health care to fulfil the unmet needs. This calls for a change in policy and attitude in the delivering of family health care.

Attitudes have changed and continue to change. The considerable accumulation of knowledge on the role and effectiveness of midwives in maternal and child health and family planning is a reflection of the changing perceptions by physicians and health administrators. Today this area of research is an entity recognised by many disciplines.

In many developing countries, a basic difficulty might initially arise from the doctor-midwife relationship. Most midwives are eager and yet fearful of taking on new responsibilities. They are fearful of failing or harming the patient-fears similar to those of the new interns. Doctors on the other hand tend to be apprehensive of being held responsible for errors they expect the midwives to make. Both these fears are of course held in good faith but in time should lessen as a professional partnership develops.

It is our hope that this Working Party would contribute positively towards a better understanding of multifaceted aspects of the Training and Practice of Midwives within the total context of Family Health care including family planning. In consequence it should enable the policy maker and the administrator to monitor the effects of existing policy and practice and highlight any need for change.

Dr. Thomas Ng Khoon Fong
Chairman,
Local Organising Committee.

FOREWORD

More and more survey and research are being carried out and it has been proved that the area of Maternal and Child Health, and the training and practice of midwives have been neglected for a long time throughout the World.

The increased pressures throughout the World in matters of economics, health, social welfare, culture and psychology have had adverse effects on developing countries. This has influenced our thinking to the point of taking positive steps in order to improve maternal and child care and the quality of maternal and child life.

The International Confederation of Midwives in collaboration with the International Federation of Gynaecology and Obstetrics during 1961 set up a Joint Study Group to look into the "Training and Practice of Midwives and Maternity Nurses". The Joint Study Group members comprised of an equal number of midwives and obstetricians representing every Continent of the World subsequently agreed to the Aim of the Group as follows:-

"To continue the improvements of Maternal and Child care and the quality of Maternal and Child Life through the inclusion of Family Planning in the services provided by midwives of all categories in their expanding role".

In view of this Aim the International Confederation of Midwives with the assured co-operation of the International Federation of Gynaecology and Obstetrics through the Joint Study Group agreed to organise Working Parties all over the World, at which midwives, obstetricians would carry out the objectives of the Joint Study Group. This has been achieved through a generous grant made by the United States Agency for International Development to the International Confederation of Midwives.

Nine Working Parties have already been convened, and now the Tenth is being held for West Asia in Kuala Lumpur, Malaysia.

On behalf of the ICM/FIGO Joint Study Group, I wish you all a profitable and meaningful Working Party. The members of the local committee and host country have worked very hard towards this Working Party. I have no doubt that all the participants representing the many governemnts and members of the health team will make individual efforts at the conclusion of this Working Party to present the recommendations they make to their governments and other relevent influential individuals in the hope that implementation will follow.

Barbara Patterson
Project Director
ICM/US-AID PROJECT

OPENING ADDRESS

BY Y.B. DEPUTY MINISTER OF HEALTH, MALAYSIA

Ladies and Gentlemen,

It gives me great pleasure to be here this morning and meet with so many distinguished workers in health fields from far and near.

It is no exaggeration to say that in many of the countries represented in this Working Party in spite of much improvement in recent years, the present family health care services are still troubled by many problems. The problems are: relatively high mortality and morbidity rates; increasing demands for services; shortage of personnel; increasing numbers of new procedures; inadequate funds to meet the spiraling costs; and a variety of dissatisfactions expressed by patients and staff alike.

We in Malaysia are no exception. Since we gather here to exchange views and compare notes, may I share with you some of our experiences and thinking on several basic issues.

In 1972 for Peninsular Malaysia the maternal mortality rate was 1.24 per thousand live births. Though greatly improved compared to a decade ago, we still consider it high and are taking active measures to further reduce it.

Again in 1972, although our children in the 0 to 4 years represented some 14% of the total population, yet death among this age group accounted for 25.6% of all reported deaths.

It is estimated that only about 1 in 3 deaths in Peninsular Malaysia are certified. Among the medically certified deaths reported in 1972, complications in pregnancy, childbirth and puerperium is the second major cause of death in women aged 15 to 44 years and accounted for just under 4% of all deaths in Government Hospitals.

To turn now to Midwifery itself - the main theme of this Working Party. It is relevant to intimate a situation which is not unlike many countries represented here. In 1972, diseases of early infancy represented some 2% of all admissions to our Government Hospitals and 20% of all deaths, thus highlighting the importance of midwifery services in our family health programme. Another facet of the problem relates to the fact that many deliveries still occur in rural areas (54% for Peninsular Malaysia) where medical and health services are still in the process of development and sophistication. At present our rural health services look after about 30% of the total deliveries and most of these are conducted by auxiliary midwives.

Overall, approximately 27% of deliveries in Peninsular Malaysia are classified as "unsafe deliveries" i.e. being conducted by untrained personnel. Traditional birth-attendants or bidan kampong as we call them are mainly responsible for these deliveries. Based on some of our experiences a pertinent question which this Working Party may wish to address itself is:- what are the socio-cultural factors which prompted some rural mothers to seek services of a bidan kampong when a trained midwife lives right amongst them? I believe this is a crucial question and the reasons need to be uncovered before the role of a trained midwife could be expanded in many rural settings. As in some of the

countries represented here, we in Malaysia accept the fact that these traditional birth-attendants will continue to practise midwifery for some time to come. However, it is Malaysia's objective to ultimately replace these traditional birth-attendants with trained midwives.

Meanwhile, we have registered 2,702 of these bidan kampong and the register is now closed. Many of them attended a three-week orientation course which included basic midwifery, health care and family planning at various large maternity hospitals in Peninsular Malaysia. We also have some experience in the study of the effectiveness of utilizing these traditional birth-attendants to motivate family planning acceptors.

There is, we all agree the need to include family planning as an integral part of socio-economic development. This is best exemplified by the words of the Honourable the Prime Minister when he declared open the ILO/ECAFE Asian Symposium on Labour and Population Policies in Kuala Lumpur on 27.7.72. He said, "The neglect of reducing the population inflows is perhaps the greatest of demographic hazards of the 70s. It is therefore clear that neither the miracle of the green revolution nor the recent technological breakthrough has succeeded in removing the need for a population policy in Asia."

I note with keen interest that "Integration of family planning, paediatrics and nutrition with midwifery training programme" is one of your major topics for discussion. Malaysia is presently in the process of integrating family planning into the rural health services. I believe we have some valuable experiences to share in this area and no doubt we will also benefit from your deliberations during this Working Party.

Since 1973 Malaysia has introduced a new category of auxiliary - the Community Nurse or Jururawat Desa as it is known in Malaysia. The scheme arose as a result of demands from the rural population that they need more services than just midwifery. Hence the multi-purpose Jururawat Desa was created to offer treatment of minor ailments, basic child health care, immunization, and health education in addition to her primary role as a midwife. Is this concept of a multi-purpose worker a trend in the right direction? How can she be adequately trained? Will she be able to perform the duties expected of her? What should be the medical backup? We hope you will help us to find out the correct answers.

The midwife is a key member of the multi-disciplinary team approach of total family health care package. She is the grass root, frontline health worker in the rural areas. Her actions and interactions could have far reaching influences in making or breaking the rural populations' acceptance of modern health care and family planning. She therefore deserves every support we can muster. She must be given clear cut policy guide line; legislative protection, adequate training, proper supervision, and last but not least a reasonable remuneration commensurate with her responsibilities. It is my assessment that in all the countries represented here there is political will, administrative capability and technical know-how to reappraise and expand the role of the midwife in this regard.

SOME ASPECTS OF TRADITIONAL HEALTH ATTITUDES IN RURAL AREAS

Dr. Siti Hasmah bt. Hj. Mohd. Ali,
KMN., SMK., PCK.

It is most encouraging to note that more and more emphasis is now being made to focus attention on the human elements of medical and health problems. Knowledge of attitudes, customs, habits, aspirations and behavioural patterns of people is as essential and important as knowing the technical skills of curing disease and of preventing ill-health.

How often have we heard questions being asked of the sick "why did you come so late for treatment? Why didn't you come to see the doctor as advised?" Health problems are human problems. People perceive their own health problems and try to solve them quite differently from the "medical and health cultural" group. By virtue of the intensive training in medical and health care, we have formed our own attitudes, beliefs and values regarding medicine and health. Unfortunately, our own beliefs and values are significantly different and strange to those whom we intend to serve and those whom we attempt to serve.

Knowing the people and their life-styles therefore, is very essential for the promotion of health, especially in the planning of any national medical and health programme.

The socio-economic development plays an important role in determining attitudes and beliefs of the people. The better the socio-economic situation in the family or community, the greater is the acceptance to change. There is understanding and appreciation of good health practices. A mother who is illiterate or has low level of education cannot be expected to appreciate the cause and cure of diseases and is a poor contributor to perpetuating healthful living in her ownself and family. Lack of knowledge of the necessity to eat certain types of food has been a factor in cases of malnutrition among infants and toddlers. Failure to appreciate the importance of the need to attend ante-natal clinics regularly has caused many abnormal conditions being detected too late in pregnancy.

Delay in seeking medical help may not be entirely due to ignorance. Poverty and financial problems add to the negative attitude towards health. Even if a family desires medical attention, the distance a man has to travel in order to bring his sick family to a health centre or hospital requires him to seek transport. This means money. In situations where travelling requires him to have some of his meals away from home, and also of his family, this again requires money. It is therefore obvious that a family with low income will try as far as possible to delay taking the sick to a health centre or hospital if the health problem is regarded as minor.

Admissions into hospitals are mostly free for rural patients and the medical and health services in rural areas are also free, but yet, we have come across defaulters who cannot afford to pay for even their bus fares.

The occupational pattern in certain areas often do not help in encouraging good health practices. Kubang Pasu District is entirely in the Muda Irrigation Scheme where double cropping requires the people to be in the fields most of the time. The womenfolk are responsible for sowing, planting and harvesting the padi while the menfolk till the land, thrash the padi and transport them to their homes. The jobs have to be done at the correct time and intervals to avoid loss of the padi grain from heavy rain which means loss of income. Following this seasonal pattern of paid-planting and harvesting, records in health centres have shown reduction in ante-natal attendances, child health attendances and in the general outpatients' department. Health campaigns have to be postponed to a more appropriate time when the people are more free to listen and accept any health advice.

Health is therefore a matter of low priority until physical or functional impairment occurs.

Acceptance of modern scientific medicine and health education varies from area to area. It depends upon the family pattern that exist in the community, the traditional concepts of health and disease and their attitudes towards modern medicines and hospitalization.

Most of the rural Malays lived within consanguine family units. Their extended families live either with them in the same house, in which case, the older parents are still considered as the head of the family, or within the same compound, in which case, the influence of the elders is still great.

Respect for the elders and respect for the man as the head of the family is a traditional social custom. The implications of this in respect of health are many:

> the elders are the deciding authority in all matters of health. Delays in bringing patients to hospital are often due to delay in getting the "casting vote" for admission. Respect for the elders deters others from making firm decisions of their own and also creates fear of being held responsible should the patient die in hospital.
>
> the man as head of the family has less difficulties in deciding for himself should he want to go to hospital, but the moment he consults his own parents or in-laws regarding his own wife and children, he is automatically stripped of his authority and responsibilities.
>
> the woman has very much less say in health matters. She is trained to respect her husband and look after his needs and of his children. She waits for him to decide, even when she is having p.p.h. This situation is not only found in the rural areas but also among the educated in urban areas.

Fortunately, social patterns among Malays have changed. The newly weds live apart from their doting parents and migrate to other areas. The men and women, including the village elders are continuously exposed to health education. The young are able to decide for themselves and their families without displaying undue respect for their elders. Women's Lib probably have not penetrated far enough into the rural areas but the women have improved their status in rural society nevertheless and their views are heard and respected.

Traditional concepts of health and disease vary from area to area depending upon the distance from health workers' influences and communication. Some of the concepts and practices promote health but many do not. Health workers again are instructed to encourage those which are good but to avoid those which are detrimental to health. Those which are between extremes are reinforced if they can be allowed to change to a better alternative. For example, mothers who believe that fish-eating produces worms in children, should be encouraged to give meat instead as an alternative without displaying disrespect to her own belief about fish.

A healthy body as defined by the rural people is a body which perspires. For an infant, a healthy body is a cool body. Medical Officers are familiar with patients who say that they have not perspired and are unwell. How many times have we found infants and toddlers moribund with bronchopneumonia admitted wet from head to foot because of the attempts to "cool" the child during the fever.

Sponging the body is less practiced among Malays than full bathing. An infant or child is bathed because he is "hot". While sponging is the accepted practice of bringing down a child's temperature, it is not properly done and too frequently done. The consequences are that the child with simple form of fever comes in with complications of severe respiratory infection.

Illnesses is only associated with pain, severe discomfort and/or functional impairment. A man with slight cough or fever would not seek medical help as these ailments are considered minor and temporary discomforts of life which one has to put up with.

Diseases are attributed to God, to supernatural powers and predisposing causes. Attributing diseases to fate prevents a man from seeking medical help until the situation deteriorates. Belief that a woman who dies at childbirth becomes a martyr and a child who dies has a place for himself and his mother in Heaven creates some complacency among relatives in seeking medical aid.

Certain diseases attributed to acts of God as a punishment for something which the person did, deters him from even joining his own community for fear of being stigmatized and boycotted. This is so in cases of leprosy. Filariasis cases marry among themselves, the leprosy cases shunned the public.

Nevertheless, belief in God's will has not prevented the Malays from believing also that evil powers and spirits are responsible for certain illnesses. Treatment is therefore aimed at exorcising these spirits by bomohs.

Health workers may be wrongly influenced by rural people who do not take preventive measures against illnesses. They do have preventive methods of avoiding diseases, though most unscientific and illogical, they claim that their traditional methods have in some cases proved effective.

For example, the wearing of various kinds of tangkals or talisman around the neck, wrists, abdomen and ankles of children to prevent a long list of illnesses, including mental deficiency. The placing of the kacip (betelnut cutter) under the child's pillow to prevent evil spirits. The wearing of a pin or a metallic thing by ante-natal mothers when she goes out to avoid danger.

The various food taboos: the heaty foods and cooling foods are avoided in certain illnesses and those which are believed to cause allergic reactions and irritations are not given to children and convalescing mothers.

Consulting the bomoh is traditional. There is no delay in consulting these traditional medical attendants for minor ailments. They are easily available. Delay lies in the failure of the bomoh to recognize the change of the patient's condition early and the reluctance of the patient or the relatives to show disrespect to him by changing treatment. However, bomohs have now recognised the limitations of their responsibility to manage and cure most diseases of bacterial origin, and they have even advised their patients to seek a doctor when their treatment fail.

This is an important change which could be utilized to improve health attitudes amongst the rural people. Bomohs should be given as much attention as the kampung bidans. Though for reasons of lack of confidence in scientific medicine is lessening, bomohs are still being consulted by tradition. These bomohs can be good health promoters in their own localities if given the proper guidance.

Another traditional medical attendant which requires attention and supervision is the Mudin. He performs circumcisions on young boys in the kampungs. Mudins are middle-aged men who learn the art of circumcision by apprenticeship from their fathers who are also Mudins. They are responsible only for the circumcision and not the post-operative care of the child. His "surgical" equipment consists of a piece of buffalo horn split in the middle to act as a pair of forceps, and a small "golok" which is the cutting instrument. No pre-operative sterilization is done except for the boy to have a very cold bath before the circumcision. He is then made to sit on a banana trunk into which is stuck the buffalo horn "forceps". The foreskin is then caught in the split horn and cut. No medicines are applied on the wound. Bleeding is reduced by everting and pulling backwards of the remainder of the foreskin over the penis. The wound is then bound with either rolls of kite paper or very young and tender banana leaves. For his service the mudin is paid between $10 to $15.

Since the mudin does not take care to ensure cleanliness and is not responsible for post-operative care, bleeding from the wound and sepsis is very common. These children are brought to health centres and hospitals by their parents for suturing of the bleeders or for proper dressings and treatment. Most parents now bring their sons to hospitals and health centres for circumcision provided the Medical Officer of the Hospital Assistant is a Muslim and can perform the operation.

For those who stay in remoter areas, the mudin is still called. These mudins should be given proper training regarding aseptic techniques of circumcision and be provided with clean dressings and lotions. Some of them have voluntarily requested gauze and flavine lotion to improve their dressing techniques.

Expansion of rural development programme and health education have helped greatly in changing the attitudes and confidence of the people towards western medicine but hospitalization is still not readily sought by those who are greatly in need of proper care and treatment, example, mothers with toxaemia of pregnancy would still hesitate to be admitted for various reasons whereas those with not urgent complaints would insist on admission.

The close unity in the family and the sense of responsibility for each other favours home care for the sick. Sending a case to hospital gives a feeling of total abandonment and desertion of the member. To avoid this unspoken accusation, the whole family and often the community, evacuates with the patient to the hospital. The problems that arise are known to many of us.

Fear per se of the hospital is waning but dislike for the hospital still persist. Rigid hospital rules, inability to perform certain religious rites for the sick and the dying, lack of sympathy patience and tact by medical workers, bad past experiences or relatives and friends are some of the contributory causes obtained during interviews.

It cannot be overstressed that patients who are discharged well, happy and satisfied are the best motivators of health. Those who either go to the hospital on their own or take heed the advices given by medical and health workers should be encouraged to stay in hospital where health education can be given at its best.

Cultural Implications in Maternal Care

At no part in the life of a Malay woman do customs and beliefs be seen so strictly complied with, as during the pre-natal, natal and post-natal periods. Again, reliance upon traditional concepts and practices vary depending upon the availability of the trained Government midwife and her relationship with the people whom she serves.

By tradition, the kampung bidan is booked for the delivery but this will not deter the mother or her relatives to call in a Government midwife eventually, especially in times of emergencies. This is also true when the Government midwife is booked.

The kampung bidan is an essential birth attendant in promoting good family health. While discouraging new recruits from rendering traditional midwifery, every effort is now being made to utilize the existing kampung bidans as motivators of health and diverting their skills to a more harmless service to rural mothers, without losing their recognized status in the community.

Some of the traditional practices and beliefs during the ante-natal period are as follows:-

1. Appetite for certain types of foods during pregnancy are appeased by relatives as best as possible. Considering that normally the mother may not have good food and eat much less all efforts are attempted by husband and relatives to get the desired food. It is also believed that if the mother's appetite or food fads are not fulfilled, the infant when born will suffer from excessive salivation.

2. Preventive measures against accidents, complications of pregnancy and possible abnormalities of the foetus, take the form of restriction of normal activities of both the husband and the wife. Husbands are not allowed to hunt or kill; no heaty foods are included in the mother's diet; she is not allowed to put up her hair high on the head lest she should have retained placenta; she should not wear tight scarves around her neck to avoid cord-round neck in the foetus.

3. There is no ante-natal care in kampung midwifery. Confirmation of the pregnancy at 3-4 months, formal booking of the midwife at 7 months and calling the midwife at start of labour are all that are necessary for a pregnant mother.

4. Preparation for the new infant is not encouraged and even if attempted, the preparation is never complete. The belief is that fate may change situations and cause disappointment.

5. The ceremony of "melenggang perut" or pelvic rocking. In certain states this ceremony is also known or included in ceremonies concerning the foetus - mandi tian - and booking of the kampung bidan - menempah bidan. This ceremony is performed only for the primigravida at 7 months pregnancy and at the home of the maternal parents. The main purpose is to offer prayers for a safe delivery of the mother and child.

   The ceremony begins by a bath in which the young mother and the kampung bidan take part. A raw egg is rolled over the mother's face while she is standing and then allowed to roll down her body inside her sarong. As the egg falls to the ground, she steps on it as an indication that whatever evil that has been drawn from her body and foetus is stamped out. Limed water is then poured over her body.

   The melenggang perut is done by kampung bidans who sit on either side of the young mother, while she lies on seven sheets of batik. The idea is to make a knot over the abdomen with each sheet which is then pulled away from the back of the mother from alternate sides.

   To facilitate each batik to be pulled away, the mother has to sway her body from side to side and naturally arches her back to get rid of the sarong. This seems to be the only form of real exercise during the ante-natal period. Pelvic rocking is recommended even in Western midwifery for loosening of the joints and for easy labour at term. Unfortunately, this ceremony is performed only once in the life of a married woman. Perhaps kampung bidans and rural mothers should be encouraged to perform the melenggang perut more often but without the pomp and feasts that go with it.

   Determination of the sex of the foetus is also included in the melenggang perut. Its efficacy is very doubtful but it is done nevertheless for completion of the ceremonies. Coconuts are rolled over the mother's abdomen and allowed to roll away in between her legs, and depending upon the position of the eyes of the coconuts the sex of the foetus is determined - upwards for boys, and downwards for girls.

Traditional practices in delivery

Booking a kampung bidan requires certain preparation, for the bidan at start of labour rather than more for the mother and the infant. The rice, the candles, the raw thread, resins, betel leaf tray and its condiments in addition to the initial payment is traditional to ensure the safe delivery of the mother.

There is very little preparation for the labour itself. A small cup of warm coconut oil is required for lubrication of the perineum when necessary. If available, a Flower of Jerusalem is used in determining the condition of the cervical os. It is a dried and shrunken flower which opens up slowly when soaked in water. The time it takes to unfold completely is taken as an indication of a ripe os. Drinking the water helps the mother in relieving pain and facilitate delivery.

What disturbs us all is the management of the mother during first stage of labour, especially when accompanied by obstruction and/or abnormal foetal positions. Pressure on the abdomen in delayed labour has been the chief cause of uterine rupture and eventual death of the foetus and often the mother. Much as we want to believe that kampung bidans are no longer practising pressure on the abdomen, investigations have shown that some still do, probably due to desperation or sheer ignorance.

Guarding the perineum is a recognised procedure of kampung bidans for they wished to be noted as being more careful and skilled than the Government midwives. Kampung bidans use oil to lubricate and stretch the perineum and also use improvised perineal pads as guards. What is objectionable is when they use their own heels as perineal guards.

The old fashioned bamboo for cutting the cord has now been replaced by a pair of scissors. My personal feeling of the change is that, though the scissors are more convenient for cutting and sterilization, it has not completely achieved its primary aim of preventing tetanus neonatorum. The bamboo is cut fresh from the tree and sharpened. The cord is cut after the placenta is completely expelled. The bamboo is then broken into halves and with the placenta is disposed of. It is never washed and retained for use a second time.

Considering the intelligence of the kampung bidans, their reliability, their knowledge of sepsis and asepsis and difficulties in sterilizing scissors in remote rural areas, how useful is a pair of scissors in preventing tetanus in infants? Perhaps a survey to compare the incidence of tetanus derived from kampung bidans using the traditional bamboo and scissors would give us some idea.

Post-natal Practice

Among the many traditional practices during the post-natal period, most of them demote rather than promote health.

1. The mother is sponged and cleaned with warm water after delivery. Her clothes are changed, her hair now tied up very high on the head and a binder is tied comfortably around the abdomen. This definitely gives a lot of relief and comfort to the mother. Rural mothers however are not taught nor encouraged to use any sanitary napkins - modern or improvised - because of the belief that it will present free flow of lochia. Further more the disposal of sanitary pads pose certain problems. By habit and beliefs blood-stained clothing are never allowed to be washed by other people or exposed for fear of being charmed. It is considered not aesthetic to allow even the kampung bidan to wash the soiled clothes unless compensatory payment in cash or kind is made.

The Ministry's move to provide post-natal mothers with toiletries is a positive move towards educating mothers in personal hygiene. Health workers have not only to explain and teach the mothers the proper use of sanitary napkins but also assure them that these would not in any way prevent the flow of normal discharge. Proper disposal of the napkins are also taught to them.

Post-natal massage is one responsibility of the kampung bidan which is greatly approved and encouraged by health workers. It begins on the 1st post-natal day for only three days. The mother is massaged with warm oil from the neck to her toes. The beneficial effects of a good massage are well known. It tones up the muscles, helps the circulation and gives the mother a sense of well-being. Kampung bidans are encouraged to concentrate more on this function rather than on midwifery. The changes for post natal massage for three days may be less than the actual accouchment fees but if the usual three days are extended to seven or ten days, the kampung bidan would have been able to regain the loss of her charges.

After the massage, the mother is given a warm bath followed by three other practices, all of which are aimed at speeding the involution of the uterus and supposed toning up of the abdominal muscles.

3. Berbarut (applying tight abdominal binder): this is applied after lime and chalk (kapor) have been rubbed over the abdomen to give warmth. The binder may be a many-tailed bandage or six yards of cloth of 1½ foot wide which is tied as a series of knots in front of the abdomen to support the sagging muscles. Binders keep the abdomen of kampong mothers trim and slim.

4. Menungku is the application of hot iron or bricks on the abdomen. It is fomentation but what actually happens is that the skin of the abdomen is burnt to a parched black skin because the iron or brick is applied too hot. The muscles are destroyed or loses its tone. While applying the hot foments, pressure is often applied over the enlarged uterus. Whether this could initiate early prolapse of the uterus in young mothers or inversion of the uterus post-natally, if done excessively, we do not know.

5. Berdiang or bersalai - this is less practised in rural areas and is cumbersome. It requires the mother to sit above glowing hot embers or by woodfire to ensure stoppage of lochia quickly. It is also supposed to prevent another pregnancy.

6. Food taboos: These are based on the beliefs of certain foods are too heaty or too cooling for the mother. Most fruits and vegetables are "cooling" and would cause abdominal distension cramps and delay involution of the uterus. Even water is considered too "cool" and if taken in excess is supposed to cause distension and delays involution. "Heaty" foods are the various meat and poultry. When most of the nutritious foods are categorised in either one of the heaty or cool food groups, it is not surprising therefore to see a mother eat only ikan kering, pepper and rice and only one glass of warm water to drink in a day. The ill-effects of continuous

practice of this food pantangs are familiar to medical and health workers. Urban mothers do practice food pantangs but because normally they eat well and stay in good health, the ill-effects are not obvious. A rural mother live in subnormal health conditions even before pregnancy takes place. Any more changes in this normal subnormal condition would deteriorate the condition further and ruin the mother's health entirely.

It is most heartening to note after 17 years of service that food pantangs are no longer in existence in most rural areas. Social changes, rural development and persistent health education have contributed largely to the change from a diet which is definitely destructive to one which is moderately complete, nutritious and beneficial.

7. Traditional medicines for post-natal mothers consist of concentrates of various herbs, mixtures of spices taken with honey and raw eggs. These are given to either expel blood clots, give warmth and strength back to the mother. Kampung bidans and mothers themselves have either combined with or take traditional medicines separately from vitamins and iron tonics obtained from health centres and doctors. Recognition of the beneficial effects of vitamins and iron tablets have also helped to reduce the number of acute peripheral neuritis and severe ill-health.

Conclusion

Health is largely a matter of good habits and clean surroundings. The poor state of health among the rural Malays, the high mortality rates among infants, toddlers and mothers are the results of unhealthy practices and beliefs.

Based essentially on misconceptions and ignorance, most traditional practices prevent good health. Very little can be said for the retention of these practices. Extensive health education by staff both in the rural areas and hospitals will help to eliminate those practices which are detrimental, and to encourage those which are good. Utilizing the traditional medical and birth attendants as motivators of health is essential.

THE ICM/US - AID PROJECT

by
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The International Confederation of Midwives consists of 55 National Midwifery Associations, some of which are Midwifery Sections of a National Nursing Association. For a Midwifery Section to be accepted into membership it must, within the Nursing Association, be responsible for conducting its own affairs and have its own chairman or president and other officers and have its own constitution. The ICM is a non-governmental, non-political and non-sectarian organisation and accepts into membership any national midwifery association is acceptable to its own Government provided that:-

i) its constitution is in accordance with the ICM constitution;

ii) that the application for membership is sponsored by two associations which are already members.

In 1960 at a General Assembly of the International Federation of Gynaecology and Obstetrics (FIGO) a Study Group was set up to examine the training and practice of midwives and maternity nurses. The Chairman of this Study Group approached the Executive Secretary of the ICM for co-operation and this resulted in the setting up of the ICM/FIGO Joint Study Group which has been very active ever since. After four years of intensive research, the Joint Study Group published "Maternity Care in the World" which gave information on maternal and child care and midwifery training and practice in 174 countries of the World and at the present time we are in process of bringing this material up to date. The individual country reports which participants have already received have been prepared in order that they may be validated, corrected, added to and approved by the Government of the country concerned prior to publication of the new edition of "Maternity Care in the World" which we hope to have ready early in 1976 and we anticipate that there will be information on approximately 220 countries and will include material on midwife participation in family plnnning services. Both the Council of ICM and the General Assembly of FIGO agreed that the Joint Study Group should continue to work closely in the interests of maternal and child health but neither of the parent organisations have much in the way of financial resources to continue research on a global basis.

In 1969, a European Conference was convened in London and participants from 21 countries attended at their own expenses. This conference led to a European Working Party consisting of an equal number of midwives and obstetricians and a report on the Training and Practice of Midwives in European Countries" was produced. When it was presented to the 15th Triennial Congress for Midwives held in Chile later that year, the South American midwives requested that a similar survey should be arranged in that Continent but the Joint Study Group had no financial resources at that time. It was only as a result of the 16th Triennial Congress for Midwives held in Washington DC in 1972 that money was made available through a substantial grant from the United States Agency for International Development (US - AID) to the ICM with the assured co-operation of FIGO. This grant has to be used to convene Working Parties in developing countries to encourage obstetricians and midwives within a cluster of countries to examine the maternal and child health services, to make their own recommendations for their improvement and working in co-operation, endeavour to make an impact on their return to their own country for the implementation of the recommendations they themselves have made. Already Working Parties have been held in Accra, Ghana for anglophone West Africa; in San Jose, Costa Rica for Central America; in Yaounde, Cameroon for Francophone

Central Africa; in Nairobi, Kenya for anglophone East Africa; in Bridgetown, Barbados for the Caribbean countries and territories; in Dakar Senegal for francophone West Africa; in Bogota, Colombia for the South American countries; in Manila, Philippines for the East Asian countries and now here in Kuala Lumpur for the West Asian countries.

A midwife is appointed as Regional Field Director for the area in which the Working Party is being held. She is from the area itself and is conversant with customs and traditions and in addition to being present at the Working Party she makes pre and post Working Party visits to each of the countries involved. She, together with the Field Director and Project Director is responsible for the final report which is eventually distributed to all participants and to the Minister of Health of all governments.

There are eight midwife and eight obstetrician members of the ICM/FIGO Joint Study Group and every continent is represented either by a midwife or by an obstetrician. It is the earnest wish of all of us to encourage the expansion of the role of the midwife so that she is able to give total care to the mothers and babies of the world. She has an important part to play in prenatal care and health education including nutrition, in intranatal care, in postnatal care including family planning and in the supervision of less qualified personnel. The practice of our profession is important but it is a salutary fact that in some areas of the world there are still 80 per cent of women who have no professional attendance during the maternity cycle. Until there are sufficient professional midwives to provide such care we must make use of the personnel available - e.g. the traditional birth attendant who is respected in the community which she serves. Let us identify her, give her basic training and supervise her and even introduce her to the principles of family planning so that she can at least be used as a motivator. It is important that she should know what to do but equally what not to do and she should therefore be encouraged tc refer her patients for medical attention where possible and if there is no doctor available, at least to a professional midwife.

National cooperation between obstetricians and midwives is equally important as international cooperation and each should appreciate the value of the contribution made by the other. Local seminars would help to encourage this and the ICM/FIGO Joint Study Group would be willing to render any possible assistance if invited to do so.

FAMILY HEALTH CARE IN DEVELOPING COUNTRIES

by

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Today I have been asked to address myself to the topic "Family Health Care in Developing Countries". The time allotted for this presentation is approximately 30 minutes, and should 30 hours have been allotted, I would strongly doubt that this subject be adequately addressed - so vast are the problems and so feeble appear to be the national responses aimed at the health sector in general and at this aspect of international health in particular.

Rather than attempt to lecture to you all experts in the health field - especially expert in your speciality areas and so much more so about your own countries - perhaps we can examine together as colleagues our abysmal failure as professionals in our chosen field of endeavour. I would dare to assert among us, that had the medical profession been a profession of bankers or farmers, the world would have long ago been bankrupt or have starved to death. Any why is this so? Let us ask ourselves why after 25 years of the functioning of a World Health Organisation or 100 years after health systems of one sort or another, colonial or national, approximately 80% of the world's population exists outside the contact of formal systems of health care delivery? Certainly the answers are to be found in the nature of national politics, national economic and development policy and national systems of priority setting. But these are only partial answers - for it is my impression that the reason, in a large measure, lies within the nature and philosophy of the health professions.

As health professionals we have been trained to view illness as particulate, and health as isolated from the rest of our existence. We have not really been trained to view health as environmentally linked or dependent upon the nature of a given community. Training of health professionals has taken place primarily in urban settings in our own countries or in metropolitan centres in foreign countries. Thus the end products of professional training have been professionals best suited only to those settings existing in urban or metropolitan areas dependent upon significant technical gadgetry and diagnostic systems and upon other professional support. Hence the problems of health care in developing countries can in one sense be attributed to significant flaws in the philosophy of the training of health professionals. A second conceptual flaw lies perhaps in the viewing of health care delivery as static - that is that the patient comes to the professional rather than vice versa or a mixture of stationary and mobile services.

Finally, the greatest short-sightedness could perhaps lie in our excluding our populations from the benefits of scientific and medical technology by isolating whole communities themselves, their traditional workers and traditional systems from participating in the planning, design, and development of programs set up in their behalf.

If we accept the above assertions as valid, how then might we begin our search for solutions to the problems that beset us all - hopefully, the uniting

purpose of our attending this 10 day West Asia Working Party. If indeed the participating countries are to successfully face the challenge of making advances in the health field available to a majority of their people, then there will be a need for a far more comprehensive look at the magnitude of such a venture that we usually permit ourselves to take. First we would want to know in each instance:

What are the existing needs? (Needs must be determined at both the national and local levels).

What is the extent of existing resources (traditional and modern).

How should we organize, most effectively, to achieve set objectives?

How would we measure our efforts in attaining agreed-upon objectives?

What is the national commitment to health services for the entire population?

Once answers to the above have been aggregated, then planning for delivery of services can be begun in light of national, regional and local commitments.

Even though the national perception of local need might vary sharply with that of the local perception, the involvement of local determination in the establishment of local need is a sine qua non - an absolute essential - for effective health care programming.

PROBLEMS OF NATIONAL COVERAGE

The WHO has stated the ultimate objective as "the attainment by all peoples of the highest possible level of health." Obviously such an objective must be viewed as an ideal even though bearing in mind that the highest possible level of health for any given country is relative and might vary in content as widely as that of Cuba, on the one hand, and Tanzania on the other; and certainly varies extremely widely when viewed from the standpoint of the expectations - static or rising - of different populations.

The organisation and structure of any given system, to achieve acceptable goals of population coverage, must be based in the commitment to use all national resources. There has existed in every society, since the beginning of recorded history systems of health care delivery. Such systems in spite of their lack of sophistication and/or technical and scientific know-how, continue to operate. It should follow, therefore, that when such traditional systems are incorporated - through re-design, re-training, and supervision of traditional workers - into existing national systems of health care delivery, that entire populations stand to benefit.

To cite relevant examples, most clinical reports will show that women who begin labour spontaneously after 37 weeks of pregnancy and before the end of the 42nd week without having shown any symptoms of abnormality will account for approximately 70% of pregnant women. According to Bannerman, 70% of all women in developing countries who go through pregnancy, are delivered without any form of service from a trained midwife or health professional. On the other hand, when all forms of primary health care are assessed, 75 or 80% are said to be delivered by traditional health workers, male or female. Hence, we as national planners and programmers can discover within our own countries a wealth of manpower resources. With public education, adequate training, supervision and coordination, numerous workers with their

traditional systems of communicating, rooting in time and culture, can be absorbed in national systems. Thus the extraordinary amount of knowledge held by health professionals can then be made available to entire populations through significant delegation of function which may then be performed by these traditional workers.

CULTURAL SENSITIVITY

The transfer of knowledge or information, scientific or unscientific, modern or traditional is a vital part of every culture and is handed down from generation to generation. Once again and especially in Maternal and Child Health, the traditional worker has proved to be a significant force in the success or failure of information transfer. Many programs, uniquely family planning programs, have failed when overlooking the pivotal role ascribed to cultural mores and the place of the traditional health worker - significant person - in the design and development of programs to be implemented in his or her communities.

THE COST OF HEALTH CARE

The costs as well as National Budget allocations for Primary Health Care - Preventive, urative, and Rehabilitative - vary widely from country to country.

A general average for health services in National Budgets would be between 7 and 12%. Yet today, it is stated that Cuba is spending more than 50% of its National Budget on Health and Education; while in Tanzania 3% of the National Budget was allocated to health in 1974 and in Iran, the allocation was 2.1%.

Despite the varying size of budgets, however, a chronic problem seems to be the recurrent expenses column of budgets which sometimes account for approximately 70-80%. These recurrent expenses are eaten up principally by administrative costs, primarily staff salaries and building and equipment maintenance, thus leaving little for new programs.

ALTERNATIVE APPROACHES TO FUNDING

When considering the expansion of health services to entire communities or populations, significant costs must be anticipated. Recurrent costs for any new effort must be anticipated and provided for as well as likely inflationary trends assessed. Hence a variety of sources for funding in addition to national budgets must be explored.

Regional and local governments can be encouraged to use regionally and locally generated taxes to a greater extent in the health sector.

Rural populations are accustomed to paying for health services and continue to do so when services are effective;

Rural communities when involved in the planning, design and implementation of services oft times accept or volunteer to be responsible for significant costs: e.g. the provision, repair and maintenance of clinic buildings;

Since only a fraction of a given community demand health services a any given time, then community-wide prepaid schemes should be explored;

Transportation costs are also significantly minimized when local systems of transportation are utilized to the fullest extent: eg. horseback, boats, bicycles, etc.

The shift of percentage of National Budget allocation from urban and peri-urban areas to rural areas must be speeded up; (see Table A below).

TABLE A

Health development budget expenditures in Tanzania: 1969/70-1974/75
(in percentages)

	1969/70	1970/71	1971/72	1972/73	1973/74	1974/75
Hospital and ancillary services	63	52[a]	52[a]	27[b]	15[b]	12[b]
Rural health centres and dispensaries	7	24	33	35	33	24
Preventive services	9	1	2	10	2	8
Training	16[c]	22[c]	13[c]	18[d]	48[d]	55[d]
Manufacturing	5	1	0	10	2	1

[a]About two-thirds in Dar es Salaam

[b]Less than 10% in Dar es Salaam

[c]Around 85% in Dar es Salaam

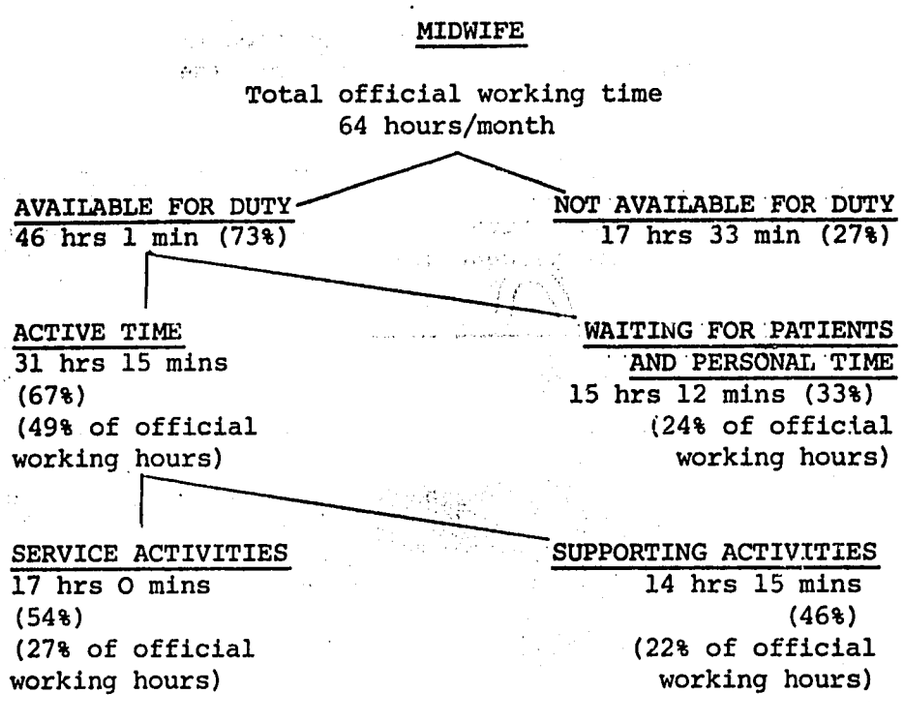
[d]Less than 2% in Dar es Salaam

From the table it can be seen that during the three years 1969-1972 over half the development budget had gone into hospital services (of which two-thirds were spent in Dar es Salaam), but over the last three years hospital expenditure has fallen to only slightly over a tenth of the budget (and only a fraction in Dar es Salaam). Hospital construction has been replaced by expenditure on rural health centres and dispensaries and the building of schools for the training of rural workers.

MAXIMISING THE USE OF MANPOWER AND FACILITIES

Reports from several countries point to the fact that the mere construction of a facility and its staffing by no means guarantee optimal usage. Recent studies from Indonesia underscore these phenomena (see diagram on next page).

UTILIZATION OF OFFICIAL WORKING TIME*



*Ministry of Health
Nurse, Midwife Activity Study - Bakassi 1971
Ministry of Health with assistance of WHO Indonesia 0086

UNDER UTILIZATION OF FACILITIES AND TRAINED MANPOWER

Research studies in Java as early as 1969 (Sarnarto) and as recently as 1973 (Goenawan), supported by findings in 1971 and 1972 (Soetopo) concluded that the utilization of the existing health services provided in health facilities was extremely low. Parallel studies during these periods (Pardoko, Sarnarto, and Goenawan) revealed that either health facilites are inadequately staffed or that the activities of the staffs of health facilities were partly elective or both. Studies by Sulianti et al, a Household Survey, showed that in the communities surveyed, approximately 5% of a population of 40,000 would visit a health facility in any given month. But it has been repeatedly shown that when planning for the delivery of primary health services, community participation in site selection, in establishing the hours of operation and the choice of building to be used, can add immeasurably to the optimum use of services provided.

Although concern about the "brain-drain" no longer appears to be widespread, it is instructive to examine the migration of physicians into one North American country over a ten-year period (See Table B); and even though doctor migration has attracted prime attention, the size of the movement of nurses from developing to industrialized nations has, perhaps, been underestimated.

**TABLE B

Physicians Admitted to the United States as Immigrants
During the 10 year Period, 1962-1971*

Fiscal Year	Immigrant Physicians
1962	1,797
1963	2,093
1964	2,249
1965	2,012
1966	2,552
1967	3,326
1968	3,128
1969	2,756
1970	3,158
1971	5,756
Total	28,827
Average 1962-66	2,141
1967-71	3,625

*Source: Immigration and Naturalization Service, US. Department of Justice. Data are for 12 month period ending June 30.

**Thomas D Dublin, MD., Dr.PH. The Migration of Physicians to the United States, New England Journal of Medicine 286: 870-877 (April 20) 1972.

INTERSECTORAL RELATIONSHIPS

An important consideration when planning for health services delivery is the extent to which the activities for all other sectors will impinge on those planned within the health sector.

The building of a new major road or accessory roads could have significant effect on the epidemiology of certain diseases by influencing the rate and extent of transmission.

The introduction of new crops by agricultural agencies hopefully improve the nutritional status of the community concerned whether they are added to the diet or used as cash crops. The diversion of existing waterways or the introduction of irrigation systems can alter ecology patterns and thus the epidemology of certain diseases.

The health status of a community can directly affect its productive capacity by time lost from work caused by illness.

Finally the planning at national and regional levels for the introduction of new industry or the expansion of existing industry and have significant impact on the movement of population and its resulting density, disease transmissions and the overall ecology of a given region. Hence health planning can no longer continue in isolation nor can the health impact of planning within other socio-economic sectors, be disregarded.

CONCLUSION

In one of the final resolutions of the twenty-eighth World Health Assembly, the promotion of National Health Services relating to Primary Health Care is viewed as using "an integrated approach of preventive, promotive, curative and rehabilitative services for the individual family and community", and concludes that the "majority of health interventions should be undertaken at the most peripheral practicable level of the health services by workers most suitably trained for performing these activities." Given the high percentage of the world's population still existing outside the reach of formal health service systems, the goal of providing them primary health care need not seem impossible. Realistic time periods for the accomplishment of total population coverage should be anticipated so that the undertaking not appear to be insurmountable and the goal impractical to attain. Thus, we have examined together some aspects of the status of Primary Health Care in Developing Nations, nations other than those represented at this Working Party. Perhaps this exercise will prove to be more than an exercise and will further stimulate and encourage you to continue the important work detailed in the working party agenda; and in some small way, contribute impetus to the attainment of your praiseworthy goals.

Thank you.

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FAMILY HEALTH SERVICES IN PENINSULAR MALAYSIA

by

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1. INTRODUCTION

The concept family health in its broadest sense embraces total health of all members of the family. Some expand the scope of family health even further to include the social, economic and welfare dimensions to ensure total well-being of the family. The reasons for the broad based definitions are understandable, for the health status of the family is closely associated with the socio-economic and ecological environment of the family.

For operational reasons, however, a more restrictive and functional definition of family health is necessary. It is recognised that much of the health needs relate to the child and the pregnant and lactating mother. It is accepted that the long term health gains would be substantial and health efforts more rewarding if directed as these high risk groups. Therefore, one operational definition of family health states,

> "... health care for all members of the family, particularly the health of the mother and the child. The major components of family health programmes thus are the maternal and child health services, nutrition, sanitation and family planning."

This operational definition was accepted at a National Seminar on the Role of Specialists in Promoting Family Health, held in Pulau Pinang in August 1973.

2. HISTORY

Present day family health services had its beginning over fifty years ago, more than thirty-five years before Malaysia achieved Independence in 1957.

In 1923 legislation was introduced to control the practice and training in midwifery in the Straits Settlements. Legislations were later enacted to cover the Federated and Non-Federated Malay States.

With the declaration of Independence in 1957, the Federal Government took over the responsibility for medical and health services in the country. After the end of the Emergency in 1960 public health services, particularly the rural health services, were able to develop in a more systematic and equitable manner throughout Peninsular Malaysia.

In the meantime the financially autonomous local authorities such as in Penang, Kuala Lumpur and Malacca, continued to provide maternal and child health services in their own areas, independent of the general health services in their own areas, independent of the general health services provided by the Medical Department.

3. RURAL HEALTH SERVICES

3.1 Rural Health Services Scheme

The Rural Health Services Scheme was a major breakthrough in the provision of integrated curative and preventive services in the rural areas, with the maternal and child health services forming a major component of these basic services.

Mooted in 1954, the scheme envisaged a network of rural health units throughout Peninsular Malaysia, each unit covering a rural population of approximately 50,000 people, and consisting of one Main Health Centre, four Health Sub-Centres and twenty Midwife Clinics cum Quarters. In effect there would be a Midwife Clinic for every 2,000 persons, a Health Sub-Centre for every 10,000 people (the Main Centre also functionning as Health Sub-Centre) and a Main Health Centre supervising and coordinating the services for 50,000 people.

A diagrammatic presentation of the Rural Health Unit is shown in APPENDIX I.

The basic services would cover:-

(a) Medical care

(b) Dental care

(c) Maternal and child health care, consisting of

- antenatal care
- domiciliary midwifery
- post natal care
- child health care
- immunization
- applied nutrition
- school health services

The earliest record of Maternity and Infant Welfare Services is that of a Centre started in Kuala Lumpur in 1923, run by a Lady Medical Officer, one Sister and two Staff Nurses. A bus was utilized to fetch Malay women from the surrounding villages, in view of the lack of public transportation in those days.

Initially the centre was used more as an outdoor dispensary. Gradually work developed along preventive lines. A training scheme was started to train local girls. Other clinics were started in Selangor, Perak, Johore, and Kedah as well as in the Straits Settlements.

A domiciliary midwifery service was organized in 1927 by a Health Visitor in Singapore (which was one of the Straits Settlements). Through this service work began to be extended to the rural areas, although it can be said that generally existing services were mainly confined to the urban areas.

Maternity and infant welfare services were interrupted during World War II, except for the centre in Kuala Lumpur and for midwifery services provided by a few midwives working without supervision and guidance.

Immediately after the war in 1945, the Maternity and Infant Welfare Centres were reorganized, although the bulk of work was mainly along curative lines. At this time malnutrition was especially noticeable among child-bearing women and among children under five years. Beri-beri was a serious and killing disease. The centres played the part of relief centres for the distribution of milk, vitamins and other food supplements.

In 1947 a School of Nursing was established in Penang. In 1954 the first School for Health Visitors was opened in Penang. Soon after the first Rural Health Training School was set up in Jitra with WHO/UNICEF assistance, providing rural orientation for assistant nurses and midwives as well as Public Health Overseers in the auxiliary personnel to man the newly established Rural Health Services.

Admittedly the 1948-1960 Emergency was a setback in the development of health services in the rural areas, particularly maternal and child health services. However during this period medical and health care services were started in the resettlement villages, including Maternity and Infant Welfare Clinics, School Dental Clinics and clinics run by voluntary organizations such as the Red Cross and St. John Ambulance Brigade.

These developments occurred mainly in the West Coast States with little development in the East Coast States as state health administration was still vested in the hands of the respective State Governments, and the East Coast States were economically less developed than the West Coast States. Even in the West Coast States there was unevenness in the distribution of the quantity and quality of health care services.

(d) Public health nursing

(e) Communicable disease control

(f) Environmental sanitation

(g) Health education

(h) Simple laboratory procedures and

(i) Maintenance of records

The staffing pattern is shown in APPENDIX II. The main categories of technical staff provide services separately for medical care, dental care, maternal and child health care and environmental sanitation. Health education is carried out by every member of the rural health team, while laboratory service is provided by the medical care and MCH personnel. Apart from basic personnel including auxiliary personnel manning all the health centres including the main centre, additional supervisory personnel are provided at the main health centre itself, including the Medical and Health Officer and Dental Officer, to supervise and coordinate the services provided by the Rural Health Unit. Nursing personnel comprise 75% of the technical manpower at the rural health unit, indicating the importance given to maternal and child health care in the rural areas.

3.2 Progress of physical construction

During the First Malaya Plan of 1956-1960, progress in physical construction was understandably slow because of the Emergency which had begun in 1948. By the end of 1960 there were on the ground only 8 main health centres, 7 health sub-centres and 25 midwife clinics. With the ending of the Emergency in 1960 the Second Malaya Plan or the Rural Development Plan of 1961-1965 saw a dramatic development of the rural health services. This development was only slowed down in the later years of the Plan because of the Indonesian confrontation and because physical development was found to be outstripping the provision of staff to man these centres. This development was further strengthened and consolidated in the First and Second Malaysia Plans of 1966-1970 and 1971-1975. By the end of 1975 there will be in all 62 Health centres, 239 health sub-centres and 1366 midwife clinics cum quarters:-

Table (1) - Physical Construction of Rural Health Units

	Main Health Centre	Health Sub-Centre	Midwife Clinic cum Qrs.
First Malaya Plan (1956-1960)	8	7	25
Second Malaya Plan (1961-1965)	31	115	618
First Malaysia Plan (1966-1970)	8	76	300
Total end of 1970	47	198	943
Second Malaysia Plan (1971-1975) Estimated completion by 1975	62	239	1366

The extent of physical development since 1960 is shown by the population coverage. In 1960 a midwife clinic covered 127,500 persons. This coverage will be reduced to 4300 persons per clinic by the end of 1975. Similarly the population coverage of a main centre will be reduced from 637,500 in 1960 to 109,000 by the end of 1975.

Table (2) - Facility: population ratio of Rural Health Unit

Year	Estimated Rural Population	Facility : Population Ratio		
		MHC	HSC	MCQ
1960	5.1 million	1:637,500	1:340,000	1:127,500
1965	5.8 million	1:148,700	1: 36,000	1: 7,200
1970	6.2 million	1:132,000	1: 25,000	1: 5,200
1975	7.2 million	1:109,000	1: 23,000	1: 4,300

3.3 Reorganization of the rural health services

It had been realized as early as 1966 that future expansion based on the original facility:population ratio might be impractical and expensive. The necessity of providing an integrated rural health service based not only on local needs and demands but also on the changing concepts of public health practice which had also been recognised.

Since 1968 new developments were beginning to make thamselves felt in the rural health service activities, with implications of increased workload for the rural health staff in the future - notably the school health programme, applied nutrition and family planning activities. In 1969 operations research was carried out in selected rural areas on health needs and how these were being translated into demands for service by the people. The new developments, together with the findings of the

operations research completed in 1971, resulted in a reorganization of the rural health services in the mid-term review of the Second Malaysia Plan in 1973.

Essentially the reorganization of the rural health services involves the conversion of the three-tier system of main centre, sub-centre and midwife clinic to a two-tier system of health centre and rural clinic (Kelinik Desa), as well as increased staffing in the health centres. The reorganization, to be gradually implemented and completed by 1990, implies the upgrading of all sub-centres to main health centres, each with a doctor and dental officer and other staff, and covering not 10,000 but up to 20,000 people. At the periphery it implies the conversion of the MCQ into a functional sub-centre, staffed by two multipurpose community nurses (Jururawat Desa) instead of one midwife and covering 4,000 population instead of the original 2,000. (See APPENDIX III). The new staffing pattern with increased personnel is shown in APPENDIX IV. It is worth noting that when the reorganization is completed, the total number of health personnel in the two-tier system will be less than that of the original three-tier system.

As for MCH service in the reorganized health centres, there will be a health sister in charge of each centre and the number of assistant nurses increased from two to three. In addition, each rural clinic (Kelinik Desa) will have two multipurpose Jururawat Desa instead of one staff midwife.

As a stop-gap measure integrated mobile teams will be operating in the remoter areas, each team providing curative as well as MCH services for 10 village centres, until such time when permanent centres are made available, when the mobile team personnel will then be absorbed to form the permanent health centre staff.

It can be said that the Jururawat Desa or multipurpose community nurse, and the mobile teams, constitute a primary health care system in the Malaysian context.

4. MATERNAL AND CHILD HEALTH CENTRES

The rural health units in a number of rural areas were developed from the original maternal and infant welfare centres. However there still exist 33 such centres now called Maternal and Child Health Clinics (MCHC) in the non-metropolitan urban areas. They are staffed mainly by nursing personnel, such as health sisters, public health nurses, assistant nurses and trained staff midwives. These clinics provide maternal and child health services including family planning service, usually run either by the Family Planning Associated or the National Family Planning Board staff. They supplement the MCH clinics provided by the local authorities.

5. DEVELOPMENT OF FAMILY HEALTH SERVICES

5.1 Factors leading to the development of family health services

A number of factors have contributed to the development of the family health service concept in Malaysia. The integration of the family planning service with the rural health services in particular with the MCH service necessitated, in view of the relative conservatism of the rural population, an educational approach emphasizing on the need to improve family health, particularly that of the mother and child, through family spacing. The Malaysia experience of the integrated approach in improving the nutritional status of the child through a four-pronged strategy of improving food production and economy; education on home economy and nutrition; improved health and sanitation and supplementary feeding of the vulnerable groups such as mothers, infants, toddlers, pre-schoolers and school children again pointed to the need for efforts by individual families to improve their state of health and nutrition. The school health programme calling for the involvement of parent-teacher associations in improving the health of school children in activities such as the worm control campaign also pinpointed to the need for emphasis on the family unit as the basis for community involvement in the improvement of their own health and sanitation status.

But the turning point was undoubtedly the need to integrate family planning service with the rural health services. Family planning service had officially beenstarted in 1967 by the National Family Planning Board, a semi-goverment body set up through the Family Planning Act of 1966, and coming under the aegis of the Prime Minister's Department. The Board had initially started family planning service in the urban areas, but began to face difficulties when expanding its activities into the rural areas from 1969 onwards. The expansion programme of the Board had necessitated the recruitment of nursing personnel by the Board from the Ministry of Health. Further expansion by the Board on its own into the rural areas would have meant further staff losses from the Ministry of Health, thereby weakening the existing MCH services on the ground. The integration of family planning service with the rural health services to be carried out particularly by the existing MCH personnel was therefore necessary, not only to minimize staff losses from the Ministry to the Board, but also to provide family planning service as part of a package service for family health care.

In order to integrate family planning service with the rural health service without jeopardizing the existing MCH service, it would be necessary to strengthen the rural health services, especially the MCH services.

Assistance by the World Bank (IBRD) and UNFPA to the strengthening of MCH/family planning services from 1973 marked a turning point in the development of the family health services in this country.

5.2 Strategy for strengthening family health service

5.2.1 Objectives. In the Second Malaysia Plan of 1971-1975, the objectives of the medical and health programmes include:-

> "To consolidate the existing health services with continued emphasis on rural health and extend its coverage into more remote areas.
>
> To expand the training programme to provide the medical and health manpower required.
>
> To promote the general health of the population by improving environmental sanitation and nutritional standards on a national scale.
>
> To support and supplement the Family Planning Programme through functional integration with the Rural Health Services.
>
> To strengthen the development and planning capability and service of the Ministry of Health".

In line with these objectives, the strategy for strengthening the maternal and child health/family planning services called for:-

(a) extension of health services into the remoter areas

(b) improvement of the quality of health services provided, and

(c) emphasis on special programme areas.

5.2.2 Extension of health services into the remoter areas would be implemented by means of physical construction of more health centres and rural clinics, expansion of existing clinic space, provision of additonal personnel and sending mobile teams to cover the remoter areas as a stop-gap measure until permanent facilities are made available.

5.2.3 Improvement of the quality of health service would be carried out by standardizing various MCH procedures, developing and expanding the Under-7 Clinics, cutting down time spent by technical staff on non-technical duties by providing additional clerical staff and by streamlining the existing records system, upgrading the MCQ to functional health centres (Kelinik Desa) as well as by developing a category of multipurpose auxiliary worker called Jururawat Desa (community nurse) to operate the Kelinik Desa. The quality of service provided would also be improved by improved supervision through a new category of officer called the State Maternal and Child Health Officer as well as through an intensified training programme.

5.2.4 Special programmes will be intensified in the Second Malaysia Plan through the Third Malaysia Plan of 1976-1980. Of these the integration of family planning service with the rural health services will be

intensified in 20 selected districts as Intensive Input Demonstration Areas. The Applied Food and Nutrition Project (AFNP) will also be expanded to cover 37 districts where the toddler mortality is higher than the national average. The National Environmental Sanitation Campaign will be expanded in the Third Malaysia Plan to cover the whole country, but in the intensive input districts and AFNP areas, sanitation activities will be intensified and integrated as part of a total package service for family health care. In these special programme areas, totalling 37 out of 70 administrative districts in Peninsular Malaysia, priority will also be given in the provision of physical facilities, equipment, vehicles and additional personnel based on the two-tier system.

6. SOME ASPECTS OF THE FAMILY HEALTH SERVICES

It would be relevant here to highlight some of the programmes directly or indirectly related to family health care services in the country.

6.1 Intensive Input Demonstration Districts

It has been mentioned earlier that the integration of family planning service with the rural health service necessitated a strengthening of the rural health services, in particular the maternal and child health services. This has been facilitated by a loan from IBRD and a grant by UNFPA through an agreement signed in early 1973 with the Government of Malaysia. A plan of action was drawn aiming at integration of family planning services with the rural health services to be completed by the end of 1976. A major component of this plan involves the selection of 20 health districts as intensive input districts in which the total family health care will be strengthened and intensified and family planning service provided as part of the total family health programme.

The immediate objective of this project is to demonstrate and assess the effectiveness of an intensive approach of family health care incorporating family planning as an integral part of the MCH services. The long-term goal is to reduce morbidity, mortality and fertility as an integral part of the social and economic development by having wider coverage and better quality of services through the intensified and integrated approach in family health including family planning.

The components of the project are:

(a) Strengthening the maternal and child health services by improving rural health unit physical facilities, provision of vehicles and equipment as well as adequate staff to carry out service and supervisory visits, with emphasis on manpower preparation and training, and the design of standardized procedures.

(b) Provision of family planning service integrated with the MCH services.

(c) Strengthening food and nutrition programme and education.

(d) Strengthening information, education and communication activities by designing, protesting and utilizing I.E.C. materials for more effective approach by NFPB and Ministry of Health.

(e) Strengthening school health programme including family health education in schools.

(f) Strengthening of the management of the family health programme including family planning service.

(g) Study of MCH records and returns to analyse the efficiency, coverage and standard of service.

(h) Training of staff including Health Inspectors etc.

(i) Special evaluation efforts to assess the performance and the effects of the programme.

Evaluation will be built into the project and will cover analysis of performance in relation to the efforts expanded, as well as analysis of achievement in relation to the goal in terms of the impact of the project on morbidity, mortality and fertility and possible impacts on the social and economic situation. The proformas required for evaluation have already been pretested and the project will be fully implemented by the end of the year.

.2 Applied Food and Nutrition Project (AFNP)

The Government's development plans particularly since 1966 have given priority to the needs of children, so that they can become economically productive in adult life. One health problem of the pre-school child, particularly the toddler, is malnutrition, especially protein-calorie malnutrition. The relationship between malnutrition and infection as well as brain development has been established and the Government has been concerned with the relatively high dropout rate in rural schools.

In 1968 children of the 0 - 5 group, comprising 16% of the total population in West Malaysia, contributed 30% of total deaths. In 1969 they contributed 29% of total deaths.

The fall in the Toddler Mortality Rate (an index of protein malnutrition) was seen to be slower in the rural areas, comparing TMR of Malay children with Chinese children:-

Table (3) - Toddler Mortality Rate of Malay and Chinese Children

Year	TMR Malay	TMR Chinese	Difference
1957	14.11	6.59	x 2.1
1960	10.85	4.44	x 2.4
1968	7.24	2.63	x 2.7
1969	6.42	2.48	x 2.6

It was recognised that malnutrition is influenced by many factors such as economic, educational, social-cultural as well as health factors. To tackle malnutrition would require a multidisciplinary approach involving the agricultural, educational, informational, health and rural development agencies working together at grass-roots level. Unfortunately this had not been done in the past - hence the malnutrition problem as seen by the widening gap of toddler mortality between urban and rural areas.

In 1969, an Applied Nutrition Pilot Project was launched in Kuala District of Selangor as a community development project. The strategy used was a four-pronged one with emphasis on collaborative efforts by the various government agencies concerned coordinated by the District Office, as well as on participation by the people through various community groups such as village development committees, farmers' associations, youth clubs and women's groups. The four-pronged strategy covered:-

(a) Improved economy and food production involving agricultural extension activities,

(b) Educational activities including nutrition, education, home economy, community education and school health activities,

(c) Health and sanitation activities including maternal and child health care, immunization, family planning and environmental sanitation, and

(d) Supplementary feeding at clinics, pre-school childcare centres (TBK) and schools.

An assessment in 1973 showed that the integrated approach was a success. There was a new spirit of cooperation seen among the government officials and valuable experience was gained in the methods of getting community participation at grassroots level. Various community organizations, inactive at the onset of the campaign, later

on displayed confident leadership and initiative in improving local conditions without prompting by government agencies. Although the area selected for the pilot project did not have major malnutrition problems (toddler mortality in Kuala Langat in 1967 was 5.7 per thousand, compared to the national average of 3.68), improved nutritional status was indicated by the fall of toddler mortality in Kuala Langat to 2.7 in 1972, compared to the national average of 3.37. This improvement was also shown by an assessment of the weight by age of children attending the clinics from the pilot project area.

Following this pilot project, the Government is now expanding the campaign as an Applied Food and Nutrition Project (AFNP) in the Third Malaysia Plan of 1976-1980, to cover 37 districts involving approximately 3½ million people, where toddler mortality is higher than the national average.

The activities of the health services under AFNP will include:-

Nutrition surveillance,

Supplementary feeding,

Nutrition education,

Strengthening of various MCH activities, in particular the Under-7 Clinic,

Family Planning,

Communicable disease control including immunization,

Stepping up of environmental sanitation, and

School health programme.

6.3 The Pre-School Programme

The Ministry of Rural Economic Development has a project for pre-school children in rural areas known as Taman Bimbingan Kanak-kanak or T.B.K. The object of this project was to "promote social,emotional, physical and mental development of pre-school children".

The Ministry of Health is involved in this project in an advisory capacity and also to cooperate with these Centres at local level in the following areas:-

(i) standards for physical facilities and safety features,

(ii) environmental sanitation,

(iii) health surveillance, immunization and treatment of minor ailments,

(iv) food preparation, supplements and nutrition aspect:

(v) hygiene and health education

(vi) parent-teacher organisation.

This project has been gaining popularity and the demands have been exceeding the resources beyond expectation. The present plan for T.B.Ks is as follows:

Year	No. of T.B.Ks	No. of Pre-School children
1973	247	6,175
1974	300	7,500
1975	400	12,000
1978	1,025	25,500

6.4 School health programme

The school health programme was launched by the Joint School Health Committee of the Ministry of Health and Ministry of Education in 1967.

The programme covers four components:-

- School health service
- School health education
- School health environment and
- School-community co-operation for health

A major development of the school health programme involves the concept of school-community relationship, with the school outing as a change agent to improve the standard of health in the homes through the pupils and the Parent-Teacher Association, and working in close collaboration with the Village Development Committee and other organisations. School activities, developed in the Kuala Langat ANP, include nutrition education, tied up with school feeding and the development of the school garden, poultry farm or fish pond. Teacher training has been stepped up and a Health and Nutrition Education Training Centre set up in Kuala Trengganu by the Ministry of Education. It is anticipated that schools will play a significant role in improving health and nutrition in the community. This development will greatly strengthen the family health care services in the country.

6.5 The Jururawat Desa (JD) Programme

The Jururawat Desa is a multipurpose community nurse whose functions will cover:-

- Midwifery services
- Maternal and child health care
- Family planning
- Home visiting

- Immunization
- Health education
- Reporting of communicable diseases and insanitary conditions
- Medical care for minor ailments and first aid measures
- Simple laboratory procedures, and
- Maintenance of records

It is planned to have two Jururawat Desas to man each Kelinik Desa covering up to 4,000 people in the rural areas. Order of priority for locating them will be firstly in Land Development Schemes (Felda), remoter clinics, clinics around training schools and other clinics. Eventually the Jururawat Desa will replace all midwives and assistant nurses in the rural health services.

THE COMMUNITY APPROACH IN FAMILY HEALTH CARE IN MALAYSIA

It was earlier stated that the turning point in the development of family health services as a package service for the improvement of family health and sanitation, with special reference to the health of the mother and child, came with the need to strengthen MCH services in order to integrate family planning service with the rural health services, with IBRD and UNFPA assistance.

In implementing these services so as to involve family participation, especially in the rural areas, an approach has been developed, concurrent with the Government's community development programme.

In Malaysia, community development had its beginnings in 1953, after the start of the Emergency, but it was only after the end of the Emergency in 1960 that community development was built into the Government's national development plans.

The Operation Room techniques developed during the Emergency were adapted to develop an infrastructure for planning and co-ordinating various development activities in peace time, at the beginning of the Rural Development Plan of 1961-1965. Initially Development Committees were set up at national, state and district levels. In 1962 Village Development Committees were set up through Directive No. 3, thereby providing a set-up for community involvement at grass-roots level.

The beginning of the First Malaysia Plan of 1966-1970 saw a new phase in the community development programme with the launching of GERAKAN MAJU (Operation Progress) in 1966. It was during this phase that health was recognized as one of the four community problems which would have to be solved through co-ordinated efforts of government agencies and the community, the other three being poverty, illiteracy and apathy. This was further emphasized with the launching of GERAKAN PEMBAHARUAN (Operation Renewal) in 1972 after the start of the Second Malaysia Plan of 1971-1975.

It is thus seen that community development has been adapted and modified at different stages to the changing needs and priorities of the current national development plans. Strong emphasis is given to the integrated approach, with interdepartmental collaboration and collaboration between the government agencies and the community as the two key elements of this integrated approach. Today national as well as community development activities are co-ordinated through the Village Development Committee at village level. The Implementation Co-ordination and Development Administration Unit (ICDAU) of the Prime Minister's Department forms the secretariat for the national level action committee. The State Development Officer (SDO) co-ordinates activities at state level through the State Action Committee, under the chairmanship of the state Chief Minister (Menteri Besar). The district level committee is chaired by the District Officer. On the basis of the ANP experience a full-time Assistant District Officer (Community Development) is now provided at district level to co-ordinate various community development activities, including the Applied Food and Nutrition Project.

This infrastructure is therefore the vehicle by which various family health programmes will operate, particularly if these programmes or activities involve an intersectoral approach.

It is recognized that the family is an integral part of the community and that it would be important to get the family's involvement in improving their health and sanitation requiring community support, particularly through community leaders and various community organisations such as the Village Development Committees, Farmers' Associations, Youth Clubs and various groups.

The community approach through groups is necessary, not only because of the value of community groups in influencing change, but also because it is more economical and less time-consuming to approach community groups rather than individual families.

The community approach, in which health staff, including MDH staff go out to campaign in the community particularly meeting them in groups through the holding of exhibitions, discussions and participating in various activities on the ground, is therefore an <u>active approach</u> compared to the clinic approach, which is a passive one in which clinics are set up and the people come to the clinics to utilize the available facilities. The key to this approach is collaboration with community leaders and organizations such as youth clubs, women's groups etc. In the AFNP this approach is also an <u>integrated</u> one, because of the close collaboration between various government departments and between these departments and the community in tackling the community's malnutrition problem.

In the community approach to family health care, it is necessary to utilise various community resources. One resource which has not been fully utilised in Malaysia is the bidan kampung or <u>traditional birth attendant</u>.

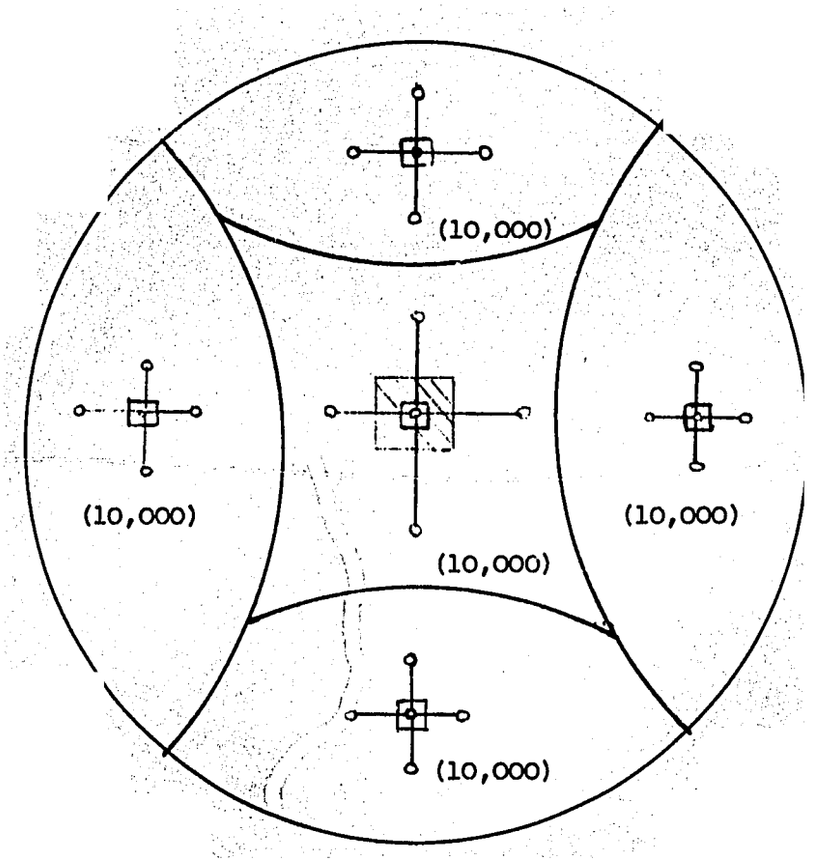
So far 2,731 traditional birth attendants have been registered under the Midwives Registration Regulations 1971. Of these about 200 have been trained by the National Family Planning Board as family planning motivators. The Ministry is at the moment reviewing the role traditional birth attendants vis-a-vis the trained Government midwives within the larger context of family health care so that they will be able to work together, with the traditional birth attendants supporting the role of the Government midwives while retaining their own traditional role which is generally accepted by the rural society.

It is hoped that the deliberations of the Working Party will be able to assist the Ministry in formulating a practical programme of involving the kampung bidan in promoting family health in this country.

APPENDIX I

SET-UP OF A RURAL HEALTH UNIT FOR 50,000 RURAL POPULATION

(THREE-TIER SYSTEM)



KEY:

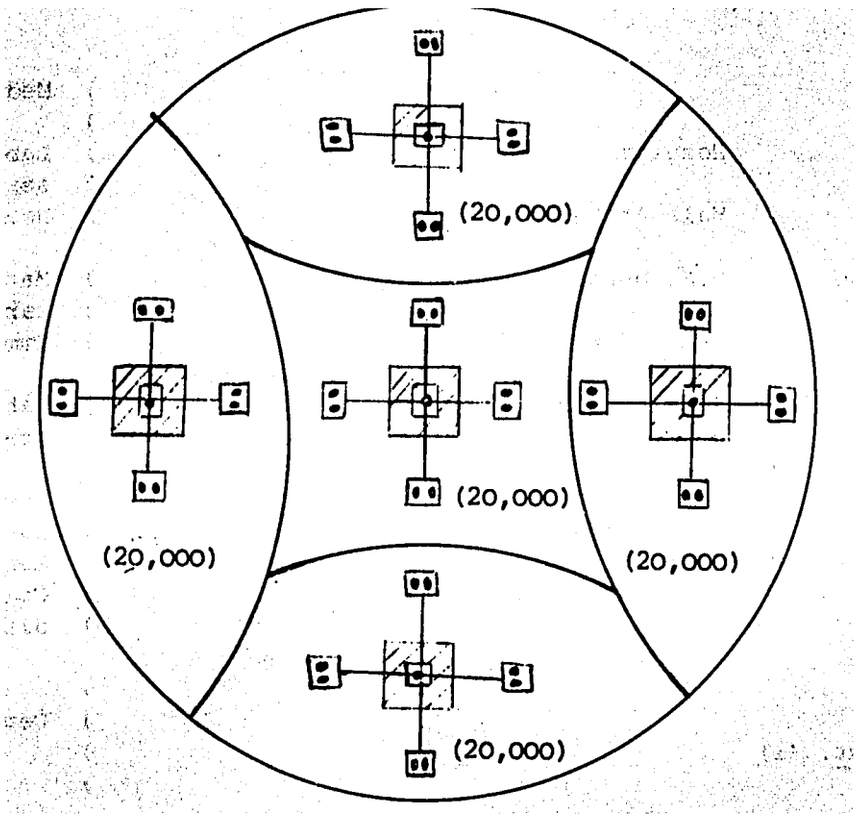
- o Midwife Clinic cum Quarters (MCQ) for 2,000 persons
- □ Health Sub-Centre (HSC) for 10,000 persons
- Main Health Centre (MHC) for 50,000 persons
- (Note: Three-tier system of MHC, HSC and MCQ)

APPENDIX II

STAFFING PATTERN FOR RURAL HEALTH UNIT

At Main Health Centre (50,000 pop.)	At Health Sub-Centre (10,000 pop.)	At MCQ (2,000 pop.)	Basic Services
Medical & Health Officer			Medical Car
Hospital Asst. Dispenser	Hospital Assistant		Laboratory services
Male Attendant (1)	Male Attendant (1)		Health Education
Public Health Nurse	P.H. Nurse		Maternal & Child care
Asst. Nurse (2)	Asst. Nurse (2)		Immunisation
Midwife (1)	Midwofe (1)	Midwife (1)	
Female Attend. (1)	Female Attend. (1)		Laboratory Health Education
P.H. Inspector			Environmental sanitation
P.H. Overseer (1)	P.H. Overseer		Health Education
Sanitation Labourer (2)	Sanitation Labourer (2)		Communicable disease control
Dental Officer			
Dental Nurse			Dental Care
Dental Surgery Asst. (1)			
Dental Attendant			
Clerk (1)	Clerk (1)		Administration and records
Driver (2)	Driver (2)		
Gardener (1)	Gardener (1)		

REORGANIZATION OF RURAL HEALTH UNITS FROM THREE-TIER TO TWO-TIER SYSTEM, FOR 100,000 RURAL POPULATION



NOTE:

(a) Upgrading of Health Sub-Centresto Main Health Centres covering 20,000 population

(b) Upgrading of MCQ to Kelinik Desa (functional health centre) covering 4,000 population

APPENDIX IV

NEW STAFFING PATTERN OF THE TWO-TIER SYSTEM

	Main Health Centre			Health Sub-Centre ++			Midwife Clinic Cum Qrs. ++			Remarks
	Existing	Proposed	Increase	Existing	Proposed	Increase	Existing	Proposed	Increase	
1. Medical Officer	1	1	-	-	1	1	-	-	-	++(a) HSC to be upgraded to Main Centre Status (b) MCQ to become Kelinik Desa
2. Hospital Assistant	1	1	-	1	1	-	-	-	-	
3. Dispenser	1	1	-	-	1	1	-	-	-	
4. Junior Lab. Asst.	-	1	1	-	1	1	-	-	-	
5. Public Health Sister	-	1	1	-	1	1	-	-	-	
6. Public Health Nurse	1	1	-	1	1	-	-	-	-	
7. Assistant Nurse	2	3	1	2	3	1	-	-	-	
8. Midwife*	1	1	-	1	1	-	1	2	1	* To become Jururawat Desa
9. Public Health Inspector	1	1	-	-	1	1	-	-	-	
10. Public Health Overseer	1	2	1	1	2	1	-	-	-	
11. Sanitation Labourer	2	4	2	2	4	2	-	-	-	
12. Clerk	1	1	-	(1)	(1)	-	-	-	-	() Already in scheme, not enforced
13. Clerical Assistant	-	1	1	-	1	1	-	-	-	
14. Attendant	2	3	1	2	3	1	-	-	-	
15. Driver	2	3	1	1	3	2	-	-	-	
16. Gardener	1	1	-	1	1	-	-	-	-	
17. Watchman	-	1	1	-	1	1	-	-	-	

* Where domiciliary midwifery lead is heavy, two Jururawat Desa will be posted

INTEGRATION OF FAMILY PLANNING WITH THE RURAL HEALTH SERVICES

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1. Introduction

Family Planning activities in Malaysia can be traced as far back as 1935-1936 (through individual effect), but this was followed by Johore (1954), Perak (1956) and Malacca (1957). The FFPA was formed in 1958 and Family Planning Associations were formed in all 11 states in 1961.

1.2 The National Family Planning Board a semi-autonomous government body was formed in 1966 to formulate a policy and programme in Family Planning on a nation wide basis in Peninsular Malaysia. The service programme began in May 1967 and was planned in four phases commencing in the metropolitan areas at phase 1 and gradually extending into the rural areas at phase 3 and 4 respectively. The expansion into phase 1 (1967) and phase 2 (1968) was rapid phase 2, as scheduled. Expansion into phase 3 in 1969 was impeded by staffing and other problems. The National Family Planning Board was therefore facing an acute problem as to how to provide Family Planning service into the rural areas where about 70% of the total Malaysian population are located. In addition the Ministry of Health viewed with concern the recruitment into the Board of government medical and health personnel. This continuing recruitment from the limited staff available in the country may eventually weaken the existing health structure which provide health services to mothers and children.

2. The concept of Integration:

An "integrated health service" has been defined by WHO as the service necessary for "the health protection of a given area and provided either under single administration or under several agencies with proper provision for the co-ordination of these services". By integration is meant the incorporation of family planning as an integral part of the health services. Integration could be either "physical" or "functional".

In the context of Family Planning, physical, integration means that the unit which is responsible for Family Planning Programme is itself located within the Ministry of Health. Functional integration simply means that Family Planning activities are incorporated into the day to day activities of existing health personnel.

Thus, the following types of integration are possible:-

(a) Physical integration without functional integration

(b) Physical integration with partial functional integration

(c) Complete physical and functional integration

(d) Functional integration (partial or complete).

The integration of Family Planning services with the Rural Health services takes this form of integration where Family Planning services is provided by the Maternal and Child Health Staff as part of their daily activities but the overall responsibility for the National Family Planning programme continues to be the responsibility of the National Family Planning Board by virtue of the Family Planning Act 1966.

3. The case for Integration of Family Planning with the basic Health Services:

3.1 Demographic considerations have stimulated large scale development of Family Planning progrmmme in most developing countries since the 1960s. It is too early to evaluate the impact of these programmes on fertility in relation to population growth but it is evident that these programmes have had a substantial effect on increasing public discussion and awareness of the possibilities of regulating childbearing and in increasing the practice of family planning. However, success was seen only in small nations which are relatively more advanced economically when compared to other countries and where literacy, urbanisation and industrialisation are fairly high, characteristics that are associated with a fall in birth rates in other countries which do not have organised Family Planning Programme. In countries with low populations and the lowest levels of general development the impact are still too small for significant measurement to be made. High levels of mortality particularly in infancy appears to present an important obstacle to family planning in these area settings. The high birth and death rates are interwoven into social and cultural traditions and organisations where a woman's status is related to her fertility and subfertility is regarded as a personal catastrophe.

The absence of health, educational and other social services present immediate obstacles to Family Planning. In these settings, therefore, it is only logical to say that Family Planning should be provided as part of other basic health services essential for the lowering of mortality and improvement of health status.

3.2 Delivery of Family Planning Care

The health services play a key role in the successful provision of Family Planning Care. Many birth control methods require health personnel particularly techniques supervision, follow up and management of side effects. The usefulness and success of these different methods depend on several factors such as their effectiveness in preventing pregnancy; the health risks entailed in their use; their cost and simplicity of use, and other considerations that influence their acceptability. These factors interact and influence the selection of specific methods for

programmes and the choice and continued use of methods by individuals or couples. Basically, the "risks" associated with any method must be compared with the risk of not using any method at all.

3.3 Other advantages have been advanced for integrating Family Planning with general health services. Some of these are:-

(1) Utilisation of existing health facilities and personnel:

It is better and more economical to build a programme into an existing structure. Integration will reduce duplication of functions and enable maximum use of existing resources.

(2) Provision of a series of services: Services to protect and promote health are best provided in a sequence rather than fragmentally i.e. family planning should be an integral part of a total health package for family health.

(3) Unique opportunity of health workers to contact people:

The services provided for mothers and children through ante-natal clinics,child health clinics, home visiting, domiciliary deliveries and outpatient departments provide close contact of health workers with families, providing opportunities for family planning work.

(4) "Trust" among people: Permanent community health services that include maternal and child care are needed for the acceptance of family planning. As long as parents have a reasonable assurance that the children they already have will survive in good health they will be more ready to practice family planning. Health workers who have already gained acceptance by the people are able to propogate family planning from a position of trust.

(5) "Teachable moments" for mothers: Family Planning is related to every phase of the maternity cycle, biologically as well as in service and educational aspects. If it is integrated into maternity care and related to the phases of the maternity cycle when woman's needs are greatest, its potential availability and effectiveness are enhanced.

(6) Technical Advantage: I.U.C.D. insertion and female sterilisation are technically easier soon after delivery. Family Planning services can therefore be incorporated into maternity services with advantage.

(7) Privacy for mothers: There are women in our society who do not take an open interest in family planning because of conservatism or shyness. Such women may be more easily reached when they attend Maternal and Child Health Clinics where Family Planning is offered as a more discrete service.

(8) Teamwork approach: An integrated service will make available health personnel from the general health services and the Maternal and Child Health Services to work with the community and to gain their support for family planning programmes.

(9) Statistical advantage: It has been shown statistically that of the women who become pregnant again after a delivery, half will have conceived within three months of the first menstrual period after delivery while about 4/5 do so within a year (Taylor 1965). Thus contraceptive advice and service provided shortly after parturition would give greater effectiveness in reaching target groups.

4. Organisation

The integration of Family Planning with the Rural Health Services is a service or functional integration, whereby Family Planning is provided as part of the total Family Health packet to the people. The service programme utilizes medical, paramedical and auxiliary personnel of the Rural Health Services. The National Family Planning Board continues to be responsible for the overall development of the National Family Planning Programme, by virtue of the Family Planning Act, 1966.

4.1 The Central Co-ordinating Committee:

At National level a Central Co-ordinating Committee (C.C.C.) was formed in 1970. The main task of this committee is to set up certain guidelines and plans for implementation of the integration programme so that the programme should be carried out in a co-ordinated manner. The C.C.C.'s functions are to define the aims and objectives of the integration programme; to define and co-ordinate the role and responsibilities of the Ministry of Health, the National Family Planning Board and the Family Planning Association in the integration process; to set up guidelines and criteria for expansion of the service programme and selection of areas for implementation; to develop a system of supplies and logistics and evaluation and to recommend future plans and policies related to the integration programme.

4.1.2 The Central Co-ordinating Committee consists of members drawn from the senior staff of the Ministry of Health, the National Family Planning Board, the Federation of Family Planning Association and a co-opted member i.e. the MCH/FP advisor attached to the Ministry of Health. The Director of Health Services, and the Director General of the National Family Planning Board are alternate Chairman of the C.C.C.

4.2 Sub-Committees:

The C.C.C. is assisted by various Sub-Committees namely Services, training, information and evaluation. An Action Committee consisting of Chairman and relevant members of the Sub-Committees and chaired by the Director of Health Services, meet from time to time to review the recommendation of the various sub-committees and to follow up decisions made at C.C.C. meetings and to take immediate action wherever possible in between the C.C.C. meetings.

4.2.1 The Service Sub-Committee:

This committee is responsible to the Central Co-ordinating Committee in planning the details for implementation of the integration programme in accordance with the criteria and guidelines set by the Central Co-ordinating Committee. These include selection of areas for implementation of the programme, development of an effective supply system to integration areas; study of problems on implementation and evaluation reports in order to make the necessary recommendations to the Central Co-ordinating Committee.

The Director of the Service Division National Family Planning Board is the Chairman of the Committees.

4.2.2 The Training Sub-Committee:

This Committee is responsible to the C.C.C. in planning developing and co-ordinating the various training programmes for all categories of personnel involved in the integration programme.

The Director of the Public Health Institute is the Chairman of this Committee and its membership includes the Director of Training from the National Family Planning Board and the Medical Director of the Federation Family Planning Associations.

4.2.3 The Information Sub-Committee:

The Information Sub-Committee is responsible to the C.C.C. in planning, developing, co-ordinating and evaluating the information and education aspects of integration.

4.2.4 The integration Sub-Committee is responsible for planning and developing the evaluation of the programme with a view to make specific recommendations in relation to implementation of the programme.

4.3 The State Co-ordinating Committees:

At state level, a State Co-ordinading Committee, co-ordinates and evaluates the implementation of the integration programme in each of the 11 states in Peninsular Malaysia. The Chairman of this committee is the State Director of Medical and Health Services, and the National Family Planning Board Information Officer is the Secretary. Members should include the representative for State Secretariat, State Information, State Welfare Service, Religious department and all State NFPB Officers and State MCH/FP Officer, Health Matron and State Health Education Officer.

5. Plan and Implementation:

In anticipation of some practical and administrative problems which might be encountered in immediately integrating Family Planning Service on a nation-wide basis, it was, therefore, decided that the implementation of the programme would be carried out in two stages which would be included in Phase Four of the National Family Planning Programme. The integration programme started in 1971 and it is envisaged that by 1976, the whole of Rural Health Services in Peninsular Malaysia will be covered by this programme.

5.1 The Study Project and the Service Demonstration Programme:

(Phase 1a: 1971-1973)

This was to cover a population of about 947,000 from eight Health Districts selected from seven out of the eleven states in Peninsular Malaysia (see Appendix I). This involves provision of Family Planning Services at 40 Main Health/Sub Health Centre and 140 Midwife Clinic-cum-Quarters.

5.1.1 The Study Project was to cover a total population of 245,000 in two areas, where Family Planning would be integrated with the Rural Health Services and action studies carried out to determine the nature, extent and level of integration possible by existing health personnel, as well as to assess the administration was to be carried out for two years and the evaluation of this project would determine future direction and policies toward integration of Family Planning with the health services, throughout the country.

Results from the study projects were also fed into the Service Demonstration Programme to enable adjustments to be made, in the light of experiences and scientific information obtained.

The Study Areas include Tanjong Karang in Selangor, Parit Jawa in Johor. The two areas had minimum prior exposure to family planning activities, have similarities in the areas for physical facilities, district resources ratio and rurality measures.

In these areas the workload of existing health personnel would be determined in order to estimate the type and number of additional staff needed to effectively implement the programme.

5.1.2 The Service Demonstration Programme:

Simultaneously with the study project, integration of Family Planning with the Rural Health Services was initiated on a bigger scale as service demonstration programme, to cover a population of 702,000 from areas. The service programme utilizes medical, para-medical and auxiliary personnel of the Rural Health Services in the same manner as they are utilized in the study projects.

In both study and Demonstration Areas, two approaches in Family Planning would be tested.

(i) The Clinic or MCH approach where in Family Planning education and service would be carried out within the usual scope of activities of the MCH services.

(ii) The combined Clinic-Community Approach where in addition to utilizing the MCH approach, this educational approach would aim at getting active community support through involvement of various community leaders and organisations providing Family Planning as a package deal of total health care.

6. Expansion Programme (Phase Ib and IIa - IIb: 1974-1976):

While the study Project and Service Demonstration Programme were in progress, plans were made to expand the integration programme with IBRD and UNFPA assistance. This expansion took into consideration the initial results of the Study Project and Service Demonstration Programme as well as the findings of the Ministry of Health Operations research on rural health services carried out in 1969-1971. Expansion of the programme to cover the rest of the rural population has been divided into three stages as seen in Table 1.

Stage of Programme	Year of Implementation	COVERAGE			
		MHC	SHC	MCQ	Population
Phase I -b	1974	15	52	297	1,862,455
Phase II-a	1975	26	-	124	3,634,875
Phase II-b	1976	-	115	485	
Grand Total Phase I & II					6,475,161

Table I Expansion of Integration Programme 1974-1976

6.3 The Intensive Input Demonstration Areas (1974-1978):

An agreement was signed between the Government of Malaysia and the International Bank for Reconstruction and Development (IBRD), on 9th February 1973 and between the Government of Malaysia and the United Nations Fund for Population Administration (UNFPA) on 5th February 1973, to implement the Population Project, with loan from IBRD and Assistance from UNFPA. Under this agreement the Rural Health Services would be strengthened in order that Family Planning could be effectively integrated. Fourteen Health Districts out of the total forty seven were selected for Intensive Input Demonstration Programme. With the change in the Health districts since January 1974, the total number of Health Districts involved will be 20. In those areas, the pattern and intensity of delivering family planning services as an integrated part of Family Haalth care would be magnified and new techniques of stimulating demand would be tested and evaluated. This type of demonstration would help in the development of long term policies along sound lines, (see appendix II). The details of the implementation and evaluation of this programme are being worked out. In these health districts the total Family Health Care will be strengthened and intensified and Family Planning will be provided as part of this total Family Health Programme. A third Assistant Nurse will be located in most of the Health Centres by 1975 and extra facilities and vehicles provided to make this possible.

7. The Results:

7.1 The Study Project Area:

Computation of productivity ratios was carried out to measure and evaluate the effective workload of Rural Health Services and the effects the integration project has on these services since 1968 to 1972 in the Study Areas. In the two study areas, it was found that the productivity ratio for all Health Centres seemed to have decreased generally and in many cases the decrease was substantial. In particular the home visiting services seemed to have decreased in almost all centres.

A study of acceptability of various contraceptive methods was also carried out. Some of the findings indicate a lack of even emphasis on all contraceptives, and the I.U.C.D. is only a third alternative method after the pill and condom. The staff lack training and confidence in I.U.C.D. insertion and existing facilities are inadequate for insertion, especially equipments.

A comparative study on some of the characteristics of acceptors in integration areas with that of the national programme was also carried out in 1971. Some of the findings indicated that the characteristics of the integration acceptors follow a somewhat different pattern from that of the national programme acceptors, partially due to the rurality of the integration project. This is especially evident in such characteristics as level of education, type of employment, income level and past family planning history.

A survey of attitudes of Nursing personnel, and time spent on family planning and haalth services was carried out in August 1972. 73% of the responding staff reported that there were definite problems in finding adequate time to motivate and provide Family Planning and routine health services effectively. There was evidence that the workload has increased but generally the attitudes of the nursing staff are very favourable towards family planning and the concept of integration.

7.2 The Status of Integration:

As of December 1974, integration of Family Planning Services have been completed in phase 1a and is nearly completed in phase 1b. Implementation will commence at a health centre once one supervisory and one auxiliary staff have been trained. Implementation thereafter will be hastened by giving preference for training those personnel who have not been trained.

In the long-term plan, the service and evaluation committees are now collecting data on physical facilities and actual population coverage of each facility with a view to work out the approximate number of eligible women who could be reached by each facility, so that a more practical and reasonable target of achievement could be worked out. It would also be possible from this to work out the coverage for each agency implementing the national programme i.e. the NFPB, the Ministry of Health and the Family Planning Association as well as the coverage by the proposed Mobile Rural Health Units.

7.3 Training of Personnel:

7.3.1 Types of training: Four types of inservice training course were developed as follows:-

- 4 day seminar for Senior Administrators (State Directors of Medical and Health Services, Deputy Director of Medical and Health Services, Matrons, etc.)
- 3 week course for supervisory staff (Medical Officers, Public Health Sisters and Public Health Nurses)
- 3 week course for Nursing Tutors
- 3 week course for Auxiliary Staff (Assistant Nurse and Midwives).

(a) The Training of Senior Administrators, supervisory staff and Tutors were carried out by the National Family Planning Board according to curriculum approved by the Central Co-ordinating Committee. Up to June 1974, eight courses have been conducted and 538 officers have undergone the desired training. (for details see appendix IIIa).

(b) Training of Auxiliaries: During 1971 and 1972 training of auxiliary staff was conducted locally by supervisors who had been trained centrally. This training was found to be unsatisfactory. Therefore, a formal Regional training was planned in 1973 with assistance obtained from UNFPA. The auxiliaries are now trained at 5 Regional Training Centres for three weeks, by Tutors who have been specially selected and trained for this purpose. The Five Regional Training Centres are located in Alor Star, Telek Anson, Kuala Lumpur, Malacca and Kuantan.
Two full time tutors arrange and conduct about 9 training courses per year at each Training Centre. Six of these are Public Health Nurses from Ministry of Health and four are Nursing Staff from the National Family Planning Board. There are about 2,700 auxiliaries to be trained and it is expected under this plan, training would be completed within three years and if this could be achieved, it would be in line with the implementation of the service programme. As of December 1974, 857 auxiliaries have been trained.

8. Acceptors in Family Planning:

8.1 Acceptors trend: The acceptor trend in all integrated areas follow generally the same pattern. During the first few months after the implementation of the integration programme, the number of acceptors continues to reach a high peak level and thereafter decline to follow a fluctuating level which is generally higher than the level before integration. However, the monthly average number of new acceptors and revisits after implementation of the programme were higher than many of the NFPB's clinic performance. The first year continuation rates in some integration areas also appeared to be better than the national continuation rates as computed from the 1969 Acceptor Follow up survey. This could probably be attributed to three factors:-

- The input in terms of medical, nursing and other supporting staff from the Ministry of Health is considerably higher than that of NFPB.

- The area and population coverage by the Health Staff also seems to be more intensive and extensive.

- The follow-up and continuous reassuring and advice during home visiting services also promote much better continuation rates.

8.2 Numbers of acceptors:

The total number of acceptors recruited in 1971 to 1973 were 12,485 which represented 20.5% of the target of 81,000 for the three year period. For details see table (2).

TABLE 2 - TARGET POPULATION AND ACHIEVEMENT 1971 - 1973

Year	Target Population to be reached	Annual No. of Acceptors	Achievement %
1971	9,000	2,963	33.0
1972	16,000	4,903	30.6
1973	36,000	4,619	12.8
TOTAL:	61,000	12,485	20.5

These targets were computed based on the total district population and not on the actual facility: population coverage.

In terms of population coverage by areas under stage 1(a) the programme has covered about 7.4% of the estimated eligible women in the district concerned.

The acceptor rate per 1,000 eligible women ranged from a low of 44 in Johore and to a high of 151 in Perlis and is summarised in appendix IV.

8.3 Information and Education:

8.3.1 Approaches:

There are two approaches by the C.C.C. for information, motivation, and education, namely the MCH approach and the combined MCH Community approach. The programme within integration consists of the following components:

- Publicity activity - Information programme
- Community motivation and Education
- Commencement of Integration Activity
- Continuing Educational Activities
- Reinforcement and Maintenance

8.3.2 Publicity activities have been minimised for political reasons and thus far only one one-day workshop was conducted for administration/politics and health and NFPB personnel in the eight health districts under phase 1a. Since then the approach has been limited to the MCH approach.

8.3.3 Production of Information motivation materials:

The following materials have been produced and circulated:

- Two poster (NFPB)
- 1 Flip Chart (Ministry of Health)
- Flip Chart Book (NFPB)

Two workshops were held in this connection by the Ministry of Health and NFPB. The first in June 1973 in Penang was to prepare a flip chart for use by health personnel on Maternal and Child Health and Family Planning. The second was held in February 1974 in Kuantan to prepare flip charts and talking points in Family Planning for use by Health personnel in integration areas. Both these flip charts and talking points are being edited and will be printed in due course for ciruclation and utilization.

9. Future Plans:

9.1 Strengthening of Rural Health Services:

In assessing the role of the rural health services in the family planning programme in 1971, it was realized that with the existing facilities, the rural health services would only be able to reach about 54.3% of the rural acceptor target set by NFPB for the Second Malaysia Plan. This would imply that NFPB and FPA would have to cover the rest of the rural target acceptors. However, to do this, the Board would have to recruit additional personnel, many of whom would most probably come from the existing rural health Staff of the Ministry of Health. This would weaken the rural health services and reduce further its family planning services coverage. The answer is therefore clear. Family Planning service must be integrated with the rural health services, and the rural health services must be strengthened.

Although it was originally planned that the experiences of the study Project and Service Demonstration Areas would assist the Ministry determining the types of additional staff required in the integration, a number of factors necessitated an acceleration of the planning for strengthening the rural health services:-

- indication of IBRD and UNFPA assistance;
- need to incorporate the plans in the mid-term review of Second Malaysia Plans; and
- the Ministry's operation research findings on rural health services carried out in 1969 - 1971.

Accordingly plans for strengthening the rural health services, which receive IBRD and UNFPA assistance, were incorporated in the mid-term review and approved. To strengthen the rural health services and to have more effective coverage of the rural population the present three-tier system of rural health unit will be converted to a two-tier system in future. Each unit of two-tier system will consist of one Health Centre and 4-5 Kelinik Desa serving a population of 15,000 to 20,000.

The Kelinik Desa will replace the existing MCQs and will ultimately be manned by two Jururuwat Desa instead of one midwife. The Jururuwat Desa is a multipurpose health worker. Initially existing midwives will be trained for six months to fulfill the extra function of medicare, immunisation, child health, simple laboratory technique and family planning. Plans are underway for direct intake and training of Jururawat Desa.

All Sub Health Centres will be upgraded to Health Centres with a Doctor for 15,000 to 20,000. The staffing pattern will be modified. A third Assistant Nurse will be posted to each health centre based on priority, as well as a clerical assistant whose function includes the development and maintenance of an effective record system. Further the record system will be standardised and simplified. Rural Health Services would be expanded to cover remoter areas initially through Mobile Health Teams under the charge of a doctor and ultimately by establishment of static centres. There will also be increased emphasis on special programmes which include Family Planning integration, Applied Food and Nutrition Programme, Pre-school Health Programme.

As of June 1973, there are 88 medical doctors, 521 sisters and public health and staff nurses, 617 trained Assistant Nurses and 1571 government midwives working in rural health services in Peninsular Malaysia.

The present quality of MCH services would be improved by development of standardised MCH procedures and manuals, standardisation and simplification of MCH records, development of specific targets to be reached by the MCH services and improvement in the quality of service provided by MCH personnel. The appointment of a Medical Officer Health in charge of MCH and Family Planning at state level in January 1774 will make these plans possible.

9.2 Review of targets for family planning:

The Central Co-ordinating Committee is at the moment revising the target acceptors in the integration programme, to be based on the actual population covered by each facility rather than of the total district population in which the facility is located. In this way the target to be reached will be more realistic and the results will reflect the actual performance more accurately.

9.3 Intensive Input Demonstration Areas:

A comprehensive working profer is being prepared on the Intensive Output Demonstration Areas, with details for implementation of each component activity, including activities for strengthening family health care through which family planning service will be provided, as well as criteria set for evaluating these activities.

10. Conclusion:

The successful implementation of integration of Family Planning with the Rural Health Services will require full co-operation and support from MOH, the NFPB, the FFPA and related agencies.

Under the present political situation in Malaysia where the racial distribution of the three major races is an important political consideration, in the implementation of the programme, the only way Family Planning services will reach the Rural Population will be through the Health Services. In addition experiences in other countries have shown that family planning service only, without an effective MCH service is not the answer.

The successful outcome of each pregnancy and the reduction of infant mortality and maternal mortality are essential for Family Planning to succeed. In Malaysia, if the integration programme succeeds, then the National Family Planning programme has achieved its objectives.

EXPANSION OF INTEGRATION

1. Concept of Integration:

This is a functional or service integration which simply means that Family Planning activities are incorporated into the day to day activities of the health personnel.

The Ministry of Health is responsible for implementating the integration programme according to schedules worked out by the Central Co-ordinating Committee. The integration programme involves provision of Family Planning services by health staff, at rural health facilities. The objective is towards complete functional integration at rural health facilities.

In phase II of the service programme of the NFPB, clinics should have been established at District Hospitals. However, because of problems related to "space" clinics were instead established at health centres in some areas. For this reason implementation of integration are two types.

Partial integration where staff for the static NFPB clinic will continue to assist the health staff for a certain period until the health staff are ready to take over.

Complete Integration where the health staff from the very beginning will provide Family Planning service.

2. Implementation:

Implementation of Family Planning service at Rural Health Centres is the responsibility of the Ministry of Health. Implementation of service should follow the following guidelines:-

2.1 Implementation is according to areas agreed by the Central Co-ordinating Committee. The C.C.C. will circulate copies of this schedule of implementation to the State Co-ordinating Committee and to all Medical Officers Health involved.

The MCH is responsible for the programme in his health district and will:

(a) Prepare a plan for implementation of the service programme in his areas according to schedule.

(b) Ensure all the necessary staff are trained.

(c) Provide Family Planning service according to the following guidelines.

* Service should be provided not less than three months after an adequate number of staff have been trained.

* Service can be provided when at least one supervisory and one auxiliary are trained.

(d) Once his area is ready, the MOH should contact the local NFPB personnel to get their assistance to order contraceptive supplies etc., making sure at least one months's notice is given before the date of implementation.

(e) A one-day workshop is to be organised just before or soon after implementation has started. This to be planned by the state MCH/FP Officer and the state NFPB Medical Officer/ Supervisor and State NFPB Information Officer with the District Medical Officer Health and local NFPB staff.

f) In health centres, where NFPB have already started static clinics, NFPB staff will continue to assist the health staff until such time (which can be determined by the MOH and local NFPB staff as the health staff can take over ("portial integration").

Where NFPB only provide mobile clinics, NFPB staff will continue to come on the appointed days to slowly hand over the clinic to the local health staff. This usually takes about three months.

Where FPA is providing service, FPA will also withdraw from the health facility, but will continue where necessary to provide supportive and complementary services for the area, but not within the health facility.

(g) The MOH is responsible for local organisation and supervision of integration and is assisted by the Health Sister.

(h) The local NFPB sister/staff nurse will provide technical assistance and advice in Family Planning to the local staff through the health sisters. These include indenting for supplies, keeping supply records, returns, problems related to contraceptive use, referral of cases for vasectomy, PAP smear and other problems.

(i) Local administrative and other problems related to integration should be discussed and possibly settled at monthly meetings to be organised by the Medical Officer Health for both health and Family Planning personnel. If such problems cannot be settled locally then they should be referred to the state MCH/FP officer and if necessary to the state Co-ordinating Committee and even the Central Co-ordinating Committee.

2. State Level Function and Responsibilities:

At state level, the state MCH/FP Officer is responsible to State Deputy Director (Health) in the organisation and supervision of Family Planning services in integrated areas. The MCH/FP Officer should:

(a) Prepare a plan for the implementation of integration areas in the state according to schedule. (Details should be worked with the respective M.O.H.).

(b) Ensure all the necessary staff are trained as scheduled.

(c) Ensure that all transfers from integrated areas should be replaced by trained personnel.

(d) Plan a one-day workshop just before or soon after implementation has started, together with NFPB state officers and local personnel involved.

(e) Prepare a quarterly report on integration to the state Co-ordinating Committee, a copy of which should be sent to the C.C.C. the Ministry of Health and the NFPB.

3. Central level:

The C.C.C. is the body responsible for planning, organising and evaluating the implementation of integration. The Service Division of the Board and the Family Planning Section of the Ministry will be jointly responsible for implementation of the service programme integration areas and the NFPB officers from the headquarter can visit integration clinics to provide advice and technical assistance, from time to time. Similarly the other divisions of the Board will provide supportive functions and service.

3.1 The evaluation division will continue to be responsible for collection, analysis and evaluation of integration data and sending the necessary report to the C.C.C. the Ministry, the State and also the local Health Officers.

3.2 State MCH/FP Officers and Health Education Officers through the State Co-ordinating Committee will work closely with the Information Division of the Board in planning programmes on Information and Communication in integration areas.

3.3. The Training Division of NFPB will continue to provide training of supervisory personnel and to a certain extent auxiliary personnel.

3.4 The FFPA/FPA will continue to provide complementary and supportive services as identified by the central co-ordinating committee.

4. District Level:

4.1 Medical Officer of Health

Responsibilities

(i) To be responsible for development and supervision of Family Planning in his area.

(ii) To be responsible to the Chairman of the State Co-ordinating Committee - (C.M. & H.O.)

(iii) To assess the progress made in the implementation of the programme and to submit his findings to the Chairman of the State Co-ordinating Committee.

(iv) Responsible for planning and organising in-service Training Courses in Family Planning at District and local levels. These Training Programme will be assisted from the Central Level whenever and wherever possible. As far as possible the training is to be localised and Family Planning Courses will be conducted within regular office hours (within the frame work of the Ministry of Health). The central training committee will assist in drawing up the curriculum and other relevant details.

(v) To maintain adequate supplies of all materials, equipment and accounting for money received if any.

(vi) Evaluation and special project.

4.2 Medical and Health Officer:

Responsibilities

(i) To be responsible to the Medical Officer of Health;

(ii) To supervise the clinic staff and to guide the local programme in his area;

(iii) To participate in providing Family Planning Service;

(iv) To help the M.O.H. in the maintenance of adequate supplies of all materials, equipment, accurate record, reporting and accounting for money received if any.

(v) To assist in training the programme at the local areas.

(vi) Evaluation and special project.

4.3 Public Health Sister:

Responsibilities

(i) To assist the Medical Officer of Health in the implementation of the Integration Programme;

(ii) To supervise every aspect of the programme;

(iii) To assist the M.O.H. and Medical and Health Officer in maintaining adequate supplies, proper records and returns etc.;

(iv) To assist the Medical Officer of Health to conduct in-Service Training Programme in Family Planning.

4.4 Public Health Nurse:

Responsibilities

(i) She will be administratively responsible to the Medical and Health Officer and under the Technical Supervision of the Public Health Sister in carrying out the normal duties as set by the Ministry of Health. In addition, she will undertake to offer Family Planning Services like motivation, rendering services to the patients, supervising and assisting the Trained Assistant Nurse (both NFPB and the Ministry of Health) in their normal routine duties.

(ii) She will assist the Medical and Health Officer in the storage, distribution and maintenance of proper records of all contraceptives in the clinic.

(iii) She will also be responsible in the maintenance and furnishing of monthly returns (face sheets) to the Medical and Health Officer who will despatch these to the NFPB by the 7th of each month.

Duplication of face-sheets and indigency forms are not necessary.

4.5 ROLE OF TRAINED ASSISTANT NURSE AND STAFF MIDWIFE IN THE INTEGRATED FAMILY PLANNING PROGRAMME OF THE RURAL HEALTH SERVICE

Introductory Note:

Family Planning is government policy in this country. With the integration of family planning with the rural health services the assistant nurses and staff midwives play a very important role as their close relationship with mothers and families provide opportunities for promoting family health.

Functions:

In the integration of family planning with the rural health services the functions of the TAN/SM in rural health services are as follows:-

1. To give information, education, and counselling about family planning during:-

   (a) Ante-natal session
   (b) Post natal session
   (c) Child health session
   (d) Home visiting
   (e) Group meeting when necessary

2. To provide family planning services.

3. Referrals and follow-up of acceptors and defaulters.

Areas of responsibility include:-

1. Preparation of clinic facilities for family planning services

   The trained asssistant nurse/midwife is responsible for routine preparation of clinic facilities for family planning services including checking up on supplies and equipment.

2. Receiving, welcome and registration of mothers

   a) Receiving and welcoming mothers who come to clinic for family planning services.

   b) Registration of mothers for family planning services.

   Interview and Screening

   a) Interviewing and recording all the necessary particulars for example - name of acceptor, age, address, etc.

   b) Screening of mothers for initial acceptance of oral contraceptives. (Check against the checklist provided for Nursing and Midwifery Staff prescribing oral contraceptives).

   c) Routine check up of family planning acceptors every six months.

5. Education, information, motivation and counselling of individuals and groups

a) Giving of individual advice and group talks on family planning at MCH clinics and during home visits.

b) Discussing any problems or apprehensions which mothers may have.

c) Informing mothers of possible side-effects of various contraceptives.

d) Reassuring acceptors when there are misconceptions or rumours regarding the pill or other family planning methods.

d) Mothers/Patients with any contraindications for oral contraceptives are to be advised on other methods and referred as indicated.

6. Assisting with technical procedures at Health Centres

a) Preparations for the insertion of Intra-Uterine Contraceptive Device and Pap smears, and assisting Mecical Officer during the procedures.

b) Assisting Medical Officer/Public Health Nurse for the administration of injectable contraceptives.

c) Prepare and assist Medical Officer for vasectomies.

7. Dispensing of Contraceptive supplies:

a) Dispensing contraceptive pills, condoms and other contraceptives to acceptors.

b) In the absence of a PHN, she may give the initial supply (one cycle only) of oral contraceptives.

c) After the initial supply, she may issue up to three cycles of pills as resupply. (Checklist is to be used in taking history and conducting examinations for the screening process).

8. Record Keeping:

a) Recording all the necessary particulars of mothers e.g. name, age, number of children and address.

b) Maintaining records of all acceptors defaulters and of contraceptive supplies.

c) Preparing records of defaulters for follow-up.

d) Submitting regular returns as required.

9. Referrals:

Refer to Public Health Nurse/Medical Officer:-

a) All new acceptors as early as possible after initial supply.

b) Any patient who does not conform with the check-list at initial interview.

c) Acceptors with complaints and complications.

d) Patients needing other methods e.g. intrauterine contraceptive device, injection, tubaligation, vasectomy, etc.

10. Follow up of acceptors and defaulters

a) To follow up acceptors at the clinic.

b) Send "Follow up" letters to acceptors with missed appointment. If sending of letters is not practical, home visits are to be made.

c) Visiting acceptors with missed appointments who have not responded to "follow up" letter and those with complaints and complications. Contraceptives may be supplied during home visits if necessary.

11. Maintenance of Supplies:

a) Indenting and maintaining adequate supplies of contraceptives.

b) Ensuring proper storage of contraceptives.

FAMILY PLANNING ACCEPTORS

TARGET FOR THE THIRD MALAYSIA PLAN

1 The estimates for the expected number of acceptors for T.H.P. was calculated based on the 1970 census population and P.H.S. survey data and is as shown below: The rural acceptors is taken as 70% of the total acceptors. The target for Integration areas is calculated as 80% of the total rural acceptors target and the balance of 20% will be derived from other sources i.e. estate, new villages and traditional midwife programme etc. The total integration acceptors, about 140,000 will be from Intensive Input Areas (calculation is based on actual facility population coverage for 1973).

Year	Total urban and rural acceptors	Rural Component		
		Total	Integration	Other Sources
1976	90,000	63,000	50,400	12,600
1977	100,000	70,000	56,000	14,000
1978	110,000	75,000	60,000	15,000
1979	120,000	34,000	67,200	16,800
1980	130,000	31,000	73,300	18,200
Total 1976-1980	550,000	383,000	306,400	76,000

2 Sources of Integration target acceptors:

1. Intensive Input Demonstration areas covering 20 health districts where Family Planning integration have been completed in 1971-1973. Of the total integration acceptors, 140,000 will be from Intensive Input Areas (calculated based on actual population/facility coverage for 1973).

2. Expansion areas was (stage IIa) which are expected to be completed by 1975.

3. Other health facilities which were carry over from S.M.P. T.N.P.

4. Areas to be covered by new health facilities in T.H.P.

5. Mobile Health Teams (12 teams are expected to begin functionery in 1975, and 50 more are requested by T.H.P.)

CHECK-LIST FOR NURSING AND MIDWIFERY STAFF PRESCRIBING ORAL CONTRACEPTIVES

A. History: Ask if the patient has had a history of any of the following:-	Yes	No
Yellow skin or yellow eyes		
Mass in the breast		
Discharge from the nipple		
Excessive menstrual periods		
Increased frequency of menstrual periods		
Bleeding after sexual intercourse		
Swelling or severe pains in the legs		
Severe chest pains		
Unusual shortness of breath after exertion		
Severe headaches		

B. Examination: Check the following:-	Yes	No
Yellow skin and yellow eye colour		
Mass in breast		
Nipple discharge		
Varicose veins		
Blood pressure (yes = above 160)		
Pulse (yes = above 120		
Sugar in urine		
Protein in urine		

Instruction: If all the above questions in A and B categories are answered in the column "No", you may give the initial supply of contraceptive pills. If any of the above are answered in the column "Yes" then the patient must be referred to Public Health Nurse/Medical Officer before oral contraceptives may be prescribed.

THE EXTENT MIDWIVES AND BIRTH ATTENDANTS ARE INVOLVED IN MATERNITY AND CHILD HEALTH AND FAMILY PLANNING SERVICES IN SRI LANKA

by

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The growing trend in Sri Lnaka is towards hospital delivery with discharge from hospital 48 hours after normal labour. The Government appreciated this trend several years ago and changed the scope of a field midwife's work from that of a person mainly concerned with child birth to one responsible for all aspects of Maternal and Child Welfare. Family Planning is considered an intrinsic part of Family Health.

There are no Traditional Birth Attendants - in the sense that an untrained midwife hangs up a board and waits for customers. A small percentage of deliveries - estimated at two percent - are conducted by relatives or older woman friends, untrained in midwifery. The people have long been familiar with the Government Field Midwife's sign board, which everyone of them must prominently display outside their homes. She has always been an honoured and respected person in the village.

The Sri Lanka Midwife is the key front-line worker in Family Health. The extent of her involvement can be gauged by a glance at her list of duties.

DUTIES OF THE MIDWIFE

The Field Midwife has seven spheres of activity.

1. ANTE NATAL CARE

Mothers must be visited in their homes as early in the pregnancy as possible. They are registered, examined and given a date to attend the Clinic of the M.C.H. At the Clinic, she writes out the Clinic Card, weighs the patient, tests her blood and urine and prepares her for examination by the doctor, Midwives give Health Education talks at all Clinics.

2. NATAL CARE

She must deliver all mothers who prefer home delivery, but she must strongly urge monthers with a complication in the present or past pregnancy to delivery in hospitals equipped for surgery and blood transfusion - especially the "Dangerous Multigravida" with more than four children. After a delivery, the midwife must fill in a standard form certifying the birth and ensure that the parents register the birth within ten days.

3. POST NATAL CARE

The midwife must make five post-partum visits within the first ten days after a delivery, irrespective of whether the mother has a home or hospital delivery. She must advise the mother of the value of spacing her children, point out the dangers of high parity and the ease of salpingectomy - if the mother has all the children she ever wants to have.

4. BABY & INFANT CARE

Immunisation is an important aspect of her duties. Babies born in hospitals are given BCG vaccine 24 hours after birth. Those born at home must get this at the Clinic within a month. Oral vaccine for Polio and Triple vaccine are given later in the clinic during infancy. Vaccination against Smallpox must be done during infancy.

5. PRE SCHOOL CARE

During her home visits she keeps a lookout for vaccination and immunisation dodgers and persuades the parents to bring the children to get these at the Clinic.

Advice on nutrition, especially after a child is weaned from the breast, is invariably included. A powdered milk called "Thrikosha" is distributed free to mothers and children at M.C.H. and hospital clinics.

6. SCHOOL CARE

The midwives influence seeps into the school too. She goes as a team with the M.C.H. and Public Health Inspector (P.H.I.). She must get her "Hookworm Certificate". This involves the giving of treatment to 2,000 children under the supervision of the P.H.I. followed by an oral examination by the M.C.H. She conducts "Little Mothers Classes" for children over 14 years old and gives talks on subjects like Home Making, Child Care, Sanitation and First Aid.

7. FAMILY PLANNING

Besides talks given at home and clinics, the midwife must contact organisations concerned with Family Planning and persuade mothers and older children to attend their lectures and film shows. She provides condoms and oral contraceptives to the families and get a commission on sales. She keeps records and sends a monthly "return" to the M.C.H. giving number of acceptors, drop-outs and side effects.

INCREASE THE INFLUENCE OF MIDWIVES

The Government has given high priority to mass education of the public on Family Health, using all mass media of communication, and has recently appointed a Director of Communication Strategy. As the influence of this program spreads, the midwife will be able to use her wide experience and knowledge to the maximum possible extent. She will be working among people made receptive by Health Education - including the idea that the bigger the population the less family can benefit from the total National wealth. Person to person communication is one of the best means of changing old ideas for new and better ones. The Sri Lanka Midwife will soon become a foster mother and friend to all mothers and their young children.

THE ROLE OF MIDWIVES AND THE TRADITIONAL BIRTH ATTENDANTS IN MATERNAL AND CHILD HEALTH AND FAMILY PLANNING IN MALAYSIA

By

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In Malaysia the practice of midwifery is in the hands of obstetricians, medical officers, nurse midwives, midwives, Jururawat Desa/Community Nurse and the traditional birth attendants or the Kampong Bidans.

In 1972 about 27% of deliveries were conducted by the TBAs, a further 27% occur in Government Hospitals and private institution and almost all of the remaining normal deliveries are by the Rural Health staff e.g. the midwives and the Jururawat Desa.

The midwife and the Community Nurse are the ones who are greatly involved in Midwifery practice, their role and functions in the community have however extended but midwifery is still their concern. They therefore are important members of the public health nursing personnel and have an important role in the promotion of the health of the expectant and nursing mothers and also of the newborn infants. This means that the health of both mother and child lies in the hands of the midwife/J.D. in attendance. They can be considered as the backbone of the Maternal and Child Health services because they are the ones who give direct care to the mothers and babies during pregnancy and parturition and the post-natal period, they are also a link between the mothers and the health services. They are educators and advisers in health services and have an important part to play in the prevention of maternal mortality and morbidity and of premature and still-birth and neonatal deaths.

Ante Natal Care

The midwife of J.D. holds a weekly ante natal session for mothers within her operational area of 3 miles radius from their station and does her home nursing before holding her ante natal session. The average number of cases seen by her per session i.e. for the whole day is about 10-20 cases. A midwife/J.D. who has a high number of attendance and unable to cope with her work may get help of another midwife nearest to her clinic.

Mothers attending the A/N clinic are given tablets ferri sulphate Vitamin B Co. Vit. C, Calcium Lactate and Folic Acid, as routine tablets. All cases of anaemia are also given supplements e.g. milk powder.

All abnormal cases detected are referred to the P.H.N. before referring to the Medical & Health Officer.

The Midwive/J.D. are giving health talks regarding Personal Hygiene, care of breasts, and breast feeding, preparation of home delivery, clothing for the newborn and also Family Planning e.g. motivation and methods used, and cooking demonstration on A/N and P/N diet during the A/N session.

All booked cases for home delivery are visited in the home for at least four times by them. Default cases are also visited and followed up by the midwife concerned in the home.

Domiciliary Midwifery

The midwives/J.D. conducts 2nd to the 5th gravida. Primips and those who are 6th gravida onwards are advised to go to hospital but in some instances they are also conducted by the midwives because of some reasons or other they refuse hospital delivery.

P/N Care and Care of the Newborn

The midwife pays eight visits to both mother and child during the P/N period. She bathes the baby for the first three days and thereafter taken over by the mother. However the midwife continues with the care of the cord if it has not dropped off yet. The newborn is weighed on delivery day and again at the end of the 10th day, the mother is advised regarding Personal Hygiene, diet, feeding and care of the newborn. Record of the nursing care of both mother and child is kept in the mother's home during the ten days period. The mother and child will be visited again after the 10th day and on the 20th day. Necessary care will be given if there is a need. The advice given to the mother during this visit includes family planning e.g. motivation and methods used, post natal check up and to attend Child Health Clinic at the Health Centre.

The Traditional Birth Attendants

Since time immemorial the TBA or the Kampong Bidan has an indispensable role in the practice of midwifery. They are village women and learnt the art of Midwifery through apprenticeships from an older practical midwife and this practice has been passed from generation to generation. The Kampong Bidan is necessary to the mother and she caters to the cultrual needs of the family, Being unqualified she may or may not be skillful in conducting the birth of the baby but this lack of technical skill is compensated by her age, experience and human relationship. Majority of the bidans has much influence over the women folk. She ranks high in the village hierarchy and is generally respected. She participates in all traditional and religious rituals that involve birth, marriages and deaths. As a midwife she cares for the mother during her post natal period and the newborn baby for three days or until the cord is off. She helps in washing clothes and also cooks for the family. She follows the mother and child through various rituals related to childbirth.

Some time the TBA becomes a consultant in any health matters and gives marriage counselling. She attends to brides prior and after marriage ceremonies and follows them up into their first pregnancies with more ceremonies and feasting.

From the various functions required of her by the community the TBA has established very close contact and personal relationship with the mother and the family. Utilization of TBAs for cultural reasons and for their closeness with the community will make them good health promoters in both MCH and F.P. services.

These kampong bidans were requested to register their names at the nearest Health Centre or office for the purpose of checking their midwifery bags, submitting their monthly returns of delivery cases for advice and guidance.

Formal short courses of training lasting 3 weeks to 3 months were held irregularly in each state. Talks and demonstrations which were given include simple personal hygiene, family planning, prevention and spread of infection, as well as preparation for home delivery in its various stages. Contraindications to domiciliary midwifery and the complications of pregnancy and labour were taught so as to enable the "Kampong Bidan" to recognise this early and seek medical aid. She is also taught the proper management of the mother and the newborn during post natal period.

After the above short course, the kampong bidans were given UNICEF midwifery kits.

Under the Midwives Act 1966 and the Registration Regulation 1971 this category of midwives are required to register with the Midwives Board as "Untrained Midwives" before they are allowed to practice, so that more effective supervision can be done by the Local Supervising Authority. The closing date of registration for this category of Midwives was 31st July 1972 and after this date no further registration was entertained. The number of kampong bidans registered up to date was about 2,700 out of these, the age range extend beyond 70 years old, only about 38% are in the 20-59 age group who will remain active for another 10-30 years.

In Bangkok last year, at the International seminar on The Role of TBAs in Family Planning, the utilization of TBA in Family Planning Services alone was debated and they conclude that "since MCH is the entry point for Family Planning" the TBA should be given a multipurpose function.

The TBAs have successfully been recruited in a few states as F.P. motivators and suppliers of oral pills. She also motivates the A/N mothers to attend Health Clinics and refer all primigravidas and abnormal cases to hospital for delivery. Malaysia has started its kampong bidan projects in F.P. work with success.

In conclusion, the TBAs will have limited roles in Family Health in the near future but recruitment of TBAs will help to spread the Health Services in the community and to change their roles, requires them to be suitably trained and properly compensated for.

MIDWIVES INVOLVED IN MCH/FP OF NEPAL

by

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Mr. Chairman, delegates and distinguished guests,

Attending the International Federation of Gynaecology and Obstetrics International Confederation of Midwives at Kuala Lumpur as a "Country Midwife Participant", I feel a deep sense of pride for this privilege which has been extended by this ICM/FIGO. I am much grateful to the ICM/FIGO for giving me the chance of presenting the roles and responsibilities of midwives in maternal and child health and family planning programme of Nepal. I wish to draw to the atttention of country representing midwives that, in our country, we do not have midwives exclusively. Nurses in Nepal have to practise in general nursing as well as specialize in midwifery. Due to Nepal being a land-locked country, the transportation and communications have not been well developed. Thus, the health needs for mothers and children are very difficult problems of today.

Socio-economic Features

The population of Nepal has nearly doubled from 1930 to 1972. According to the 1952-1954 census, the population of the country in 1952 was 1.5 million. In the year 1961, it had increased to 9.4 million. In the year 1972 it had gone up to 11.6 million and up to mid-July 1975, it had increased to 12.6 million. According to the central bureau of statistics of 1972, the birth rate was 200 per 1,000 and the annual growth rate was 2.07. Hence the population will double in 33 years. With reduction in infant mortality and eradication of communicable diseases, the death rate has been reduced still further. On the production side, the average per capita income is only $80.00 per year. Hence in order to bring an equilibrium between the population growth and economic output of the country, the Government has adopted a policy of family planning.

Family Planning and MCH in Nepal

The idea of family planning was started by the Nepal Medical Association as early as 1958, which is now working as Nepal Family Planning Association. In 1965, our foresighted leader, the late King Mahendra, announced family planning as a national policy of His Majesty's Government of Nepal in the Third Plan period. In July 1966, Family Planning and M.C.H. projects were undertaken by H.M.G. with the collaboration of USAID. The achievements of MCH/FP up to mid-July 1975 are shown in table No. 1.

During the fifth plan (1975 to 1980) period, the family planning and maternal and child nealth programme will be launched all over the country in order to maintain a proper balance between increases in production and

population so that living standards of the people can be improved. With a view to limiting the growth of population, the Plan has set a target of bringing down the crude birth rate from the estimated 40 per 1,000 to 30 per 1,000. Likewise, mortality of children will be reduced from 200 per 1,000 to 150 per 1,000 during the planned period. In order to achieve these targets, additional family planning and maternal and child health centres will be opened and 7 lacs couples between the age of 15 and 45 will be provided with family planning services. Similarly, ante-natal and post-natal services will also be provided to 7 married females and 5 lacs children below the age of 5 will be innoculated with B.C.G., D.P.T. and small-pox vaccination.

Sudhinis (traditional birth attendants)

In the rural areas, poor housing, poor drainage and poor disposal of waste products have caused health hazards. Further, some newborn babies might have received injury or infection as a result of unhygienic and unskilled handling by the traditional birth attendants popularly known as "Sudhinis". Sudhinis existed and practised long before the midwives. Their wealth of experience enabled them to provide the "mothers" with some form of health care. Theoretical and practical training would make them more skilful and thus help them to improve the quality of their services.

As Nepal has not enough midwives and doctors to attend to deliveries, we have to utilize the existing Sudhinis by giving them a training of aseptic precaution, pre-natal care, intra-natal care, post natal care, etc. It was in keeping in view of the objectives that the Family Planning, Maternity and Child Care Project has launched the Sudhinis training programme in September 1975 for 30 Sudhinis and in October 1975 for 34 in two zones, to mark the International Women's Year. Before this, in 1974, a three-day long midwifery training programme was organized, jointly sponsored by the Nepal Family Planning Association, District Panchayet and Mission Hospital to traditional birth attendants of remote areas and in 1973-74, 30 Sudhinis had been trained under Panchawat Ministry with 15 in each group for a three month course.

Midwives involved in MCH/FP services

In our country, up to this day, we do not have certified midwives personnel. The curriculum of general nursing is so designed in our country that when one is qualified she is fit to provide comprehensive nursing services to all the needy people of the country. Nurses assigned to Nepal Family Planning and MCH project are responsible for planning, organizing, administering, and directing the larger clinic operations and supervising delivery services linked to that clinic. Their goal is to increase the numbers of married couples using family planning, to improve the health of mothers and children and to increase the numbers of supervised deliveries of infants. They may also have some informational and motivational activities through their contact with individual patients, professional health or non-health staff working in official positions, conducting some lectures, etc. However, their primary responsibility will be to run efficient and effective family planning and MCH clinics that are established to serve large numbers of patients. These clinics could be linked with active maternity and delivery services with a strong post-natal approach to women on family planning and infant care. Linked with this is direct responsibility for increasing the numbers of supervised deliveries in the area that the hospital serves. Frequently, they will be called upon to plan and direct mobile clinic operations to expand the FP/MCH program to neighbouring areas. Personnel employed in FP/MCH are as follows:

Title	No. of position - 1975	No. of position - 1976
Senior Public Health Nurse	5	3
Public Health Nurse	4	5
Staff Nurse	14	22

In September 1975, MCH/FP was started for the training of senior nurses for IUDs insertion under the Experimental and Development Project.

Objectives:

(1) To provide an IUD fitting service by nurses in as many FP/MCH centres and clinics as the staffing patterns allow.

(2) To promote the use and popularity of IUCD with the women of Nepal.

(3) To train all senior nurses to (a) insert IUCDs, (b) recognize the anatomical contra-indications for IUCD and to screen out such women, and (c) to educate clients in the wearing of the IUCD so as to promote confidence in this method.

Training will be based at Prasuti Criha, Bir Hospital and at FP/MCH Central Clinics.

Assistant Nurse Midwives will be responsible for information, services and clinical work in FP/MCH and delivery services. Their goal is to increase the numbers of married couples using family planning to improve the health of mothers and children and to increase the numbers of supervised deliveries of infants. They will work mainly in established health clinics or hospital but also may be responsible to carry out some mobile activities by means of vehicles. Occasional home visits may be required but their primary responsibilities are to assist in developing sound, effective and efficient clinical services. The existing assistant nurse midwives in FP/MCH is 40 and the proposed will be 55.

Preparation of ANMs in five zones of Nepal is to meet the needs of health services for MCH/FP at the peripheral level, health post as well as the hospital. But the aims of preparation of ANMs is based on fulfilling the nursing needs at the village level than the hospital. ANMs play vital roles in delivering of health services to the mother and child at the peripheral level as well as to meet pre-natal, intra-natal and post-natal services at health posts.

All the doctors, nursing staff as well as other para-medical personnel are engaged in this noble task with all their devotion.

With this presentation, I would like to clarify that our nurses play vital roles in midwifery programmes as well as in carrying out the comprehensive health care in the integrated health services of Nepal.

TABLE NO. 1

Total Couples who accepted different methods of contraception by Year

Fiscal Year Method:	1966-67 2023/24	1967-68 2024/25	1968-69 2025/26	1969-70 2026/27	1970-71 2027/28	1971-72 2028/29	1972-73 2029/30	1973-74 2030/31	1974-75 2031/32	TOTAL
1) IUD Acceptors (for the first time)	1806	2614	1183	1109	711	1162	607	862	1110	11,164
2) Vasectomy acceptors	N.A.	1062	3292	3888	4441	3900	4161	5166	3783	29,693
3) Pill Acceptors(New)	13	200	1355	10263	13496	15868	24056	27166	26943	119,360
4) No.of Pill cycles distributed	13	1203	8133	36329	62865	56831	125178	202590	197061	720,203
5) Condom acceptors(New)	33	1256	1914	14480	18785	22908	35713	52075	65814	212,978
6) No. of condoms distributed	495	113130	172260	227636	327098	479326	725016	1233624	1207731	4,486,316
7) Laparoscopy	-	-	-	-	-	-	558	810	580	1,948
TOTAL COUPLES (NEW)	1852	5132	7744	29740	37433	43838	65095	86079	98230	375,143
1) Cum clinic (incl. District Office)	12	27	41	60	66	141	151	224	41	
2) Cum District Office	-	-	-	25	25	30	30	32	5	
3) Booklets	1600	27497	51250	94136	88522	99575	141828	145450	85814	775,672
4) Posters	8000	2700	9793	26245	42020	25421	38811	27710	21134	201,834
5) Display Board	3	10	27	40	184	340	216	98	112	1,030
6) Spot Announcement	90	156	1185	1796	983	1276	812	934	991	8,223
1. Total Budget	*98030/-	*501000/-	*2038354/-	3999000/-	6888000/-	7500000/-	5314006/-	7952100/-	10900000/-	
2. Expenditure		-	1709674/-	3171880/-	4899549/-	4031638/-	5011641/-	7939206/-	10314588/-	

* Family Planning Budget only (Rest are both F.P. and M.C.H. Services)

TABLE NO. 2

M.C.H. ACTIVITIES BY YEAR

Fiscal Year / Services	1966-67 & before 2023/24	1967-68 2024/25	1968-69 2025/26	1969-70 2026/27	1970-71 2027/28	1971-72 2028/29	1972-73 2029/30	1973-74 2030/31	1974-75 2031/32	TOTAL
1. Ante-natal mothers (new)	4905	3498	4042	5989	6119	8806	11100	13096	13251	70,806
2. Ante-natal mothers (old)	6298	5003	6070	8654	9164	14862	17507	19706	18100	105,364
3. Post-natal mothers (new)	791	725	826	1254	1583	1835	2306	3231	3530	16,081
4. Post-natal mothers (old)	456	570	630	900	1043	1442	2394	3157	2635	13,227
5. Infants (new)	10563	6695	8437	12094	13063	20502	29553	40585	43184	184,676
6. Infants (old)	20294	13108	16291	19720	20913	31590	48944	67727	67692	296,284
7. Pre-school children (new)	15001	7737	10126	16405	21392	34393	56926	79199	73091	314,270
8. Pre-school children (old)	33097	14930	20687	26804	32605	48489	78147	121172	101231	477,162
9. Smallpox vaccination	5582	6036	4361	10846	9891	13824	15220	29234	33076	128,070
10. B.C.G.Vaccination	5280	9315	10655	9192	9202	14778	15368	12929	17397	104,116
11. D.P.T.Immunization	-	-	-	-	-	5089	27595	43766	40275	116,725
12. No. of deliveries at Ikarna	-	-	-	-	42	89	78	75	84	368
13. No. of Vasectomy Mobile camp	-	-	-	25	101	88	91	103	70	478

THE EXTENT TO WHICH MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS ARE INVOLVED IN MATERNAL AND CHILD HEALTH/FAMILY PLANNING SERVICES OF THAILAND

There are three categories of Midwives involved in Maternal and Child Health/Family Planning Services.

1. Professional Nurse Midwife
2. Auxiliary Midwife
3. Traditional Birth Attendants.

The presentation of this paper will focus only on the additional function of the professional nurse midwife and auxiliary midwife which is expanded role of nurse and midwife.

PROFESSIONAL NURSE MIDWIFE

Recruits for professional training must be between the ages of 17-25 years and have had 12 years general education. After three and a half years training course in general nursing and midwifery leads to registration as a professional nurse midwife. The routine pre-natal, post natal and delivery are carried on with additional role of nurse midwife as follows:-

Ante Natal Care:	- Heart, Lung check up - External version
Delivery:	- Abnormal delivery except high forceps and caesarean section - Episiotomy - Suturing of perineum
Post Natal Care:	- Administer drugs after delivery - Post-natal physical check up - Intra Venous
Supervision:	- Supervision of all auxiliary midwife in responsible area.
Training:	- Nurse Midwife, Auxiliary Midwife, TBA.
Family Planning:	- IUD insertion and removal.

AUXILIARY MIDWIFE

Recruits for auxiliary training must be between the ages of 17-25 years and have had 10 years general education. After 18 months training course in midwifery leads to registration as an auxiliary midwife (locally called Health Midwife). The routine pre-natal, post-natal and delivery are carried on with additional role of auxiliary midwife as follows:-

Ante Natal Care:	- Heart, lunch check up - Urine for sugar, albumin test, blood haemoglobin - External version
Delivery:	- Normal delivery with episiotomy and suturing of perineum
Post-natal care:	- Administer drugs after delivery - Post-natal physical check up - Intra Venous

Family Planning:	- Follow up the result of IUD - Suggest method of contraceptive - Family planning motivation - Prescribe pills and condom

TRADITIONAL BIRTH ATTENDANT (Moh Tam Yae)

This group is untrained people. They play an important role in the village, unpaid service but for their own prestige and the respect they receive. During 1960 - 1969, over 18,000 Moh Tam Yae had been trained by the Thai Government and UNICEF for four weeks training under the guidance of nurse midwife supervisors on provincial level. Their performance is as follows:-

Ante Natal Care:	- Routine care with hygiene and environmental sanitation advice
Delivery:	- Normal delivery with safety techniques - Notify or refer abnormal cases to nurse midwife
Post Natal Care:	- Mother and Child Care
Family Planning:	- Family Planning motivation

THE EXPANDING ROLE AND SCOPE OF PRACTICE OF ALL CATEGORIES OF MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN THE FIELD OF FAMILY PLANNING

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The role and scope of midwives, including traditional birth attendants, in maternity care described in the WHO technical report series in 1966 were as follows:

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

As we can note here that family planning is mentioned as part of a midwife's extended field in some countries. In 1972 the report of conference and meeting held at the Central Midwives Board in London summarizes the results of a study group that midwives' task include supervision during pregnancy, labour, and the postpartum period, and infant care including preventive measures. Their responsibilities extend to health counseling, health education and family planning. Here family planning is mentioned as midwives' definite extended responsibilities.

From my experience, there are certain types of midwives existing in Asian countries at the present time. Most midwives in the public sector who work in hospitals and public health services include:

1) the nurse/midwife who is a graduate from the professional level nursing school with additional training in midwifery;

2) the regular midwife who is trained for three years in the professional midwifery school; and

3) the auxiliary midwife who is trained for only two years of midwifery course. Midwives in the private sector are mostly in the middle and old age and they are qualified as a midwife after a few years of on the job training in hospitals.

The role and scope requiring the midwife to cover and function have been greatly expanded in recent years, especially since many governments adopted the policy of starting family planning programs and integrating family planning into health services. The demand for midwives in the public sector to expand their role has been an urgent one. Family planning services added to the health services certainly created an overload work situation in countries where health services are well utilized by the public. Under this situation health clinics are always

crowded with mothers and children. Malaysia is a good example of this condition. Countries where health centers and services are not well utilized, family planning added to the health services certainly fill up the gap for health workers to use their time more effectively. From my own experience working with midwives in the health and family planning services in some Asian countries I have seen a wide range of roles which midwives have been playing. Other than the previously mentioned activities, they have been engaged in case finding activities as well as in the functioning of case supervision, in diagnosis and treatment of minor illness and accidents, in participating in community development and nutrition education activities, in participating in school health services, in inserting IUDs, in using service statistics to make some simple epidemiological observations, and in managing administrative tasks where administrative personnel is not available in the health unit. Again I am quoting Malaysia where the Ministry of Health is in the process of converting auxiliary midwives in rural areas to become community health workers (Jururawat Desa), who serve as multipurpose health workers for the rural community.

As for the private sector I know that some privately practicing midwives own private maternity wards using private doctors as consultants and insert IUD's and perform induced abortion by herself.

One group of people in the rural areas who are still active in attending deliveries in many developing countries and who cannot be neglected, are the traditional birth attendants.

TBAs are called Bidan Kampong or Dukun Bajis in Indonesia; Hilot in the Philippines; Moh Tam Yae in Thailand; and Kampong Bidun in Malaysia. The estimated number of TBAs in Indonesia is 60,000, in the Philippines 32,000, in Thailand 30,000, and in Malaysia 3,000. The estimated proportion of deliveries attended by TBAs and by untrained persons between 1971 - 1972 in Indonesia was 80 per cent to 90 per cent, in Thailand 75 per cent, in the Philippines 48 per cent, and in Malaysia 27 per cent. Utilization of these TBAs in these South East Asian countries is actively going on.

Some effort has been made to compile information about TBAs on questions such as: What is the size of this group, what are the TBAs background characteristics, what customs do they follow regarding childbirth, what is the proportion of deliveries being attended by TBAs, how are they trained to practice as kampung bidans, what is their attitude toward family planning, can they be utilized in health and family planning programs, etc.

As to the issue about place and value in utilizing these traditional birth attendants in family planning and in health services considering the development of health manpower and facilities in the country the following questions arise:

1) What functions should we ask the TBAs to perform?
2) What system should be designed for the operation?
3) How should we recruit and train them?
4) What would be the optimum performance target?
5) How should we compensate the TBAs?
6) What supervisory channel should be established?
7) How should we assess individual performance for adequate action to be taken?
8) How should we evaluate the project?

In Malaysia the effort was focused on organizing these TBAs (kampung bidan) to utilize them in the national family planning program, with the following eight steps:

1) a few clearly designated functions
2) simple and clear system of operation
3) recruitment and training
4) optimum performance target
5) compensation for the TBAs
6) supervisory channel
7) routine assessment of individual performance
8) evaluation of the project

The implementation of the project was made in January 1972 and gradually expanded. By the end of April 1975 ten of the eleven states in Peninsular Malaysia had the project.

1. Designated Functions

TBAs were requested to perform two main functions:

a) to recruit new acceptors and to encourage the previous program dropouts to return for family planning, and

b) to resupply oral pills.

2. System of Operation

The operational system included the following steps:

a) Recruitment of family planning acceptors through motivational activities focussing on the following three factors:

a-1 Create an awareness of the availability of family planning.

a-2 Mention that spacing of pregnancies is beneficial to the Mother's and childrens' health.

a-3 Suggest that family planning helps to raise the standard of living, gives her a better chance of educating her children, and creates a happy family environment.

b) Using the initial acceptance coupon for recruitment

c) Visit by Acceptor to the clinic to receive family planning

d) Resupply by Kampung Bidans using green coupons

e) Follow-up visit by bidans in case of failure to come for resupply

f) Monthly meeting between bidans and nurses

3. Recruitment and Training

The recruitment was made through the local health authorities based on the judgement and knowledge of the nursing supervisors in each state. The training was very specific with emphasis on learning by doing and by role-playing as frequently and repeatedly as possible. The training concentrated on the practical exercise of the operational steps. During the course, bidans were assigned to supervisors. Bidan-supervisor relationship, proper channel of instruction and communication and personal relationships were established during the three-day training period.

4. Performance Target

We hoped that each Bidan would recruit five new acceptors a month. Some recruited more than ten acceptors a month and some none, which resulted in an average number of two new acceptors a month. The important part is the resupply of pills for those mothers who already accepted the initial supply from the clinic nurses. A bidan in Kedah reached a height 159 mothers for resupply in April 1975. Some bidans persuaded the mothers to have tubal ligation or tried to persuade the husbands to have a vasectomy to reduce the number of resupply. Some also tried to give three to six cycles of pill resupply at one visit.

5. Compensation

We started to pay a flat allowance to each bidan each month (M$30 and about $13). An incentive payment was made periodically according to performance in terms of the number of new acceptors recruited and the number of resupplies of contraceptives to mothers. The monthly allowance was also increased for bidans with excellent performance records.

6. Supervisory Channel

The most important supervisory channel was a monthly meeting designed for working purposes and for receiving allowances by the bidans from their supervisors at the clinic. The steps for the monthly meeting are clearly designed and carried out.

7. Assessment of Bidan's Individual Performance

The number of acceptors recruited and the number of resupplies performed are recorded by the individual bidan shows no performance, she gets a warning. If she continues to perform unsatisfactorily, she is dropped from the project. On the contrary, if a bidan does a good job, her record will be good for a bonus and increased allowance.

8. Evaluation of the Project

A total of more than 7,000 acceptors were recruited by the TBAs between January 1972 and April 1975, with a total of about 4,000 active TBA months. On the average, each TBA recruited two acceptors a month, ranging from none to 20 depending on the state and the duration of the project operation. Another important aspect is the number of continuing users (case-lead) for each bidan is from 12 in Perak, with only three months duration of operation, to 65 in Malacca with 36 months of operation.

Seventy-eight per cent of women said that the coupon was given to them at their home; and 18 per cent of them got the coupon from the bidan's house. 50 per cent come to the clinic for family planning services within one week after receiving the coupon. The preliminary analysis revealed that, as of May 1974, 20 per cent of women whose deliveries were attended by our project bidans visited the clinic for family planning services, ranging from 10 to 29 per cent for each state.

A special survey to interview the TBAs in the project and nursing supervisors of the TBAs was conducted from February to April 1975. Most of the TBAs walked to recruit acceptors; 32 per cent said they rode or were driven by bicycle and 24 per cent used the bus.

Almost all bidans answered that after delivery was a good time to recruit women for family planning. The common difficulties TBAs incurred in recruiting acceptors were side effects and rumours about the oral pills, husband's disapproval, mother's or mother-in-law's disapproval, and the desire for more children. The most commonly reported rumours were the fear that oral pills would not dissolve in the body and would cause harm to the woman or to the baby born, the interference of the pill with sexual relationships, and fear of having difficulties in having

subsequent babies after discontinuing the pill. When asked if the TBAs had ever been asked to perform an abortion in the last year, 79 per cent answered that they had not. As to the question, "What do women who practice family planning tell you about feeling it is against the Muslim religion?", 63 per cent of the TBAs responded that their clients never felt it was against the Muslim religion, 28 per cent responded that they sometimes did. To the question, "What is the attitude of the Muslim leader in your village about family planning?", 70 per cent of the TBAs said their Muslim leader approved, 20 per cent felt the leader was indifferent, only 4 per cent felt that the leader was against family planning. When the TBAs were asked "Does the Muslim leader ever try to discourage people in your village from accepting family planning?", only about 2 per cent of the TBAs responded yes. It would imply that formal objection to family planning practices by Muslim leaders in Malaysia is not especially significant.

Supervisors were asked whether or not they believed that the clients really took their contraceptive pills after receiving them from the TBAs. Eighty-five per cent of the supervisors answered yes. They gave such evidence as that the resupply coupons were handed in regularly, that the pill packages were often checked by the supervisors and by the TBAs to see if the pill is really being used, and that many of the women were not getting pregnant.

Malaysia's experience in utilizing of TBAs in family planning has been going on for more than three years. We have demonstrated how TBAs can be utilized in a national family planning program by training, organizing, and supervising them in a systematic way. In a similar manner, the TBAs can be utilized not only for family planning but also for maternal and child health services in rural areas. In utilizing TBAs, we have to realize that not all of them are competent. We have to be prepared to drop incompetent ones from the program from time to time. Competent TBAs can play an important role for the health and family planning program to rural areas. Supervision is most important. A close working relationship between TBAs and supervisors is a vital factor in having a good program.

When I received the letter from ICM at the end of August the topic was "The Expanding Role and Scope of Practice of all Categories of Midwives including Traditional Birth Attendants". I felt uneasy then because of the enormity implied under this topic. When I came here on Friday I was very happy to see from the program that an additional sentence of "In the field of Family Planning" was added at the end of the same topic because this would be much more appropriate for me to discuss the subject in a specific way and I have re-written my discussion and added some following general remarks.

From my experiences in a few family planning programs in Taiwan, in Thailand, in Malaysia and in Singapore I have seen the following role and scope being performed by midwives and I think that at least these functions should be covered by midwives in the field of family planning.

1. <u>Motivating and Recruiting Eligible Clients</u>

   Midwives are in a unique position to have a close relationship with mothers and the family through attending deliveries. Information, education and communication activities can be carried out during ante-natal, natal and post-natal period. From her experience she will be able to sense how, when and whom to motivate. She will be in a best position to know the family's background information and condition. She needs skills and maturity and she should be confident herself to convince her clients. From my experience working with TBAs I often observed that the TBAs are much more talented than many midwives working in the public sector. During the training course we asked government midwives to demonstrate motivational activities but in many occasions we saw TBAs had performed much better job than the demonstration by midwives. TBAs had shown no shyness, much more confident, knew how to approach in a local traditional way and were most convincing. We have to learn a lot more from TBAs in motivating rural folks.

2. Providing Services

The midwife is one of the essential members of the team in health organisation to provide contraceptive services. She attends the family planning clinics and visits homes in helping and providing initial and follow-up services. She should know the basic facts about oral pills and should know how to screen clients for pills. She should know that the condom is being manufactured in perfect condition these days, that the condom has different colours and even now has different sizes, that the condom does not need to be worn from the beginning, that the condom is now as thin as 0.025 mm and no need to be particular about the feeling, that the condom will not burst with 51 litres of air or 7 big bottles of beer, etc.

Continued motivation to her clients for the continuation of contraceptives is an important role for midwives. She should visit clients as often as possible. Service attitude and behaviour by providers including midwives are most important. As I mentioned previously the TBAs visit their clients' home often to resupply contraceptives rather than just waiting for their clients to come to them.

3. Midwives as Trainees and as Trainers

Midwives will be trained in the field of family planning both in their basic and post-basic training. Experienced, able and senior midwives will eventually needed to become trainers to train young professional midwives, auxiliary midwives and TBAs.

4. Midwives as Supervisors

Like other categories of health staff a midwive can be a good supervisor. She can load and guide while working together with her staff. The relationship would be better to start from the training period and to extend to the field. During recent years many governments took action to extend health care delivery services including family planning by establishing village health workers to cover the population in remote rural areas. The barefoot doctor in the People's Republic of China is a famous example. The concept of barefoot doctors being practiced and made widespread after Chariman Mao commented in 1965 that the Ministry of Health is serving the urban elite and not serving the majority of rural peasants. Basic health delivery care services through village health workers are being developed in many countries in Asia, such as Iran, Afghanistan, Nepal, Bangledesh, Thailand, Vietnam, Korea and Papua New Ginea. In Korea a project was implemented to rent a sterile delivery kit to families in the rural areas to be ueed by the family member in case a midwife is not available to attend the delivery. The International Development Research Center of Canada has been supporting these activities. The movement is certainly an encouraging act to fill the gap in areas where even a midwife does not exist to serve the people. Many manuals and guides on this subject are being produced not only by different provinces in China but also by WHO Geneva and by individual countries. Midwives in the rural health units will certainly be in the position of working together with these village health workers, perhaps even in a supervisory or coordinating capacity, as an important member of the health team to serve the rural community.

5. Evaluation within Her Capacity

She can make use of service records in making service statistics and interpret the fact to improve the services. She also can make an epidemiological observation to guide the direction of activities.

6. Administrative Function

As we all know part of midwives' responsibility includes record, returns, logistics and other administrative activities. It is inevitable for a midwife to have this responsibility but the time spent for this administrative matters should be brought to the minimum.

It will become endless if I am going to cover every detail of a midwife's role and scope in the field of family planning and I am sure that all of us here are familiar with this. I will stop my discussion here by repeating that factors required for midwives in the expanding role will certinaly include knowledge, skill, experience, judgement, maturity, management ability in delivery of services and in personnel, etc. These factors should be carefully built into both basic and post-basic trainings.

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INTEGRATION OF FAMILY PLANNING WITH THE MIDWIFERY TRAINING PROGRAMME OF ALL CATEGORIES OF MIDWIVES

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Introduction

Training of personnel is an essential component for the effective implementation of any programme. It forms a vital administrative tool to improve programme performance and to meet programme objectives. For Family Planning, as for other health activities, the availability of trained manpower is always a crucial problem and has been a major handicap in programme implementation in many countries. Although for most countries in Asia, the initiation of organised government Family Planning programmes were based on demographic considerations, there is now increasing awareness of the need to integrate family planning with the health services. For this to be possible, existing personnel need to be trained in family planning to start the programme, and in order to ensure uninterrupted and thus, effective service in the long term plan, there is need to include family planning subjects in the training curriculum of all categories of health personnel and especially in the midwifery training programme.

The midwife could be a doctor, a nurse of an auxiliary health worker trained to be a midwife. It is obvious that both midwifery and family planning are concerned with reproduction and thus with the care of the woman throughout the pre-natal, natal and postpartum periods as well as in between pregnancies. Although in the past the midwife was only concerned with the pregnancy and delivery and for a short period after delivery, now she has to broaden her scope to look at the outcome of each pregnancy as a result of the adequate health care of the woman even before she becomes pregnant. Her interest should also centre around the successful outcome of each pregnancy and the growth and development and survival of each child born into the family.

Family Planning as a health programme is a recent development and the direct involvement of health workers trained in midwifery in Family Planning is also a recent phenomena. Thus Family Planning subjects have not been included in the midwifery training curriculum in many countries.

In some countries, however, a beginning has been made but the scope for Family Planning in health has not been properly defined in order to ensure that the subjects included in such training are sufficient to allow the doctor, the nurse and the midwife who graduate from the training course to provide family planning services. In some other countries there is still resistance from those concerned in curriculum development to integrate Family Planning subjects into an already overcrowded training programme. In such instances, there is need to emphasise the need for such integration and to create a climate for effective curriculum change or revision.

2. The Case for Family Planning as a Health Programme:

The interest in providing Family Planning as part of the National Health Programme is even more recent than the initiation of National efforts in family planning. Our experience of over ten years since such programmes were started

have indicated problems in providing Family Planning as a service separate from health.

The control of mortality is made possible by technological skills now available to eradicate disease, to improve food production and nutrition and to improve public health services. Birth or natality on the other hand depends largely on personal decisions and actions of millions of couples. Faced by various obstacles such as economic, socio-cultural, religious, political and managerial, the programmes thus far established in many countries in Asia have shown little success in terms of reduction in birth rate. Success was seen only in small nations which are relatively more advanced economically and where literacy, urbanisation and industrialisation were high - characteristics which were associated with a fall in birth rate in those countries which never had organised governmental efforts in Family Planning. In countries with big population and low levels of general development the impact is too small for any significant measurements to be made. The absence of health, educational and social services present immediate obstacles. It does appear that the level of health in any country is one of the critical factors determining individual and group action in family planning. Parents who are satisfied that their children are likely to survive show a greater tendency to practice family planning. Thus, it is those countries where infant and childhood mortality are still relatively high where reproduction remains unregulated or even uncontrolled. The high birth rate and death rates are interwoven into the social and cultural traditions and organisations where a woman's status is related to her fertility and infertility or subfertility is regarded as a personal catastrophe.

It has been shown that the Family Planning or in other words the contraceptive approach towards population planning can only support but not replace efforts towards social and economic upliftment. However, good health is essential for economic development. In order to bring about improvement in health status with reduction in infant and childhood mortality what is needed is a sustained effort to strengthen the health infrastructure and to provide at least essential curative and preventive services including family planning. In these settings and in those where the political situation poses a problem for an effective family planning programme, the answer would be to integrate family planning with the existing health services. The emphasis would then be towards provision of a comprehensive Family Health Care including family planning.

Further, it is now recognised that so long as the contraceptive technology requires health services for its delivery and so long as health services for the majority of the population is provided by the public sector, as is true in most developing countries, Family Planning services themselves will become and continue to be an important new component of health services.

3. The Relationship between Family Planning and Health:

One of the most significant achievments in the field of Family Planning is the increasing awareness amongst health workers of the relationship between reproductive patterns and health. It is now accepted that actions to achieve optimal reproductive pattern is as fundamental a health care as efforts in nutritional care, environmental sanitation and communicable disease control. Thus advice and service on spacing, timing and controlling of the number of children and other facts on family planning including infertility are in essence an integral part of the everyday practice of family and community medicine.

Various studies have provided evidence of the relationship between occurrence, timing and spacing of pregnancies and health. Family Planning and limitation of family size may lower maternal, perinatal, infant and child mortality and morbidity, especially if practised by women of high risk. For example large family size, high parity, pregnancy below the age of 18 and above 35 years of age, short intervals between pregnancies and abrupt weaning

are linked to various degrees of morbidity and mortality of mother, child and the family. High parity causes a risk of maternal and infant death which increases with each pregnancy beyond the third and increase significantly after the fifth.

Hazardous, illegal abortion is another health concern. Many women choose to intercept their pregnancies and jeopardize their health rather than face an unwanted pregnancy.

There are also distinct clinical contraindications to pregnancy in which family planning is essential in helping to prevent the aggravation of existing disease, such as cancer, cardiovacular and renal diseases, anaemia, hemolytic diseases, diabetes mellitus and hypertension. Repeated pregnancies may also aggravate certain psychiatric and neurological conditions and aggravate the damage resulting from past obstetric injuries. Pregnancy spacing can also help to improve maternal health especially in those areas where a woman's life is characterised by a continuous cycle of pregnancy and lactation resulting in a serious nutritional drain leading to maternal deprivation syndrome.

Family Planning to space pregnancy can also effect child health favourably. The "small for date" babies is the result of foetal under nutrition probably caused by rapid and repeated pregnancies. The principal cause of death during the first two years of a child's life in developing countries is diarrhoeal disease which is the result of a synergism between infections and low resistance due to poor nutrition and characteristically illnesses arise when an infant is weaned abruptly because of an intervening pregnancy.

Effective Family Planning can have a favourable influence on the health development and well being of the family members and is therefore an important preventive measure in health care of the family. It may also improve the quality of life through its impact on family health. For example when children are born at the most favourable times and are wanted, it is more likely that they will be well cared for and that their environment will be conducive to normal growth and development, while family members can more easily share an emotionally satisfying relationship that will promote family health.

4. The Scope of Family Planning activities:

Family Planning comprises a number of activities which may vary from country to country depending on various factors such as the national policies and objectives with regard to family planning and health, the pattern of health organisation, socio-cultural factors and the stage of technological development. However, generally the family planning activities, which can be provided by health workers include the following:

1) Motivation and Education:

This involves providing the necessary knowledge to health personnel about birth control methods, how they are to be used and what are the problems involved and how to overcome them and other pertinent information necessary for them to inform people so that they can motivate them to start and to continue birth control. In addition health personnel should also be able to provide guidance on the timing, spacing and the number of children to be born, based on their knowledge on the health implications of childbearing both on the normal mother and those with high risks.

2) Provision of Birth Control Care:

Birth control begins when a patient starts to use a method or even undergo an operative procedure. A trained health worker should be able to identify and thus contact eligible couples and also to recognise contraindications and then to provide the necessary care for birth control which also include history taking and physical assessment of the patient. Further continuing care is also necessary to ensure that the method is used effectively, safely and conveniently as long as desired.

3) Provision of other related services:

There is now an increasing emphasis on providing such special services as cancer screening through PAP smear, vaginal examinations and pregnancy tests and even marriage counselling.

4) Advise on Infertility: is often included as part of family planning service.

5) Education for parenthood:

This consists of educating couples, future parents and the public on such matters as the relationship between their reproductive behaviour and their own health and welfare and also the health and welfare of their children and future generation in their community and their country.

6) Record keeping: is an essential component of family planning care as this would assist in the evaluation of the services provided.

Activities concerned with provision of family planning care can be divided into three phases similar to any other health activities.

1) The Contact Phase: where the first contact is made which can take place in a wide variety of situations such as a general child health clinic, in the course of antepartum or post-partum care, home visits or even during such services as cooking demonstrations.

2) The starting phase which relates to the initiation of the use of birth control which can be provided during any of the above services.

3) The continuing care phase which involves an appropriate schedule for check-ups, the provision of further supplies, the provision of treatment for minor or serious complication and provision for changing of methods when necessary or when indicated. It also involves the appropriate management of accidental pregnancies which may occur inspite of use of contraception and also continued motivation and further advice on contraception.

Implications:

The concept of integrating family planning with the midwifery training programme logically presupposes the existence of an overall plan which recognises the integral role training and education will play in the achievement of a successful action programme. However, there may be instances, where there is a definite commitment by the government to provide a national programme in family planning but the department of health or Ministry of Health itself is not fully committed to the programme.

Thus, under such circumstances efforts should be made to strengthen policy level leadership so that clear guidelines on procedures and job description of all categories of health personnel can be worked out which will then make the task of planning for a revision in the curriculum much easier.

International agencies play an important role in providing fellowhsip for short courses in established institutions where leaders or potential leaders can acquire a broad understanding of population dynamics, extensive knowledge of the health aspects of family planning, mastery of the principles of programme planning, development, management and evaluation; and an understanding of the concept of ecological balance in national development. Further seminar both nationally and internationally arranged for such personnel on a regional basis may further stimulate their interest in this field.

Once there is a definite policy then a comprehensive training programme with definite objectives and adequate content and duration can be planned and integrated into the existing curriculum.

Specific objectives will allow the development of a teaching programme which will enable the student to acquire the necessary knowledge, skills for the delivery of family planning services to his or her future clientele.

Personnel assigned leading roles in teaching and service will have to be provided with adequate training so that they will acquire the knowledge and skills necessary and this will certainly expedite decision making and implementation.

The training of trainers or tutors will include instructing them in the plan for programme development, timetable requirements and priorities in addition to other basic knowledge and field experience necessary to enable them to perform their functions effectively.

Before the initiation of a large-scale education and training programme it is always advisable to test the procedures, the content etc. by means of pilot courses and field trials which should be carefully evaluated. This may help determine problems and therefore enable adjustments to be made before full implementation is carried out.

Of course continuous evaluation of the programme is necessary so that such feedbacks will enable further adjustments in curriculum and teaching methods to be made from time to time.

The training load will of course depend on service objectives and programme which will determine the manpower required. This in turn will determine the budget and the expansion of the training institution in terms of space, equipment and staff.

Field Training:

Because family planning is an action oriented programme, the necessity of providing adequate field experience in training is obvious. One way of providing such opportunities is to develop a field practice demonstration area. In addition to providing the field experience required, these field demonstration centers could also act as an area for field research in all aspects of Family Planning activities providing the instructors therefore with a "social laboratory" so that they can acquire new skills and knowledge to further their own professional development.

Universities and other institutions of higher learning in the country, should play an early and prominent role in the promotion of integration of family planning into existing curriculum. The teaching of human reproduction should be provided in an integrated manner especially in undergraduate and also post graduate training of doctors and other health personnel.

It would also be desirable for universities to take the initiative to organise seminars, workshops and even exhibitions on family planning and population dynamics. Universities can also participate in teacher preparation, development of more effective teaching method, and promotion of basic and applied research in education and training for health and family planning.

Conclusion:

The integration of Family Planning into the midwifery training programme is necessary if Family Planning is to be provided as part and parcel of an integrated family health care service by health personnel. It is an accepted fact that the majority of health personnel are those providing maternal child health and midwifery service. Although initial training should emphasise the training of existing personnel to provide the service, however, uninterrupted and effective service can only be provided if all health personnel acquire the knowledge and skills immediately at the time of graduation. Most countries phased their integration programme and inspite of this and an active in-service training programme, one of the most critical problems faced is the transfer of staff from an area with integration to an area outside integration and the replacement with untrained personnel. Thus, it is highly recommended that integration of Family Planning into existing midwifery curriculum must be implemented simultaneously with in-service training programme so that this problem can be minimised.

APPENDIX I

ADVANTAGES OF INTEGRATION

The health services play a key role in the successful provision of Family Planning Care. Many birth control methods require health personnel particularly techniques of supervision, follow-up and management of side effects. The usefulness and success of these different methods depend on several factors such as their effectiveness in preventing pregnancy; the health risks entailed in their use; their cost and simplicity of use, and other considerations that influence their acceptability. These factors interact and influence the selection of specific methods for programme and the choice and continued use of methods by individuals or couples. Basically, the "risks" associated with any method must be compared with the risk of not using any method at all.

Other advantages have been advanced for integrating Family Planning with general health services. Some of these are:-

(i) Utilisation of existing health facilities and personnel:

It is better and more economical to build a programme into an existing structure. Integration will reduce duplication of functions and enable maximum use of existing resources.

(ii) Provision of a series of services:

Services to protect and promote health are best provided in a sequence rather than fragmentally i.e. family planning should be an integral part of a total health package for family health.

(iii) Unique opportunity of health workers to contact people:

The services provided for mothers and children through antenatal clinics child health clinics, home visiting, domiciliary deliveries and outpatient departments provide close contact of health workers with families, providing opportunities for family planning work.

(iv) "Trust among people:

Permanent community health services that include maternal and child care are needed for the acceptance of family planning. As long as parents have a reasonable assurance that the children they already have will survive in good health they will be more ready to practice family planning. Health workers who have already gained acceptance by the people are able to propagate family planning from a position of trust.

(v) "Teachable moments" for mothers:

Family Planning is related to every phase of the maternity cycle, biologically as well as in service and educational aspects. If it is integrated into maternity care and related to the phases of the maternity cycle when women's needs are greatest, its potential availability and effectiveness are enhanced.

(vi) Technical Advantage:

I.U.C.D. insertion and female sterilisation are technically easier soon after delivery. Family Planning services can therefore be incorporated into maternity services with advantage.

(vii) Privacy for mothers:

There are women in our society who do not take an open interest in family planning because of conservatism or shyness. Such women may be more easily reached when they attend Maternal and Child Health Clinics where Family Planning is offered as a more discreet service.

(viii) Teamwork Approach:

An integrated service will make available health personnel from the general health services and the Maternal and Child Health Services t work with the community and to gain their support for family planning programmes.

(ix) Statistical advantage:

It has been shown statistically that of the women who become pregnant again after a delivery, half will have received within 3 months of the first menstrual period after delivery while about 4/5 do so within a year (Taylor 1965). Thus contraceptive advice and service provided shortly after nutrition would give greater effectiveness in reaching target groups.

APPENDIX II

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EXPANDED AREA OF TRAINING FOR MIDWIVES "PAEDIATRICS"

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BACKGROUND

It has been shown that repeated and closely spaced pregnancies result in nutrition depletion of mother and interrupted lactation, with adverse consequence for the health and the stability of the entire family. Studies are under way to quantify the beneficial effects (i.e. the reduction in mortality and morbidity among mothers, infants and young children) that derive from the availability of methods of spacing and limiting pregnancies. As a corollary, it is assumed that a reduction in infant and child mortality will give parents a reasonable assurance that the children they already have will survive. With such an assurance, they can afford to make an emotional commitment to those children and to adopt fertility regulating practices.

Reduction in infants and child mortality and morbidity cannot be achieved by family planning alone. To be effective, this aspect of care must be integrated with services leading to adequate medical care, improved nutrition, immunization against childhood diseases, improved child rearing practices, the provision of portable water, and improved sanitation.

Expert Committees on Maternal and Child Health of the World Health Organization have defined the ideal maternal and child health services as those ensuring that:

1. ..... every expectant and nursing mother maintains good health, learns the art of child care, has a normal delivery, and bears health children.

2. Every child, wherever possible, lives and grows up in a family unit with love and security in health surroundings, receives adequate nourishment health supervision, and efficient medical attention, and is taught the elements of healthy living.

DEFINITION OF HEALTH

Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. (W.H.O.)

Child Health: Health is taken to mean the state in which the child achieves the best use of his genetic endowment and accomplishes the most satisfactory adjustment to the environment into which he must mature. Thus it includes the study of the normal child and his development from conception, of his mental and emotional as well as his physical well-being, and of the family and social environment in which he lives (International Paediatric Association, 1962).

PROBLEMS OF CHILD HEALTH AND CHILD HEALTH CARE

In fact, most maternal and child health problems are public health or community problems that can be solved only by applying general measures to an entire community or region. Overpopulation in relation to food supply, malnutrition, poverty, ignorance of the principles of nutrition and sanitation, and the prevalence of infection spin a web of ill-health, in which most of them are caught to some extent and to which many succomb. Certain facts stand out.

THE HUGE POPULATION OF CHILDREN: In developing countries, where nearly one-half of the population may consist of children under 15 years of age. These tragedies predominate in the mortality and mobidity data of those countries.

The pattern of population growth in modern times has been characterized by a great differential between the developed and the developing countries. In half-century 1950-2000, the rate of natural increase in developing countries is likely to average 25 or more per 1,000 population, as contrasted with 10 or fewer per 1,000 in the developed countries. The population of developing countries will therefore double in 31 years or less, while that of developed countries will take 70 years or more to double.

It is obvious, however, that the rapid increase in population is a serious problem in most areas and it is equally obvious that there are only two ways of combating this increase, first by high mortality and secondly by low fertility. In some communities of the developing country, family planning has made great progress. Nevertheless, in some countries, where such tremendous importance attaches to having a son and heir, family limitation cannot be expected to succeed until there is reasonable assurance of survival for a child. Thus child-health work must have its impact on mortality before effective population control can be instituted.

POVERTY: The relationship between economic development and health is a two-way interaction; economic development can influence health levels, and health improvement can influence economic development. By every index, Asia, and particularly the Far East, which has the largest population of any region of the world, has the lowest per capita food production and consumption. These deficiencies, particularly in animal protein, fall most heavily on the growing child, particularly in the period from 1 to 4 years of age, when the child is weaned, when he is often given less of a share of the family food than its working members and when he is most apt to have to deal with infections and parasitic infestations.

IGNORANCE OF HEALTH CONCEPTS: Poverty is not the only cause of malnutrition and disease, although it plays a major role. Lack of understanding of health concepts, which take for granted, and belief in folklore about health may be equally important factors. Every community has ideas and practice relating to child-rearing that are passed down from mother to daughter. Educational, social and medical workers with a westernized education unfortunately tend to deplore and discourage many of these when they come across them in developing countries. A detailed knowledge of local beliefs and practices and the extent to which the population hold and follow them is however needed, and we should study them during period of practice.

Many beliefs and practices have intrinsic value. An attempt should be made to separate customs into the following groups.

1. Beneficial practices: for example, true demand breast-feeding, the continual physical contact between the infant and adults, giving simple tasks to children so that they feel needed.

2. Innocuous practice: for example, wearing beads and bangles, rubbing the infant with oil.

3. Practices believed to be harmful: for example the use of uncleaned instrument in cutting the umbilical cord which cause tetanus neonatorum. Semi-solids, in the form of rice (either soft-boiled or pre-chewed) and mashed banana are usually introduced early, usually in the first few days of life. In measles, herbs may be applied to the eyes which damage the conjunctiva.

CHILDHOOD MORBIDITY AND MORTALITY: Among the emerging nations (a large part of the world's population), about 50 percent of all deaths occur in children under five years of age. In economically advanced countries this proportion is less that 10 percent. "What makes these figures tragic is that many of these deaths in the developing countries are avoidable, if living conditions could be improved and the present knowledge could be applied".

Infancy is the period of greatest risk in all parts of the world; nevertheless, some developed countries have reduced infant mortality to less than 20 per 1,000 live births. In these countries, death among children predominate in the first week of life and are due to problems such as congenital malformation, intrauterine anoxia and extreme low birth weight. Death is expected not more than one per 1,000 live births for the ages of between one and four years. In these years, death from infection and its complications are rare; those from malnutrition are nearly nonexistent; accidents, especially from automobile, are by far the leading causes of death.

Circumstances are drastically different in developing countries. Infant mortality rate between 40 and 80 per 1,000 live births are quite common; in few countries, rate persists above 100. Precise data on the causes of these deaths are not available, but unquestionably they are due in the main to infection and to malnutrition.

The major hazards to health of children of the world are malnutrition, gastroenteritis, respiratory infections (including tuberculosis), childhood infections (measles, pertussis, malaria) and parasitic infestation. These are diseases caused by poverty and ignorance of health concepts. The hazards are prevented in large measure by proper food and sanitation.

THE NEWBORN: Many children sicken and die during the perinatal and neonatal periods in developing countries. These are periods of great emotional significance. The delivery of mother and the birth of the child are subject to more beliefs and superstitions than any other period of life. In many developing countries, particularly in rural areas, a baby who dies in early hours or days of life may be buried without being registered, either as a birth or death. The deaths in early infancy are also the most resistant to medical care. For instance, between 1900 and 1954 the crude death rate in U.S.A. fell from 17.9 to 9.12 per 1,000 population; the infant mortality

rate dropped from 150 to 26.6, but the proportion of deaths from "disease of early infancy" rose from 3.7 percent to 4.3 percent of the total.

Neonatal deaths are due mainly to Birth Trauma, Infections, Low Birthweight (including prematurity) and Congenital Anomalies.

NURSING CARE OF CHILDREN: The nurse has an essential part to play in the care of every child in the hospital. But she can play this part only if the doctor lets her take her essential place in the health team. Nursing entails the physical care required for comfort, and teaching the patient's mother how to give this care. The nurse will build up the mother's confidence in her own ability to observe the changes in her child. She gives her the emotional support necessary to foster recovery, maintains her confidence in the treatment, giving the treatments prescribed by the doctor, and observes the response of the patient.

The quality of the nursing care that can be provided will be determined not only by the ability of the nursing personnel and the attitude, but also by their number. The world shortage of nursing tutors trained in effective teaching and communication methods is a serious limitation in every developing country. In determining a nurse's functions in particular circumstances a critical minimum level of nursing is what matters, recognizing that with increased staff increased service can be offered.

The major difference between nursing in Europe and America and that in developing countries is the amount of teaching done. This is not so much in formal teaching but through the nurses in all their actions assisting the mothers from a rural society who have little understanding and appreciation of scientific medicine and technology. The interpretation of all that goes on in the treatment of the child must be the concern of the nurse.

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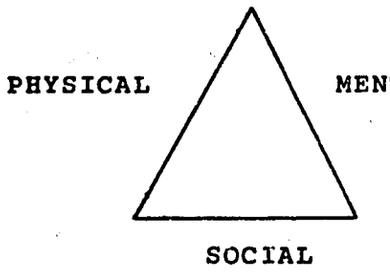
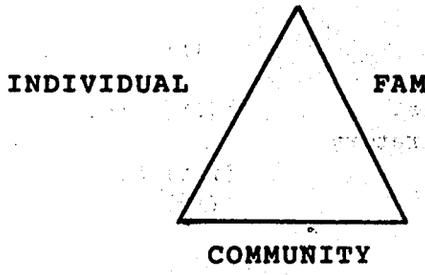
PRACTICAL PREVENTION OF NEONATAL DISEASE*

*From Williams C.D. and Jelliffe D.B. (1972) Mother and Child Health, Oxford Medical Publications, London.

	PREVENTION	
INFECTIONS General (septicaemia, skin, respiratory tract)	(i) Cleanliness by birth attendant and family at end after birth (ii) Minimum interference during birth (e.g. intravaginal manoeuvres) (iii) Avoidance of indigenous dressing to cord (iv) Hospital admission for chemotherapy for all neonates born by prolonged (48 hours) or difficult labour	
Diarrhoea	(i) Breast-feeding (ii) Avoidance of neonatal feeds, herbal remedies, etc. (iii) Newborn by mother's bed, not in nurseries (iv) If artificial feeding absolutely necessary, great care with cleanliness or preparation	
Opthalmia neonatorum	(i) Antenatal detection and treatment of maternal gonorrhoea or non-specific pelvic infection (ii) Routine chemoprophylactic eye applications at birth	
Tetanus neonatorum	(i) Cleanliness in cord care (e.g. cutting instruments, hands, dressing) (ii) Avoidance of dangerous indigenous cord dressing (especially if this contains animal dung) (iii) Immunization of pregnant women or all women	**Training of indigenous birth attendants**
Congenital syphilis	(i) Antenatal blood test, and treatment of pregnant women, if necessary	
BIRTH TRAUMA	(i) Antenatal supervision and early referral of potential obstetrical problems (e.g. contracted pelvis, small stature, twins) (ii) Avoidance of local traumatic practices during delivery (iii) Avoidance of indigenous herbal oxytoxics	
LOW BIRTHWEIGHT (including prematurity)	(i) Early detection and treatment of acute or chronic general or obstetrical disease or abnormality (ii) Improved diet in pregnancy with special reference to locally available foods (especially vegetable protein mixtures) (iii) Avoidance of excessive physical work (iv) Antimalarials during pregnancy (v) Folic acid supplements (vi) Child spacing	





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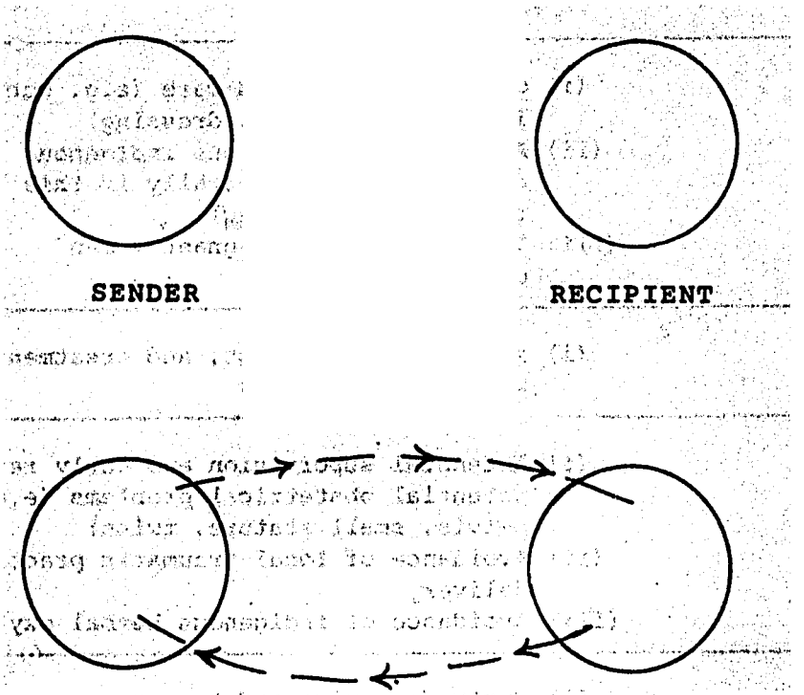

COMMUNICATION IS TWO-WAY

THAILAND

BASIC DATA, 1971 (Midyear Estimates)

Total population		37,399,000
Population, Bangkok - Thonburi		3,368,000
Married women, aged 15 - 44		4,736,970
Children under age 15	(43.7%)	16,377,000
Population density		70 per square km.
Crude birth rate		41 per 1,000 people
Crude death rate		11 per 1,000 people
Rate of natural increase		3.0%
Population increase per year (1970)		1,182,000
Percentage of population residing in rural areas		85%
Percentage of population of Buddhist religion		94%
Percentage of population employed as farmers		80%
Labor Force		17,000,000
Female Labor Force		8,000,000
Number of provinces (changwat)		71
Number of districts (amphur)		556
Number of sub-districts (tambol)		5,036
Number of villages (muban)		59,934

POPULATION GROWTH IN THAILAND (Second Edition)

Manpower Planning Division
National Economic Development Board

National Family Planning Program
Ministry of Public Health

Institute of Population Studies
Chulalongkorn University.

1972

MORTALITY RATES TO FIVE YEARS OF AGE

		'Slum' Marginal Areas of Bangkok	Rural (Bang Pa-In) 65km from Bangkok	National Records
Infant	0 - 27 days	28	33	7 -
	0 - 11 months	55 - 60	50 - 61	25
Children	1 - 4 yr. (per 1,000 Live births)	20	20	
	1 - 4 yr. (per 1,000 Child 1-4 yr.)	29	-	22

From the above statistics, the paediatric population are as high as 44 per cent, compared with about 25 per cent in the developed country.

NUTRITIONAL STATUS AND GROWTH IN BANGKOK AND RURAL AREAS

Using Boston standard growth curve with Gomez nutritional classification, the survey data from Bang-Pa-In and marginal areas of Bangkok reveals that most of the children are undernourished.

Percentage and Degree of Malnutrition of Pre-School Children

	Marginal Areas of Bangkok	Rural (Bang-Pa-In)
No. of children (0 - 72 months)	850	793
No. of malnourished (0 - 72 months)	82.6%	57%
No. of 1^{o} - 3^{o} malnutrition (0 - 5 mths)	74.6%	8.0%
1^{o} malnutrition (76 - 85%)	31%	37%
2^{o} malnutrition (75 - 61%)	43.3%	19%
3^{o} malnutrition (60% or lower)	8.3%	1%

Children in the marginal or slum areas of Bangkok are more severely malnourished then those in the rural central area. Improper feeding, early substitution of breast milk by rice, banana and sweetened condensed milk are commonly practised, due to low socio-economic problems. Usually the lactating mother has to earn for her family. Poor housing and poor hygiene lead to frequent infections and consequently more severe malnutrition.

Dr. Pensri Khanjanasthiti

IMMUNIZATION OF CHILDREN

Two studies on immunization, one came from the Infectious Diseases Control Department, Ministry of Health which was conducted in 1971 - 1972 using four sampling areas in the North, North-East, Central and Southern part of Thailand. The other study came from three marginal areas of Bangkok. The data are as follows:

i) Immunization Coverage (%)

Age Group	Smallpox	B.C.G.	DT or DTP	Polio
All ages (0-14)	54.7	22.0	21.5	6.6
Up to 1 year	11.3	3.3	10.6	5.8
1 - 4 years	34.8	15.7	24.8	10.2
5 - 9 years	77.1	29.2	26.5	6.2
10 - 14 years	95.8	40.1	24.2	4.4

ii) Adequacy of Basic Immunization (Smallpox, BCG & at least 2 DT or DTP)

Age	Coverage (%)
All ages (0 - 14)	8.8
Up to one year	2.3
1 - 4 years	7.3
5 - 9 years	11.3
10 - 14 years	14.3

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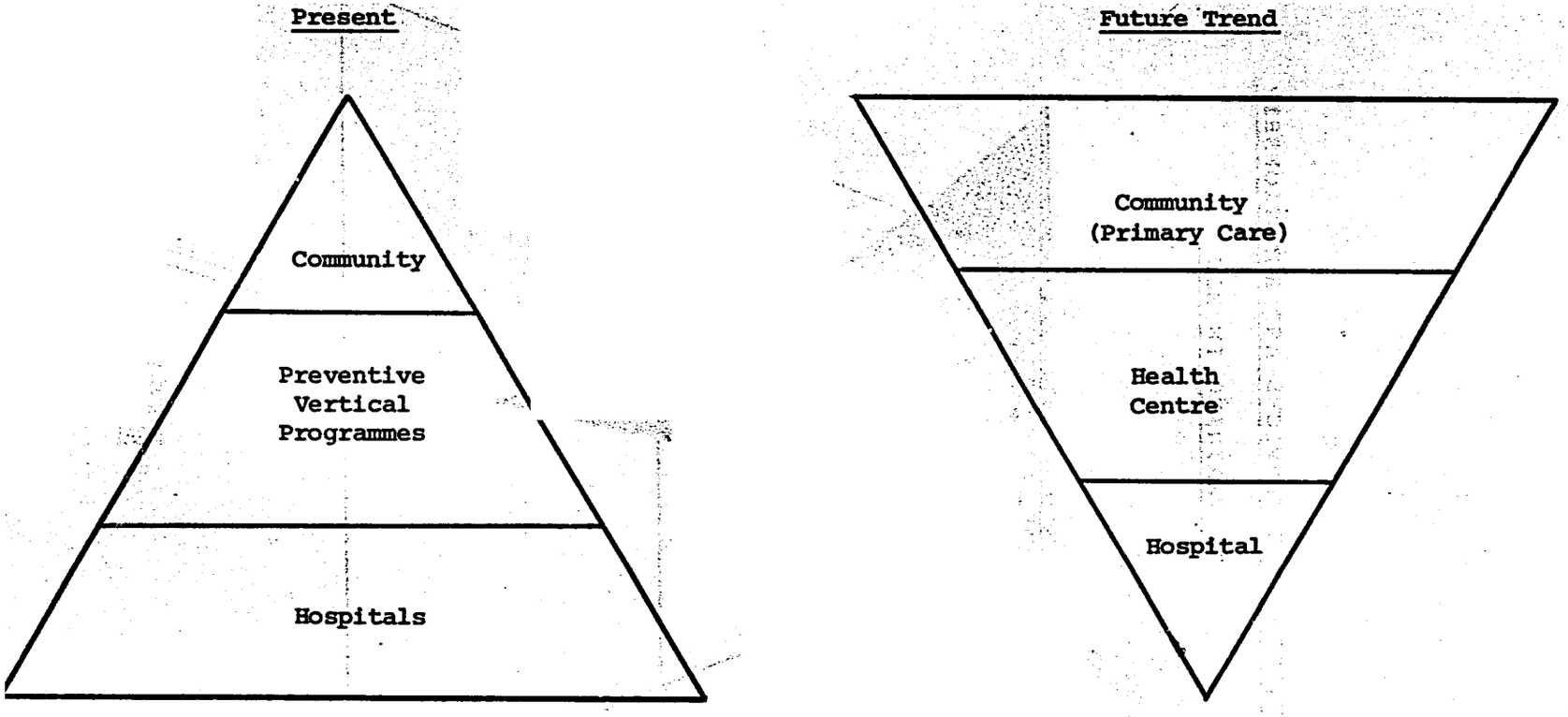
NEWBORN: LEADING CAUSES OF HOSPITAL ADMISSION 1963 - 1972

Deliveries in hopsital	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972
Immaturity	221	183	257	272	313	388	484	405	483	479
Congenital malformations	88	95	98	95	94	95	128	131	122	146
Diarrhoea of the newborn	56	84	27	41	77	48	103	98	129	170
Post natal asphyxia	52	44	59	37	48	25	45	101	101	167
Opthalmia neonatorum	52	17	18	8	43	54	22	3	2	4
Pneumonia of the newborn	42	39	29	28	12	12	14	20	11	2
Birth injury	22	65	64	37	55	76	79	25	51	39
Intracranial and spinal injury	22	30	45	32	16	14	6	20	25	24
Haemorrhagic disease of the NB	19	30	25	16	11	9	9	17	18	9
Haemolytic diseases of the NB	6	11	21	17	30	36	57	55	36	48
Sepsis (umbilical)	9	22	54	1	38	15	6	3	-	2
Total admission	697	815	822	686	890	913	1287	1430	1332	1627

Deliveries outside hospital	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972
Diarrhoea of the NB	153	102	112	180	79	188	188	174	300	229
Immaturity	141	40	53	44	42	77	107	112	85	93
Tetanus neonatorum	55	63	77	88	67	64	60	62	57	48
Pneumonia of the NB	37	32	19	24	18	11	20	40	49	59
Cong. malformations	32	32	32	35	32	54	49	57	54	68
Birth injury	24	10	8	5	8	12	6	6	14	18
Post natal asphyxia	18	9	10	7	36	4	5	8	21	34
Septicemia and pyema	43	43	85	74	78	78	45	39	20	21
Hemolytic dis. of NB	4	1	5	3	4	6	15	13	7	9
Total admission	661	477	533	602	454	614	585	652	855	765

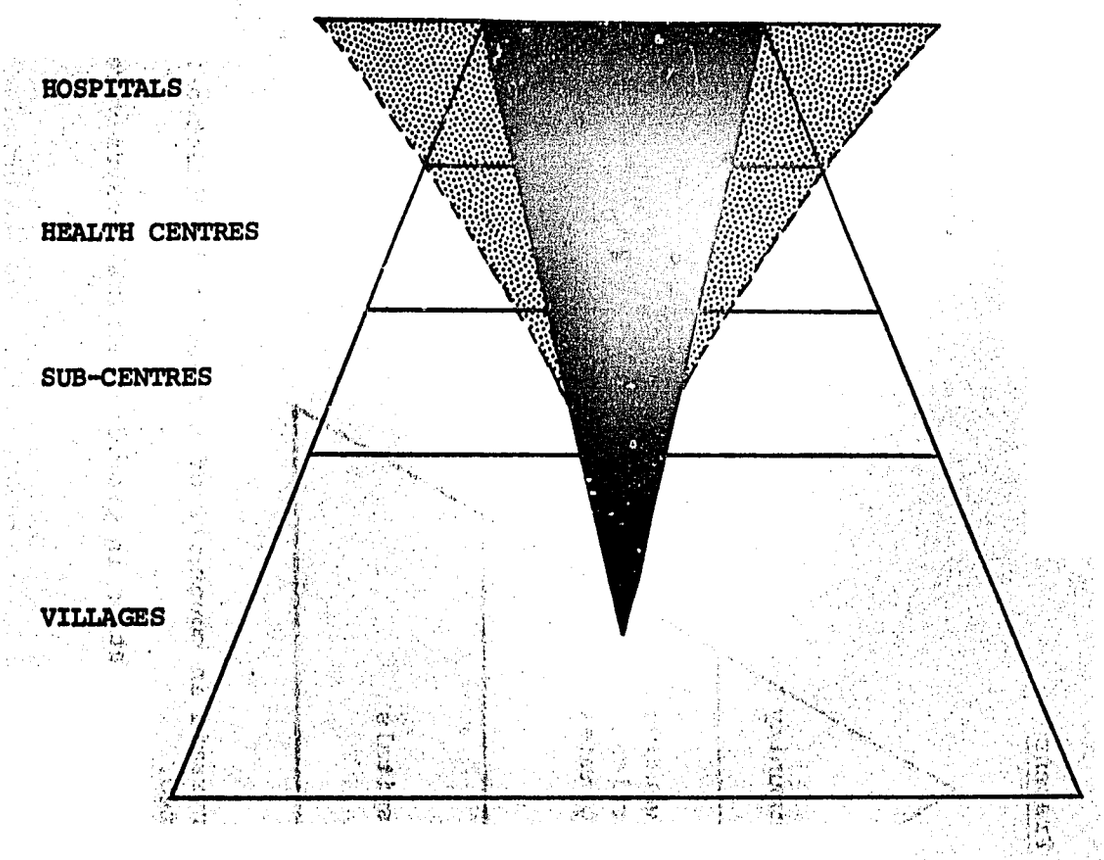
REVERSING THE SERVICE PYRAMID

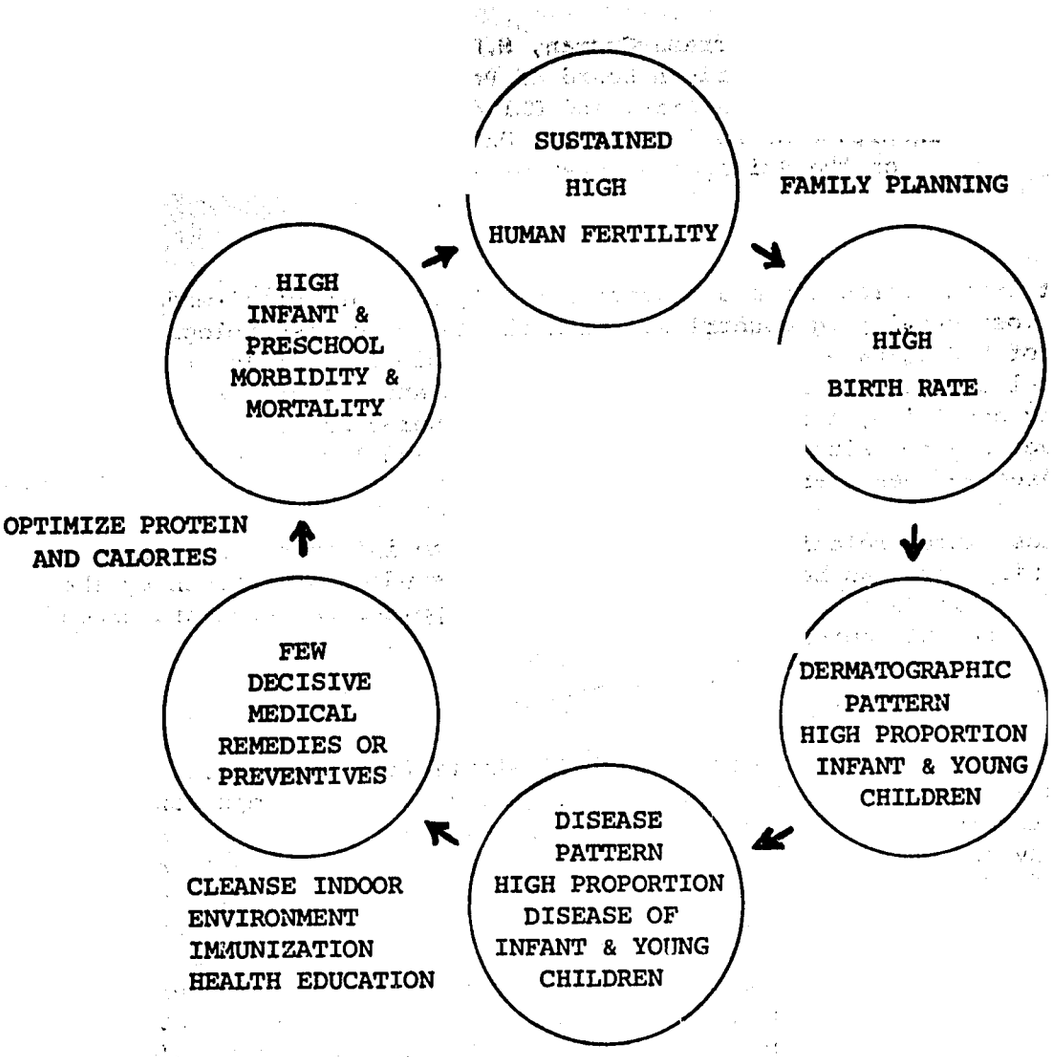


The present service pyramid in countries of the Region is directed towards institutional care, and is disease oriented.

The future trend is a concentration in providing minimal health care to the rural population, with a community health bias.

EXISTING MCH SERVICES AND RELATIONSHIP TO TRAINING IN MCH





BASIC CORE DERMOGRAPHIC DISEASE PATTERN

(INFANT & YOUNG CHILDREN) OF THE DEVELOPING COUNTRY

NUTRITION, INFECTION AND FAMILY PLANNING

by

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Malnutrition, infection and excessive family size are still major health problems in most developing countries. With the advent of technological advances, discoveries of biologicals and availability of antibiotics, affluent countries have practically wiped out nutritional deficiencies and infectious diseases. In developing countries, these have remained unconquered basic problems. The groups susceptible to malnutrition are the pregnant and lactating mothers, pre-school children 1-4 years and infants.

The close inter-relationship of malnutrition to infectious diseases and excessive family size has been shown in some field studies undertaken by the Institute of Public Health, University of the Philippines in rural and urban slum areas in the Philippines.

MATERNAL FETAL RELATIONSHIP

Since growth and development of a child starts from conception, it is logical to start with maternal nutrition. It has always been emphasized in nutrition literature that the best insurance for a healthy infant is a mother who is healthy and well-nourished throughout her entire life as well as during pregnancy. Good nutrition is important to the reproductive efficiency of mothers. Mothers having successive and closely-spaced pregnancies ususally suffer from maternal depletion syndrome. Maternal depletion syndrome is a term applied to mothers who have had rapid and closely-spaced pregnancies so that there is no more time for physical and mental recuperation to enable her to restore her depleted nutrient stores. Other factors which influence pregnancy outcomes are the maternal age, pregnancy interval and pregnancy order.

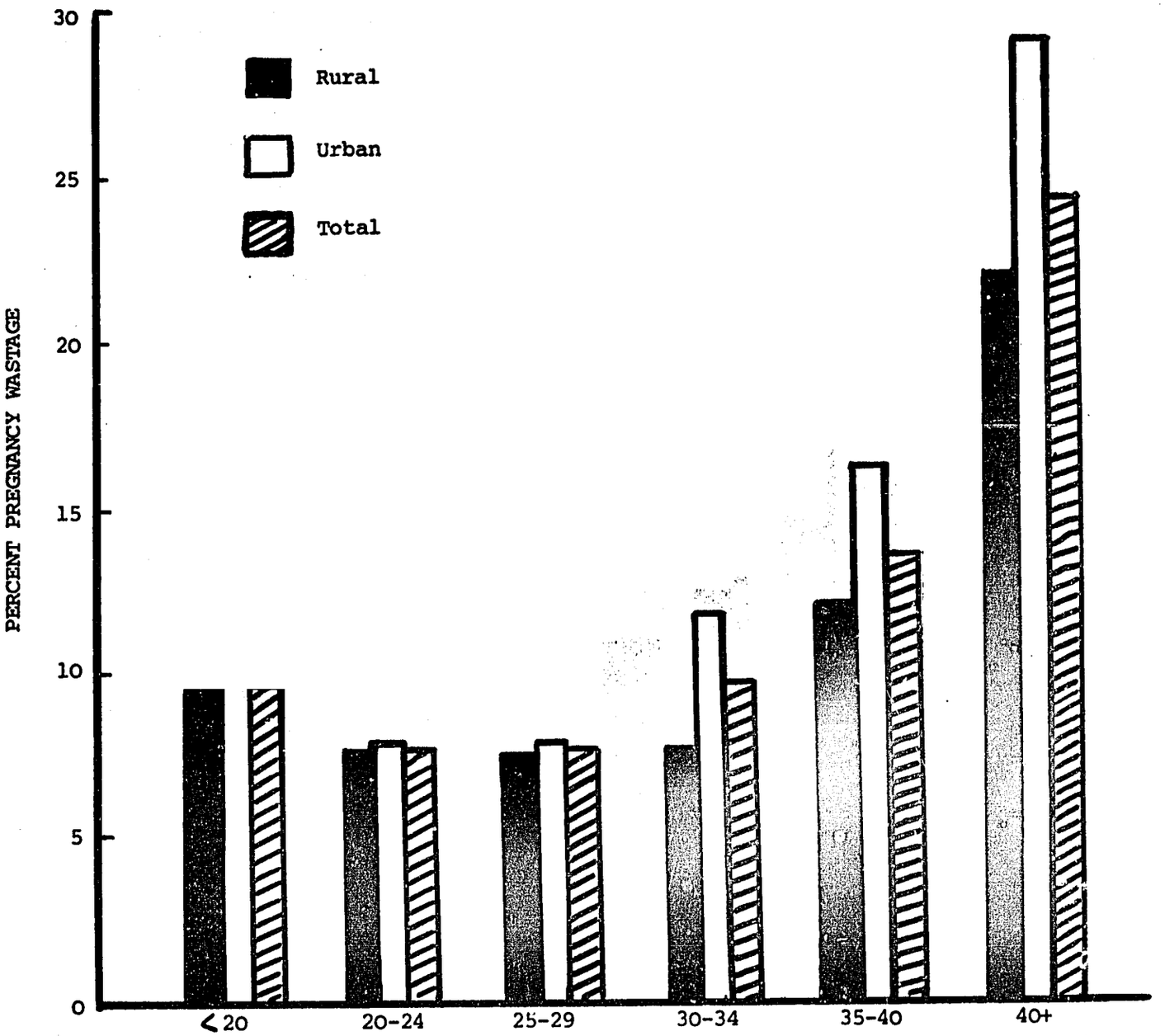


Figure 1

PERCENT PREGNANCY WASTAGE BY MATERNAL AGE AND RESIDENCE
"FAMILY FORMATION AND FAMILY HEALTH"
PHILIPPINES 1971

This graph demonstrates that mothers 20-29 years of age have the lowest pregnancy wastage (defined as stillbirths and abortions in this particular study); after age 30 years, pregnancy wastage increases with increase in age.

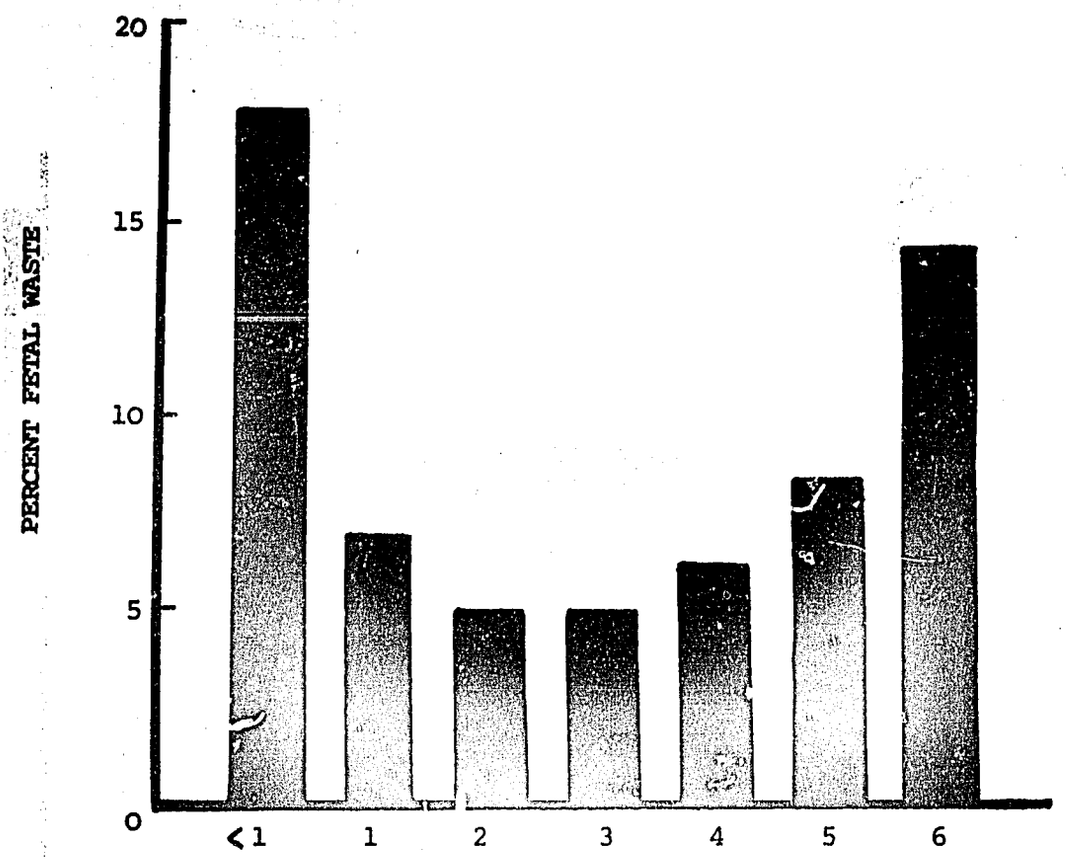


Figure 2

PERCENT FETAL WASTE BY PRECEDING PREGNANCY INTERVAL
"FAMILY FORMATION AND FAMILY HEALTH"
PHILIPPINES 1971

This graph portrays that pregnancy interval of 2-3 years has the lowest percentage of fetal waste or conversely the highest livebirths.

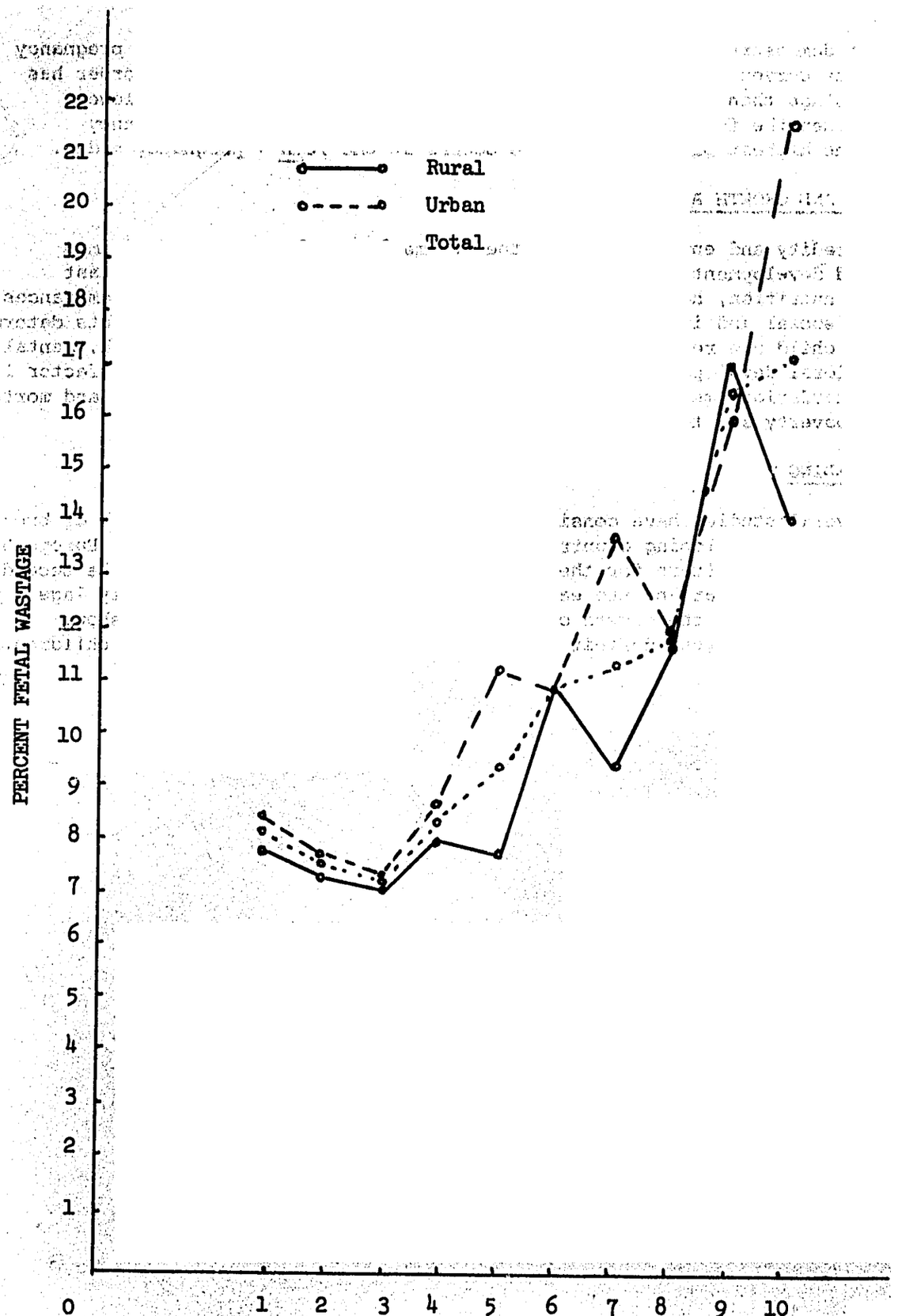


Figure 3

FETAL WASTAGE (PERCENT) BY RESIDENCE, MATERNAL AGE, PREGNANCY ORDER
"FAMILY FORMATION AND FAMILY HEALTH"
PHILIPPINES 1971

It demonstrates the relationship of per cent fetal wastage to pregnancy order. The curves in this graph are J-shaped. The first pregnancy order has higher wastage than the second pregnancy, with the third having the lowest wastage, then the fetal wastage increases with the increase in pregnancy order. The highest pregnancy wastage occurs at the 10th + pregnancy order.

NUTRITION AND GROWTH AND DEVELOPMENT

Heredity and environment are the two main factors influencing human growth and development. Among the environmental factors playing important roles are nutrition, housing, sanitation, illness, socio-economic circumstances including social and intellectual stimulation. The environmental aspects determine whether a child can reach his full genetic potential of physical growth, mental and behavioral development. Malnutrition is now recognized as a major factor in growth retardation, mental subnormality as well as childhood morbidity and mortality whenever poverty and too successive pregnancies exist.

BREAST-FEEDING

Several studies have consistently shown that the physical growth of breast-fed children in developing countries is usually normal and follows the European or North American pattern for the first five months of life. During the second half of the first year and the early pre-school period, growth commonly lags behind. Eventually, the growth curve of these impoverished children shows approximately a two year deficit compared with that of well-nourished children.

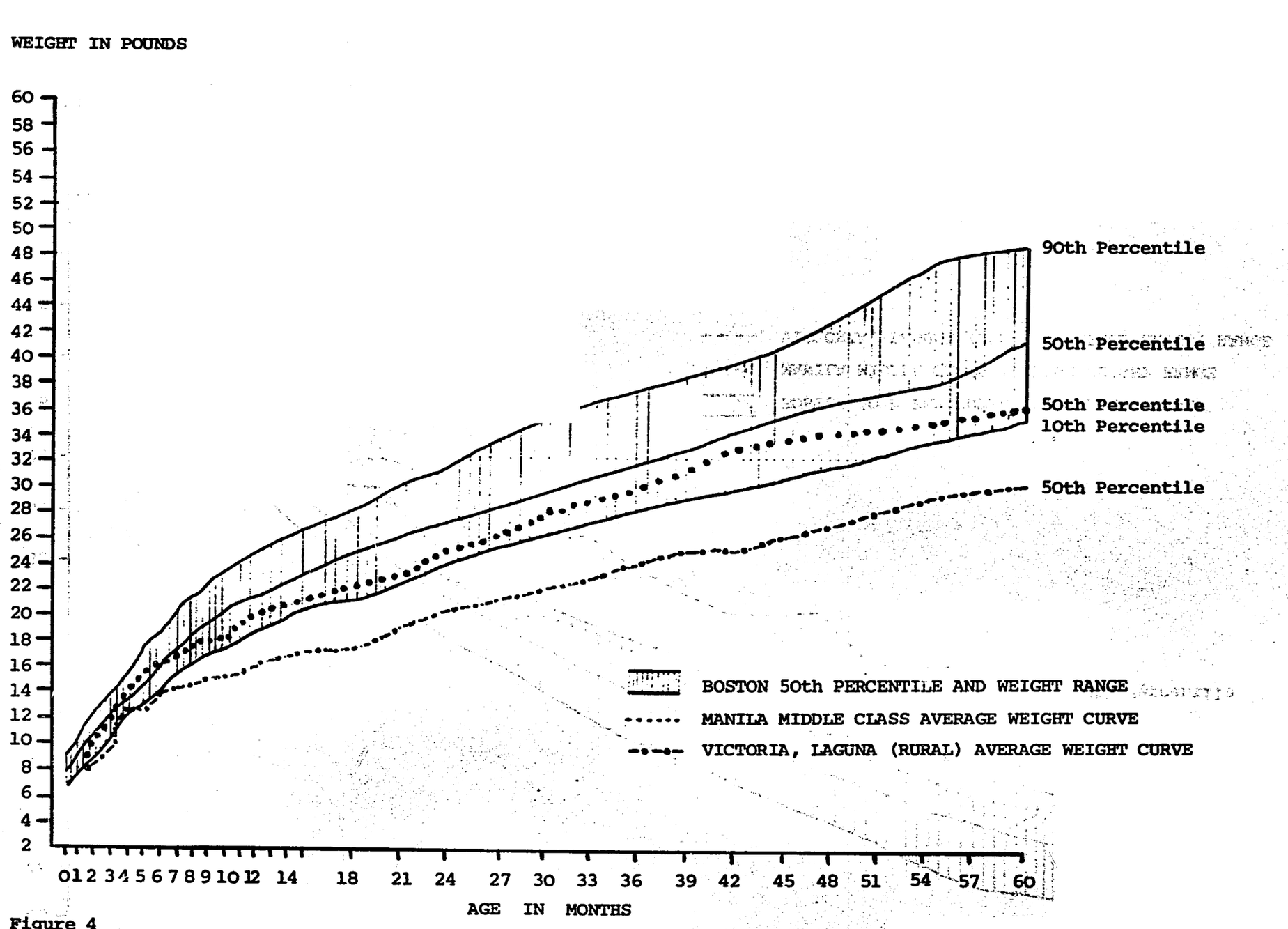


Figure 4

AVERAGE WEIGHTS OF INFANTS AND PRE-SCHOOL CHILDREN
LAGUNA, MANILA AND BOSTON
MALES AND FEMALES COMBINED

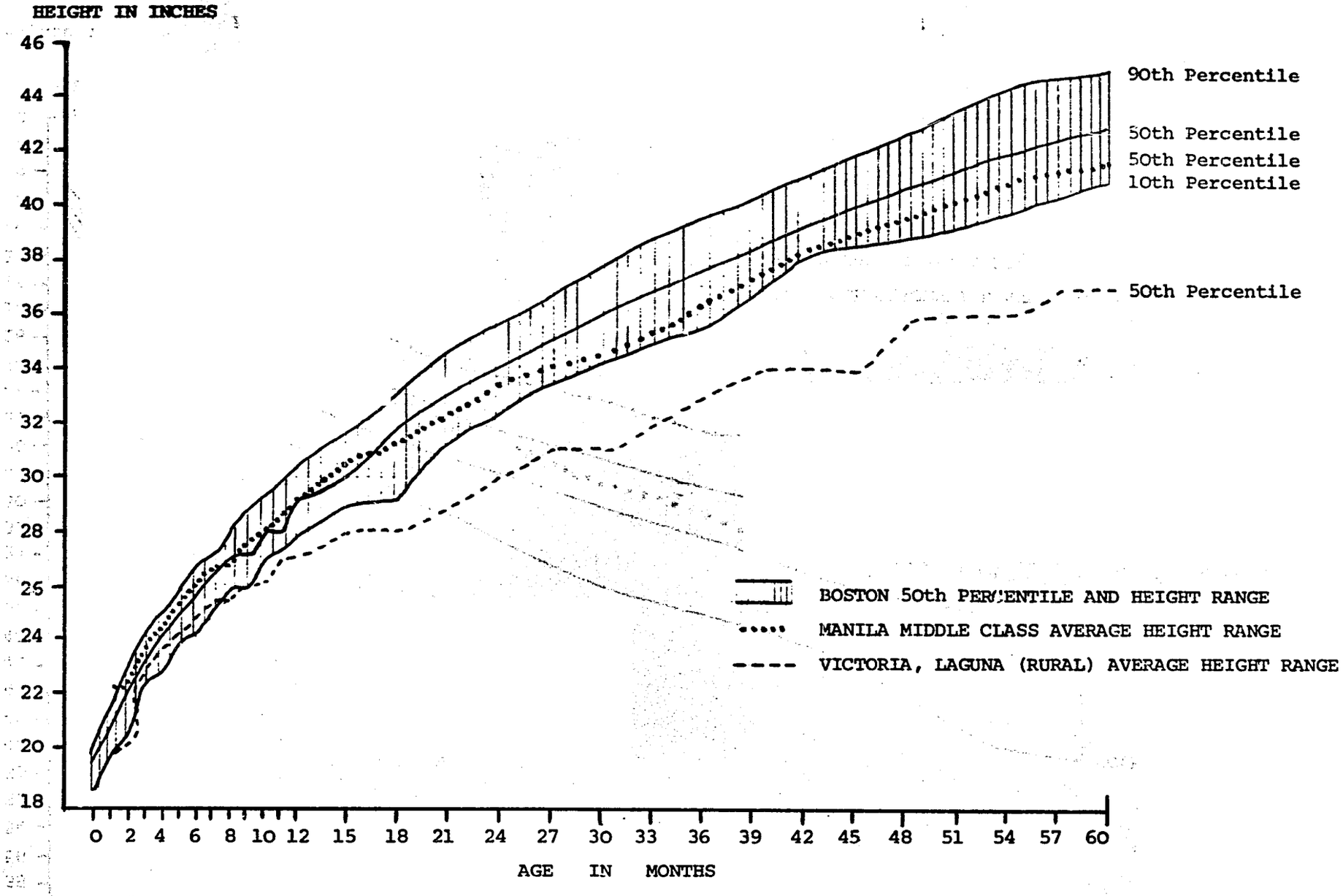


Figure 5

AVERAGE HEIGHTS OF INFANTS AND PRE-SCHOOL CHILDREN
LAGUNA, MANILA AND BOSTON
MALES AND FEMALES COMBINED

Graphs 4 and 5 showing the comparative growth curves for height and weight of three groups of children - the American, middle class Manila and the rural (Victoria, Laguna) subjects confirm the above-mentioned universal observation of the growth pattern of breast-fed children. It can be seen that the breast-fed rural babies from the low-income group compare very well with American babies and Manila middle class babies up to 4 or 5 months of age. After that, the height and weight curves of the rural children level off and start to lag behind until the gap widens and this gap persists up to 5 years of age. On the other hand, the average or 50th percentile middle class Manila child's height and weight curves compare reasonably well with the 50th percentile American child. This tends to show that a Filipino child given the proper environment like good nutrition, adequate housing, all the necessary immunization and good medical care can reach the maximum potential for physical growth. Even their developmental performance using the Gesell Test showed comparatively earlier age at reaching the various milestones particularly in the field of motor behaviour (roll over, crawl, sit up, stand up and walk earlier).

The two-year deficit is also demonstrated in this study, whereby a three-year old rural child has an approximately equivalent weight and height of a one and a half year old Manila child.

TABLE I - Proportion (%) of 565 Children in Victoria, Laguna with Varying Degrees of Malnutrition by Age Group According to Gomez Classification*

	AGE GROUPS		
	0-11 Months (100)	1-3 Years (384)	4-6 Years (102)
Normal	34.2	3.2	1.0
1st Degree	7.4	36.8	48.5
2nd Degree	35.4	51.6	45.5
3rd Degree	3.0	8.4	5.0

* Gomez Classification:-

3rd Degree malnourished - 60% and below of standard weight for age.
2nd Degree malnourished - 61-74% of standard for age.
1st Degree malnourished - 75-90% of standard weight for age.

Reference: Iowa Standards.

According to the mode of classification, it can be easily noted that the percentage of malnourished children increasingly rises with age. Among children below one year of age, 34.2% have weights that conform to a normal level; on the other hand, over 95% of subjects over one year old easily qualify as undernourished children. This table further illustrates that the 1-3 years old is the most vulnerable age group garnering the highest percentage of 2nd and 3rd degree malnourished children.

NUTRITION AND MENTAL DEVELOPMENT

There is a great deal of concern today over the possible effects of malnutrition on mental development. Malnourished children may not only fail to achieve optimal physical growth, but maybe unable to realize their full potential for mental maturation.

In humans, the greatest growth spurt for the brain occurs during the fetal period. By the end of the first year of life, the brain has assumed approximately 70% of its adult weight and by the end of the second year its growth is almost complete.

Other investigators like Winick have shown that in both animals and humans, brain growth may be retarded by malnutrition. The earlier the nutritional deprivation, the more severe the retardation. Evidence is becoming more and more weighty that malnutrition in infancy permanently affects the minds of the children who have been afflicted. The consensus seems to point that six months of age is the most critical period of high risk to malnutrition. This tragic consequence can be prevented by breast-feeding the babies particularly from the low income groups throughout the first year of life.

MALNUTRITION AND INFECTION AND PARASITISM

Malnutrition increases the severity of infectious diseases and infection aggravates malnutrition. Serious forms of nutritional disorders like full blown kwashiorkor is frequently triggered by an infectious episode in a child with marginal malnutrition. The common childhood diseases like upper respiratory infection, measles and diarrhea bring markedly increased mortality and morbidity.

In these studies, it was quite common to encounter children with multiple diseases occuring at the same time. It was the exception rather than the rule, to find a child normal in nutritional status and without any illness present at the time of the medical examination.

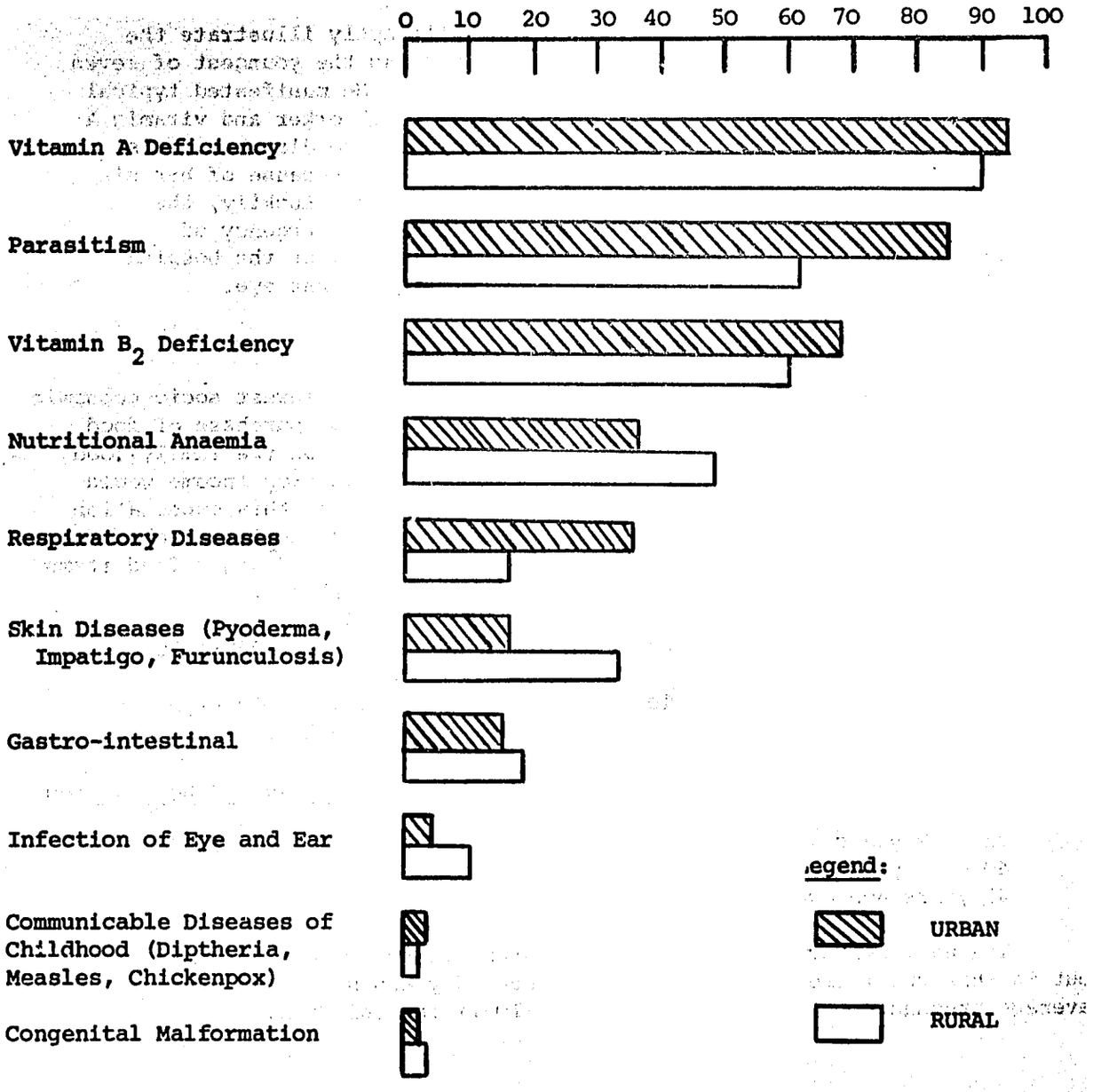


Figure 6

DISEASES RECOGNIZED BY PHYSICAL EXAMINATION IN INFANTS AND PRE-SCHOOL CHILDREN PASAY CITY (URBAN) AND BARAS, RIZAL (RURAL) 1971-1972

This graph shows the prevalence rate of 10 leading causes of illness in these children. The leading morbidity causes are due to deficiency diseases, parasitism and infection.

The case history of one of the subjects will aptly illustrate the synergism of malnutrition and infection. The boy was the youngest of sever children of a 27 year old Gravida 8 para 7 monther. He manifested typical marasmus at the age of 1 year, precipitated into kwashiorker and vitamin A deficiency when he had successive bouts of pneumonia and diarrhea. His mother could not be convinced of hospitalizing the boy because of her six other children who needed care and supervision at home. Luckily, the paternal grandmother visited the family and realized the urgency of hospitalization. The boy recovered after a month's stay at the hospital but he had corneal opacity which impairs his vision on that eye.

MALNUTRITION AND EXCESSIVE FAMILY SIZE

Theoretically speaking, it is expected that in the lowest socio-economic group, wherever families are dependent on cash income for purchase of food, every additional member of the family adds to the strain on the family food budget. On the other hand, rural families who depend on crop income would be better nourished than their urban counterpart. However, this expectation was not true in the rural area of study. Majority of the families sell their produce such as eggs from chicken and duck raising, fish and other food items instead of serving them to the family especially the children.

TABLE II - Fertility Picture of Women in Victoria, Laguna 1969-1970

The average number of children per every married woman is higher than the national average figure 5 of 6.7 children as shown below:

Age Group	Average Pregnancy	Average Living Children
35 - 39 years	8.4	6.98
40 - 44 years	9.7	7.93
45 years and over	12.0	10.00

The national average number of children per every married woman is 6.8 but in this rural area, when a woman reaches 45 years she would have had an average pregnancy of 12 and an average of 10 living children.

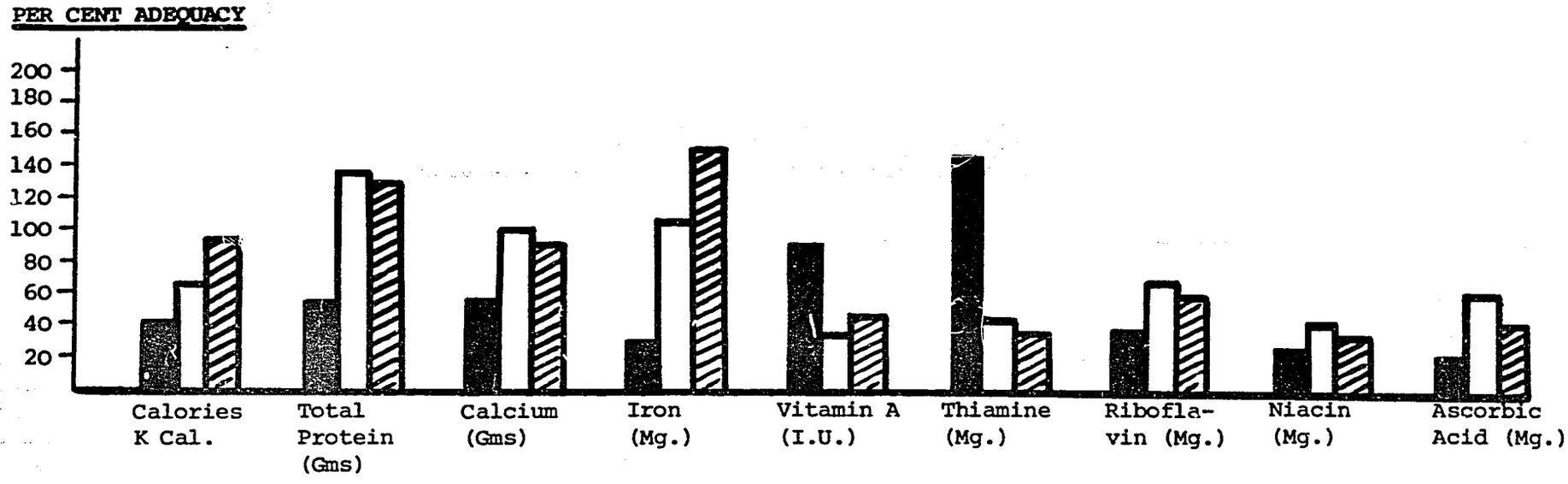
TABLE III - Malnutrition in Infants and Pre-school Children in Relation to Family Size Rural (Baras, Rizal) and Urban (Pasay City) 1971-1972.

Table III demonstrates the positive association between malnutrition and excessive family size which is best illustrated in the second degree category of malnutrition (Gomez classification). The trend of rising prevalence of malnutrition is noted with the increase in the number of living children in both areas especially in the rural group.

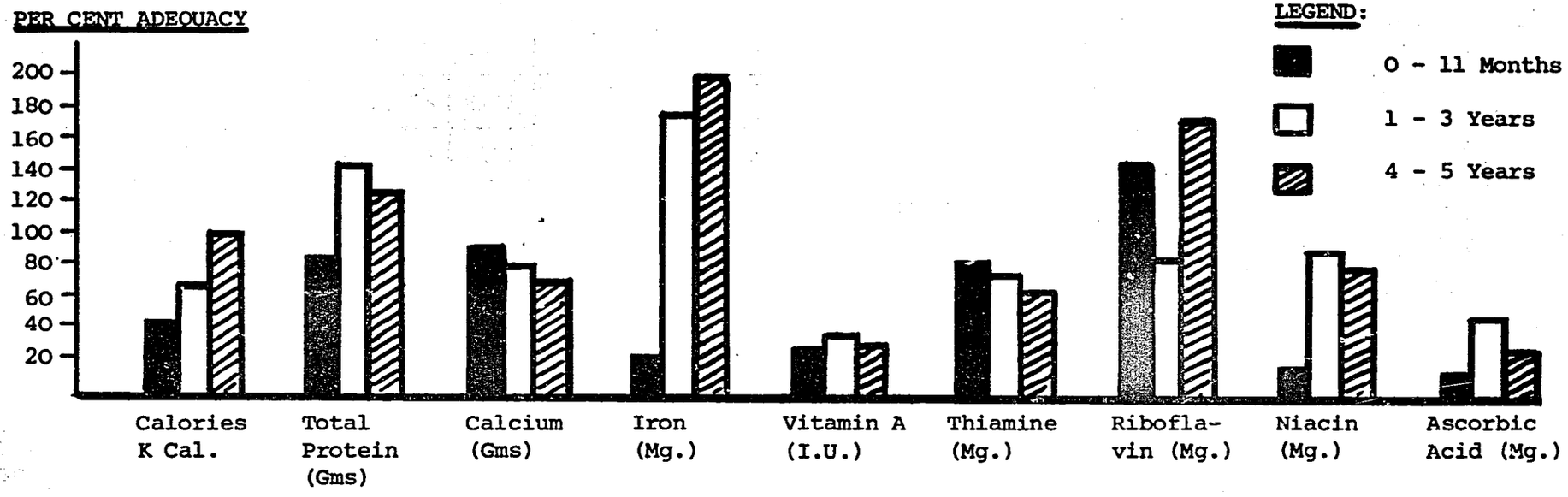
The nutritional intakes of children 0-5 years in a rural area and an urban slum district were assessed and compared.

Family Size (No. of Living Children/ Family)	Total Number of Children RURAL	MALNOURISHED RURAL (BARAS. RIZAL)								Total Number of Children URBAN	MALNOURISHED URBAN (PASSAY CITY)							
		TOTAL		1stDEGREE		2ndDEGREE		3rdDEGREE			TOTAL		1stDEGREE		2ndDEGREE		3rdDEGREE	
		No.	%	No.	%	No.	%	No.	%		No.	%	No.	%	No.	%	No.	%
1	20	18	90.0	15	83.3	3	16.7	0	0	30	23	76.7	18	78.3	5	21.7	0	0
2	85	69	81.2	50	72.5	18	26.1	1	1.4	105	88	83.8	56	63.6	29	33.0	3	3.4
3	83	70	84.3	47	67.1	23	32.9	0	0	94	74	78.7	39	52.7	34	46.0	1	1.3
4	67	54	80.6	33	61.1	21	38.9	0	0	59	54	91.5	31	57.4	22	40.7	1	1.9
5	37	32	86.5	19	59.4	13	40.6	0	0	38	35	92.1	19	54.3	15	42.9	1	2.8
6	34	28	82.3	18	64.3	8	28.6	2	7.1	36	35	97.2	17	48.6	18	51.4	0	0
7	23	21	91.3	12	57.1	9	42.9	0	0	23	23	100.0	10	43.5	13	56.5	0	0
8	6	6	100.0	3	50.0	3	50.0	0	0	9	9	100.0	4	44.4	5	55.6	0	0
9	8	8	100.0	2	25.0	6	75.0	0	0	5	4	80.0	1	25.0	2	50.0	1	25.0
10 or more	6	4	66.7	1	25.0	3	75.0	0	0	3	3	100.0	3	100.0	0	0	0	0
TOTAL	369	310	84.0	200	64.5	107	34.5	3	1.0	402	348	86.6	198	56.9	143	41.1	7	2.0

TABLE III. Malnutrition in Infants and Pre-school Children in Relation to Family Size Rural (Baras, Rizal) and Urban (Pasay City) 1971-1972.



PER CENT ADEQUACY FOR SPECIFIC NUTRIENTS OF CHILDREN IN A RURAL AREA (BARAS, RIZAL), AS COMPARED TO RECOMMENDED DAILY ALLOWANCES FOR FILIPINOS BY AGE GROUPS, 1971-1972.



PER CENT ADEQUACY FOR SPECIFIC NUTRIENTS OF CHILDREN IN AN URBAN AREA (PASAY CITY), AS COMPARED TO RECOMMENDED DAILY ALLOWANCES FOR FILIPINOS BY AGE GROUPS, 1971-1972.

Figure 7.

The nutritional intake data expressed in per cent adequacy of recommended dietary allowances for three specific age groups depicts the inadequacy of nutrient intakes except that of protein and iron which are high, but do not jibe with the growth patterns and biochemical determinations. Despite of the high protein and iron intake, the height and weight curves were below the 3rd percentile of the Boston standard. Nutritional anemia and low albumin values were prevalent. These findings could probably be explained by the fact that most of the sources of protein and iron are of vegetable origin. Protein coming from vegetables cannot compare with the good biological value of animal protein. It must also be considered that the multiple and frequent illnesses, phytates in the diet and parasitism could hamper effective absorption and utilization of these nutrients.

In conclusion, it is hoped that the vicious cycle caused by the triad of infection, malnutrition and big family size as demonstrated in this presentation may generate concern from all health personnel. It is also hoped that enthusiasm and concerted efforts be exerted to break this vicious cycle at all points. Health programs should be geared toward the goals of improving nutrition, controlling infections and curbing of rapid population growth through intense health education and availability and accessibility of family planning services.

FAMILY PLANNING TRAINING PROGRAMME FOR SUPERVISORS IN MALAYSIA

by

Dr. Loh Sow Khin
Director of Training and Medical Research
National Family Planning Board
Malaysia

This paper begins with a definition of the word "supervisor". As used in the context of our training programme, a "supervisor" is a person performing management functions involving some degree of supervision over one or more subordinate staff. Thus, the public health nurse in the Ministry of Health, or the Ketua Kelinik (head of a clinic) within the National Family Planning Board's structure is a supervisor since both do perform supervisory functions. In short, then, a supervisor is any staff at or above the level of a public health nurse. Hence, doctors are also included under this category.

The training of this category of staff began following the establishment of the National Family Planning Board in 1966. The Board, which was established under an Act of Partliament, is entrusted with a number of responsibilities which include the training of all personnel involved in the family planning extension work throughout the country. Initially, the training programme was geared to the training of the Board's newly recruited staff, which range from the medical officers all the way down to the family planning workers. However, this training was later extended to certain supervisory staff from the Ministries of Health, Information, Welfare, Education, statutory bodies and from the private sector.

Then came the Integration Programme in 1970. This programme involves the integration of family planning services with the rural health services. Naturally, staff have to be trained first before family planning services in the integration areas can be started. The Central Co-ordinating Committee which oversees the Integration Programme, established a number of subcomittees, including a training subcommittee, to implement the integration programme more effectively. The Training Subcommittee, comprising representatives from the National Family Planning Board, Ministry of Health and the Federation of Family Planning Associations, plans suitable curriculum for the training of the various categories of supervisory personnel involved in the integration programme. Curricula, of course, are tailored according to the objectives of a particular training course.

Objectives of the Training Courses

The objectives of a particulartraining course depend on the type of personnel to be trained and their utilization in the National Family Planning Programme. For courses involving supervisory personnel, the objectives are designed to provide the trainees with adequate theoretical and practical knowledge in all aspects of family planning, including the health and socio-economic benefits of family planning in addition to contraceptive methods and family planning programmes. (See Appendix I).

Course Content

The curriculum for supervisory training is comprehensive and covers the health and socio-economic aspects of family planning, health education, family planning programmes, human reproduction and contraceptive technology, management of patients with side effects from contraceptives; leadership and human relations. (See Appendix II) The course which is of three weeks' duration, includes a pre-test and an end-of-course test to help evaluate the training programme. Also included are the practical aspects of family planning, such as insertion of intrauterine contraceptive devices, male and female sterilizations and filling of acceptor forms. In addition to the National Family Planning Board's own staff, the speakers for the various topics include lecturers from the University, the National Productivity Centre, Ministry of Health, Federation of Family Planning Associations, the Employees Provident Fund, economists, religious leaders and others.

The wide variety of topics and speakers involved goes to show that family planning training is multi-disciplinary in nature, involving not only the medical sciences but also economics, sociology, demography, psychology, religion, etc. Indeed, family planning training may be regarded as a specialized field in itself.

From January 1970 up till today, some 756 supervisory personnel, mainly public health nurses and staff nurses, from integration areas have been trained in family planning. (See Appendix III).

Initially, the Board had to use its own fund to finance the training of the integration staff but since 1973 all such training has been funded by the United Nations' Fund for Population Activities (UNFPA).

It is hoped that when all the staff in integration areas are trained in family planning, training for supervisors in other ministries and private sector can be intensified.

APPENDIX I

Integration Course for Medical Officers
of Health and Medical and Health Officers

1. Participants: Medical Officers of Health
Medical and Health Officers

2. Venue: National Family Planning Board Headquarters
Bangunan UMNO Selangor
Jalan Ipoh
KUALA LUMPUR

3. Objectives:

1. To give a basic theoretical knowledge in all aspects of Family Planning.
2. To provide participants with knowledge of Family Planning Programme in Malaysia.
3. To provide sufficient practical training in all aspects of Family Planning to enable them to organise and conduct Family Planning service in their own areas.
4. a) To stress the concept, need and the plan for integration of family planning with the rural health services.

4. a) i) Responsibilities and relationship to National Family Planning Board and to each category of workers.
ii) Family Planning as an integral part of Maternal and Child Health Programme.
iii) Concept of the team approach in the supervision of the integration programme.
iv) Importance of community participation in the implementation of Family Planning Programme.

To prepare the participants to implement 'integration' at the local level.

i) Role and inter-relationship of each category of Health Worker in integration.
ii) Administration and finance - staff and public.
iii) Supply System.
iv) Cafeteria method of Family Planning.
v) Techniques of records and evaluation.

APPENDIX II

CONTENTS

DETAILED CONTENTS

Topic	Theory	Practical/Demonstration
1. Why Family Planning?		
Basic demography	1 hour	-
Demographic, economic and social aspects of Family Planning	1½ hours	-
Maternal and Child Health	1 hour	-
Abortion	1½ hours	-
	5 hour	-
2. Family Planning in Malaysia		
Historical Review of Family Planning in the World and in Malaysia	1 hour	½ hour (Film)
Family Planning and the New Economic Policy	1½ hours	-
National Family Planning Programme and Policy	1 hour	-
The role of FFPA in the National Programme	1½ hours	-
		5½ hours
3. Reproductive Physiology		
Review of Reproductive Physiology	1 hour	-
Problems of Infertility	1 hour	-
Pregnancy Test	¾ hour	-
	2¾ hours	
4. Contraceptive Methods		
Hormonal Contraceptives	1¾ hours	-
IUCD	1 hour	3½ hours
Conventional Methods	1½ hours	-
Ovulation Method	1½ hours	-
Sterilization - Male	1 hour	2½ hours
Sterilization - Female	1 hour	2¾ hours
Recent advances in contraception	1 hour	-
Menstrual Regulation	1 hour	1 hour
Review of contraceptive methods	1½ hours	1 hour
		22 hours

Topic	Theory	Practical/Demonstration
5. Management of patients/clinical procedures		
Clinical sessions	-	10¾ hours
Cytology	1½ hours	-
		12¼ hours
6. Health Education		
Misconceptions in Family Planning	1¾ hours	-
Socio-economic and Cultural Background of Rural Population	1 hour	-
Overall Concept of Community Participation in Family Planning	1¾ hours	-
Factors Influencing Human Behaviour	1¾ hours	-
Problems of Family Planning Communication	1¾ hours	-
	7 hours	-
Leadership and Human Relations		
Purpose and objectives of Leadership and human relations	1 hour	-
Resistance to change Indirect efforts to improve efficiency	1 hour	-
The structure and responsibilities of management leadership styles	1 hour	-
The supervisors' essential qualities	1 hour	-
Responsibilities of the supervisors	1 hour	-
Foundation for good relations factors affecting the individual	1 hour	-
Importance of systematic handling of human relations problems. A method of problem handling (T.W.I.) Importance of getting the facts.	1 hour	1½ hours
How to get opinions and practice in handling group member's problem	-	2 hours
What is an effective supervisor	1¾ hours	-

	Topic	Theory	Practical/Demonstration
7.	Leadership and Human Relations (Cont.)		
	Syndicate discussion on given topics	-	1½ hours
	Practice in four step mothod of handling member's problem	-	2 hours
	Role playing	-	2 hours
	On the Job Training	6 hours	-
			23¾ hours
8.	Religion and Family Planning (2 lectures)	3¼ hours	
		3¼ hours	
9.	Integration of Family Planning with Rural Health Service		
	Concept, Need and Plan for Integration of Family Planning with Rural Health Services - The Role of Ministry of Health personnel in the Integration programme.	1 hour	
	The Role of N.F.P.B. in the Integration Programme	½ hour	
	Administration/responsibilities	1¼ hours	
	Information Programme	1¼ hours	
	Supply Programme	1¼ hours	
	Evaluation Programme	1¼ hours	
	Workshop (Preparation and Presentation)	-	3¼ hours
			10½ hours
10.	Role of Voluntary Agencies in Family Planning		
	The Role of F.F.P.A. and other agencies in the National Family Planning Programme	1½ hours	-
	Visit to I.P.P.F.	-	1½ hours
			3 hours

APPENDIX III

SUPERVISORY PERSONNEL TRAINED IN INTEGRATION COURSES FROM JANUARY 1970 TO JUNE 1975

Year	Type of Course	DM & HS	Deputy DM&HS	SMOH	MOH & M&HO	MATRON	PHS/SR	PHN/SN	Total
1970	Seminar on Integration (4 days)	11	14	-	-	21	-	-	46
	Integration Course (3 weeks)	-	-	-	-	-	25	48	73
1971	Integration Course (3 weeks)	-	-	-	6	-	-	11	17
1972	Integration Course (3 weeks)	-	-	-	19	2	11	75	107
1973	Seminar on Integration (4 days)	-	-	4	1	5	-	-	11
	Integration Course (3 weeks)	-	-	-	24	-	13	112	149
1974	Integration Course (3 weeks)	-	-	-	29	6	20	104	159
1975	Integration Course (3 weeks)	-	-	-	13	1	9	96	118
(up till October 1975		-	-	-	23	-	11	41	75
	TOTAL	11	15	4	115	34	89	487	755

Abbreviations:

DM & HS	- Director of Medical and Health Services
Deputy DM & HS	- Deputy Director of Medical and Health Services
SMOH	- Senior Medical Officer of Health
MOH & M & HO	- Medical Officer of Health and Medical and Health Officer
Matron	- Matron
PHS/SR	- Public Health Sisters/Sisters
PHN/SN	- Public Health Nurse/Staff Nurse

TRAINING OF AUXILIARY HEALTH WORKERS IN FAMILY PLANNING

by

Dr. J. Varughese, MBBS, DPH, MPH,
Director Public Health Institute.

One of the implications of Integrated Family Planning services with the Rural Health Services was to re-train the health workers to enable them to offer Family Planning services as part of their routine Maternal and Child Health Services. To achieve this, the Central Co-ordinating Committee formed a training sub-committee to look into this aspect. The first task of the training sub-committee was to establish the number and category of health workers to be trained. Broadly speaking, there are two categories of health workers in Malaysia that needs training. The first category consists of Supervisory staff (Medical Officers of Health, Nurses, etc.) and the second category consists of Auxiliary Health Staff including Assistant Nurses and Auxiliary Midwives (staff midwives). In this paper I will deal only with the training of the Auxiliary Health personnel.

The plan for the training of Auxiliary Health Workers was carried out in 1972. At that time it was anticipated that there were about 2,700 Auxiliaries and Midwives to be trained throughout Peninsular Malaysia. Various strategies for the training of these health workers were considered. One of the strategies considered was to train the supervisory staff and then to get the supervisory staff to conduct in-service training programme in their respective districts, to train the auxiliary staff under them. This was tried out in some States, but was later abandoned as there were a lot of administrative and technical problems. Therefore an alternative strategy was adopted. In view of the large number of staff to be trained, and the urgency to train them within the period of 2-3 years, it was found necessary to establish Formal Regional Family Planning Training Centres with the specific function of training Auxiliary Staff in family planning. These centres although of a temporary nature (to function for 2 or 3 years) were set up with full time staff, equipment and other facilities necessary to conduct proper training courses. Five such centres have been established in Malyasia and all of them are housed in buildings which are either rented out or on loan from other departments. They physical facilities include living accommodation for students, class-room and office space. Vehicles, office equipment and teaching aids were also provided. Each centre had two full time trainers and other supportive staff assigned to them to be responsible for the training programme.

In developing the training programme for the Auxiliary staff the following points were considered:-

i) Training of trainers;

ii) Development of curriculum for Auxiliary staff;

iii) Financial and administrative implications for the training programme.

iv) Evaluation of the training programme.

Training of Trainers:

This was the first activity that had to be undertaken as the 10 trainers assigned for this programme were not fully trained to function. A nine months training programme was developed for the trainers. The objectives of this programme is given in Appendix A. The details of this training programme is shown in "Appendix B". From "Appendix B" it can be seen that although the actual technical training programme of family planning was only 8 weeks to make them effective family planning trainers, a number of other activities had to be incorporated. This included some aspects of human relations, teaching methods, supervised practical experience in clinical work and in teaching. After having undertaken all this basic training to make them competent in family planning techniques and teaching methods, the 10 trainers were then involved in planning and developing the curriculum for the Auxiliary training course. Having developed this curriculum the 10 trainers under supervision then conducted a training course for the Auxiliaries and then evaluated it to see if there were any short-comings in the course. Based on this evaluation the curriculum was again modified and another training course conducted. These training courses were in a way a pre-test of the effectiveness of the curriculum developed by the trainers. Having been satisfied with the curriculum developed by the trainers, and their ability to conduct courses, the 10 trainers were then posted to the Regional Family Planning Training Centres to carry out further training courses.

Development of Curriculum for Auxiliary Staff:

In developing the curriculum of the Auxiliary health staff, the first step was to obtain the job description of the trainee Auxiliary staff from the Ministry of Health. This enabled the trainers to know exactly what functions and activities the Auxiliary Health Staff were expected to carry out in the various clinics with regard to family planning programmes. Based on this job description, the trainers then worked out the tasks that had to be performed by the Auxiliary staff. This then enabled the trainers to work out details of knowledge, attitudes and skills that the trainee auxiliaries had to be competent in. This background analysis was the basis on which the actual curriculum was developed and it was found that a training programme for about 3 weeks was required to train the Auxiliary staff to be competent to perform their functions. The course objectives and the course outline is shown in "Appendix C". The 3 weeks course highlights the following:

i) The need to motivate the trainees themselves in family planning.

ii) The need to stress the health aspects of family planning was highlighted. Only a general over-view of the socio-economic and demographic aspects were included.

iii) More emphasis was given on various methods of contraception and the management of the acceptors.

iv) Health Education - including motivational aspects was given emphasis.

v) The role of the Auxiliary staff was highlighted.

vi) Less emphasis was given on lectures and more time given for practicals, role play and case studies, etc.

In terms of distribution of time it can be said that:

i) 27% of the time was given for lectures
ii) 23% for Role Play, Case Studies, films and discussions
iii) 35% for practical work
iv) 15% for other activities including evaluation and review.

Regional Family Planning Training Centres

Five Regional Family Planning Training Centres were established and became functional in early 1974. Four of these centres are being administratively supervised by the District Health Office and the State Health Department with overall technical supervision from the Public Health Institute. The other centre is supervised technically and administratively by the National Family Planning Board. As mentioned earlier, they are fully staffed and equipped to conduct family planning courses. Each centre conducts between 9 and 10 courses a year for about 20 to 25 students and it is planned that in three years time all the Auxiliary Staff will be trained. It can be seen from "Appendix D" that of the 2,626 Auxiliaries to be trained, up to September 1975, 1,701 Auxiliaries have already undergone this training programme. One more course is scheduled to be run this year in which about 100 auxiliaries would be trained making the total of about 1,800 auxiliaries trained up to December 1975. Therefore by the end of this year, 68.5% of the auxiliary staff would have already been trained and by the middle of next year almost all the auxiliary health workers would have completed the training health programme. This is a few months ahead of our schedule.

Financial and Administrative implications for the training programme

Great care was given to planning this aspect of the training programme as it would not be possible to implement the training programme if sufficient funds and resources were not allocated for it. This programme was funded mainly by UNFPA and by the Government of Malaysia. Provisions for the following were made:

i) allowances, lodging and transport for the trainees;
ii) rents and utilities, etc.
iii) provision for transport, office equipment and audio-visual aids;
iv) allowances for trainers;
v) allowances for supervisory staff to visit training schools;
vi) salaries for supportive staff.

It was found that it is better to over-budget slightly as there would be incidental expenses which cannot be anticipated.

It was also found necessary administratively to have a full time senior officer responsible for the training programme. Unless this is provided for especially during the early stages of establishing the centres many of the administrative problems could delay the implementation of the programme. In Malaysia a Medical Officer of Health with experience in Maternal and Child Health and Family Planning was assigned full time to this programme.

Evaluation of the Training Programme

In May 1974 an evaluation of the performance of the auxiliaries trained at the Regional Family Planning Training Centres was conducted. The objective of the study was:

i) To assess the trainees ability to perform their role in family planning as defined by the Ministry of Health.

ii) To assess the trainee's opinion of their training in family planning.

iii) To find out the difficulties experienced in providing family planning services.

iv) To determine the supervisor's assessment of the trainees ability to perform their functions in family planning.

The evaluation utilised a three pronged approach consisting of:

i) Interview with trainees using a comprehensive questionnaire

ii) Questionnaire filled by supervisors of the trainees (i.e. Publi Health Nurses.

iii) Direct observation of the trainee performance in famil planning activities.

Analysis of the data showed that generally the trainees were able to perform their functions. However, a number of inadequacies were noted. Fr the point of view of the training programme, the main finding was that the practical training was inadequate. Many of those who were unable to perfor the functions stated that inadequate supervision and lack of administrative support were the main factors.

The main findings of this evaluation are as follows:

i) Inadequate training especially in the practical work;

ii) Clinic administration - this included deficiencies in physical facilities, records and returns, supplies and storage;

iii) Health Education - especially lack of audio visual aids and problems in conducting group talks;

iv) Contraceptive devices and management of acceptors - this included problems relating to clinical procedures, management of side effects and handling of defaulters.

Based on this diagnostic study it was decided to call for a Conference of field training supervisors and trainers to find out ways and means whereby the practical aspects of the training programme could be strengthened. This conference attended by both training and service staff prove to be very useful as it raised a number of problems related to field training. These were discussed and possible solutions and recommendations made.

Major Problems faced in Training of Auxiliary Staff

1. One of the major problems in the field of training is the provision of adequate field training experience during a short training course. This was aggravated by the insufficient case-load in field training areas and insufficient numbers of field training supervisors from the service side.

2) Delay in the utilisation of trainees after they have completed their training programme led to some of the auxiliaries forgetting what has been taught.

3) Lack of administrative support for the trainees for example insufficient supplies etc.

4) Lack of on the job supervision of the trainees by the supervisors.

Summary

A comprehensive family planning training programme for auxiliaries health staff was planned, developed and implemented. This included training of the trainers, establishment of temporary Regional Family Planning Training Centres, development of job specific task orientated curriculum, implementation of the programme and the evaluation of the training programme to see if the trainees could perform the function they were expected to carry out.

The training programme has progressed as scheduled and 68.5% of the trainees have already been trained. (This is slightly ahead of schedule). Major problems faced in the training programme:-

i) Inadequate practical training during the three weeks training programme.

ii) Insufficient administrative and supervisory support to the trainees on their return to their respective centres after the training programme.

APPENDIX A

Programme for Training of Trainers for the Training of Auxiliaries in Integration Areas

Objective

1. To equip the nursing sisters with the knowledge and basic understanding of Population Problems and Population Dynamics, to enable them to understand and thus accept the need for a National Family Planning Programme, in order to prepare them to impart their knowledge to trainees later on.

2. To give a basic theoretical knowledge of the various aspects of the need for a planned family (biological, economic and social).

3. To give a basic theoretical knowledge in all aspects of the need, the development of Family Planning activities in Malaysia and the need and plan for Integration of Family Planning into the Rural Health Services. To prepare the participants with various aspects of the integration programme and its implementation.

4. To give a basic knowledge in the fundamentals of reproductive anatomy and physiology to enable them to understand the method and technology used in population control.

5. To provide a basic knowledge both theoretical and practical in the various methods of contraception used in Malaysia's National Programme.

6. To provide participants with the knowledge in attitudes, behavioural changes and factors affecting the acceptance of Family Planning and how to overcome them.

7. To provide them with the knowledge and technical aspects of motivating towards acceptance of Family Planning.

8. To prepare them to train the auxiliaries who would be involved in the integration programme.

APPENDIX B

Outline of the programme for the preparation of ten nurses as trainers of auxiliary nursing staff for family planning work.

Tentative Programme

Phase of Training	Durations	Venue
1. Human Relations	1 week	National Productivity Laboratory. (National Productivity Centre).
2. Technical aspects of Family Planning: Theory and Practicals.	8 weeks	National Family Planning Board and Federation of Family Planning Association
3. Teaching Methodology: Theory	1 week	N.P.C.
4. Supervised Experience: a) Practical Experience in all aspects of clinic work.	6 weeks	N.F.P.B.
b) Practical Experience in Teaching, supplemented by additional session on methods of teaching.		N.P.C./N.F.P.B.
5. Study tour of family planning programmes in other countries.	6-8 weeks	To be determined
6. Development of Curriculum for Auxiliary Training Course; Administrative Aspects of Setting up Regional Operations.	4 weeks	Public Health Institute
7. Practical Experience Conducting two courses for Auxiliary staff at the Central Level: Modification and Finalization of Curriculum.	8 weeks	N.F.P.B. and P.H.I.

The UNFPA has agreed to provide the funds necessary for this training programme.

APPENDIX C

Three Weeks Course for Auxiliary Health Staff

Course Objectives

General Objective

For the Trained Assistant Nurses and Midwives to be able to acquire knowledge and skills necessary to provide family planning services through their role in the Rural Health Services.

Specific Objectives

1. To understand and accept the needs for family planning and how it affects family health.
   (a) To understand the health aspects of family planning and to be able to apply this knowledge in the MCH Services.
   (b) To know and be able to correlate socio-economic factors in relation to family health.
   (c) To know the basic facts of the Malaysian Demographic situation.
2. To know the National Family Planning Programme in Malaysia.
   (a) To know the government's policy and programme in Malaysia.
   (b) To know the other family planning agencies in the country.
3. To be able to understand the contraceptive methods used in the family planning programme in Malaysia.
   (a) To know the fundamental anatomy and physiology of male and female reproductive system.
   (b) To know the relevant contraceptive methods.
4. To understand their role and function within the family planning integration programme.
5. To develop skills in motivating eligible couples to practise family planning.
6. To master practical procedures of providing contraceptive services.
   (a) To be able to provide contraceptive services.
   (b) To be able to manage problem cases.
   (c) To be able to follow-up defaulters.
7. To master procedures of record keeping and maintenance of supply system

Course Outline

Topic	Lecture	Role Play	Syndicate/Case Study	Film	Practical Session	Discussion	Programmed Material	Total Hours
1. Why Family Planning			2					2
(a) Health Aspect								
i) Family Health	1							1
ii) Maternal Health	1½		2					3½
iii) Abortion - Its causes and effects on the Health of mother	1							1
iv) Child Health	1½							1½
(b) Socio-economic aspect and demography								
i) Socio-economic factors affecting family health	1			½				1½
ii) Population growth and its effects.	1							1
2. Family Planning in Malaysia								
(a) History of Family Planning in Malaysia	¾			½				1¼
(b) Family Planning Programme - Integration, National Family Planning Board	¾							¾
3. Anatomy and Physiology								
(a) Female reproductive system	3			½				3½
(b) Male reproductive system	1							1
4. Methods								
(a) Conventional methods	1¾						¼	2½
(b) Rhythm methods	2							2
(c) Hormonal methods	2¾	1½		½				4¾
i) Pill								
ii) Injections								
(d) Intra-Uterine Contraceptive Device	1			½				1½
(e) Sterilisation	1			½				1½
5. Role of Trained Assistant Nurses and Government Midwives in the Integration Family Planning Services with the Rural Health Services	1½				6½			8
6. Management of Family Planning Acceptors								
(a) Registration, supply, routine examination and referral.	2				27			29
(b) Follow up of defaulters						¾		¾

Topic	Others	Lecture	Role Play	Syndicate/Case Study	Film	Practical Session	Discussion	Programmed Material	Total Hours
7. Health Education									
(a) Techniques of motivation		1½	3¾		½				5¾
(b) Group talk			2						2
(c) Misconception and Taboos in Family Planning							1		1
(d) Community relationship				3½					3½
(e) Islam and Family Planning							2		2
8. Records - Evaluation and supply		¾				2			2¾
9. Supply System		1							1
10. Others									
Opening Ceremony	½								½
Registration	½								½
Orientation	1								1
Exercise and evaluation	3½								3½
Review of session	4								4
Course Evaluation	3¾								3¾
Closing Ceremony	2								2
TOTAL:	15½	27¾	7¼	7½	3½	35½	3¾	¾	101¼

APPENDIX D

Number of Auxiliaries trained in Family Planning Centres from 1973 to September 1975

Negeri	Assistant Nurses	Government Midwives	Rural Community Nurses	Total
Perlis	11	15		26
Kedah	63	131	6	200
P. Pinan	37	77		114
Perak	72	118		190
Kelantan	44	58	1	103
Trenggan	41	78		119
Pahang	50	67		117
Selangor	96	125	19	240
N. Sembila	40	59	5	104
Melaka	37	64		101
Johore	56	135		191
Total	547	927	31	1505
Courses for rural Community Nurses in Rembau and Jitra				196
		Grand Total:		1701

Total to be trained 2626 (approx. 2700)

Percentage already trained from 1973-1975 (1701) = 64.8%

Percentage to be trained (925) 5.2%

PLANNING OF FAMILY PLANNING TRAINING PROGRAMMES

by

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1. An ad hoc group on inter-agency consultations set up by the ACC Sub-Committee on Population of the United Nations distinguishing between education and training stated:

> "Education is a generic term that refers to all processes that bring about changes in levels of information, knowledge, understanding and performance, and in behaviour patterns of individuals. Its aim is to assist individuals, to their fullest potential, to develop attitudes, values, skills, habits and roles appropriate for the societies in which they live."
>
> ".... no fundamental difference exists between education and training since the processes and aims of training are not at variance with the processes and aims of education. In training, the focus is more restricted and specific, the duration more limited and the setting usually institutionalized. One thinks of training in relation to the acquisition of one or more specific skills or techniques required for the performance of specific tasks. Education may also include the development of skills and techniques in the context of a broader learning process." *

2. In a family planning programme it is usual to use the term job oriented to qualify training. Its purpose is to re-emphasize that training programmes should aim at the 'acquisition of one or more specific skills or techniques required for the performance of specific tasks' by programme personnel. Family planning training, perforce, will have to be job oriented for a long time because of the large number of workers involved, the rapidity with which they have to be trained - necessitating short initial exposures which in turn demand re-training and refresher training, and the need to provide for the turn-over in certain categories of staff.

3. The felt-need for job oriented training for the majority of family planning workers does not preclude a planned programme of advanced professional education in the various specialities for persons holding leadership positions at different administrative levels. However, even in these cases the initial exposure to the programme is through job oriented training or by on-the-job training, to be strengthened, in suitable cases, by an academic programme. Furthermore, with a view to meeting the long-term needs of the programme resource within the programme organization. This aspect of man-power development is not discussed in this paper.

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* ACC Sub-committee on Population, Report on the ad hoc Group on Inter-Agency Consultations on Definitions of Education, Training, Communication and Motivation Aspects of Family Planning, UNESCO, May 1970.

2. NEED AND SCOPE FOR PLANNING OF THE TRAINING PROGRAMME

4. Planning is sometimes described as a process for the optimum utilization of available and potential resources to achieve a specified objective. Ideally, it should pervade all human activities - big or small. In the case of family planning training, because of the magnitude of the task, the inevitable limitation of resources - both human and financial, and its strategic contribution to programme operations, it is imperative that the training programme has to be planned very carefully if it should achieve its objective of adequately preparing the man-power needed for the programme.

5. Planning of training is an integral part of the planning of the total programme; it proceeds with the planning of the total programme and should reflect the policies, objectives, needs and emphases of the programme. * Therefore, it has to be flexible enough to accommodate changes in programme emphasis and programme operations. In turn, the training organization should advise the programme administrator on possible changes which hold promise for improving programme operations from lessons learnt in the training process and in the follow up of trainees in the field. Planning for training in the national family planning programme takes place at different levels, the objectives and achievements of the peripheral training units conforming and adding up to those at the national level. Curriculum planning and development is an integral part of planning of the training programme.

6. In view of the needs of the group for which this paper is prepared, greater emphasis is placed on planning at institutional and individual levels and curriculum planning. Only passing reference is made to planning at other levels.

3. NATIONAL LEVEL PLANNING

7. At the national level, the objective of planning for the training programme is to provide (adequately) trained man-power to work at different echelons of the programme organization and to maintain the man-power at a high level of efficiency. A perspective plan showing long-term needs and annual targets will have to be prepared. This would involve: an assessment of the man-power required for the programme (taking into account the potential turnover of staff) and its composition: setting annual targets for accomplishment; identification of available physical facilities and projection of additional ones that need to be created; assessment of human resources that are available and new ones that need to be developed; preparation and refinement of curricula; determination of needed equipment and teaching material; allocation of responsibilities; setting up of criteria for measuring the intermediate progress of the training programme; developing a system for the continuing education of workers in the field; and establishing a pattern for refresher training. Obtaining the required funds for an elaborate programme would, no doubt, pose some difficulties; therefore, while the planned financial outlay should be commensurate with the magnitude of the task and the standards expected of the training programme, it should not be extravagant or appear to be counter-productive.

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* See United Nations Economic Commission for Asia and the Far East, Report of the Working Group on Training of Personnel in Family Planning Programmes, Bangkok, 1972.

8. Some of the activities arising out of the plan would have to be implemented at the national level and should be planned for; others should be delegated to subordinate levels.

C. INTERMEDIATE LEVEL PLANNING

9. At intermediate levels of administration - regional, state or provincial - the planning process would have to contribute to developing the national plan and then to implementing the approved plan. Both long-term and annual plans will have to be prepared. In contributing to the national plan it would be necessary to assess the man-power required for implementing the programme in the area, identify available human and material resources and those that need to be developed, and prepare financial estimates. A plan of operations for implementing the approved training plan would include: training of trainers - both in-country and overseas; preparation of a roster of persons to be trained; allocation of responsibilities to different training centres; procurement of needed transport, equipment and teaching material; provision for the timely release of funds allotted to the training institutions; and supervision of training centres.

D. INSTITUTIONAL LEVEL PLANNING

10. At an institutional level where there is more implementation than planning, there is still need for planning but of a different complexion and at different stages. The first stage is where the institution participates in the national and/or provincial plans. Given the programme needs, targets, and expectations in the institution and its own resources, how much and to what extent can the institution meet those needs and what augmentation of resources would be necessary to rise to programme expectations?

11. The second stage of institutional planning is, when once there is an approved plan and the institution's responsibilities have been determined, how will it proceed to discharge those responsibilities? This will involve the preparation of annual plans to implement the task assigned to the institution. A time schedule will have to be prepared showing the serveral batches of each category that will be trained at different times; this should take into account the availability of all physical facilities required as it is possible that more than one group may be in training at a given time. There should be adequate time provided to the training faculty for planning and evaluating each training course, for engaging in field work and conducting field studies to improve the content of training, for other activities aimed at professional development, and for follow up of trainees in the field. Responsibilities will have to be assigned for the conduct of each training course and evaluation procedures set up.

12. A third stage of institutional planning is when a specific training course is to be offered. Beyond that is planning at the individual level and is concerne with the planning of lesson units. These are considered at a later stage in the paper, after discussing planning of a curriculum.

E. CURRICULUM PLANNING AND DEVELOPMENT

13. An important element in planning a training course is the curriculum. Although the curriculum for use in a training course would have been prepared at the national level and recommended for use by all training institutions, generally, it is considered as a starting point waiting to be made more practical and more directly related to the functions that the workers have to perform. A curriculum is not a static entity. The general pattern has been that the first version of a curriculum is based on what some one or a group of persons thinks the workers ought to know. Gradually, by trial and experience, it develops into something that is based on what each category of workers has to do in the field. In this process there is much pruning of unnecessary knowledge, and strengthening of the specific knowledge, skills, techniques, and methods of operation the workers have to learn; knowledge that will be imparted will have to serve as a background against which the worker can understand and appreciate his role in the total programme, and to provide him with a meaning for the various tasks that he has to perform.

14. Ideally a curriculum has to be based on the job description of each category of workers and should develop from the grass roots, building upon the experience of trainers in the classroom, clinics and the field, evaluation of the course-offering by trainees, and by follow up visits in the field by trainers to former trainees. If training institutions are conscious of this responsibility, planning of each training course will go far beyond a routine exercise of drawing up a time-table of teaching sessions and assigning teachers, to discovering and assessing the strengths and weaknesses of the current curriculum and enriching a subsequent course with lessons learnt from an earlier one. It is admitted that for a major change of a curriculum the collective wisdom and experience of the several training institutions should be pooled at the national level. Such a procedure, while allowing flexibility to each training centre to study, evaluate and modify, will still retain a degree of uniformity in the overall course-offering.

15. There has already been a brief reference to a curriculum being evolved out of a job description. A job description will reflect the needs - in terms of knowledge and skills required to perform the jobs - of a particular group which have to be met by training. By inference, therefore, a job description should be simple and precise and reflect clarity of thought in the administrator with regard to the jobs that have to be performed in programme operations; each job should form a separate entity in the job description. Since a given job may be composed of several tasks, it would be necessary, for the purpose of evolving a curriculum to break down each job in the job description into its component tasks. Each task demands of the persons who perform the task a certain quantum of knowledge and a set of skills. Therefore, such a task analysis will provide information on all the knowledge and skills (in broad terms) that a person has to acquire to be able to perform the jobs expected of him. When this information is organized under suitable headings it becomes the basis of planning the curriculum to be used in the training of that particular category of worker.

a. Objectives

16. There are well-defined steps in planning a curriculum based on the knowledge and skills required for performing a set of jobs. The first step, as in any kind of planning is to determine and state clearly the objective or objectives These are derived from the jobs in the job description and the tasks obtained from the task analysis. Objectives should be precise, specific and behaviour oriented; their achievement should be measurable against pre-determined criteria. There are teacher (institutional) objectives and learner objectives which are complementary to each other. Each curriculum should have an overall objective, with each specific objective having a few component sub-objectives. Since these objectives are based on the task analysis of a job description, the more unambiguous a job description is, the more specific and precise will be the objectives.

17. As an illustration, the job description of a midwife, among other things, may include: 'She will insert IUD in suitable women' and 'She will provide follow up care to women in whom she has inserted the IUD'. The overall objective of the training course (teacher objective) will be 'to prepare the midwife to be able to insert the IUD and provide follow up care' and that of the learner, 'to equip herself with knowledge and skills to be able to insert the IUD and provide follow up care'. The specific learner objectives will then be ' to be able to insert the IUD in suitable women' and ' to be able to provide follow up care'. Some of the sub-objectives of the first specific objective will be:-

to refresh her knowledge of the anatomy and physiology of the female reproductive system;

to acquire basic knowledge of the IUD and its mode of action;

to know the contra-indications to the use of IUD as a contraceptive;

to be able to screen cases with regard to suitability for IUD insertion;

to be able to prepare the case for IUD insertion;

to learn the procedures and techniques for inserting the IUD;

to be able to insert the IUD;

to be able to explain in simple non-technical language the effects of IUD insertion to the case; and

to maintain necessary records and send appropriate reports.

With regard to the second specific objective, the sub-objectives will be:-

to acquire an understanding of complications and side effects that could occur immediately after insertion and over a period of time;

to provide reassurance to women with simple complaints to as to persuade them to retain the IUD;

to be able to manage cases with complications and side effects; and

to recognize when referral to a doctor should be made.*

b. Content

18. The objectives will indicate what specific knowledge and skills are required to attain each of them. The next step is to organize all the knowledge and skills that the learner has to acquire in order to obtain a logical sequence and avoid repetition. Based on this is to be developed the content that should be covered to help the learner acquire new knowledge or refresh existing knowledge necessary to perform the tasks and to evolve within himself a rationale for his job. The kind of practical exercises - laboratory, clinic, field etc. - that learner should experience to enable him to develop the skills required to perform the tasks should be stipulated. A time allocation for each major area in the 'content' should be specified which would be commensurate with its degree of relevance to achieve the overall objective.

c. Methods and material

Methods of instruction are of crucial importance in determining the effectiveness of a training course. While lectures help to impart knowledge in a systematic manner and have a place in a training exercise, the accent in job-oriented training should be on using methods which promote the active participation of the learner; this applies both to acquiring knowledge and developing skills. Supervised field work, clinic practice, projects, laboratory exercises, role play, and group work are some methods which facilitate the learning process.

20. Teaching materials include books and booklets, monographs, reports, case studies, pamphlets, flip charts, films, filmstrips, slides, photographs, video tapes, casettes, models and others. A variety of these is available through some international agencies; the verbal ones will have to be translated into the local language where necessary. Curriculum planners should select the most suitable ones for each area of content with a view to assisting or reinforcing the teaching-learning process and the teachers should learn to use them effectively. It is the responsibility of the national agency to procure them for the training centres, and subsequently to develop a system whereby the training centres will receive suitable new materials as and when they become available.

21. In the early stages of a national training programme it may be useful to provide a synopsis for each subject area that has to be taught. This could be done either at the time the trainers are being trained or could be sent to them on a regular basis; the latter implies that the synopsis is periodically revised. Eventually, when the trainers have acquired some experience, it should become the trainers' responsibility to develop and improve upon the synopsis.

* For further information on preparing objectives see Mager, Robert F. Preparing Instructional Objectives, Pala Alto, California, USA Pearon Publisher, 1962.

d. Location

22. Selection of the proper location for teaching the different content areas - classroom, clinic and the field - is important. By and large, classroom exercises provide background knowledge whereas clinic and field experience will facilitate the learning of skills. In job-oriented training, the greater the time spent on work in the clinic or in the field the nearer will the training be to achieving the objective of preparing the person for the job he has to perform. The curriculum should indicate the location or locations where each subject area should be taught and, perhaps, the distribution of time available when more than one location is recommended.

e. Evaluation and feedback

23. The ultimate test of a training programme is how adequately it prepares the worker to perform the prescribed jobs in his work situation. Performance on the job is so compounded by intangibles and extraneous factors that an Expert Group convened by ECAFE (now called ESCAP) found it difficult to establish a direct cause and effect relationship between training and job performance.* Therefore in most cases, one has to be satisfied by measuring the extent to which a training course has enabled the learner to gain the knowledge and acquire the skills required for the performance of his job.

24. The curriculum should set down criteria and methods of measuring the extent to which the overall objective and the major and sub-objectives have been achieved through the training experience. Some of the criteria could be the degree to which the skills have been acquired, the correctness of the technique, the confidence of the trainee, the knowledge gained, and the ability of the trainee to relate that knowledge to his work. Continuous observation during the training period, periodical trainer-trainee meetings, performance before and after training could be some methods by which the trainees' learning can be assessed. Evaluation by trainees of the content, methods of instruction, clinic and field experience, physical facilities and others provide to the training centre an assessment of its own strengths and weaknesses and should be planned for.

25. Follow up visits to trainees in their job situations and discussion with their supervisors can give useful leads. While these are not meant to measure the impact of training, they can indicate the supervisors' expectations in the training programme and the extent to which they have been met, the relevance of what has been taught in the training centre to the actual work situation, subject areas that need to be strengthened further during training, effectiveness of methods of instruction used and such like. Such a feedback can provide invaluable information on strengthening the curriculum when planning the subsequent training course.

F. PLANNING A TRAINING COURSE

26. From what has been said of the need for a continuing improvement of the curriculum it follows that the planning of each training course (for the same category of workers) should be considered as a new and creative exercise. In the planning process, the whole curriculum - objectives, content, methods and material, location evaluation - should be reviewed in the light of trainers' experience in conducting

* United National Economic Commission for Asia and the Far East, Report of the Expert Group on Developing Indices for Measuring the impact of Training on Job Performance of Field Workers in Family Planning Programmes, Bangkok, 1973.

the training course, evaluation of the course by trainees, evaluation of trainees by trainers, results of follow up visits to trainees if any, the acquisition of any new knowledge or experience by the trainers, any shifts in programme operations - local or national - and such like. This examination will serve to make any changes in the curriculum that may be indicated which, in turn, should be reviewed critically when the revised curriculum is offered in an ensuing course.

27. Planning of a training course and its implementation are not entirely separable and tend to overlap. These activities include: providing advance information to prospective trainees; reservation of hostel accommodation (it is assumed that there may be more than one training course at any given time); arrangements for payment of stipends - if any - and other costs; preparation of a time table; assignment of teaching responsibilities in the classroom, laboratory, clinic and the field; identification of and advance intimation to guest teachers; reservation of classroom and laboratory space; and equipment; detailing of transport; preparation for clinic and field work; collection and/or preparation of teaching material; and selection of evaluation procedures. Responsibilities have to be assigned for each activity or group of activities.

PLANNING A LESSON

28. At the individual level of planning in a training programme is the preparation of a plan to teach a given unit which might be a single exercise or comprise more than one activity. Classroom instruction, laboratory exercises and clinic or field practice have to support each other and all these have to contribute to presenting an integrated picture of the subject. The main point in planning of the whole teaching unit is to ensure a sense of unity in the different activities that go to form the unit and to bring out the inter-relationship among them. Separate anddetailed plans have to be prepared for each activity.

29. Generally, a lesson plan is associated with classroom instruction, but its principles can be used for planning other teaching activities. Basically, a lesson plan is a guide to the teacher in organizing the teaching session. It is guided by an objective to be achieved. The relationship of this session to what has been taught previously and its relevance to the overall objective of the training course has to be indicated so that the trainee can see the individual lesson in the total perspective of the training course. The content that has to be conveyed should be traced in logical order and organized under suitable headings. Instructional methods that will be used should be identified and materials required to aid the teaching process obtained. The relationship between the particular exercise and associated activities such as laboratory sessions, clinic or field work, or classroom instruction should be brought out clearly. The stages at which the lesson will be evaluated and the criteria that will be used have to be determined and incorporated into the lesson plan. A brief summary after each major area has been covered to serve as a recall and a final one at the end of the lesson to reiterate the main points are essential parts of the lesson and should be built in into the plan. References for further reading concludes the lesson plan.

H. SUMMARY

31. In a family planning programme, training, for a long time, will have to aim at the 'acquisition of one or more specific skills or techniques required for the performance of specific tasks' by programme personnel. The training task, though vast, is of crucial importance to programme operations, but, invariably, is beset with a limitation of resources. Therefore, careful planning is necessary if the objective of training - preparing the man-power required for the programme - is to be attained. Planning for training takes place at the national, regional, institutional and individual levels. At the institutional level, there is considerable emphasis on planning for implementation - offering the series of training courses assigned to it. At the individual level, planning is concerned with organising the teaching of a unit or a session.

32. Curriculum planning is an essential part of planning of the training programme. A curriculum should be based on the job description and should develop through lessons learnt in offering the training course and by follow up visits to former trainees. It should indicate the objectives, content, methods of instruction, instructional material to be used, location of teaching, criteria for evaluation. Results of the evaluation of one training course should be used to strengthen the curriculum of a subsequent one.

CONTINUING EDUCATION IN FAMILY PLANNING

by

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The need for continuing education in health and health related fields is one that is universally felt. This is a result of the change in medical technology leading to the development of the new concepts in the delivery of health care. In addition, the critical physician shortage has led to the exploration of new channels for meeting consumer needs. One avenue which has gained international acceptance is the use of para-medical personnel to deliver some of the care previously administered by the physician.

Family Planning is increasingly being recognized as an integral part of maternal and child health services. It is therefore important for personnel working in this area to be prepared to provide this service.

Midwives, wherever we are, regardless of professional training have traditionally functioned in the role of caring for mothers and children. This places us in a unique position to participate in family planning activities. In many countries, the midwife has been identified as the most appropriate person to deliver this service as part of the maternal and child health care. As more and more nations begin to recognize family planning as a component of their national communities' health needs, we midwives will be increasingly called upon to add family planning to our professional activities. These activities may encompass direct patient care including procedures in contraceptive techniques, clinical administration and supervision and education of personnel in family planning. In order to address ourselves adequately to these activities, additional preparation may be required. This is especially true since family planning is a comparatively recent development in the area of health care. This paper will discuss briefly the utilization of long and short term programs for continuing education in family planning for all levels of midwives.

Pre-Requisites to Planning Education Programs:

Before undertaking any plans for educational preparation of personnel in family planning, certain information must be gathered. An accurate knowledge of the need for family planning services, manpower and educational resources must be established. Evaluation of the need for family planning services must consider the needs as seen by the consumer, the government and the health care provider. Collaborative planning among these three groups will considerably reduce the problems of legislative constraints to allow freedom of practice of new procedures as the need arises; facilitate consumer acceptance and utilization of services and eleminate the age old assumption that the professional knows best the needs of the consumer.

Valuable i ut from the consumer might require further education but would be well worth the effort. It is important to communicate to the consumer the benefits of family planning to the health of the mother, child and family as a whole. Consumers must be convinced of the health and well being of their children before they can be expected to plan the spacing of future pregnancies.

In addition to knowledge of the need for family planning services, availability of financial resources must be determined. This factor will influence the types of programs to be utilized or developed. Today, many sources of funding are available, of many of which I am sure you are aware. Some of these are : International Planned Parenthood Federation, World Bank, United Nations, Ford Foundation, Population Council and the U S Agency for International Development.

Assessment of manpower resources must consider the total manpower needs in relation to the population to be served. The varying categories of midwives must also be evaluated in terms of educational preparation and professional functions. Among the professionally qualified midwives will be those who received their education prior to the incorporation of family planning into nurse-midwifery practice. These midwives will require complete training in family planning. Others will have had exposure to family planning possibly in the theoretical framework and will require training in different areas.

Once knowledge of the foregoing is at hand, assessment of the existing programs should be undertaken to determine which, if any, will best meet the established training needs. Exploration should be at an international, national and local level. Where there are no existing national or local programs, consideration should be given to the development of a self-sufficient program. Its major advantage is that preparation for utilization can be more appropriately geared to meet each country's specific needs.

I shall now present to you some ideas regarding training in long term programs for professional midwives. Professional midwife is in this context one who has received midwifery training in a recognised program. These include Nurse-Midwife and Auxiliary.

Long Term Programs

A long term program may extend from two months to six months. These types of programs are best suited for the preparation of high level professionals for educational, clinical and administrative responsibilities. Such programs should enable the trainee to acquire a broad understanding of population dynamics, in depth knowledge of the methodology of family planning, program planning and development, management and evaluation, principles of learning and teaching and curriculum development. In the beginning some countries may find it essential to rely on training programs in other countries for the development of this calibre of personnel.

One such program which has been extensively utilized in the preparation of foreign midwives is the Downstate Medical Center program in Brooklyn, New York, U S A. The 10 year old program of 8 - 12 weeks duration has prepared 259 foreign midwives in family planning to date (Slide 1) The curriculum in this program covers comprehensive instruction in all phases of family planning; understanding in the basic concepts of anatomy and physiology of the reproductive system, complete indoctrination in the methods of family planning and an introduction to experimental methods under investigation; development of proper methodology by each trainee; accurate record keeping and follow up of patients; instruction in demography; the economics of family planning; orientation to the social problems of family planning; clinic planning and management. 1

Emphasis is also given to diagnosis and management of associated gynecological and psychological problems, referral procedures of persons with serious problems, and those requiring assistance with infertility problems.

The theoretical content is presented for the most part as didactic instructions by physicians and nurse-midwives. Clinical instruction is provided initially on a one-to-one basis, and as the student gains competence in the skills of communication, history taking, physical examination and those required for providing contraceptive care, she is gradually advanced to independen practice.

The aim is that the completion of the program each student would have performed at least 150 pelvic examination, 100 breast examinations, inserted a minimum of 20 IUDs and fitted at least 5 diaphragms.

The faculty at Downstate Medical Center recognizes the needs of students to make application of this training to a rural setting in meeting the local needs of many. Beginning this year we have utilized the facilities of a rural program located in the State of Kentucky for some clinical Family Practice observation. This has been reported to be a beneficial experience.

Other programs of this kind in the United States are located in Santa Cruz, California and Chicago, Illinois. The California program is utilized to meet the needs of French speaking individuals.

Although recourse to foreign training facilities may be necessary and advisable in the beginning, a fundamental and urgent objective for each country is to develop a self-sufficient and broad education system wherein the continuing educational needs of its health personnel can be met. Programs such as Downstate's should be utilized to prepare key personnel responsible for planning services and training programs. These individuals should in turn work together in developing service-related training courses. This would enable the development of a curriculum with direct relevance to the trainees functioning. Countries such as Ghana, Nigeria, Thailand, the Philippines and others have successfully developed their own programs.

In developing these programs it is necessary to keep in mind that programs such as Downstate's should only be used as a guide. Extensive modification may be required to meet the specific needs of each country. For example, malnutrition being a major problem in many developing countries would require heavy emphasis on nutrition in the curriculum, or, a high demand for surgical sterilization would warrant inclusion of theory and practice regarding this procedure in the curriculum.

Many countries have felt the need for initiating different levels of educational programs to meet the manpower needs in the area of family planning. A good beginning point for some longer term programs is the integration of family planning content into the existing midwifery training curriculum.

The frequent response to the suggestion of curriculum expansion to facilitate education of health care practitioners has been that, "the curriculum is too crowded, there is a shortage of staff, and too many students."[2] Although this problem is well recognised, the integration of family planning into nurse-midwifery training should not be a difficult understanding. Much of midwifery deals with the female reproduction, the

understanding of which provides the basis for family planning methodology. The new content could for example include concepts related to population dynamics, effects of family planning on family life, the methods available for use, their mode of action, side effects and contra-indications. This may be introduced as an extension of post partum care to include the inter-conceptional period. In this case the traditional teaching approach of didactic instruction may be most appropriate.

Newer approaches to education should also be explored and utilized when feasible. One approach I would like to suggest in integrating family planning into existing curricula is through the use of a module. A module is a self-contained and independent unit of instruction. The content of the unit is based on objectives which are clearly stated. This allows for the development of curriculum to meet specific program needs. To assist the student in the achievement of each objective, several sub-objectives are specified, successful completion of which constitute the achievement of the broader objectives. Further facilitation of the learning experience is provided by a learning guide to give the learner specific direction in meeting the objectives.

The student could be given this unit at a point in her training acceptable to both herself and her instructor. She could be allowed to cover the theoretical content at her own pace, consulting with the instructor only when clarification is necessary. A post test is given when the student feels she has mastered the content, to evaluate achievement of the terminal behavior.

Instructions in clinical techniques may be initiated at this point if the training program allows for it, or in some other continuing education program.

Whether the teaching approach be didactic instruction or modular learning, successful completion of a midwifery program with family planning content gives the individual the necessary orientation to participate in family planning activities at the level of counselling and education. It also provides the base upon which to build the clinical skills required to be a full family planning practitioner.

These skills may be acquired in the following ways:

1. Where there is a large medical center available, several trainees can be prepared in the skills required for their functioning under the supervision of nurse-midwives and/or physicians. This would be preceded by intensive classroom instruction with the use of models.

2. A group of trainees from different areas or facilities could be prepared in the classroom for a short period of time in the techniques and procedures of family planning, then continue in a preceptorship like training with a midwife or physician in their own clinical facilities.

3. Another approach would be to have an instructor work with the trainee in her own clinical setting until competence and confidence is achieved. This could be looked upon as an in-service type preparation. In both these situations, the Instructor need not be one from the area but could be one who travels from area to area performing these training activities. This is currently being done in some of our rural areas in the U S A.

4. In cases where trainees must leave their communities to be trained, but cannot be relieved for long periods of training, she may be trained in one skill at a time for a week's duration, then return to her facility for additional practice to be returned at a convenient time for training in other skill. This would be repeated until all the skills are learned. This approach to training is being used at the University of Juarez in the state of Durango, Mexico.

Where trainees are highly motivated, the modular approach could be used for preparing personnel in out-lying rural areas in the theoretical aspect. A training coordinator could be appointed to be the resource person for the students, providing clarification where necessary, administering the post test and arranging for clinical experience in one of the foregoing situations.

The advantages of the modular type of curriculum is that it does not require a great deal of instructors' time during the initial phase of training and allows for program related clinical preparation.

Short Term Preparation for Professional Midwives

Other forms of continuing education for midwives of a short term nature would include workshops and seminars to cover topics such as nutrition, human sexuality, physical assessment and curriculum development.

They could be shared by a national or international and interdisciplinary groups, and last from one day to one week.

Nutrition

The workshop approach may provide the needed knowledge in nutrition which is vital to the midwife's practice. She should not begin to offer family planning services before first assessing the patient's nutritional status and offering guidance where necessary. Her knowledge in nutrition should enable her to extend her counselling beyond that of the mother to include the rest of the family, especially infants and children. A broad knowledge in nutrition is therefore essential and should cover all aspects from infant to adult including pregnant and lactating mothers.

Human Sexuality

Many at this time frown upon the idea of including human sexuality as an important component of the midwife's education. This attitude needs to be thoughtfully evaluated. It is clear that we live in times of transition and that many of us are uncomfortable with the changes taking place. If we allow ourselves to be paralyzed by these discomforts, we will never advance to the level of preparation required to care for families adequately. Seminars or workshops in human sexuality should aim at helping midwives understand their own sexuality, offer ways of dealing with the patient's feeling about their sexuality, and a basic understanding of male and female sexual problems. If the midwife can handle her own feelings of sexuality, she will be better able to understand and discuss the sexual problems of her patients, provide guidance and make appropriate referrals where necessary.

Physical Examination

Workshops in physical examination could provide the midwife with the skills required for a more complete evaluation of the mother and her child. The midwife is the only health personnel some families ever see, especially in the rural areas, therefore acquisition of this skill is vital. Additional content to her pre-existing knowledge of pelvic examination should include examination for gross abnormalities of the head including eyes and mouth, the neck including thyroid, the chest including breast, heart and lungs and the abdomen. This would enable her to act as a screening agent to detect any abnormalities and make appropriate physician referrals.

Curriculum Development

Many midwives are involved in education and curriculum development. Workshops on this topic could cover establishment of educational objectives, test construction, teaching methods, and evaluation. Discussion and clarification with educational consultants could greatly facilitate these efforts.

In addition to the long term and short term courses which may be undertaken, we midwives have a responsibility for our own professional development beyond these basic educational needs. One way of doing this is through subscription to and reading of professional journal publications. Recommendations of such publications are: Studies in Family Planning, published by the Population Council, and Family Planning Perspectives, published by the Planned Parenthood Federation, Inc.

Courses for Traditional Birth Attendants

Until now, no mention has been made of the traditional birth attendants (TBA) but this should not be viewed as a measure of their significance in the provision of health care to families. They have been known for years to provide caring services for mothers and babies in many countries. As a matter of fact, an estimated 2/3 of all babies born in the world today are delivered by TBAs.[3] They have no formal training in their craft, nor are they legally recognized. In spite of this however, they enjoy a position of respect and trust in their communities, and have the potential of advancing or retarding family planning activities. Bearing this in mind, together with other humane considerations for these practitioners, the question now is not whether they should continue their craft, but one of how they may be prepared to improve their care to the vast numbers of mothers and children they serve. The portion of births delivered by TBAs in many of the Asian countries ranged from 31% in West Malaysia to 87% in Java and Bali, Indonesia.[4]

A move in the direction of education for the TBAs could equip them to provide a broader range of services to the population of their communities. Furthermore, upgrading education, increasing responsibility and giving needed recognition could be the added incentive required for the TBAs full committment to family planning.

Many governments such as Thailand, Philippines, Malaysia, Peru, and others have embarked upon training programs for the TBAs to improve their current practice and involve them in family planning activities. In many of these countries, TBAs have made valuable contributions to the national family planning programs in their role as patient recruiter. However, it was found that the continuation rates of the patients recruited was lower for the TBAs than the professionals. The assumption was that this was due to the nature of the population served by the TBA - mostly illiterate and low income. Experience in many countries can validate this. In Indonesia for example it was found that Dukuns delivered 94% of the illiterate women, 40% of those with elementary school education, and none of those with secondary school education.[5] This being the case, there is then no question of the TBAs unique position to foster family planning activities especially in the rural communities.

For utilization to the fullest extent, TBAs should be provided with additional preparation. The preparation should be geared to improvement of current practice as well as information for participation in family planning activities. These may include for example basic aseptic techniques, screening procedures for pre-natal care such as urinalysis, checking for edema and bleeding, rudiments of nutrition, basic aspects of post partum care, and care of the newborn, as well as any other skills, they can perform for the care of mothers and children. The Philippines have successfully implemented such a program for training of their Hilots. Training for family planning activities should include skills in patient motivation, advantages of family planning, methods of family planning and their proper usage, their side effects and contra-indications to their use as well as referral procedures and indications for referral of patients. While some TBAs are currently dispensing some forms of contraception, such as the condom and foam, they may be prepared to re-supply oral contraceptives as is done in some countries presently.

The types of training programs for the TBAs should be short term in nature utilizing as much as possible visual aids demonstrations and active trainee participation such as role-playing and laboratory practice in a classroom setting. An added bonus could be the selection of the right trainer, one with high credibility and motivation and personally known to the TBAs. The training period should be broken into several short periods of a week at a time to cover all the skills required. Training should be followed by supervision in the field.

Conclusion

The need for the incorporation of family planning as part of maternal and child health services has become quite urgent if maternal and infant mortality rates are to be reduced. In spite of the many obstacles to improved services, especially in the rural areas, there are many steps to be taken to improve this situation. The government must first set policies which are permissive to the practice of family planning. Educators and health care planners must work collaboratively to develop services and educational programs so that preparation in manpower will be relevant to service needs. They must be aware of the changes in the educational process, of the varieties of existing programs and to be innovative in the creation of their own progams to meet their own health care needs. Health care providers must realise that Maternal and Child Health and Family Planning services are part of good health care.

Midwives all over the world have earned a place of respect and trust in our communities. Our potential for planning, implementing and administering MCH/FP services is well recognised. Let us coordinate our efforts at all levels to bring to mothers and their children thehealth care services they need for a better life.

APPENDIX I

MAIN OBJECTIVE I: PROVIDES INFORMATION TO WOMEN WANTING OR USING A METHOD OR BIRTH CONTROL

A Content Sub-Objectives:

1 Oral contraception

a) Differentiates between the different types of oral contraceptives in use in your area according to hormonal content and effectiveness

b) Describes the mode of action of the pill

c) Lists ten contra-indications to the use of the pill

d) Identifies important information to be obtained from the patient before starting or re-supplying the pill

e) Lists twelve side effects of the pill

f) Identifies the serious situations which result from the use of the pill

g) Identifies the appropriate times during the menstrual cycle and post partum for starting the pill

h) Identifies instructions for the proper use of oral contraception

APPENDIX II

LEARNING GUIDE To assist in developing the knowledge involved, the following resources are included:

1 ORAL CONTRACEPTIVES

Read: A Clinical Guide to the Pill, S Okrent
B Clinical Guide to the Pill, H Nelson
C Endocrinology and the Pill, lecture found in folder

APPENDIX III

WORK SHEET #1

The pill has two components, estrogen and progesterone, which are important in selecting a pill for a patient.

M ake two lists of the pills used in your area under the headings; "Estrogen Dominant" and "Progesterone Dominant"

WORK SHEET #= 2

The population of women differ in varying degrees of hormonal profile, some have more estrogen while others have more androgen.

List five characteristics of the high estrogen and high androgen type patients.

FOOTNOTES

1 New Horizons in Midwifery: The International Confederation of Midwives. The American College of Nurse-Midwives. London, New York, 1972.

2 Rapport, African Health Training Institutions Project Newsletter, Vol 2 No 1, July 1975

3 Studies in Family Planning, Traditional Midwives and Family Planning in Asia The population Council, Vol 6, No 5, May 1975

4 Studies in Family Planning, Traditional Midwives and Family Planning in Asia The Population Council, Vol 6, No 5, May 1975

5 Studies in Family Planning, Traditional Midwives and Family Planning in Asia The Population Council, Vol 6 No 5, May 1975

OTHER REFERENCES

1 Paramedical Personnel in Family Planning - A Creative Partnership, by The Pathfinder Fund, 1974

2 Health Aspects of Family Planning, W H O Technical Report Series, No 442

3 Lippard, Vernon; Family Planning, Demography and Human Sexuality in Medical Education J Macy Jr Foundation, 1971

4 Mojekwu, Victoria; Education and Training Implications of a New Rural Health Care Delivery System, Center for the Study of Education and Development, Harvard Graduate Schcol of Education, Comb., Mass.

LEGISLATION GOVERNING THE TRAINING AND PRACTICE OF MIDWIVES

by

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1. The topic I was given to talk on was "Legislation governing the training and practice of midwives in general". Not having the time nor the opportunity to make a comparative study of the midwifery laws in various countries, you will have to bear with me for interpreting the topic to mean the general implications of having a law or laws governing midwives. This will not be an academic paper but rather an exercise in common sense because law is basically a practical subject. I will briefly touch on the laws of West Malaysia merely to serve as an illustration.

2. What is the purpose of having legislation to govern midwives? What is the purpose of having any legislation for that matter? Generally, to transform governmental policy into legal norms, so that the rights, duties and obligations of certain classes of people are defined, so that persons who do not qualify are effectively prevented or deterred from enjoying those rights, so that the public at large is protected against any form of abuse arising from unregulated practices. In particular whenever there is a class of persons especially one which deals so closely with health and lives it is necessary to effect certain measures of control and supervision over that class.

3. A law governing midwives would primarily serve to identify persons who are deemed suitable by the Government to practise midwifery. Such midwives may be attributed rights, duties and obligations vis-a-vis the public in general. Such rights, duties and obligations must necessarily be specified under the law so that, on the one hand, midwives may perform their duties with impunity, and on the other hand, the public at large may be protected from any form of mal-practice. These rights, duties and obligations reflect the government's appreciation of the capabilities and limitations of midwives - midwives should not be expected to do more than what they should be expected to subscribe to certain standards of practice that will ensure the safety of mother and child.

4. The law also serves to exclude persons who are not deemed suitable by the Government from practising midwifery. Such exclusion is necessary primarily to prevent untrained and unskilled persons from giving wrong advice and doing acts to the detriment of the public.

5. Different legislations in different countries have different definitions of a midwife depending on the policy of each country towards midwifery practice, e.g. in Japan a midwife is defined as "a female who has been licensed by the relevant Ministry to practice midwifery or guidance with respect to the health of pregnant women, women in childbirth and newly born babies" - whereas in Italy a midwife has been defined as "someone who in addition to assisting

a mother during normal pregnancy delivery and post partum and care of the newborn, is responsible also for the surveillance of mother and child until the child has attained the age of 3 years".

6. In West Malaysia the only laws we have directly relating to midwives are the Midwives Act of 1966 and the Midwives (Registration) Regulations of 1971. Under the Midwives Act of West Malaysia a midwife is defined as "a person who for a fee, salary or other reward to compensation performs services requiring an understanding of the principles and applications of procedures and techniques for the care of normal childbearing women from the beginning of pregnancy until the end of the puerperium and the care of their infants during the neonatal period". Midwifery students are excluded in this definition.

7. The definitions, as you can see, are very general ones which need to be elaborated on under the Act - in particular by specifying the course of training a midwife has to undergo, the examinations he/she has to pass and by spelling out the terms and conditions a person has to comply with before he/she is regarded as eligible to practise midwifery.

8. The Midwives Act of West Malaysia, e.g. provides for registration of midwives and makes it an offence for any person who does not qualify to be reigstered, to practise midwifery. It should also be noted that for various reasons an untrained person may under certain conditions be registered under the Midwives Act of West Malaysia to practise midwifery. This is to include bidans or rural midwives who have been practising before the Act came into force. They are brought within the ambit of the law so that the provisions of training and practice spply to them. In this way, i.e. through registration every midwife licensed to practise may be individually identified and every unqualified and unregistered person practising midwifery may be easily exposed.

9. At this point before any of you seek to expose and denounce the doctors, may I mention that in Malaysia the practice of midwifery by medical practitioners is covered by the provisions of s.26(1) of the Medical Act 1971 which states that "every person whose name is for the time being borne on the Register as fully registered under this Act shall be entitled, according to his qualifications to practise medicine, surgery, and midwifery in accordance with the provisions of this act".

10. As midwives are defined and attributed with rights, duties and obligations there arises the need for supervision to ensure that the line is being toed. Moreover, as is often the case, as medical science advances, we may find that techniques which were considered adequate before may need to be improved or even discarded, training may need to be modified, principles of practice qualified. In view of the everchanging circumstances and in view of the need for supervision it is both convenient and advisable to have a specialised agency of body (which includes experienced doctors and midwives) responsible for regulating the training and practice of midwifery; and more generally for deciding on the rights, duties and obligations of midwives. There is a need to establish that body under a law so that its policies enjoy a legal status, its powers become a legal right and its decisions are not made in vain. Midwives would be legally obliged to comply with any relevant directions issued and decisions made by that body. It follows that the powers of such body need to be specified so that midwives may know the extent of their obligation.

11. Perhaps I should mention here that in Sarawak and Sabah the supervising authority is an individual, namely the Registrar. There is of course the axiom that "two heads are better than one" and the argument of the opportunity for group representation in a body. However, the feasibility of having a body as opposed to an individual as the supervising authority depends on the circumstances in each country.

12. Under the Midwives Act of West Malaysia the relevant body is the Midwives Board. I think Puan Rosina will be elaborating on the functions and powers of the Board later on. It suffices for me to say that this Board is given the power, inter alia, to regulate the training of midwives and the practice of midwifery. Perhaps one of its most important powers is the power to remove the name of a person from the Midwives Register in certain circumstances. This power provides a safeguard against improper registration, negligence, misconduct and malpractices. To my mind, when there arises the question of whether a person should be allowed to practise his profession or not it is fitting that he be judged by a tribunal of his own peers. In this respect, the law ensures the observation of the of the rule of law that a person be given the opportunity to be heard before he is judged.

13. Last but not least the law serves to impress upon the public the danger of unqualified and unsupervised persons meddling with the health and lives of mother and child, and the seriousness of midwives not subscribing to prescribed standards of practice and procedure, by generally making it an offence to practice midwifery in contravention of the law and prescribing penalties of fines and imprisonment. Thus, here we may find the courts stepping in to support the effort of the supervising authority.

14. We see, therefore, that the law in distinguishing qualified midwives from the unqualified ones, in specifying the midwives' rights, duties and obligations in regulating the training, practice and discipline of midwives, in conferring on the supervising authority a legal status and in making undesirable practices criminal offences serves to articulate the policy of the Government to strengthen the implementation of the policy, and to extend such policy to cover not only Government employees but also the entire public. In doing this, the law seeks to ensure that a balance is maintained between the rights of the individual and the rights of the community in which he lives.

HISTORICAL REVIEW OF MIDWIFERY SERVICES AND LEGISLATIONS IN MALAYSIA

by

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International definition of "Midwife"

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

Sphere of Practice

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the new born 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 ante-natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

This was approved and accepted by the Council of the International Confederation of Midwives at its meeting in Washington in November 1972, and at the General Assembly of the International Federation of Gynaecology and Obstetrics in Moscow.

Definition of "Midwife" in accordance with Midwives Act 1966

"Midwife" means a person who for a fee, salary or other reward or compensation, performs services requiring an understanding of the principles and applications of procedures and techniques for the care of normal childbearing women from the beginning of pregnancy until the end of the puerperium and the care of their normal infants during the neonatal period but shall not include students in midwifery schools or training institutions who perform midwifery services under the supervision of their instructors.

In short, a midwife is a woman, who for the time being is certified and registered under the Midwives Act of 1966 to practise midwifery.

The Birth Attendant

Since time immemorial the traditional birth attendant or the kampong bidan has an indispensable role in the practice of midwifery. This practice has been passed from generation to generation. The kampong bidan is necessary to the mother and she caters to the cultural needs of the family. Being unqualified she may or may not be skillful in conducting the birth of the baby, but this lack of technical skill is compensated by her age, experience and human relationship. The majority of these kampong bidans are popular and influential in the community.

Leglislation and Register

The earliest record of Midwifery Legislation passed in 1923 is that of the Straits Settlements Ordinance and the Federated Malay States Midwives enactment. This legislation was a means to combat the unhealthy practices of midwifery and to give authority to the Public Health worker. The Lady Medical Officer attached to the Infant Welfare Centre carried out the functions of the local supervising authority and maintained a register compiled from records kept in the various Sanitary Board areas where the enactment was enforced.

The Pre-War Phase

The Nurse Midwife - in the 1930's

The training of local Nurse Midwives in the colonial days was "on the job" apprenticeship in nature. It was understood that the training programme was for three years and commenced with the first year in general nursing, followed by the second year in midwifery and the final year in general nursing. Lectures, theory and practice were given by Matrons and Sisters, and Doctors assisted in some lectures. On completion of thr three years of training, the nurses sit for the general nursing and midwifery examination and qualify as trained Nurse.

The second type of Midwifery Training was part of the four year training programme. A nurse on completion of the three years general nursing, and on qualifying by examination, spends a further year in midwifery training and on passing the examination, qualifies for the post of a Staff Nurse.

Training of this nature again varied from State to State and was controlled in accordance with each State Midwifery Ordinance or enactment. The majority of the nurses so trained worked in General or District Hospitals and might or might not have been practising midwifery. Some were posted to the Maternal and Infant Welfare Centres to provide service to mother and child. They also assisted in the training and supervision of Non Nurse Midwives and Kampong Bidans.

The Non Nurse Midwife (Division II Midwives)

The earliest record of the training of Division II Midwives dates back to 1936. The training was of a practical nature and the duration of the course was in some States only for three months which was later extended to six months. This was later found to be inadequate and thus midwifery training was extended to one year. Midwives have been trained for many years in every state throughout the Federation and qualified by an oral and practical examination. On qualifying, they were expected to return to their kampongs and serve as private midwives. The Government gave them a subsidy of five dollars as an incentive for each case they conducted and this had to be certified by the Ketua Kampong. In some States, a monthly allowance

of $30 was given to such midwives.

Girls with lower education were only attracted to do midwifery and with the sub-standard form of training and without domiciliary orientation, they could not compete with the indigenous untrained traditional bidans; and midwifery as a recognized profession, was never fully accepted by the rural population.

The Untrained Kampong Bidan

The enactments enforced in the various states did not authorize to register the kampong bidans or control their practice, so effective supervision was not possible. Malpractises continued and the traditional midwives increased in number and maternal and infant mortality remained high.

Post War Phase

In-service training of nurses and auxiliaries in Midwifery continued in the majority of the bigger hospitals. The auxiliary midwives functioned in maternity wards, welfare centres and kampongs and modern widwifery became more popular in the kampong. The traditional bidans were encouraged to attend clinics with their bags inspected regularly and they were given talks on simple health and midwifery practice.

Rural Health Service Scheme

The concept of the Rural Health Service was first mooted in 1954 with the assistance of W H O. The scheme envisaged a Rural Health Unit for every 50,000 population and each unit comprising of one Main Health Centre, four Health Sub-Centres and 20 Midwives Clinics, 25 Midwives will be posted within the area of the District Health Unit and each midwife serving a population of 2,000. The basis of the scheme is the rural midwife, since it is thought that the basic approach to the family is best done through women of child bearing age and then to the children.

Federal Midwives Ordinance 1954

The Midwives Ordinance formulated and passed through the Legislative Council in 1954, provided for a Midwives Board to be set up. This Board drew up a new regulation for the conduct and training of midwives, and through this ordinance attempts were made throughout the Federation to train Nurse and Non Nurse Midwives, in accordance to the regulation formulated.

Historical Features 1955 - 1970

This is the most significant and eventful period of the development in Midwifery Training and control of Midwifery Practice.

Midwifery Training

In 1950, the first Malaysian nurse midwife was offered a scholarship to take up Midwifery Tutor's Course in England. In 1952 the organised school for nurse midwife was started in the Maternity Hospital in Penang. This was followed by Kuala Lumpur in 1953, Malacca and Ipoh in 1954 and Johor Bahru in 1955.

It was during 1954 that the first Federal Midwives ordinance was passed but it was enforced only in some states as according to its regulation some of the states were unable to implement it. Therefore, the Ministry of Health took over and centralised the five midwifery schools for nurse-midwives (Division I) and thirteen midwifery schools for non nurse-midwives (Division II) Training regulations and conduct of examinations were stipulated and advised. All midwives were registered in their own states.

From 1955 the establishment of domiciliary midwifery became necessary as the demand for midwifery service was increasing. As a result of a growing appreciation of the value of the ante-natal and post natal services, there is an increasing demand for additional maternity beds and for domiciliary service especially, with the expansion of rural areas in the development of the country.

The Midwifery training course for nurse-midwives is of one year's duration, with the inclusion of 3 months domiciliary practice.

The Midwifery training course for non nurse-midwives is of 2 years duration with 18 months in the Maternity Unit and six months in the Domiciliary Midwifery Training Centre.

The Trained Assistant Nurse does 12 months of midwifery training in the Maternity Unit and followed by six months of Domiciliary Midwifery Practice.

Midwifery Legislation and Act

The first Federal Midwives Ordinance of 1954 was enforced but some of the states were unable to fully implement it and so, it was repealed. With the full implementation of the Rural Health Service Scheme and as the medical and health services have improved in all the states, it has been able to enforce the Midwives Act.

Midwives Act 1966

The Midwives Registration Regulations 1971 was enforced on the 22nd April 1971 to control all practising midwives including the traditional midwives (Untrained Kampong Bidan) through registration.

This act applies only to Peninsular Malaysia, it was passed by Parliament on 16th July 1966 and came into force on 1st August 1968. The Act provides for the establishment of a Midwives Board which is empowered to:

(1) approve institutions as Training Schools to provide training qualifying for registration;

(2) regulate the course of training, conduct of examination, issue of certificates and badges;

(3) regulate the practice of midwifery and conduct of midwives;

Maternity Services

In 1973 the total number of obstetric beds at Government Hospital was 2,292 and a total number of 109,641 women were delivered in Government Hospitals for the year 1973. 82,263 domiciliary deliveries were conducted by Government midwives.

Births in Government and Private Institutions

1965 and 1972

PARTICULAR	1965 PENINSULAR MALAYSIA		1972 PENINSULAR MALAYSIA	
	Total	Percentage Total Births	Total	Percentage Total Births
Births Registered	295155	-	308347	-
Births in Government Hospitals	84301	28.56	108488	35.18
Births Delivered by RHS and MCHC	64555	21.87	83840	27.19
Total Births by Government Institutions	148856	50.43	192328	62.37
Percentage to Registered Births	50.43	-	62.37	-
Births in Private Hospitals	10544	3.58	14678	4.76
Births in Private Maternity Hospitals	12171	4.12	3897	1.26
Births in Maternity Homes	7737	2.62	15484	5.02
Total Births in Private Institutions	30452	10.32	34059	11.05
Percentage to Registered Births	10.32	-	11.05	-
Total Births in Government and Private Institutions	179308	60.75	226387	73.42
Percentage to Births Registered	60.75	-	73.42	-

It is estimated that 26.6% of the total deliveries were conducted by traditional midwives.

Domiciliary Midwifery

In the Rural Health Scheme, the staff midwife division II is the front line worker for the domiciliary midwifery service. In most rural areas, maternal health services are provided by midwives and supervised by Public Health Nursing Staff. The staff midwife has therefore a great responsibility to shoulder the lives and well-being of the mother as well as the new born.

In some rural areas the traditional midwives attend to deliveries. The popular ones deliver about 10 -- 12 cases per month. On the average traditional midwives deliver 2 - 3 cases per month. Being what they are, recognition of these traditional midwives was essential for they are just as indispensable as the government midwives to the rural mothers in places where government facilities are still not available. This was made possible by the enforcement of the midwives registration regulations, 1971 and all midwives had to register if they wished to practise.

Registration Regulations Section 11 (2) (b)

Any person untrained in the practice of Midwifery, who within four years of the commencement of the Midwives Act, 1966, (ie before 1st August 1972) satisfies the Registrar that such person has during the Period of two years immediately preceding application for registration under Part II of the Register attended to women during childbirth, could be admitted to the Register.

Registered Midwives

	Dec 1972	Sept 1975
Nurse Midwives	1502	2693
Non Nurse Midwives	1998	3667
Traditional Midwives	28	3037

Supervision of Kampong Bidans has been lacking but with the registration of Kampong Bidans, more effective supervision can be made through every Local Supervising Authority to prevent negligence or malpractice.

Maternity Service

The success of the maternity service is measured by the saving of life, the improvement of the health status of the mother and baby, also, the extent to which it can help to diminish the fears, difficulties and some discomfort faced by every woman who embarks on motherhood. It is a co-operative team effort of tripartite angles of common objective of Mother, Midwife and Doctor.

TRAINING AND ROLE OF THE AUXILIARY NURSES-MIDWIVES AND PROFESSIONAL NURSES-MIDWIVES IN NEPAL

by

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Background Information

Nepal is a landlocked country in the Himalayan region. Geographically, it consists of three belts from east to west such as mountainous, hilly and the plains (Terai) in the north, themiddle and the south respectively. All these belts are characterized by habitants of different ethnic groups of people with different cultures, customs, mother tongues and economic backgrounds.

From the administrative viewpoint, the whole country is divided into fourteen zones. These zones are subdivided into seventy-five districts and these districts are further sub-divided into village panchayats, the lowest administrative unit. There are about four thousand such village panchayats where sixteen town panchayats are also included. For the purpose of development, the kingdom is divided into four developmental regions consisting of a number of zones in each region.

Predominantly (96%) of the total population of the country resides in the rural areas and only an insignificant number (4%) of them belong to the urban sector. So far about fourteen percent (13.9) of the total population is literate but there is a significant gap between the males' and the females' literacy rate. Due to many liabilities, such as difficult geographic distribution, limited communication facilities, low literacy-rate, and the like, developmental work is still very slow. Because of these limitations, medical service is lacking especially in the remote areas of the country. People are in general, still deprived of basic medical aid even today. So what are the major problems the country is facing at present will be discussed below.

Statement of the Problem

The following table shows the medical professionals engaged in the public service at present:

Doctors	374
Dental Surgeons	8
Professional Nurses	335
Auxiliary Nurse-Midwives	372
Health Assistants/Health Workers	620
Laboratory Technicians	35
Sanitarians	8
Health Educators	14
X-Ray Technicians	22

Since the medical personnel are less in relation to the total population, the main problem we are facing at present is inadequate supply of professional staff. Beside this, whatever field the doctors or nurses are engaged in at present, their service is not available to the general public as it should be due to the complex geographic distribution, inadequate infra-structures and predominantly the people dwell in rural areas. The general complaint we hear every day is that most of the doctors or nurses concentrate in urban areas where they provide their services to only 4% of the total population of the country. Therefore, to overcome these problems the following objectives are established at national level.

General Objectives

Since the country is lacking trained and qualified medical personnel, the general objective is to provide cheap medical service to the maximum number of people in a short time by recruiting and training the low levelled medical personnel so that they could be sent to the different parts of the country.

Specific Objectives

1. To recruit and train the personnel in the medical profession

2. To supply the low levelled medical professional such as Auxiliary Nurse-Midwives, Health aides, Assistant Health Workers, etc, in a short time

3. To provide common basic medical services in the rural areas

From the many kinds of medical professional groups, the main emphasis is laid upon the training of Auxiliary Nurse-Midwives and Assistant Health-Workers to appoint them to the rural areas of Nepal. Regarding the training of the Auxiliary Nurse-Midwives and their service, it will be discussed below:

Auxiliary Nurse-Midwives (ANM)

The training of the ANMs started in 1961 in Nepal where 40 trainees were produced in this field. Those having completed class eight in the school were recruited and trained in different medical institutions for two years. During the two year period, the last nine months is fully concentrated on midwifery training. After completing the training, they are appointed as ANMs and are sent to different hospitals, health-posts or Health-centres of the country. No preservice or induction and inservice training has been experienced so far. The roles of the ANMs are grouped as follows:

1. Home visit
2. Domiciliary Midwifery
3. Midwifery Emergency Attendance
4. Supervision of Local Birth-Attendants

1. Home Visit

The Main purpose of home visits is to see an antenatal or nursing mother, a new baby, a toddler or school-child or some one suffering from tuberculosis or Hansen's disease but in any case other family members are never neglected. To fulfil this purpose, every ANM is fully instructed how to approach the families, what considerations must be made and what is the benefit in studying the local situation so on and so forth. They are fully alerted to be as guests in entering the house of the families.

2. Domiciliary Midwifery

Every ANM is expected to answer delivery calls within a walking distance of the health posts. The visiting distance in general is 16 kilometers from the respective health posts. An assistant such as a Peon or an Ayah accompanies her on every visit. Those mothers staying away are received for delivery in the health posts. A room will be provided if available and they are expected to return home within 12 to 24 hours.

The ANM must always have the delivery kit for use. It must be kept clean and in a safe place and be only used for delivery purposes. The ANM must bring her home visiting bag and delivery kit box with her when she is called to attend a delivery.

Each ANM is fully instructed about the contents of the delivery kits, care of the instruments after use, how to use the kit box, home delivery procedures, management of the labour and care of the baby. Since she is dealing with the human society of different customs, habits, etc full instruction is provided to what and how an ANM should deal with people.

3. Midwifery Emergencies

Every effort must be made to examine all mothers in all stages of pregnancies: early, middle, and late, so that any abnormality can be dealt with as timely as possible. Those mothers at risk can be referred to the District Hospitals.

The ANM must satisfy herself when she sees a mother in labour that it is progressing normally. Any complication if arises, the mother must be taken to the hospital without any delay.

In such an emergency, every ANM is trained to deal in those fields such as: antepartum haemorrhage, eclampsia, prolapse of the cord, postpartum haemorrhage, manual removal of the placenta, shock, and emergency care of the baby's severe asphyxia.

4. The ANM and the Local Birth Attendant

The ANM's opportunities and responsibilities for working with the local birth attendant:

Even today very few births in Nepal are conducted by qualified staff because of lack of trained personnel. There are certain mothers who still choose to be delivered in their own home by a member of their family or a local birth attendant. The local birth attendants are women who have learned something about looking after women in child birth. They usually have years of experience but for most part, are illiterate and follow many unhygenic and harmful practices. Because of lack of the qualified midwives in relation to the number of births, we must do everthing possible to make these local birth attendants safe. Where an ANM is posted in the community, she has many opportunities to contact and establish a good relationship with those conducting village deliveries. She should aim to make herself acceptable to them as teacher, guide and support towards improved and safer delivery practices.

Each ANM must understand fully what the aims of teaching local birth attendants are, what the ANM must do, points to be considered while teaching village birth attendants and so on.

Since our country at present is not in a position to produce as many doctors as basically needed and the professional nurse midwives are posted in the hospitals at different levels but not in health centers or health posts, the best and cheapest medical service the country can provide to the common mass is by training and supplying the Auxiliary Nurse Midwives. Since these trainees generally are taken from the different rural areas, they can be very well adjusted in different village conditions. The following suggestions can be made based on experience to make these staff more effective and practical:

1. The ANM must be recruited from the remote areas and be posted to the same areas after the training is over.

2. Preservice or induction training must be given to an ANM prior to her posting to the district or village.

3. Inservice or refresher training must be organised at least once a year to keepthem up to date with the latest information.

4. Seminars or workshop eminars should be organized from time to time in order to understand their views, problems, etc and try to solve according to their need.

5. Time to time evaluation of the ANMs performance must be done to correct their mistakes and/or to bring certain changes in the established programmes.

6. Besides ANMs' training etc, the Local Birth Attendants must be clearly located as many as possible in different communities and trained to reform their old unhygenic practices.

7. The national plan m include the recruitment of certain elegible local birth attendants and train them adequately and appoint them as a helping hand to the ANMs in the communities. For example, the Queen of Nepal recently inaugurated two such training centers for local birth attendants to utilise their services to the best possible means. It also further aimed to train such local attendants so that high mortality and morbidity of mothers by such practices like abortion etc be reduced.

8. In the high school or college level of education, where should be included in the curriculum the teaching of students in the field of MCH or Family Planning, and Personal Health. If they are trained to a certain extent, they could be very well utilized at the time of need.

10. There is usually malpractice by local birth attendants in the field of illegal abortion where high accidental death of the unfortunate mothers takes place frequently. Morbidity is quite high because of such practices. Therefore, legalization of abortion should also be practiced in the strictest sense in order to save the mother as well as to maintain the family size, and if such local attendants are allowed to carry on all practices except abortion, then they should be very well trained in this field and be certified.

The above mentioned suggestions are based on the past experience during my medical profession. If these suggestions are very well taken, then, the medical service which is in a great demand at present could be fulfilled to a certain extent in Nepal.

Professional Nurse-Midwives (Graduate Nurses)

To train the professional nurse midwives, a nursing school was established in 1956 in Nepal aided by WHO. The training period since then has been fixed for three years. In the beginning, it was called as a Nursing Training Project under His Majesty's Government, but from 1972, this project is transferred to the Tribhuwan University and named as the Nursing School.

The trainees during the time of selection, must have completed school final (10th grade) There will be six semesters for training where the first four semesters are for general nursing training, the 5th one for midwifery and the last one for public health nursing. As they complete this training, they receive the certificate equivalent to the Intermediate level of education.

After the training, these professional nurses are posted to the central, zonal or district hospitals and some of them join in public health nursing. Their main roles will be to conduct normal delivery ward management, supervision of the junior staff such as ANMs, student nurse and care of the patients. Public Health Nurses work for MCH and Family Planning Clinic, and supervise Health Aides and so on.

Achievements

The following table shows the doctor-patient ratio in Nepal:

Personnel	No	Ratio
Doctors	356	1:32,461
Professional Nurses	290	1:39,848
ANMs	335	1:34,495
Health Assistants	86	1:134,372
Assistant Health Workers	606	1:19,069

If we look at the above table, it is clearly understood that there is tremendous shortage of doctors, nurses, etc in our country in comparison to other countries, especially to Western countries (Please see in the figures) Therefore in a developing country like Nepal, low levelled medical personnel such as ANM, AWH Health Aide etc are greatly needed to provide the basic medical services to remote corners of the kingdom.

Conclusion

As has been mentioned the medical facilities available for the common people of Nepal at present, one can immediately point out the scarcity of the medical professionals by seeing the doctor-patient ratio. Well qualified doctors are not plentiful and those who are well trained and qualified do not show any interest to take up the job in rural areas. Some doctors after completing their training in foreign countries try their level best to stay or settle and work in the host countries because of many constraints in their home countries where monetary gain is the basic one.

FAMILY PLANNING IN NATIONAL DEVELOPMENT

by

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1. Family Planning

The modern as well as socio-cultural factors affecting the biological consequence of mating, are usually known as Family Planning methods. Voluntary practice of such methods to regulate one's fertility behaviour is defined as Family Planning. Knowledge as well as the services relating to the control of one's fertility behaviour, has been regarded to be one of the basic human rights. For a large number of women easy access to control fertility services means a great deal of emancipation from the repeated cycles of child bearing and rearing. In short, the dynamics of Family Planning deals with all aspects of human life thus a dynamic component of development of any human society.

2. Development

Development, on the other hand, can be viewed as the dynamic changes occurring in economic as well as non economic spheres that will accelerate the growth rate of per capita consumption of calories, protein, housing, clothing, education, health and family planning services etc. One of the fundamental aspects of development is the rising aspirations among youth. This is the most dynamic of all the development variables because this, in general, leads to the intellectual and moral receptiveness to the new idea required for any progressive changes. The earlier indication of changes manifest itself in the form of increased demand of social services such as provision of improved food, housing, safe water and disposal of sanitary wastes. The fulfilment even partially of such needs would have its impact among others on reducing infant and child mortality rate. Reduction in infant and child mortality at a perceptible level would then bring about a change from the traditional norm of bigger family size to a smaller one. This phenomenon of "Demographic Transition" has been experienced also by the developed countries during their earlier stage of development. The decline in fertility started only 50 years after the infant mortality started to decline in Western Europe during the nineteenth century, whereas it took about only a decade for Japan to lower its recorded Crude Birth Rate of 33.5 in 1948 to 17 in 1957. However, the social and economic changes required for such a transition were started in the early 1920's. The time interval between the start of decline in infant mortality and its perception so as to affect fertility is the critical time, because, during this time the high fertility continues with the declining infant mortality. This leads to sudden rise in population which would offset the economic gains brought about through other efforts inclusive of improved health of the people. Therefore it is precisely during this critical period that Family Planning methods should be applied to achieve the most effective results of development i.e. averting the sudden rise of population growth.

3. Developing Society

Having thus defined development and its relationship with Family Planning, let us now analyse a developing society. Developing society represents two thirds of the human population, the majority of whom subsist on an annual per capita income of equivalent to U.S.$50 or less. Thus a developing society represents a vast majority of earth's population, subsisting on a level of income that is near the absolute poverty line. Recent publication by the World Bank indicates that three-fourths of the poorest sector of the population live in Asia and two-third of that number belong to four countries; India, Indonesia, Bangladesh and Pakistan alone. Besides 80 percent of the population belonging to such a category live in the rural setting engaged mostly in agricultural occupation. Women and children form a major component of the labour force engaged in agriculture in most of the developing countries. It is in the developing countries that five times as many babies are born compared to the developed countries. 15-20 percent of the total population of developing countries are under five as compared to 8 percent in developed countries. This represents a major component of the population with high mortality rates. The high fertility rate has a negative effect on children's health specially with regard to the malnutrition and over-crowding in relation to high prevalence of communicable diseases. Obviously high fertility behaviour runs a high parity risk of maternal morbidity and mortality problems such as placental disorders, mal presentation, toxaemia, haemorrhage, uterine prolapse, septic abortion, etc. The magnitude of health risks arising from such high fertility behaviour is manifold in the developing countries where modern maternity service is almost non existent.

4. Dilemma

The dilemma is that the women of developing countries exhibit a high fertility behaviour inspite of running a high health risk such as these arising from high parity. What is this force that motivates the couple of developing countries to have greater number of children even staking their own lives? This certainly needs deeper probing. The decision regarding the optimal number of babies desired by the average number of couples is the critical path for family planning in development. In the developing society where I belong to, we receive a Vedantic blessing from elders "Let you have as many cattles, rich harvests, sons and wealth for prosperity, good health and long life". Obviously the items desired for prosperity and good health are all related to the labour intensive agriculture setting. However, at the same time we also encounter the favours Sanskrit Sayings from 'Pancha Tantra' that only the blessed and the fortunate ones have fewer number of children giving examples of the few privileged rich people having smaller number of children. These contradictory approaches regarding the population, in the very same society, illustrate the time honoured fact that the desired number of children per couple is inversly related to its socio-economic values and stage of development as evidenced in Table 1.

TABLE I

DEMOGRAPHIC PROFILE OF 10 COUNTRIES IN RELATION TO THEIR SOCIO-ECONOMIC DEVELOPMENT STAGE

Country	Estimated Tot.Pop. Mid 1975 (in million)	Crude Birth Rate	Crude Death Rate	Annual Rate of Pop. growth (%)	No. of yrs. to Double Pop.	Infant mortality Rate	Per/capita Gross National Product	Life Expectancy at Birth
Nepal	12.6	42.9	20.3	2.2	32	169	80	44
India	613.2	39.9	15.7	2.4	29	139	110	50
Sri Lanka	14.0	28.6	6.4	2.2	32	45	110	68
Singapore	2.2	21.2	5.2	1.6	43	20	1300	70
Japan	111.1	19.2	6.6	1.3	53	12	2320	73
Rumania	21.2	19.3	10.3	0.9	77	40	740	67
U.K.	56.4	16.1	11.7	0.3	231	18	2600	72
France	52.9	17.0	10.6	0.9	77	16	3620	73
Sweden	8.3	14.2	10.5	0.6	116	10	4480	73
Poland	33.8	16.8	8.6	0.8	87	28	1350	70

Source: Population Reference Bureau, World Population Rate Sheet, 1975

From Plato down to Malthus and modern social scientists, the theory of population growth has been linked with general poverty and its inverse effect on per capita income. Stationary population size was the desired factor according to Plato for maintaining the basic principle of equality in his state. However, there is another aspect of the population which has direct impact on production, because population is one of the important variables required for production of wealth as well. There are savings like "Man is not born with only a mouth to be fed but also with hands to work". Therefore, from these two schools of thoughts we arrive at the conclusion that the population variable has two facets and we would view people both as producer and consumer of the total wealth in a society at a given time.

The above somewhat contradictory views regarding population prevail very much in the developing society, where most people subsist on less than U.S.$50 annual per capita income. Therefore the big question in family planning for development is: Would the vast majority of people subsisting on the absolute poverty line submit voluntarily to sterilization after having a demographically desired number of two living children? If so then family planning as defined earlier would indeed bring short cuts in the long march of development. If not, the present heavy emphasis on family planning as an essential formula for development should be reviewed and appropriately adjusted to meet some of the social needs that would trigger voluntary demand for smaller family size norm.

One of such social need would be the establishment of an infra-structure required for catering family planning services as an integral part of basic health care. Sterilization should receive a top priority in such an integrated package. The lack of such infrastructure in most developing countries has crippled the family planning program to the extent that it is unable to reach the vast majority of young rural couples desirous of limiting family size after having a certain number of sons.

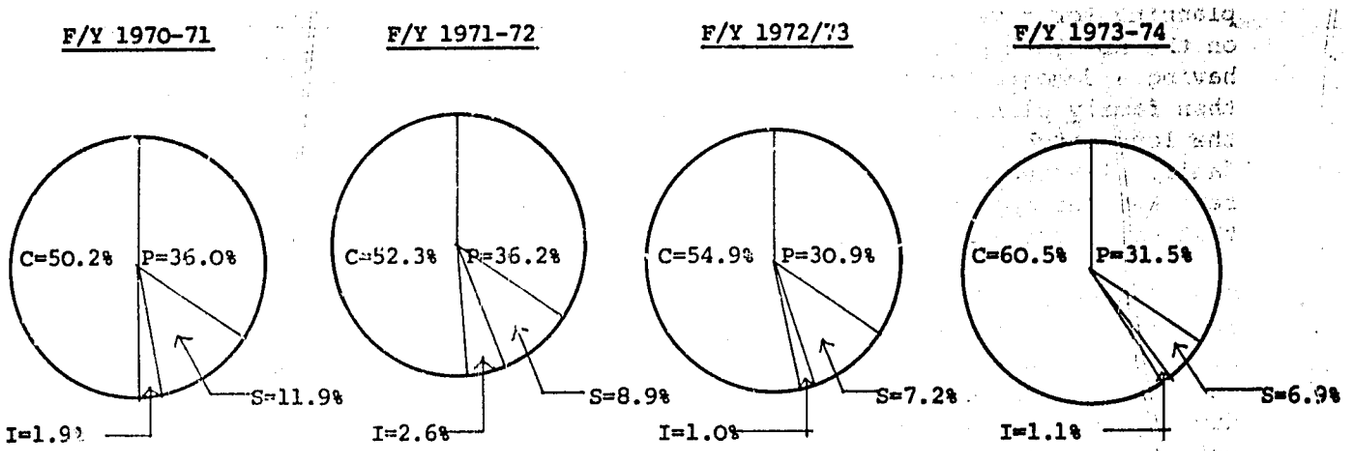
5. Family Planning in Nepalese Situation

I will now take the opportunity of presenting the above stated dilemma in the Nepalese Scenario which is one of the twenty six least developed countries in the world. After a decade of active family planning program in Nepal, the following is the comparative percentage breakdown of acceptors of various methods of family planning for four years 1970/71 to 1973/74.

It is observed from the comparative chart in Figure 1 that there seem to be a steady decline in the sterilization acceptors during the last four years inspite of a steady increase of Family Planning Clinics in the country. One of the important reasons for such a decline in the percentage acceptor of vasectomy is due to the lack of infrastructure required to cater sterilization services is quite high in Nepal as presented in Table II.

FIGURE

A COMPARATIVE PIE CHART SHOWING METHOD-WISE BREAKDOWN OF FAMILY PLANNING ACCEPTORS 1970-74



Total Number of FP/MCH Centers:			
80	111	181	224

Note: C = Condom
P = Pill
S = Sterilization
I = I.U.C.D.

Source: Nepal Family Planning and M.C.H. Project, Annual Report, 1973/74

The demographic profile of vasectomy acceptors is as following:-

TABLE II

DEMOGRAPHIC PROFILE FOR VASECTOMY ACCEPTOR FOR 1972-1973

Average age of wife	Average number of living children	Average number	Illiteracy %		% of Farming occupation of husband
			Wife	Husband	
32	5	3	48.9	34	75

Source: Nepal Family Planning & MCH Project, Annual Report, 1972/73

The figures presented in Table II indicates that the couple desiring no further child in Nepal is a young farmer with six living children of whom three are sons. The switch off point for desiring no further children seems to be two or more than two living sons as perceived by the agrarian community given the above stated social values and economic conditions.

Obviously the family size of six as a norm is a much higher number to meet the demographic target of bringing existing crude Birth Rate of 40 to 25 by 1985 as suggested by Lester Brown for attaining population stability in the developing countries. However it should be noted that provision of sterilization to these couples means protecting a large number of 32 years old women from further pregnancies for another 12 years of a biologically productive phase thus significantly reducing the birth rate. Therefore this should be viewed as the starting point for reducing the Crude Birth Rate from 40 to 25 by the year 2005. The 1971 census report indicates that 17 per cent of the total population would be of married fertile women of 15-44 age group.

TABLE III

PROPORTION OF FERTILE MARRIED WOMEN AGED 15-44 TO TOTAL POPULATION AND PERCENT OF FERTILE MARRIED WOMEN HAVING 5 OR MORE LIVING CHILDREN BASED oN 1971 CENSUS

Total population in million	% of married fertile women 15-44	Total No. of married fertile women	% of married fertile women having 5 or more than 5 living children	No. of married fertile women 15-44 having 5 or more living children
12.6	17	2,142,000	10	214,200

It is also indicated by the 1971 census that 10 percent of the total fertile married women would be having five or more living children. The magnitude of this is presented in Table III. Therefore, in view of the demographic feature of sterilization acceptors in Nepal, these women vis-a-vis couples having 5 or more living children can be regarded as the ready clients for vasectomy or tubectomy at a time if approached.

TABLE IV

DISTRIBUTION OF ACCEPTORS BY NO. OF LIVING SONS

BY METHODS

Number of Living Sons

Methods		0	1	2	3	4	5	6	7	8	Total	Av.No. of Sons
Pills	Frequency	735	1890	2157	1263	607	236	64	18	7	6977	2.0
	Percentage	10.5	27.1	30.9	18.1	8.7	3.4	0.9	0.3	0.1	100.0	
Vasectomy	Frequency	4	134	676	507	248	126	36	14	5	1746	2.85
	Percentage	0	7.7	38.7	29.0	142	7.2	2.1	0.8	0.3	100.0	
Loop	Frequency	13	45	93	53	24	7	2	1	1	239	2.3
	Percentage	5.4	18.8	38.9	22.2	10.0	2.9	0.8	0.4	0.4	100.0	

Source: Nepal F.P. & M.C.H. Project, Comparative Study of Different Methods of F.P. acceptors

The average number of living sons per acceptor of vasectomy, oral contraceptive and I.U.C.D. is two or more than two living sons as shown in Table IV. Therefore the findings as presented in Table IV, V, and VI, indicate that at the time when the client accepts oral contraceptives 22 months after her last delivery having two living sons and a history of about three years (35.6 months).

Another aspect of family planning program which needs to be reviewed is the demographic validity of the temporary but resource consuming birth control measures such as oral contraceptive in the developing country situations.

TABLE V

DISTRIBUTION OF PILL ACCEPTORS DURING 2ND HALF OF 1971-72 BY CLOSED BIRTH INTERVALS IN MONTH

Months	Number	Percent
10-14	160	3.0
15-19	313	6.0
20-24	731	13.9
25-29	876	16.7
30-34	768	14.6
35-39	670	12.8
40-45	514	9.8
46-49	387	7.4
50-59	232	4.4
55-59	156	3.0
60+	445	8.4
Total:	5,252	100.0

Average month: 35.6

Source: Nepal Family Planning and M.C.H. Project, Comparative Study of Different Methods of Family Planning Acceptors

The average closed birth interval among the clients who come to accept oral contraceptive during second half of 1971-72 as presented in Table V is 35.6 months. Similarly it is observed from the Table above that the average months between the date of last delivery and date of acceptance of oral contraceptive is 22 months.

TABLE VI

DISTRIBUTION OF THE PILL ACCEPTORS BY THE INTERVAL BETWEEN THE DATE OF LAST DELIVERY AND DATE OF ACCEPTANCE BY MONTHS

Months	Number	Percent
0- 4	665	11.1
5- 9	1,025	17.2
10-14	983	16.4
15-19	719	12.0
20-24	711	11.8
25-29	355	5.9
30-34	384	6.4
35-39	226	3.8
40-44	165	2.7
45-49	171	2.8
50-54	95	1.6
55-59	110	1.8
60+	393	6.5
Total:	6,000	100.0

Average month: 22.0

Source: Nepal Family Planning & M.C.H. Project,
Comparative Study of Different Methods of Acceptors

This obviously leads to the following conclusions: First, there are some socio-cultural factors which brings an average of 35.6 months of gap between the subsequent births therefore there is no significant impact of modern and operationally expensive temporary method such as oral contraceptives. Secondly the demographic profile of a pill acceptor (see Table VI) having two living sons with an average of 22 months of gap after the last delivery matches very well with that of vasectomy acceptors. Therefore these should be viewed as the possible ready client for sterilization rather than for oral contraceptives.

Conclusion

Finally I would like to present a few conclusions from what has been presented so far.

Family Planning as the right to choose one's family size at a given time deals with social, cultural and economic aspects of a society. Therefore this should be viewed as a vital component for the all around developeent of a society.

The child bearing decision is voluntary in most developing countries in comparison with other aspects of development such as taxation, etc. It also appears that a vast majority of young rural population of developing countries voluntarily perceives five or more living children as the optimal number needed for the context of present day socio-economic norms. The magnitude of the Nepalese married fertile women having five or more living children at a time would be as much as 2,142,000 according to 1971 census.

It also appears that a vast majority of young rural population of developing countries at their current socio-economic development stage, voluntarily perceives five or more living children as the optimal number. The magnitu e of such couples having five or more living children itself would be a large number in comparison with the existing infrastructure capability.

The number of Nepalese married fertile women having five or more living children thus desirous to limit further births is 2,142,000 according to 1971 census. However, only a fraction of such women have been served with a permanent birth control method. This is mainly due to the lack of adequate infrastructure required to deliver sterilization services. Therefore in view of the prevailing high demand for sterilization services as well as high infant mortality in developing countries such as Nepal, top priority should be given to the establishment of a sound infrastructure for the delivery of sterilization as well as basic health care in an integrated manner. This should be viewed as the investment to bring down the currently high fertility and mortality rates as part of the development strategy in the developing society.

It appears from the above illustration that the resources spent on oral contraceptives could be profitably diverted to identify and promote the socio-cultural factors which have been contributing to an ideal spacing of 35.6 months as illustrated in Table V and VI. A study made by Singarinbun and Manning in Indonesia in a breast feeding community with no access to modern contraceptives has also revealed a similar finding that there existed a gap of 35.2 and 36.2 months between the subsequent pregnancies and births respectively. These findings should be given due consideration while planning the strategy of a Family Planning Program.

However, the ultimate goal of a family planning program for national development is the zero population growth rate implying a two children norm women. This level can only be achieved through a series of programmes successfully implemented over time. An effective delivery system of contraceptive services well integrated with the basic health care will prepare the ground to achieve population stability and subsequently zero population growth.

The long term determinants such as social, economic and cultural factors of child bearing decisions of a community should be viewed broadly and beyond the field of a family planning program. The motivational and conditional factors which influence the decision of a community to have a certain number of children should be identified and dealt with so that the demographically desired number of children conducive to development becomes the perceived need of the society. This aspect of motivating the families does not strictly fall within the current understanding of family planning. I submit that the social planners must pursue the objective of motivating a family for fewer children while the basic health service must continue to expand its infrastructure to cope with the current as well as increasing demand for fertility and mortality reducing services.

It is through this dual approach of motivation and expanded infrastructure that a developing society can begin to achieve the family size norm that is consistent with its overall developmental objectives.

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GROUP DISCUSSION NO. I

TOPIC: THE PRIORITIES AND PROBLEMS IN FAMILY HEALTH SERVICES AND FAMILY PLANNING INFORMATION EDUCATION AND COMMUNICATION (I.E. & C.)

Resource Persons

Group - A	Group - B	Group - C
Dr. Norlaily Datuk Abu Bakar	Dr. Raj Karim	Dr. S.C.E. Abraham
Dr. Frank Beckles	Hj. (Dr) Siti Hasmah bte. Hj. Mohd. Ali	Dr. I. Pathmanathan
Miss Lee Yuet Ngor	Miss Mazel Lindo	Mrs. Chusie Sejpluem

GUIDELINES

1. What are the priorities in Family Health Care. On what criteria are these determined.

   a) What are the priorities in Maternal Care

   b) What are the priorities in Child Care

   c) What place has Family Planning, Health Education and Nutrition in the priorities

2. a) Discuss the problems in the provision of Family Health Services in developing countries such as planning, organising implementation, supervision and evaluation.

   b) How can these problems be minimised.

3. Bearing in mind the problems in the provision of Family Health Services and having determined the priorities in the promotion of such services, suggest how these priorities can be incorporated in the Family Health Services in developing countries.

GROUP A - DISCUSSION REPORT

Chairman:	Dr. P. H. Amarasinghe
Rapporteur:	Puan Mahelan Abdul Manap
Participants:	Miss Lamom Srichandrabhand Mrs. Salma Begum Dr. (Mrs) Savitri Gurung Dr. Thomas Ng
Observers:	Miss Maura Leavy Miss Beh Thong Cik H. Nathaniel Raja Mohaini Md. Ho Lee Kian Miss Ivy Khoo Miss Boey Swee Kam Puan Kok Kee Har

SUBJECT: THE PRIORITIES AND PROBLEMS IN FAMILY HEALTH SERVICES AND IN FAMILY PLANNING INFORMATION, EDUCATION AND COMMUNICATION

Family Health is understood by:-

1) Maternal and Child Health Care
2) Family Planning
3) Nutrition
4) School Health
5) Health Education
6) Statistics

On what criteria are they determined? They are determined by:-

1) Geographical conditions of a country, e.g. Nepal has mainly mountains while Bangladesh is criss-crossed by rivers; therefore the means of communication present different problems.
2) Literacy rate varies from 13 to 81% in the different countries.
3) The mortality rate also varies considerably.
4) Nutritional status
5) Availability of trained personnel
6) Availability of vital statistics

a) The priorities in maternal care are:-

1) reduction in maternal mortality rate

2) health education of the public and in-service training of health personnel

3) training and utilization of TBAs

4) increase in the percentage of deliveries in hospitals

5) better natal and post-natal care with special reference to limitation of family size

6) improved collection of vital statistics

Priorities in Child Care

1) improved care of mother during pregnancy and limitation of family size

2) improvement in nutrition

3) control of communicable diseases especially gastro-enteritis

4) immunization programme

5) health education for the public and health personnel

6) improved collection of vital statistics

b) Family Planning, Health Education and Nutrition should hav equal priorities.

A. 1) PROBLEMS IN PLANNING

a) Non-availability of accurate vital statistics

b) Government's commitment must be in-toto

c) Lack of co-ordination in planning and in implementatio

d) Lack of funds

e) Poor feedback

f) Lack of knowledge of the planners in all areas

2) ORGANIZING IMPLEMENTATION

a) Lack of trained personnel to convey the plan to the people

b) Lack of co-ordination between centre and periphery

c) Insufficient feedback

d) Lack of involvement at grassroot level

3) SUPERVISION

a) Lack of personnel - supervisors

b) Difficulties in communication in the rural area

c) Lack of funds - limited travelling expenses

4) EVALUATION

a) Lack of records

b) Lack of feedback

c) Lack of staff - trained evaluators

2B. Problems can be minimised by:-

1) Government should be aware of the whole problem

2) The plan should be simple, practical and acceptable to the people

3) Good co-ordination between all Government departments and voluntary organizations

4) Planning of seminars should include all key personnel required by the planners - medical, economists and the research staff

5) Improvement of living conditions by land development, food production and job opportunities.

3 How priorities can be incorporated into the Family Health Services:-

1) Health education of existing personnel by in-service training and refresher courses

2) Crash training programmes of new personnel

3) Incorporating Family Planning and General Health Education in schools, clinics and communities

4) Expand Basic Health Services in the rural areas by having more infra-structure, trained personnel and equipment.

5) Government should formulate a national policy on food, nutrition, Health and Family Planning Services.

GROUP B - DISCUSSION REPORT

Chairman:	Prof. Prasong Tuchinda
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Observers:	Dr. Loh Sow Khin Cik Hasmah Zain Miss Chee Peck Hoon Miss Soon Eng Lian Mrs. Elizabeth Leong Cik Kurshiah Bee Cik Hamidah Kamaruddin

SUBJECT: THE PRIORITIES AND PROBLEMS IN FAMILY HEALTH SERVICES AND IN FAMILY PLANNING INFORMATION, EDUCATION AND COMMUNICATION

The group had some difficulty in grasping the topic to begin with but eventually got down to the question of concluding on a criteria. A list of problems was listed before determining the priorities.

1. Insufficient care of the mother
2. Communications
3. Transportation
4. Cultural factors - includes customs and traditions
5. Attitude towards health concepts
6. Economic condition
7. Early marriages

1.A. The priorities in maternal care are listed as below with recommendations.

	Priorities Problems	Recommendations
i	Early marriages	A suitable marriageable age, i.e. 20-30 years
ii	Attitude towards health concepts	Limitation of pregnancy through family planning. Basic health education for the young to be incorporated in the general educational curricula. Adult education.
iii	Insufficient care for the mother	Equal distribution, utilization and effectiveness of health personnel.
iv	Economic Conditions	Improve the economic conditions of the country.
v	Communications	Physical communication of all types in the country should be improved. This should include personal contacts.
vi	Cultural factors	General and health education to be introduced to the community.
1.B. i	Insufficient Child Care	Parent craft - includes child rearing, immunization, nutrition, growth and development, prevention of home accidents and first aid. Health personnel - Responsible for the continuity of child care from birth to school age. (Responsibilities - prevention of disease and promotion of Health (Physical, mental and social well-being). Equal distribution, utilization and effectiveness of the health personnel.
ii	Economic Conditions	Improve the economic status of the family.
iii	Cultural factors	Educate the parents and the community on general and health education and to include and extend to the elders of of the family.

1.C. The priorities in Family Health care are as follows:

1. Health Education
2. Family Planning
3. Nutrition

	Problems		How to Minimise
2.	No definite planning objectives		Identify problems properly. Participation of the appropriate personnel.
	Organization Implementation	Manpower	Increase the number. Review the training time.
		Management	Cut off red tape, promote continuing education.
		Money	Increase budget and careful spending.
	Supervision - No continuity		A definite job description for supervisors. Refresher course for field workers as well as supervisors every 3-5 years.
	Evaluation	Not related to objectives	Set up a sound method of evaluation

3. The question is not very clear to the group but we suggest that MCH should be a priority for inclusion in the Family Health Services and Family Planning integrated into the MCH services.

GROUP C - DISCUSSION REPORT

Chairman:	Dr. Ahmad Adnan
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Observers:	Mrs. Chinda Busban Puan Hjh. Zahara Abdullah Raja Noraziah Ahmad Miss Rebecca John Md. Anna Tay Miss Chan Kum Sun Puan Umi Kelsom Dr. L. Campos

SUBJECT: THE PRIORITIES AND PROBLEMS IN FAMILY HEALTH SERVICES AND IN FAMILY PLANNING INFORMATION, EDUCATION AND COMMUNICATION

1. INTRODUCTION

The concept of family health care should cover the following services:

a) Medical Care

b) Dental Care

c) Maternal and Child Health Care, consisting of

- ante natal care
- domiciliary midwifery
- post natal care
- child health care

- immunisation
- applied nutrition
- school health services
- family planning services

d) Public Health Nursing

e) Communicable Disease Control

f) Environmental Sanitation

g) Health Education

h) Simple Laboratory Procedures

i) The Maintenance of Records

In view of the high mortality rates, that is maternal mortality, infant mortality and toddler mortality rates in all the participating countries, top priority should be given to the maternal and child health care component of the above services. This should include both the curative and preventive aspects.

2.1 PRIORITIES IN MATERNAL CARE

The group felt that in order to have a proper and efficient maternal care the following priorities should be met and made available:

1. The training and employment of more and adequate number of midwives to cope with the expansion of maternal care services.

2. Training of doctors in midwifery before they are posted to the rural areas.

3. There should be more adequate supervision of staff at all levels of the maternal care services. The supervisory staff themselves should have proper training and should have midwifery qualification. It is noted that in some participating countries there are new nurses who have just completed their basic training but without midwifery qualifications are posted to the rural areas to supervise the auxiliary midwives.

4. Each country should establish units of flying squads fully equipped with personnel and blood to cope with any emergencies.

5. There should be an improvement in communication system - transport, telephone, etc.

6. The registration of births are to be improved so that the information on the number of births in each area to be submitted to the local health services.

7. There should be an improvement in the referral system between the maternal care services and the curative services in the hospital.

2.2 PRIORITIES IN THE CHILD HEALTH CARE

In view of the high mortality and morbidity rates in children the group felt the following facilities should be given priorities:

1. The inclusion of care of the new born in the training curriculum of all the categories of midwives.

2. To make an effort to get more paediatricians in the services.

3. To get public health nurses trained in paediatric care.

4. The paediatricians although based in the central hospitals should extend their services to the periphery e.g. district hospitals and health centres.

5. The inclusion of tetanus toxoid to ante natal cases.

6. In countries where routine immunisation of the new born is not being carried out should try to organise and implement such services.

7. There should be a sufficient and continuous supply of vaccines at the various centres and clinics.

8. The referral system between hospital and the health services are to be improved.

9. Since there is a high proportion of accidents occuring at home among children, steps should be taken to reduce or prevent this.

3. PROBLEMS IN THE PROVISION OF FAMILY HEALTH SERVICES SUCH AS PLANNING, ORGANISING, IMPLEMENTATION, SUPERVISION AND EVALUATION.

It is felt that as far as Malaysia is concerned and from the working paper presented earlier no problem is anticipated in the planning and organising the services. Participants from other countries however felt that they are not competent to give any views on the problems on planning and organising because these are done at the higher level of administration.

3.1 PROBLEMS IN THE IMPLEMENTATION

1. The biggest problems in the implementation of the above services is that there are not enough trained personnel.

2. At times it is found there is an unequal distribution of personnel in the various clinics.

3. Frequent transfers of the staff before they get used to and have the confidence of the local population is also considered as a major problem.

4. Lack of transport and equipment.

5. Financial problem.

3.2 PROBLEMS OF SUPERVISION

All the participating countries felt there is a need to strengthen the supervision of the personnel in the above service. Among the problems which are highlighted are:

1. Inadequate number of supervisory staff.

2. Improper lines of supervision resulting in the various categories of staff getting different instructions from different supervisors.

3. In certain countries there are security and weather conditions which prevent adequate supervision of the ground level staff.

3.3 PROBLEMS OF EVALUATION

The group felt that a proper evaluation of the service will have to depend on a proper recording system. The problems at the moment in all the participating countries are:

1. Records are not properly kept because there is no special personnel assigned to do it. They are being carried out at the moment by the technical staff whose main purpose was to carry out the service.
2. There is no proper feedback of information from the top downwards.
3. There is no standard system of complying and analysing the records.

4. CONCLUSION

Since the various problems mentioned above involve various sections of personnel ranging from the policy makers, health planners, health trainers and health educators the suggested priorities can only be incorporated in the family health services of any country by having an integrated approach and working together of all these various levels of people involved.

GROUP DISCUSSION NO. II

TOPIC: THE INCORPORATION OF FAMILY PLANNING, PAEDIATRICS AND NUTRITION IN THE BASIC MIDWIFERY TRAINING CURRICULUM

Resource Persons

Group - A	Group - B	Group - C
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Miss Lee Yuet Ngor	Miss Mazel Londo	Mr. M. S. Murthy

GUIDELINES

1. To what extent are Family Planning, Paediatrics and Nutrition included in the present basic midwifery training curriculum of all categories of midwives.

2. In view of the midwives' expanding role in Family Health Services, how can the training curriculum be developed so as to include Family Planning, Paediatrics and Nutrition in order to provide adequate preparation for fully qualified Family Health Care midwives.

3. What are the implications involved in achieving this.

4. Make appropriate recommendations.

GROUP A - DISCUSSION REPORT

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SUBJECT: THE INCORPORATION OF FAMILY PLANNING, PAEDIATRICS AND NUTRITION IN THE BASIC MIDWIFERY TRAINING CURRICULUM

1. The present curriculum for the Sri Lanka trained midwife who is not a nurse midwife is given below:-

Part I of the midwifery training lasts one year. The syllabus is given below:-

			No. of hours Theory	No. of hours Practical
1.	Elementary Nursing		100	158
2.	Anatomy and Physiology			
3.	Community Health -			
	- Ethics	7		
	- Hygiene	20		
	- Environmental Hygiene	14	75	36
	- Nutrition	22		
	- Health Education	12		
		75		
4.	Midwifery)		149)	1,835
	Child Care)		24)	
5.	Family Planning		27	60
			407	2,089

The Practical experience is divided as follows:-

- Orientation	2 weeks
- Elementary Nursing	3 weeks
- Midwifery	
- Child Care	6 weeks
- Ante Natal Clinic	6 weeks
- Labour Room	6 weeks
- Post Natal and Baby Care	6 weeks
- Family Planning Clinic	6 weeks
- Premature Baby Room	4 weeks
- Paedetrics	6 weeks
- Examination	1 week
Total:	52 weeks

Part 2 Midwifery Training

Six months training is given at eight Public Health Centres - Kalutara, Moratuwa, Panadura, Galle, Kurunegala, Werellagama, Kankansanturai and Kandy. Trainees should have the following qualifications:-

1. Passed Part I of the Midwifery Examination.
2. Interval between Part I and Part 2 should not exceed two years.
3. Should be unmarried during the period of training.

The trainees are required to reside in the area of Field Practice.

Subjects covered during this period of training

1. Introduction to community health
2. Administration of Public Health Services
3. Vital statistics
4. Personal Hygiene
5. Maternity Welfare and Family Planning
6. Child Welfare including School Health
7. Communicable Diseases
8. Nutrition
9. Environmental Sanitation
10. Health Education

11. Record Keeping

12. First Aid

13. Elementary Care of the Sick in the Home

14. Mental Health

After the full 18 months course the trainees take up the Final Midwifery Examination conducted by the Examination Board appointed by the Director of Health Services. After passing the examination, they are registered by the Sri Lanka Medical Council.

Those who are qualified as nurse midwives have six months training in a hospital and six months training in the field - just as trainee midwives do. After the Midwifery Examination, they are registered as nurse midwives by the Sri Lanka Medical Countil.

in Bangladesh they have a similar training for trained midwives. In the case of nurse midwives, they have basic three years nursing training and one year of special midwifery training.

In Thailand, the Class I Professional Nurse Midwife has three years training but they work in hospitals and in the community. The auxiliary midwife has 1½ years training both in hospitals and in the community.

Nepal - The Graduate nurse midwife training period is for three years with six months in the maternity hospitals. The auxiliary nurse midwife has two years training with nine months in the maternity hospitals.

The Malaysian nurse midwife has a basic three years nursing training and one year of midwifery training with nine months in hospitals and three months in the field. The auxiliary midwives have two years training with eighteen months in hospitals and six months in the field.

Sarawak Professional midwives training is the same as in Malaysia, that is basic three years training and one year of midwifery training, with nine months in hospitals and three months in the field. The Auxiliary midwives have two years training, with four months in the hospital and the rest in the field.

The syllabus is the same in all the countries although the stress may be in different fields.

II. NUTRITION

Basic nutrition in relations to the area should be emphasized. Officials in the agricultural departments should be invited to planning sessions. The nutrition experts should give lectures on the best value to get out of the food budget of a family. Practical demonstrations where trainees are taken to market and shown the best foods to buy - according to the prices prevailing.

An important aspect is for trainees to collect taboos about nutrition in their areas, e.g. fish causes worms, etc. The approach should be food and nutrition rather than a pure health approach.

Nutrition for the pregnant and post-partum mothers must be emphasized.

The importance of breast feeding must be given a prominent place in nutrition. Also the diet on weaning the baby from the breast, and the introduction of solid foods - what and when.

Teach trainees in the use of a Home Garden.

Teach the value of correct cookery to get the maximum value of the food, e.g. overboiling lessens the vitamins in vegetables. Elimination of incorrect methods in cooking.

Assessment of the nutritional status of mothers and children.

Recognition of the signs and symptoms of malnutrition.

PAEDIATRICS

Trainees should be taught that there are good and bad customs in any population.

Many beliefs and practices have intrinsic value. An attempt should be made to separate customs into the following groups.

1. Beneficial practices: for example, true demand breast feeding, the continual physical contact between the infant and adults, giving simple tasks to children so that they feel needed.

2. Innocuous practice: for example, wearing beads and bangles, rubbing the infant with oil.

3. Practices believed to be harmful: for example the use of an uncleaned instrument in cutting the umbilical cord which might cause tetanus neonatorum. Semi-solids, in the form of rice (either soft-boiled or pre-chewed) are ususally in the first few days of life. In measles, herbs may be applied to the eyes which damage the conjunctive.

Emphasis should be given to nutrition as explained earlier.

Recognition of the "well-baby", the recognition of departures from the normal and of the critical disease symptoms like fever, dehydration and convulsions.

Recognition of early stages of malnutrition.

Teaching of immunisation for smallpox, tetanus and diptheria be given sufficient time in the curriculum together with practical lessons in giving these. Teach them to investigate all deaths (mothers and children) in their area.

Detection and Control of Communicable Diseases: One or two special lectures could be given on "specialized campaigns" like anti-malaria, yaws, venereal disease. Involve the mother in the education at home visits and clinics.

Encourage the simple techniques for early detection of abnormal conditions - e.g. UNICEF weight for Age chart, so mother can assess the physical development of her child.

FAMILY PLANNING

1. Simple demographic ideas
2. What happens if there is no family planning at personal and at National levels.
3. Idea that the total natural wealth has to be divided among all the families - the more in the family, the less for each.
4. Motivation - both the trainee and the public.
5. Teach only the methods she will be using.
6. Simple Record keeping - uniform throughout each countr
7. Evaluation teaching.

III. IMPLICATIONS

1. Governments of the represented countries will have to decide whether they would accept the W.H.O. concept of an "integrated health service" where the service necessary for the health protection of a given area be provided under a single administration or under several agencies with proper co-ordination of these services.
2. The planners must accept the idea that Family Health includes all aspects of maternal and child welfare - including family planning.
3. The role of the fully trained midwife to be the front line key worker when working in the field, as opposed to when her duties are confined to hospital work.
4. "Task analysis" should be the primary task before planning her job description in the future. Shifts in emphasis on the subjects should take place.
5. Additional manpower, time and money will have to be made available.
6. Establishment of special field training areas.
7. Already trained midwives to return for Refresher Courses so they can be brought up to date in their Family Health knowledge.

IV. RECOMMENDATIONS

1. Family Planning, Nutrition and Paediatrics should be given a more prominent place than is done at present in most countries.
2. Various government departments like economics, agriculture, nutrition and Family Planning agencies must be co-opted in the planning of the curriculum.

3. The involvement of the community leaders well in advance before the midwife with the expanded role comes into reality.

4. Practical work should comprise the main part of the course.

5. Materials e.g. audio-visual and modules, may be obtainable from UNICEF.

6. Tutors must already have practical experience and should be given special courses in their special field before starting work.

GROUP B - DISCUSSION REPORT

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Observers:	Cik Hasmah Zain Miss Chee Peck Hoon Miss Soon Eng Lian Cik Kurshaiah Bee Cik Hamidah Kamruddin Mrs. Cindy Nasir Taik Miss Elizabeth Leong
Resource Personnel:	Dr. Raj Karim Dr. Y.H. Chong Miss Mazel Lindo

SUBJECT: THE INCORPORATION OF FAMILY PLANNING, PAEDIATRICS AND NUTRITION IN THE BASIC MIDWIFERY TRAINING CURRICULUM

All categories of midwives are defined as follows:

a) Professional midwives/nurse midwives (3½ - 4 years)
b) Auxiliary midwives (1½ - 2 years)
c) Traditional birth attendants

The present basic midwifery training curriculum varies from country to country. Examples as quoted from a few countries:

	Country	Nurse/Midwives	Aux. Midwives	TBAs
Family Planning	Thailand	*L. 24 hrs. *P. 32 hrs.	L. 24 hrs. P. 24 hrs.	P. and *Demo - 6 hrs. (in some areas)
	Sri Lanka Bangladesh Nepal	L. 18 hrs. & P.	L. & P. 15 hrs.	-
	Sabah	L. 6 hrs. P. 6 hrs.	-	-
Paediatrics	Thailand	Newborn in health & disease 12 hrs.	12 hrs.	P. and Demo - 4 hrs. (in some areas)
		Child health & diseases 24 hrs.	20 hrs.	-
		Practice Ward attachment 3-4 mths.	4 weeks + home visiting and PH teaching	-
Nutrition	Thailand	Included in Paediatric and OB teaching	L. 44 hrs. in Nutrition of mother and child to include preparation of infant food and breast feeding	2 hrs. breast feeding. Infant and mothers diet. Food hygiene.

Most of the other countries have no exact hours of paediatric lectures and practice but said that this is included in their curricula.

Other countries placed emphasis on this field to child's and mother's diet, breast feedings, formula and food hygiene.

* L = Lecture P = Practice Demo = Demonstration

EXPANDING ROLE FOR PROFESSIONAL MIDWIVES & AUXILIARY MIDWIVES ON FAMILY PLANNING

ROLES	RECOMMENDATION	METHOD
Motivation and Education	More emphasis	Lectures Group discussion Role play Audio-visual
IUD Insertion	Anatomy & Physiology of) Reproductive Organs - Pelvic) examination - pap smear)	Lectures Demonstration Practical when laboratory facility is available
Infertility	Advise and refer to the appropriate person	Lectures Group discussion
Record and Simple Statistics	Responsibility	Lectures & Practical
For TBAs		
Motivation	Responsibility	Lectures & Role Play
Recording of Birth and Death	Responsibility	Lectures & Role Play

EXPANDING ROLE FOR PROFESSIONAL MIDWIVES AND AUXILIARY MIDWIVES ON PAEDIATRICS

ROLES	RECOMMENDATION	METHOD
Child Care from Birth to School Age:- Priorities - Assessment of growth and development, infant feeding and child nutrition, communicable disease and immunisation.	Examination and Care of normal infant and child; breast feeding. Diagnosis and treatment of simple illness. Domestic hygiene and Village sanitation. Understand community and cultural aspects.	Lectures Group discussions Audio-visual aids Practical

EXPANDING ROLE FOR PROFESSIONAL MIDWIVES AND AUXILIARY MIDWIVES ON NUTRITION

ROLES	RECOMMENDATION	METHOD
Nutrition for the family	More emphasis on other members of the family besides the mother and the child. Cooking demonstration, interaction of infection and infestation to nutrition.	Lectures Demonstration Group discussion Parentcraft Audio visual aid
Record	Weight curve	Practical
FOR TBAs		
Motivation & Education	Responsibility	Group discussion Demonstration Audio visual aids

GROUP C - DISCUSSION REPORT

Chairman:	Dr. Ahmad Adnan
Rapporteur:	Mrs. Mohan Tamrakar
Participants	Miss Joan Tan Mrs. Jebunessa Mrs. P.M.L. Ranasinghe
Observers:	Mrs. Chinda Busban Puan Hjh. Zahara Abdullah Raja Noraziah Ahmad Miss Rebecca John Md. Anna Tay Miss Chan Kum Sum Puan Umi Kelsom Dr. L. Campos

SUBJECT: **THE INCORPORATION OF FAMILY PLANNING, PAEDIATRICS AND NUTRITION IN THE BASIC MIDWIFERY TRAINING CURRICULUM**

1. Introduction

In the present day concept of family health, the training of all categories of midwives which is at the moment mainly orientated for the delivery of Maternal and Child Health alone is felt inadequate. In order to prepare the midwives for the expanded role they are expected to play, their 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 in order to prepare the midwives for the above role, an attempt is made to define first the extent to which the family planning, paediatrics and nutrition are included in the present basic training curricula of (a) nurse midwives, and (b) auxiliary midwives.

2. The Extent of Present Training

2.1. Nurse/Midwife

The duration of basic training period for nurse/midwife does not seem to vary much in all the participating countries.

i) Family Planning - it is felt that in all countries only the basic concept of family planning is presently being given in the basic training curriculum.

ii) Paediatrics - the teaching of paediatric care is presently limited to the care of the newborn and infant, which is given mainly by the nursing or midwifery tutors. The paediatrician or medical personnel are not very much involved in the training process.

iii) Nutrition - separate identity is not being given to the subject of nutrition; it is just incorporated into the maternal care and infant care teachings.

2.2 Auxiliaries

The extent of training in these fields for the auxiliaries is even less than that of the nurse/midwife.

3. How Can the Training Curricula be Developed So As to Include Family Planning, Paediatrics and Nutrition

3.1 Duration of Training Period - it is felt that the duration of basic training period of about 3 years general nursing and 1 year midwifery for nurse/midwives, and 2-year midwifery training for auxiliaries need not be extended. The inclusion of family planning, paediatrics and nutrition could be made by revision of the existing curricula, stressing on certain aspects which are thought to be more important.

3.2 Involvement of Other Training Personnel - it is felt that medical personnel especially paediatricians, as well as nutritionists, should be involved as trainers.

3.3 Stress on Health Education and Motivation - it is generally felt that the present concept of training is geared mainly to providing the actual service (technical) but not so much importance is put on the health educatio and motivation aspect. Since health education and motivation play a very important role in the efficient delivery of family health service, this subject should have a high priority in the training curricula.

3.4 Family Planning - all aspects of family planning, short of the insertion of IUD, should be taught to all categories of midwives.

3.5 Paediatric and Nutrition - in training of midwives in the field of paediatrics and nutrition the aim should be that the midwives should be able to take care of the newborn up to one month old. This includes the knowledge of:-

i) infant feeding and importance of breast milk

ii) management of low birth weight babies, and

iii) the ability to detect certain congenital abnormalities, genetic problems and common paediatric problems and diseases.

4. Implications

In the revision and the expansion of the present basic training curricula of all categories of midwives, so as to prepare them for an efficient delivery of family services, the following constraints will have to be considered:-

1. Man
2. Money
3. Material

5. RECOMMENDATIONS

1. Since the auxiliaries are now expected to play a more important role in the delivery of health services, it is felt that in certain countries their qualifications for entry level should be raised.

2. To have a more attractive salary structure, in view of the responsibility and expanding role.

3. Revision of training syllabus every 3 years after consultation with the ground level staff.

4. To establish a good follow up system in order to ascertain what was taught during the training period is being carried out properly at the ground level. This should be done both by the trainers and supervisors.

5. To organize refresher courses at least every five years.

6. To utilize all available resources for the training purposes.

7. Provision should be made for the training of tutors in the specific areas such as family planning, paediatrics and nutrition.

GROUP DISCUSSION NO. III

TOPIC: A) THE EXPANDING ROLE OF ALL CATEGORIES OF MIDWIVES AND TBAS IN MCH/FP SERVICES AND EDUCATION

B) TBAS AS MEMBERS OF THE HEALTH TEAM

Resource Persons

Group - A	Group - B	Group - C
Dr. Norlaily Datuk Abu Bakar	Dr. Raj Karim	Hj. (Dr.) Siti Hasmah bte. Hj. Mohd. Ali
Dr. Frank Beckles	Dr. Bruce Faris	Dr. Jose Catindig
Puan Rosina Hj. Abdul Karim	Miss Mazel Lindo	Mrs. Chusie Sejpluem

GUIDELINES

1. a) What are the present functions of all categories of midwives including TBAS in MCH/FP education and services.

   b) How can these functions be expanded. Discuss the implications involved.

2. a) It is an accepted fact that the TBAs are in their own way supplementing government's health programmes.

) How can their resources be more effectively utilised.

GROUP A - DISCUSSION REPORT

Chairman:	Dr. P. H. Amarasinghe
Rapporteur:	Puan Mahelan Abdul Manap
Participants:	Miss Lamom Srichandrabhand Mrs. Salma Begum Dr. (Mrs) Savitri Gurung Dr. Thomas Ng - unfortuantely not present
Observers:	Miss Maura Leavy Miss Beh Thong Cik H. Nathaniel Raja Mohaini Md. Ho Lee Kian Miss Ivy Khoo Miss Boey Swee Kam Puan Kok Kee Har

SUBJECT: A) THE EXPANDING ROLE OF ALL CATEGORIES OF MIDWIVES AND TBAS IN MCH/FP SERVICES AND EDUCATION

B) TBAS AS MEMBERS OF THE HEALTH TEAM

A. The present function varies in different countries in the countries presented, the midwives in the majority of countries are divided into:-

1) Professional Midwives
2) Trained Midwives
3) Auxiliary Midwives (except Sri Lanka)
4) Traditional Birth Attendants (except Sri Lanka)

In Bangladesh there is an additional category called the Lady Health Visitor with 1 year midwifery training and 3 months in MCH work.

The next is Family Planning workers with 1 year of Family Planning training and 3 months of midwifery.

In Nepal, there is an auxiliary health worker trained both in maternity and family planning work and a special category called the Graduate Nurse-Midwife who has a 3 year course.

FUNCTIONS:

a) Nurse Midwife - In all countries, the functions are:-

1) Ante-natal care
2) Natal care
3) Post natal care
4) Baby and infant care
5) Health education
6) Family Planning: Motivation, supplying of pills and condoms
7) In Bangladesh, they also insert IUDs.

The Nurse Midwife is allowed to give injections of Ergometrine.

In some countries, nurse midwives are allowed to give intravenous injections. In most countries they do this unofficially.

b) Trained or Auxilliary Midwives

Their present functions in all countries include the conduct of normal deliveries, the care of ante-natal and post-natal women, care of infants, health education and family planning work including motivation and supply of pills and condoms.

c) The TBAs

The functions of this category of midwives vary with the countries. In most countries, they conduct deliveries, post-natal care of the mothers and babies until their cords drop off. They help to do household work such as cooking for the family and washing clothes. After training, they do family planning work such as motivation work and re-supplying of pills. In Malyasia, the TBAs are registered with the Midwives' Board. They also advise mothers to come to the clinics for the ante-natal care.

In Thailand and Bangladesh, they are not registered but they conduct the majority of the deliveries in the homes. They are not involved in family planning work in Nepal and Thailand.

Lady Health Visitors and the family planning workers in Bangladesh, in addition to giving ante-natal and post-natal care, conduct Family Planning education, motivation, and distribute pills and condoms. They also insert IUDs.

Expanding the Functions of the Trained Midwife

Thailand has completed a pilot project to expand the role of the nurse-midwife to that of a "nurse practitioner" after a special 6 months' training. The nurse midwives were allowed to sit in civilian clothes with the Doctor in the out-patient department. The training includes the diagnosis and treatment of minor ailments. They have to conduct 20 normal deliveries, 5 home deliveries and were trained in conducting abnormal deliveries. They were taught how to suture the perineum, the techniques of external version, breach extraction and removal of placenta. After 1 year their work was evaluated and presented to the Ministry

of Health, who after consulting with all grades of medical and pre-medical personnel, authorised legislation which was passed in 1975. Other countries in Group A like Malaysia are considering proposal on the same lines. The delegates of five countries in the group felt that intra-muscular and intra-venous injections and the manual removal of placenta should be included in the Midwives training courses and Refresher courses and certificate of competence be issued to midwives already in practice. Governments of the various countries should be persuaded to legalise these procedures somewhat in the same way as Therapeutic abortion is legalised for doctors - when the mother is in danger of imminent death. The midwife will not get an absolute right to use this procedure. She can only use them when there is no other way of saving a mother's life. But all midwives should be so trained.

B. It is an expected fact that TBAs in all countries supplement the Government's Health Programme.

In some countries, the suggestion has been made to expand their role to the fullest possible extent. All countries agreed that TBAs are very influential people and most of them work with true compassion for the patient and her family with little financial reward. In Malaysia, the TBAs are registered and by the end of April 1975, 10 of the 11 states of Peninsular Malaysia had a project to expand the scope of the TBAs.

The Project

Extend the TBAs' use in Family Planning.

a) Recruit new acceptors and encourage drop-outs to return to family planning

b) To resupply oral pills.

Review of the project showed that a total of more than 7,000 acceptors were recruited by the TBAs as new acceptors of family planning.

Thailand and Nepal felt that the burden of work already placed on the TBAs precluded any further expansion of their role except in education and motivation in family planning.

GROUP B - DISCUSSION REPORT

Chairman:	Prof. Prasong Tuchinda
Rapporteur:	Miss Elizabeth Leong
Participants:	Miss Nora Hejananda Suchinta Mrs. Mita Thakur Dr. Shamsum Nahar Prof. L.V. de Saram
Observers:	Cik Hasmah Zain Miss Chee Peck Hoon Miss Soon Eng Lian Cik Kurshiah Bee Cik Hamidah Kamaruddin Mrs. Cindy Nasir Taib
Resource Personnel:	Dr. Bruce Faris Miss Mazel Lindo

SUBJECT: A) THE EXPANDING ROLE OF ALL CATEGORIES OF MIDWIVES AND TBAS IN MCH/FP SERVICES AND EDUCATION

B) TBAS AS MEMBERS OF THE HEALTH TEAM

The group started by categorizing the types of midwives in the region, as follows:-

1) Professional midwives
2) Auxiliairy midwives
3) TBAs

The present functions of the various categories of midwives:-

Professional Midwives:

1) Care of the Women - pre-natal period
   - natal period
   - post-natal period
2) Conduct normal deliveries on her own responsibility
3) Care for the newly-born infant
4) Able to recognize the warning symptoms of abnormal or potentially abnormal conditions which necessitate referral to a doctor and to carry out emergency measures in the absence of medical help.
5) She may be practising in hospitals and health units.
6) Health education in the Family and the community.

Professional Midwives: The Expanded Role and Implications

Expanded Role	How	Where	When	By Whom
1. Field & Gynaecology related to Family Planning	Lecture Practical skill	Institute & Field	Undergraduate) Postgraduate)	Obstet-rician
2. Child Care from birth to school age on prevention and health promotion, e.g. immunization, nutrition, child rearing.	Lecture Group discussion Seminars	Institute & Field	Undergraduate & continuing Education	Doctor Nurse/ Tutor
3. Health Educator	Lecture Role Play	Institute & Field	Undergraduate & continuing education	Doctor Nurse Tutor Health educator
4. Counselling and Problem of Solving	Group discussion	Institute & Field	Undergraduate & continuing education	Consultant in parti-cular field
5. MCH record of statistics	Lecture Practical	Institute & Field	Undergraduate	Statis-tician Recorder

The Auxiliary Midwives

1) Care of the women in pre-natal, natal and post-natal periods.

2) Conduct normal deliveries on her own responsibility.

3) Care of the newly-born infant.

4) Able to recognize the warning symptoms of abnormal conditions which necessitate referral to a doctor and nurse-midwife and to carry out emergency measures after trying to summon medical aid.

Auxiliary Midwives: The Expanded Role and Implications

Expanded Role	How	Where	When	By Whom
1. Motivation, prescription, supply of contraceptives and referral in family planning	Lecture Group discussion Role play Audio-visual aids	Institute & Field	Undergraduate & continuing education	Nurse/ Tutor Doctor Social Worker Health educator
2. IUD Insertion	Lecture Practical	Institute & Field	Postgraduate	Doctor Nurse/ Tutor
3. Infant and Child Care	Lecture Group discussion Seminars	Institute & Field	Undergraduate & continuing education	Doctor Nurse/ Tutor
4. Nutrition & Food Hygiene	Lecture Group discussion	Institute & Field	Undergraduate & continuing education	Nutritionist Nurse/ Tutor
5. Immunization	Lecture Practical	Institute & Field	Undergraduate	Doctor Nurse/ Tutor
6. Home Visit and Home Hygiene	Lecture Group discussion Practical, Audio-visual aids	Institute & Field	Continuing education & undergraduate education	Nurse/ Tutor & Health Education
7. Health Education	Lectures Group discussion Audio-visual aid Role Play	Institute & Field	Undergraduate & continuing education	Health educator
8. First Aid	Lectures Practical	Institute & Field	Undergraduate & continuing education	Doctor Nurse/ Tutor
9. MCH records and simple statistics	Lectures Practical	Institute & Field	Undergraduate & continuing education	Recorder & Statistician Nurse/ Tutor

TBAs

1) Care of the women in natal and post-natal periods
Pre-natal period in some countries.

2) Conduct deliveries on her own responsbilities.

3) Care of the newborn infants to a variable extent.

4) Moral and security support to the mother and family.

TBAs: Expanded Role and Implications

Expanded Role	How	Where	When	By Whom
1. Identify as a member of Health Team	Government & Recording	Ministry of Health	After local seminar	Selected nurses - teacher
2. Able to recognize apparent abnormally in pre-natal and natal period, e.g. ante-partum haemorrhages, obstructed labour, etc.	Group discussion Lectures	Field	Local seminar and continuing education	Doctor or selected nurse teacher
3. Aseptic Precaution	Group discussion	Field	Local seminar and continuing education	Selected nurse teacher
4. Infant feeding, Nutritional food hygiene	Group discussion	Field	Local seminar and continuing education	Selected nurse/ teacher
5. Motivation towards basic health care of the child	Group discussion	Field	Local seminar & continuing education	Selected nurse/ teacher
6. Motivation towards family planning and following up of the acceptor (supply of pills & condoms)	Group discussion Role play Audio-visual aid	Field	Local seminar & continuing education	Selected teacher

GROUP C - DISCUSSION REPORT

Chairman:	Dr. Ahmad Adnan
Rapporteur:	Mrs. Mohan Tamraka
Participants:	Miss Joan Tan Mrs. Jebunessa Mrs. P.M.L. Ranasinghe
Observers:	Mrs. Chinda Busban Puan Hjh. Zahara Abdullah Raja Noraziah Ahmad Miss Rebecca John Md. Anna Tay Miss Chan Kum Sun Puan Umi Kelsom Dr. L. Campos

SUBJECT: A) THE EXPANDING ROLE OF ALL CATEGORIES OF MIDWIVES AND TBAS IN MCH/FP SERVICES AND EDUCATION

B) TBAS AS MEMBERS OF THE HEALTH TE

1. PRESENT FUNCTION OF MIDWIVES

1.1 Nurse/Midwives

1. MCH/FP Education

In all the participating countries nurse/midwives do conduct health education either in an organized way or through an individual approach to their patients and the family members. The staff midwives also carried out education and training to the newly qualified and junior staff under their supervision.

2. Services

The present function of midwives are as follows:-

a) Looking after the health of the mothers during the ante-natal, delivery and the post natal periods.

b) Immunisation, treatment of minor ailments and if necessary to refer to the appropriate centres.

c) School health

d) Looking after the health of the newborns and children.

e) Participation in special health programmes.

f) Investigation of the cause of death of mothers and infants and to find out ways of rectifying the faults.

g) Training of their subordinates.

h) Supervisory and administrative.

i) Record keeping.

Auxiliaries

1. MCH/FP Education

As far as the health education, the auxiliaries have the same functions and responsibilities as the nurse/midwives above.

2. Services

The present function of the auxiliaries as far as the delivery of the MCH/FP services are similar to the nurse/midwives above, except that their responsibility is less. They are not involved in the administration and supervision and are not involved in the training of other personnel.

1.3 Traditional Birth Attendants

1. MCH/FP Education

As far as giving MCH/FP Education, the group felt that TBAs can be divided into two categories, those who have had training and come under the supervision of the government staff, do give the MCH/FP Education as required of them, whereas those who do not have any form of training or supervision by the authority are not probably giving the MCH/FP Education in the right direction.

2. Services

In addition to looking after the mother during the ante natal, delivery and the post natal stages, the TBAs also help in the domestic affairs and carry out the traditional rituals of the community.

2. AREAS WHERE THEIR FUNCTIONS CAN BE EXPANDED

2.1 Nurse/Midwives

1. MCH/FP Education

It is felt that the nurse/midwives should stress more on health education not only to the patient but also to the members of the family and members of the community.

Implications - there is a need to emphasise health education and motivation in the basic training curriculum. Health Education materials suitable to the community to which it is directed should also be made available.

In order to make them more equipped to carry on the health education and motivation the nurse/midwives should be given regular refresher's courses.

Implications - this may involve taking them away from the services which can be solved by involving only a small proportion of those in the field at one particular time.

2. Services

a) Where necessary and appropriate, the function and duty of nurse/midwives should be expanded to deal with more elaborate procedures e.g. manual removal of placenta, setting up transfusion, insertion of IUD as is being done in Thailand.

Implications - this involves a proper and retraining of the existing staff and the inclusion of such training in the training curriculum of the new staff.

b) To improve the existing referral system to the various centres whereby the feedback information is made available.

c) To give a limited curative medical care in minor ailments.

2.2 Auxiliaries

1. MCH/FP Education

In MCH/FP Education the role of auxiliaries could also be expanded as for the nurse/midwives above.

2. Services

Curative medical care of very certain minor ailments can be delegated to the auxiliaries.

2.3 Traditional Birth Attendants

1. MCH/FP Education

It is felt that the TBAs constitute a tremendous potential in giving the MCH/FP Education provided they are brought in for training and put under supervision.

Implications - this involves the training of the TBAs by the authority.

2. Services

Since in most countries the deliveries conducted by the TBAs are quite considerable they should be utilized in giving the proper and hygienic techniques of delivery.

Implications - to do this effectively a law should be made so that they are required to be registered. Training in modern methods of delivery and aseptic techniques and education on nutrition should be given.

Lastly these TBAs should be put under supervision of the authority.

B. THE TRADITIONAL BIRTH ATTENDANTS AS MEMBERS OF THE HEALTH TEAM

Generally the group felt that it is an accepted fact that TBAs are in their own way supplementing Government's health programmes. It is also felt that some TBAs espeically those who have not had training in modern techniques and do not come under the authority's supervision are probably having an adverse effect on the Government's health programme e.g. instead of giving a proper advice on diet and nutrition they may advise patients to follow the traditional taboos, and instead of doing good towards the mother's and child's health they may be doing damage towards the health programmes.

The resources of the TBAs can be more effectively utilized by:

1. Having a compulsory registration before they are allowed to practise.

2. Training them in the modern concept of midwifery, nutrition, and family planning.

3. To put them under direct supervision and control of the authority.

GROUP DISCUSSION NO. IV

TOPIC: THE DELIVERY OF FAMILY PLANNING EDUCATION AND SERVICE IS THE RESPONSIBILITY OF ALL MIDWIVES

Resource Persons

Group - A	Group - B	Group - C
Dr. Norlaily Datuk Abu Bakar	Dr. Raj Karim	Dr. Frank Beckles
Mrs. Betty Toh	Miss Mazel Lindo	Mrs. Chusie Sejpluem

GUIDELINES

1. What is understood by Information, Education and Communication (I.E. & C.) in Family Planning.

2. What is the relationship between Family Planning I.E. & C. acceptance and continued practice.

3. How does effective I.E. & C. programme contribute to the achievement of the ultimate family planning programme goal - fertility decline.

4. How best can you as midwives contribute to the attainment of the GOAL through your effective use of I.E. & C. in relation to services.

GROUP A - DISCUSSION REPORT

Chairman:	Dr. P. H. Amarasinghe
Rapporteur:	Puan Mahelan Abdul Manap
Participants:	Miss Lamom Srichandrabhand Mrs. Salma Begum Dr. (Mrs) Savitri Gurung Dr. Thomas Ng
Observers:	Miss Maura Leavy Miss Beh Thong Cik H. Nathaniel Raja Mohaini Md. Ho Lee Kian Miss Ivy Khoo Miss Boey Swee Kam Puan Kok Kee Har

SUBJECT: THE DELIVERY OF FAMILY PLANNING EDUCATION AND SERVICE IS THE RESPONSIBILITY OF ALL MIDWIVES

INFORMATION is the collection of background knowledge by the midwife and its dissemination to the public.

EDUCATION is the changing levels of information, knowledge, understanding and performance resulting in a change in the behaviour pattern.

COMMUNICATION is the two way process of the exchange of knowledge involving methods like the use of mass media and person to person contact and including feedback to assess the response of the target aimed at. The relationship between the Family Planning information, education and communication programmes and the acceptance of continued practice in Family Planning is impossible to assess. As an initial step the mass media should be utilized for a long period to educate the public. Emphasis should be given to the social and cultural patterns of the area concerned. The mass media will make the public think about the Family Planning Programme. Person to person contact is the best means of influencing attitude - especially if the advice is given by a friend or a person having the trust and respect of the community like a midwife or any other influential leader in the village.

Community leaders - (Political and Religious) and leaders of the other voluntary organisations should be orientated to the need of family planning for both the village and the nation.

Midwives should play a part in community development and with both the co-operation of the male members in the Family Health Service (like Public Health Inspectors) - provide Information, Education and Communication to all husbands in her area.

Various departments in the Government Service, the Plantation and Industrial sector leaders and teachers should be informed of the facilities in family planning afforded by the midwives and other personnel in the Health Service. Continued follow-up is vital to ensure that new acceptors will continue their family planning practice. Family Planning Information, Education and Communication programme can be most effective if Public Education on basic population characteristics on the adviseability of, avoidance of too early marriage or if married early the spacing of the children is imperative.

Effective Information, Education and Communication programme will by itself not affect the fertility decline for many years because many factors are also involved like the standards of living, the literacy rate and the change in the attitude of the population.

Legislation, like in Singapore, can effectively reduce the crude birth rate but the group felt that this goes against basic human rights at the present time.

People have been practising contraception and abortion for thousand of years. As we are dealing with human behaviour their effect is very difficult to assess, even if the Family Planning Service is available. A certain proportion of the population will accept the service. After a time the rising curve of the acceptance rate will be converted to a plateau. Public should have no false beliefs about the contraceptive methods. Economic factors loom up as the largest factor in the general acceptance of family planning methods.

How best midwives can contribute to a lowered birth rate:-

1. By practising what she preaches
2. She must herself understand the need of family planning at personal and national levels.
3. She must be an enthusiastic motivator
4. Ensure continuation of her supplies
5. Keep records and provide effective feedback information to the planners.

GROUP B - DISCUSSION REPORT

Chairman:	Prof. Prasong Tuchinda
Rapporteur:	Mrs. Kathleen Loo
Participants:	Miss Nora Hejananda Suchinta Mrs. Mita Thakur Dr. Shamsum Nahar Prof. L.V. de Saram
Observers:	Cik Hasmah Zain Miss Elizabeth Leong Miss Chee Peck Hoon Miss Soon Eng Lian Cik Kurshiah Bee Cik Hamidah Kamruddin Mrs. Cindy Nasir Taib
Resource Personnel:	Dr. Raj Karim Miss Mazel Lindo

SUBJECT: THE DELIVERY OF FAMILY PLANNING EDUCATION AND SERVICE IS THE RESPONSBILITY OF ALL MIDWIVES

The group agrees that the delivery of Family Planning, Education and Service is the responsibility of all midwives and that all midwives to include TBAs.

1. What is Understood by Information, Education and Communication (I.E. & C.) in Family Planning

By Family Planning/Information, Education and Communication, it is meant, imparting of knowledge and understanding to the consumers and vice versa, and to arouse an awareness and interest of the Services, Methods and benefits. By benefit this is in relation to raising the economic and health status of the family. Subsequently, this contributes to the well-being of the community and to national development.

2. The Group felt that since the questions on 2, 3 and 4 are inter-related, they felt that it could be discussed together.

If we have a strong Family Planning/Information, Education and Communication programme, it would increase the number of acceptors and strengthen continued practice.

By strong Family Planning/Information, Education & Communication programme, the group agrees to increase acceptors and continued practice with the following items included:-

1. The effective Family Planning/Information, Education & Communication programme should be integrated into Maternal and Child Health service.

2. Motivation by all health personnel in group discussion, individual counselling, demonstration, audio-visual aid, allied agencies (religious group), mass media and make use of satisfied acceptors.

3. Community participation for satisfactory programmes; there must be active community participation involving formal and informal community leaders in all categories.

4. There should be an efficient and effective coverage of the population, adequate facilities to ensure privacy and minimize waiting time.

5. Anticipatory guidance should be given to patients, i.e. patients to be warned and advised on the untoward effects of all types of contraception methods.

6. All health personnel should be sufficiently motivated so as to change their attitude.

7. Human relationship - a kindly approach to clients should be maintained at all times.

8. In communication, the health personnel should be able to communicate in simple language and at the level which could be understood by the clients/consumers.

9. An adequate feed back system should be ensured especially at the village levels.

10. The motivation and education of Family Planning programmes should also be aimed and understood by the husbands and the elders of the family.

11. The motivator should know, understand and respect the beliefs, attitudes, cultures and customs of the community in which she works.

12. There should be sufficient tracing of defaulters and follow-up plan.

13. There should be sufficient political and administrative support.

14. Evaluation and applied research of the whole Family Planning/Information, Education & Communication be established.

GROUP C - DISCUSSION REPORT

Chairman:	Dr. Ahmad Adnan
Rapporteur:	Mrs. Mohan Tamrakar
Participants:	Miss Joan Tan Mrs. Jebunessa Mrs. P.M.L. Ranasinghe
Observers:	Mrs. Chinda Busban Puan Hjh. Zahara Abdullah Raja Noraziah Ahmad Miss Rebecca John Md. Anna Tay Miss Chan Kum Sum Puan Umi Kelsom Dr. L. Campos

SUBJECT: **THE DELIVERY OF FAMILY PLANNING EDUCATION AND SERVICE IS THE RESPONSIBILITY OF ALL MIDWIVES**

1. What is understood by information, education and communication in family planning.

1.1 Information - Information means the delivery of certain news either to an individual or to a community. In this concept it means the delivery of news on various aspect of family planning.

1.2 Education - Education is understood to mean the process whereby an individual or community is orientated towards accepting certain knowledge.

1.3 Communication - Communication means the method by which the information and education is delivered.

2. What is the relationship between I.E. & C. in the acceptance and continued practice of family planning.

I.E. & C. only creates awareness in the concepts of family planning, what makes an individual or community accept and practice family planning depends probably on various factors which includes among other things:-

a) the removal of ignorance in the concept of family planning,

b) removal of fear that an individual has regarding the various types of the contraceptive practice,

c) economic factors,

d) social factors.

3. How does effective I.E. & C. programme contribute to the achievement of the ultimate family planning programme goal - fertility decline.

Effective I.E. & C. programme contributes to the achievement of the ultimate programme by:-

a) creating awareness of modern concept of Family planning in the individual or community

b) providing guidance as to the various methods should be adopted including the knowledge of the advantages and disadvantages.

4. How best can you as midwives contribute to the attainment of the GOAL through your effective use of I.E. & C. in relation to services.

Midwives can contribute to the attainment of the goal by:-

a) motivating the right person at the right time and the right place, e.g. during pregnancy and pueperium,

b) directing the motivation not only to mothers but also to the husband and other members of the family,

c) understanding people's behaviour, customs and religious background,

d) having more intimate and closer relationship with the mother and the family concerned so as to gain their full confidence.

CONSENSUS REPORTS ON THE FOUR MAIN TOPICS FOR DISCUSSION

I. SUBJECT: THE PRIORITIES AND PROBLEMS IN FAMILY HEALTH SERVICES AND IN FAMILY PLANNING, INFORMATION, EDUCATION AND COMMUNICATION

1. Family Health is understood to include:-

   a) Maternal and Child Health Care
   b) Family Planning
   c) Nutrition
   d) School Health
   e) Dental Care
   f) Health Education
   g) Compilation of Statistics
   h) Environmental Sanitation

2. On what criteria are they determined? They are determined by:-

   a) Geographical conditions of a country
   b) Variable literacy rates (from 13 to 18% in the different countries)
   c) Cultural and traditional practices
   d) The mortality rate varies considerably
   e) Nutritional status
   f) Availability of trained personnel
   g) Availability of vital statistics

A. The priorities in maternal care are:-

   i) Reduction in maternal mortality rate
   ii) Health education of the public and in-services training of health personnel
   iii) Training and utilization of TBAs
   iv) Increases in the percentage of deliveries in hospitals
   v) Better natal and post-natal care with special reference to limitation of family size.
   vi) Improve collection of vital statistics and registration of births and deaths.

B. Priorities in Child Care:-

   i) Improved care of mother during pregnancy, labour, puerperium and limitation of family size.

ii) Improvement in nutrition and infant feeding from birth to school age.

iii) Control of communicable diseases especially gastroenteritis and immunisation programmes.

iv) Health education to the public and health personnel.

v) Improved collection of vital statistics.

c. Top priority should be given to Health Education including instruction in the improvement of nutrition and family planning.

3. Problems in Planning:-

a. Non-availability of accurate vital statistics.

b. Incorrect interpretation of problem areas in health care.

c. Lack of coordination in planning and in implementation.

d. Inappropriate distribution of available funds within the health service.

e. Inappropriate choice of planning method and insufficient feedback for proper evaluation.

4. Problems in the Implementation:-

a. The biggest problem in the implementation of the above services is that there are not enough training personnel.

b. At times it is found there is an unequal distribution of personnel in all the health services.

c. Frequent transfer of personnel is considered a major problem before they get used to and have the confidence of the local population.

d. Allocated financial resources not always readily available.

5. Problem of Supervision:-

All the participating countries felt there is a need to strengthen the supervision of the personnel in the above service. The problems which are highlighted are:-

a. Inadequate number of suitably trained supervisory personnel.

b. Improper lines of supervision resulting in the various categories of staff getting different instructions from different supervisors in certain countries.

c. There are security and weather conditions which prevent adequate supervision of the ground level staff being carried out efficiently in some countries.

6. Problems of Evaluation:-

The group felt that a proper evaluation of the service will have to depend on a proper recording system. The problems at the moment in all the participating countries are:-

a. Records are not properly kept because there are no special personnel assigned to do it. They are being carried out at the moment by technical staff whose main purpose is to provide the actual health service.

b. No proper feedback of information from the top downwards and vice versa.

c. No standard system of compiling and analysing the records.

7. Recommendations:-

a. 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.

b. Proper identification of problem areas.

c. The plan should be simple, practical and acceptable to the people.

d. Good coordination between all Government departments and voluntary organisations.

e. Planning of seminars should include all key personnel required by the planners - medical, administrators, midwives, economists and the research staff.

f. Health education of existing personnel by in-service training and refresher courses.

g. Cash training programmes of new personnel.

h. 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.

i. Expand Basic Health Services in the rural areas by having more infra-structure, trained personnel and equipment.

j. Government should formulate national policies on food, nutrition, Health and Family Planning.

Conclusion:

Since the various problems mentioned above involves various section of personnel ranging from the 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.

II. SUBJECT: THE INCORPORATION OF FAMILY PLANNING, PAEDIATRICS AND NUTRITION IN THE BASIC MIDWIFERY TRAINING CURRICULUM

Introduction

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 the 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, in order to prepare the midwife for the above role, an attempt is made to define first the extent to which family planning, paediatrics and nutrition are included in the present basic training curricula of (a) nurse midwife and (b) auxiliaries.

The Extent of Present Training

Nurse/Midwife

The duration of training varies slightly in the five countries and also some are more student orientated, while others have a considerable service content.

i) Family Planning - it is felt that in all countries only the basic concept of family planning is presently being given in the basic training curriculum.

ii) Paediatrics - The inclusion of paediatric teaching in the present basic curriculum varies from country to country - as do the tutors, depending upon the availability of paediatricians. Also the content varies, some including care of the newborn only and others the child from birth through school age.

iii) Nutrition - A separate identity is not being given to teaching the subject of nutrition; it is merely incorporate into the general maternal and child care curriculum.

Auxiliaries

The extent of training in these fields for the auxiliaries is even less than that of the nurse midwives.

How Can the Training Curricula be Developed to Include Family Planning Paediatrics and Nutrition?

Duration of Training Period - It is felt that the duration of a basic training period of about 3 years general nursing and one year midwifery for nurse/midwives, and a 2 year midwifery training for auxiliaries, need not be extended. The inclusion of family planning, paediatrics and nutrition could be made by the revision of the existing curricula, stressing those aspects which are thought to be most important.

Involvement of Other Training Personnel - It is also felt that, where applicable, medical personnel, especially obstetricians and paediatricians, as well as health educators and nutritionists, should be involved as instructors.

Stress on Health Education and Motivation - It is generally felt that the present concept of training is geared mainly to providing the actual service (technical), and not enough importance is put on health education and motivation aspects. Since health education and motivation play a very important role in the efficient delivery of family health service, this subject should have a high priority in the training curriculum.

Family Planning - All aspects of family planning, including the management of infertility, with the exception of insertion of IUDs, should be taught to all categories of midwives.

Paediatrics - in the training of midwives in the field of paediatrics, the aim should be that the midwives be able to provide child care from birth through school age. This includes knowledge of:-

1. Infant feeding and the importance of breast milk.
2. Management of low birth weight babies.
3. The ability to detect congenital abnormalities and genetic problems.
4. Communicable disease and immunization.
5. The interaction of infection and infestation with nutrition.
6. Growth and development assessment.
7. The recognition of the "well-baby"; recognition of departures from the normal and recognition of critical signs such as dehydration and fever.
8. The ability to treat simple minor ailments.

Nutrition - since nutrition is a common problem in all countries, teaching of nutrition should be incorporated in the curriculum. Again the interaction of infection and infestation with nutrition should be emphasized.

Implications

In the revision and expansion of the present basic training curricula of all categories of midwives so as to prepare them for an efficient delivery of family health services, the following constraints will have to be considered:

1. Manpower
2. Money
3. Materials

Recommendations:

1. The Working Party participants strongly recommend that Family Planning, Paediatrics, and Nutrition be incorporated into the basic midwifery curriculum. It is therefore recommended that:-

   a. This should be implemented by modification or review of existing curricula, with emphasis on those aspects thought to be most important.

   b. Where applicable and available, medical personnel, especially obstetricians and paediatricians as well as health educators and nutritionists, should be involved in instruction.

   c. Health education and motivation must have a high priority in the training curricula of all categories of midwifery personnel and TBAs.

   d. 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 post-basic training for midwives.

   e. The training of midwives in paediatrics should prepare them to provide care for the child from birth through 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 genital problems.

      iv) Communicable disease 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 recognition of critical signs such as dehydration and fever.

      viii) The ability to treat simple minor ailments.

   It is recommended that nutrition be identified as an expanded area in the training curriculum, under the following headings:-

   1. Nutritionists and home economists should be invited to participate as instructors, with consideration for local dietary patterns, eating habits, local taboos, cooking practices, etc.

2. Emphasis on nutrition for the pregnant, post-partum, and lactating mother.

3. Emphasis be given to breast feeding, and to the correct diet on weaning from the breast, and the importance of mixed feeding.

2. That the training syllabus be reviewed every 3 years after appropriate discussion with personnel at all levels.

3. Refresher courses for midwives should be held at least every 5 years, including new advances in family planning methods.

4. Instructors and supervisors should establish a good follow-up system to ascertain whether what was taught during the training period is being practised in the field.

5. In view of the responsibilities undertaken in their expanding roles, all midwives should have a more attractive salary and career structure.

6. Since auxiliary midwvies are now expected to play a more important role in the delivery of health services, and their training is to be expanded and upgraded, it is therefore recommended that the entry requirements be raised according to their own country's educational criteria.

7. Tutors must be specially prepared for these expanded areas in the midwifery curriculum - family planning, paediatrics and nutrition.

III. SUBJECT: A. THE EXPANDING ROLE OF ALL CATEGORIES OF MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN FAMILY PLANNING INFORMATION, EDUCATION AND COMMUNICATION

B. THE TRADITIONAL BIRTH ATTENDANTS AS MEMBERS OF THE HEALTH TEAM

A. THE EXPANDING ROLE OF ALL CATEGORIES OF MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN FAMILY PLANNING INFORMATION, EDUCATION AND COMMUNICATION

1. PRESENT FUNCTIONS OF ALL MIDWIVES

1.1 Nurse/Midwives

1. MCH/FP Education

In all the participating countries nurse/midwives do conduct health education either in an organized way or through an individual approach to their patients and the family members. The staff midwives also carried out education and training for the newly qualified and junior staff under their supervision.

2. Services

The present function of midwives are as follows:-

a. Looking after the health of the mothers during the ante natal, delivery and the post natal in hospitals, clinics and at home.

b. Immunisation, treatment of minor ailments and if necessary refer to the appropriate centres.

c. School health

d. Care of the new born, and infant through school age.

e. Participation in special health programmes.

f. Participation in the investigation of Maternal and infant deaths.

g. Involved in both the organised and on-the-job training.

h. Supervisory and management roles.

i. Record keeping and submission of returns.

1.2 Auxiliaries

1. MCH/FP Education

As far as the health education, the auxiliaries have the same functions and responsibilities as the nurse/midwives above.

2. Services

The present function of the auxiliaries as far as the delivery of the MCH/FP services are similar to the nurse/midwives above, except that their responsibility is less. In some countries they are also involved in the administration, supervision and in the training of other personnel.

1.3 Traditional Birth Attendants

1. MCH/FP Education

As far as giving MCH/FP Education, the group felt that TBAs can be divided into the categories, those who have some training and come under the supervision of the government staff do give some MCH/FP Education as required of the, whereas those who do not have any form of training or supervision by the authority are not probably giving the MCH/FP Education in the right direction.

2. Services

In addition to looking after the mother during the ante natal, delivery and the post natal period, the TBAs also help in the domestic affairs and carry out the traditional rituals of the community.

2. AREAS WHERE THEIR FUNCTIONS CAN BE EXPANDED

2.1 Nurse/Midwives

1. MCH/FP Education

It is felt that the nurse/midwives should emphasise more on health education not only for the patient but also for the members of the family and members of the community.

Implications - there is a need to give emphasis on health education and motivation in the basic training curriculum. Health Education materials suitable to the community to which it is directed should also be made available.

In order to make them more equipped to carry on the health education and motivation the nurse/midwives should be given regular refresher courses.

Implications - this may involve taking them away from the services which can be solved by involving only a small proportion of those in the field at one particular time.

2. Services

a. Where necessary and appropriate, the functions and duty of nurse/midwives should be expanded to deal with more elaborate procedures e.g. manual removal of placenta, setting up intravenous infusion, inserting of IUD as is being done in Thailand.

b. To improve the existing referral system to the various centres whereby the feedback information is made available.

c. To give a limited curative medical care for minor ailments.

2.2 Auxiliaries

1. MCH/FP Education

In MCH/FP Education the role of auxiliaries could also be expanded as for the nurse/midwives above.

2. Services

Curative medical care for certain minor ailments can be delegated to the auxiliaries.

3. Reporting of births, maternal and child deaths.

2.3 Traditional Birth Attendants

1. MCH/FP Education

It is felt that the TBAs constitute a tremendous potential in giving the MCH/FP Education, provided they are brought in for training and put under supervision.

Implications - this involves the organization of training facilities by the Ministry of Health or the appropriate authority.

2. Services

Since in most countries the delivery conducted by the TBAs is quite considerable they should be prepared for the provision of proper and hygiene techniques of delivery.

Implications - to do this effectively appropriate legislation should be enacted requiring them to be registered. Training in modern methods of delivery, aseptic techniques and education on nutrition should all be given.

It is an accepted fact that TBAs in all countries supplement the Government's Health Programme.

In some countries, the suggestion has been made to expand their role to the fullest possible extent. All countries agreed that TBAs are very influential people and most of them work with true compassion for the patient and her family with little financial reward.

RECOMMENDATIONS

The Participants at Working Party recommend that:-

1. 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 the community.

2. That greater emphasis be given to health education and motivation in basic training curriculum. Health Education materials suitable to the community should be made available.

3. That all midwives be given regular refresher courses at least every five years including Health Education and Family Planning.

4. a) More elaborate procedures such as insertion of IUD and the management of maternal and paediatric emergencies e.g. giving of intravenous infusions and manual removal of placenta should be included in the basic midwifery curriculum so as to enable them to function effectively in isolation where medical aid is not readily available.

   b) Midwives assigned to remote areas should be given special refresher courses in these procedures.

5. To improve the standard of patient care, promote efficiency of service and to ensure job satisfaction, there must be better liaison and two way communication between hospital and field service.

6. Limited curative medical care of minor ailments should be part of a midwives function.

7. The reporting of all births, maternal and child deaths be a standard procedure for all midwives.

8. Immunization should be one of the essential functions of the midwife.

THE TRADITIONAL BIRTH ATTENDANTS AS MEMBERS OF THE HEALTH TEAM

Generally the group felt that it is an accepted fact that TBAs are in their own way supplementing Government's health programme. It is also felt that some TBAs especially those who have not been trained in modern techniques and do not come under the authority's supervision are probably having an adverse effect on the Government's health programme e.g. instead of giving a proper advice on diet and nutrition they may advise patients to follow the traditional taboos, and instead of doing good towards the mother's and child's health they may be doing damage towards the health programmes.

The resources of the TBAs can be more effectively utilized by the following:-

1. Having a compulsory registration before they are allowed to practice.

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, maternal and child deaths.

IV. SUBJECT: THE DELIVERY OF FAMILY PLANNING EDUCATION AND SERVICE IS THE RESPONSIBILITY 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 individual 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 awareness is very variable. Not all midwives are involved in family planning education and service.

After analysing Information, Education and Communication (IE&C) the group agreed that effective IE&C programmes contribute to the achievement of the ultimate goal by:-

i) creating awareness of modern concepts of Family Planning in the individual or community;

ii) Providing guidance with regard to the various methods which can be adopted including the knowledge of the advantages and disadvantages of each.

How best can midwives contribute to the attainment of the goal through effective use of IE&C in relation to services?

Midwives can contribute to the attainment of the goal by:-

i) analysing their own attitudes and accepting the concept of family planning as a way of life;

ii) continuous motivation at every opportunity;

iii) directing the motivation not only to mothers but also to the husbands, other members of the family and the community;

iv) understanding and respecting people's behaviour, customs and religious background;

v) having more intimate and closer relationship with the mother, the family and community in order to gain the full confidence of the people they serve.

RECOMMENDATIONS

The participants at the Working Party recommend 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 standard of service including continuous availability of supplies.

APPENDIX E

COUNTRY FOLLOW-UP ACTION PLAN

BANGLADESH

1. Information about the usefulness of this seminar organized by the I.C.M. & F.I.G.O. will be given to the Ministry of Health and the two secretaries (Health and Population Control and Family Planning), obstetricians, gynaecologists, nurse midwives and midwives of the country.

2. Attempts will be made to form Midwives' Association which is not in existence in our country.

3. There is a Gynaecological and Obstetricians' Association. This Association will be contacted by us and attempts will be made to make the Association to be one of the members of F.I.G.O. Similarly, we need help from I.C.M. to include the Midwifery Association which we hope to form in the near future.

4. Good Field Practice area does not exist in our country though we are trying to put our trainees in the Field Practice area six months. So help if necessary to establish good field practice areas.

5. We want to register TBAs and give them training so that they can be utilized in M.C.H. and Family Planning especially in rural areas. We used to train TBAs which has been discontinued long before. In this respect we require help from National and International agencies.

6. Vital statistics is poor in our country. We need help at advisory level.

7. To improve the M.C.H. and Family Planning Service in-country seminars should be held once in a year and the seminar should be attended by Representatives of the Planning Commision, Ministry of Finance, Ministry of Health, Education, Information and Broadcasting, Agriculture and Integrated Rural Development Programme and the persons involved in the immediate implementation of M.C.H. and Family Planning.

To implement the suggestions we mentioned it will be helpful if the I.C.M. visit our country and meet the planners and Secretaries of the Health and Population Control and Family Planning.

MALAYSIA

1. INTRODUCTION

1.1 Based on our existing needs and strengthened and supported by the deliberations of the West Asian Working Party on Training and Practice of Midwives, it is agreed that the midwives' role should be expanded to include nutrition, paediatrics and family planning in addition to her present basic role in midwifery.

1.2 In view of the proposed expanded role of the midwife of all categories, feasibility studies should be conducted before nation-wide implementation to assess the effectiveness with which the expanded roles are carried out and where tasks and functions may need to be modified.

1.3 In emphasizing the concept of Primary Health Care, emphasis should be on utilization of all available resources and manpower in the community, including the Traditional Birth Attendants.

1.4 It is important to recognize the midwives, particularly the so-called auxiliary midwife as a profession in their own entity.

1.5 In expanding the role of the midwife, priorities within family health care should be considered based on local needs.

2. FOLLOW-UP PLAN OF ACTION

2.1 The Maternal and Child Health Unit would discuss the recommendations of the working party after it is received with the Director of Health Services. Following that it will be presented to the Director General of Health Services and Secretary General of Ministry of Health for clearance of policy decisions as required.

2.2 The final report and recommendations will be circulated i.e. information concerning the working party deliberations will 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.

2.3 The Maternal and Child Health Unit will 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.

2.4 The role of the traditional birth attendant will also be discussed and a training programme formulated after policy clearance is obtained from the Ministry.

2.5 It is intended to carry out feasibility studies of such expanded roles before national implementation in order to access the effectiveness with which the expanded roles can be carried out and to determine if tasks and functions need to be modified.

2.6 It is 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.

2.7 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 e.g. giving of intravenous infusions and manual removal of placenta. If this is agreed upon, follow up will be taken in order that this be included in basic midwifery curriculum.

NEPAL

On arrival in Kathmandu, Nepal, we shall approach the Ministry of Health, Department of Health Services, and the members of the National Planning Commission and explain our activities and reactions to the Seminar we attended recently.

We shall call a meeting involving the Dean of Institute of Medicine, the Chief of FP/MCH project, Nursing Administrator and the Chief of the Nurses Campus to discuss the following topics:-

1. Conferences (whole topic discussed and recommended etc.)

2. The expanced role of Midwife

3. To discuss strategy of how to get government adoption and funds.

We shall also call a separate meeting involving all private sectors e.g. Nepal Women's Organisation, 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.

We shall finish out the news about our visits, participation, activities, and reaction of the Seminar in our leading newspapers e.g. Rising Nepal, Gorkhapatra etc.

SRI LANKA

Sri Lanka has a comprehensive course for midwives, which will change the role of the midwife from that of a person mainly concerned with childbirth to a person responsible for all aspects of Family Health, including family planning.

Recommendations

1. A Country Seminar should be organized by the Ministry of Health, with the Minister or Junior Minister as Chairman to propagate the ideas gathered during the sessions of the Working Party. Participants must include Medical Officers, para-medical 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 curriclum changed as and when required. Without feasibility assessments through feedback reports, the success of the programme cannot be guaged.

3. A Midwives' Association should be formed, affiliated to the International Confederation of Midwives.

4. A Midwives' Journal - funded by Government - must 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 can be discussed.

5. Incentives can be offered to midwives working in remote rural areas. This may help those of them 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.

THAILAND

Changing of government policy and regulation

1. Information, the changing of government policy and regulation to al categories of midwives including TBAs.

2. TBAs

   2.1 Finding of TBAs in the country

   2.2 Registration of TBAs after training

   2.3 Some incentive should be considered after registration

   2.4 Periodical supervision, followed up and refresher course.

	Nurse/midwives	Auxiliary Midwives	TBAs
Regulation	I.E. & C. in Family Health	I.E. & C. in Family Health	I.E. & C.- country wide - short term I.E. & C.- long term - some areas
Curriculum modification	Review present curriculum. Curriculum committee consists of appro-priate education and service division in all levels. The case curriculum level	Same To meet the expanded role of auxiliary midwives, the period of training should be extended to 2 yrs. (present 1½ yrs) others same	Same

Content	Nurse/Midwives	Auxiliary Midwives	TBAs
Health education Family planning Paediatric Nutrition	Institute Community	" "	Community

Post Basic Training	Nurse/Midwives	Auxiliary Midwives	TBAs
Post Basic Training/Continuing Education	Refresher Course	-	-
Post Basic Continuing education	every 3-5 years	every 3-5 years	supervision every 3 mths. Lectures & Demonstration every year
Seminars/Workshop	National level - 5 yrs. Provincial level 2-3 yrs.	-do-	
Service			
Working with TBAs			
Working with professional organisation			

LIST OF FILMS SHOWN

1. The Day before Tomorrow
2. Margaret Sanger
3. Sterilization for the female
4. Vasectomy - Technique
5. Mothers' Club of Sul Hwa
6. Baap - Re Baap
7. PA!MOI - Traditional Birth Attendant of Thailand

APPENDIX G

EVALUATION QUESTIONNAIRES

I. ADMINISTRATIVE ASPECTS

This questionnaire has been prepared to assess the administrative aspects of the Working Party as an aid in the planning and operation of future meetings of this nature. Please check the appropriate statements and write your comments legibly. Your frank criticism, suggestions and comments are cordially invited.

1.	Travel arrangements were:	Excellent	Satis-factory	Reasonably Satis-factory	Unsatis-factory
2.	Physical arrange-ments of the site of the conference were:	Excellent	Adequate	Fairly Good	Unsatis-factory
3.	Accommodation and services were:	Excellent	Adequate	Fairly Good	Unsatis-factory
4.	The total length of the Working Party was:	Very Satis-factory	Adequate	Too Short	Too long
5.	The working hours were:	Very satis-factory	Satis-factory	Too Short	Too long
5.	The information given about the Working Party was:	Very helpful	Helpful	Of some help	Of little help
7.	Documentation to cover the subject matters were:	Excellent	Satis-factory	Fairly good	Poor
3.	Opportunities to become acquainted with other partici-pants and staff were:	Ample	Satis-factory	Fairly good	Poor

9. What improvements on the administrative aspects would you suggest for future meetings of this nature?

II. TECHNICAL ASPECTS

This questionnaire is intended to evaluate the technical aspects of the Working Party by utilizing your opinions and comments. We would appreciate your answering the questions very frankly. If you do not feel able to answer a question it is better to leave a blank than to make a statement that does not satisfy you.

Because the questionnaire does not carry your name, the first four questions will give additional meaning to the remainder of the questionnaire. Kindly answer these questions by putting a tick against the appropriate answer.

A. 1. Is this the first time you have been outside your own country?

Yes No

2. Have you ever attended a seminar, a workshop or intercountry Meeting before?

Yes No

If yes, where: _____

when: _____

3. Were you eager to attend this one?

Very eager
Fairly eager
Rather reluctant

4. Are you pleased you attended this Working Party?

Very pleased
Fairly pleased
Not pleased

B. Working Party Objectives

The agenda was designed to meet the six objectives listed below. We would be interested to know your opinion on whether these objectives were adequately met in the time allowed.

Objective 1. - To exchange information on countries present situation of MCH/FP Services.

Objective 2. - To exchange information on training and functions of all categories of Midwives and TBAs.

Objective 3. - To identify common problems in MCH services especially in 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 motivation.

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

Please answer these questions by putting a tick (✓) in the appropriate column.

Questions	Obj. 1	Obj. 2	Obj. 3	Obj. 4	Obj. 5	Obj. 6
1. Which objective did you consider the most important before the seminar started?						
2. Which objective was most satisfactorily achieved in the seminar?						
3. Which objective was least adequately achieved in the seminar?						
4. If you could have a further two days to work on one objective, which one would you select?						
5. On which of the 6 objectives did you yourself participate most in the disucssions?						

C. Agenda

For each of the agenda items there were presentations focused on a theme presented by the 16 speakers followed by a disucssion of major issues brought to the total group for conclusions. Would you please let us have your opinions on these by placing a tick (✓) in the columns provided.

i) Usefulness of presentation to you

Titles of Presentation	Very Useful	Fairly Useful	Of Little Use
1. Family Health Care in Developing Countries			
2. Family Planning Information Education & Communication (I.E.&C.)			
3. The expanding role and scope of practice of all categories of Midwives and TBAs.			
4. Integration of Family Planning, Paediatrics and Nutrition with the midwifery training programme of all categories of midwives.			
5. Family Planning Training Programme in Malaysia.			
6. Planning of Family Planning Training Programme			
7. Continuing Education in Family Planning			
8. Legislation governing training and practice of midwives			
9. Family Planning in National Development			

ii) Time given to discussions of major issues

Title of Major Issues	Adequate	Too Much	Too Little
1. The priorities and problems in Family Health Services and I.E.&C.			
2. a) The expanding role of all categories of Midwives and TBAS, in Family Health Services especially in Family Planning I.E. & C.			
b) The traditional birth attendants as members of the health team			
3. The incorporation of Family Planning, Paediatrics and Nutrition in the basic midwifery curriculum			
4. The delivering of Family Planning Education and Service is the responsibility of all midwives.			

iii) Conclusions

Each Agenda item was terminated after certain conclusion had been agreed upon - of these conclusions or recommendations	All	More Than Half	Less Than Half
1. How many reflect a need for change in your programme?			
2. How many will be acceptable to you and your colleagues at home?			
3. How many were already fully implemented in your country's programme?			

D. Please tell us in one sentence which specific feature of this Working Party pleased you most.

E. Any additional comment:

ANALYSIS OF QUESTIONNAIRES

1. ADMINISTRATIVE ASPECTS

This questionnaire has been prepared to assess the administrative aspects of the Working Party as an aid in the planning and operation of future meetings of this nature. Please check the appropriate statements and write your comments legibly. Your frank criticism suggestions and comments are cordially invited.

1.	Travel arrangements were:	Excellent	4	Satis-factory	10	Reasonably Satis-factory	2	Unsatis-factory
2.	Physical arrange-ments of the site of the conference were:	Excellent	9	Adequate	3	Fairly Good	3	Unsatis-factory
3.	Accommodation and services were:	Excellent	10	Adequate	4	Fairly Good	2	Unsatis-factory
4.	The total length of the Working Party was:	Very Satis-factory	6	Adequate	6	Too Short	1	Too Long
5.	The working hours were *	Very Satis-factory	1	Satis-factory	10	Too Short	1	Too Long
6.	The information given about the Working Party was:	Very helpful	8	Helpful	5	Of some help	2	Of little help
7.	Documentation to cover the subject matters were:	Excellent	4	Satis-factory	11	Fairly Good	1	Poor
8.	Opportunities to become acquainted with other partici-pants and staff were:	Ample	8	Satis-factory	5	Fairly Good	2	Poor

9. What improvements on the administrative aspects would you suggest for future meetings of this nature?

See Appendix A.

* One did not answer.

II. TECHNICAL ASPECTS

This questionnaire is intended to evaluate the technical aspects of the Working Party by utilizing your opinions and comments. We would appreciate your answering the questions very frankly. If you do not feel able to answer a question it is better to leave a blank than to make a statement that does not satisfy you.

Because the questionnaire does not carry your name, the first four questions will give additional meaning to the remainder of the questionnaire. Kindly answer these questions by putting a tick against the appropriate answer.

A. 1. Is this the first time you have been outside your own country?

Yes	4	No	11	- 1 abstained

2. Have you ever attended a seminar, a workshop or intercountry Meeting before?

Yes	13	No	3

If yes, where: _____)
when: _____) SEE APPENDIX B

3. Were you eager to attend this one?

Very eager	13
Fairly eager	2
Rather reluctant	1

4. Are you pleased you attended this Working Party?

Very pleased	14
Fairly pleased	2
Not pleased	-

B. Working Party Objectives

The agenda was designed to meet the six objectives listed below. We would be interested to know your opinion on whether these objectives were adequately met in the time allowed.

Objective 1. - To exchange information on countries present situation of MCH/FP Services.

Objective 2. - To exchange information on training and functions of all categories of Midwives and TBAs.

Objective 3. - To identify common problems in MCH services especially in 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 motivation.

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

Please answer these questions by putting a tick (✓) in the appropriate column.

(See Appendix C for comments)

Questions	Obj. 1	Obj. 2	Obj. 3	Obj. 4	Obj. 5	Obj. 6
1. Which objective did you consider the most important before the seminar started?	4	2	7	2	3	-
2. Which objective was most satisfactorily achieved in the seminar?	4	3	1	6	2	-
3. Which objective was least adequately achieved in the seminar?	1	-	4	1	2	6
4. If you could have a further two days to work on one objective, which one would you select?	1	2	4	1	5	4
5. On which of the 6 objectives did you yourself participate most in the discussions?	3	5	3	3	3	3

C. Agenda

For each of the agenda items there were presentations focused on a theme presented by the 16 speakers followed by a discussion of major issues brought to the total group for conclusions. Would you please let us have your opinions on these by placing a tick (✓) in the columns provided.

i) Usefulness of presentation to you

Titles of Presentation	Very Useful	Fairly Useful	Of Little Use	
1. Family Health Care in Developing Countries	10	6	-	
2. Family Planning Information Education & Communication (I.E.&C.)	9	6	1	
3. The expanding role and scope of practice of all categories of Midwives and TBAs.	11	5	-	
4. Integration of Family Planning, Paediatrics and Nutrition with the midwifery training programme of all categories of midwives	14	2	-	
5. Family Planning, Training Programme in Malaysia.	5	9	1	*
6. Planning of Family Planning Training Programme	9	4	2	*
7. Continuing Education in Family Planning	7	5	3	*
8. Legislation governing training and practice of midwives	10	3	2	*
9. Family planning in National Development	9	4	2	*

* 1 abstained

ii) Time given to discussions of major issues

		Adequate	Too Much	Too Little
1.	The priorities and problems in Family Health Services and I.E.& C.	14	-	-
2.	a) The expanding role of all categories of Midwives and TBAs, in Family Health Services especially in Family Planning I.E. & C.	14	2	-
	b) The traditional birth attendants as members of the health team	12	3	1
3.	The incorporation of Family Planning, Paediatrics and Nutrition in the basic midwifery curriculum	14	1	1
4.	The delivering of Family Planning Education and Service is the responsibility of all midwives	15	1	-

iii) Conclusions

	Each Agenda item was terminated after certain conclusion had been agreed upon - of these conclusions or recommendations	All	More Than Half	Less Than Half
1.	How many reflect a need for change in your programme?	2	5	9
2.	How many will be acceptable to you and your colleagues at home?	3	10	3
3.	How many were already fully implemented in your country's programme?	4	8	4

D. Please tell us in one sentence which specific feature of this Working Party pleased you most.

See Appendix D.

E. Any additional comments

See Appendix E.

APPENDIX A

ADMINISTRATIVE ASPECTS

(Question 9)

1. Half-day off earlier in the Congress for participants to get acclimatised.

2. Draft programme need to be sent to participants ahead.

3. The programme is too tight.

4. Would like to see country, museum, factories, etc.

5. More free time to meet and discuss with the other country personnel.

6. Would like field visit to Community Health Centres and hospital.

7. Sight-seeing programmes should be arranged; also time for shopping.

8. Sight-seeing programmes.

9a. To give clear and specific instructions well in advance.

9b. To make participants feel more at home and not left out.

10. One copy of invitation should be sent direct to Ministry of Health.

11. Administration was so good that I cannot give any suggestions.

Note: 5 gave no comments.

APPENDIX B

BREAKDOWN OF TECHNICAL ASPECTS - QUESTION A.2

NO. OF DELEGATES	NO. OF SEMINARS ATTENDED	IN-COUNTRY	VENUE															
			AUSTRIA	BANGLADESH	BERLIN	DENMARK	GENEVA	INDONESIA	INDIA	MALAYSIA	PHILLIPPINES	THAILAND	TOKYO	U.S.A.	U.S.S.R.	SWEDEN	ETHIOPA
1	3									X	X			X			
1	2								X			X					
1	2										X			X			
1	2	XX															
1	5		X			X		X	X			X					
1	4			X						X	X		X				
1	2									X	X						
1	2						X							X			
1	1				X												
1	1													X			
1	1									X							
1	3														X	X	X
1	1										X						

APPENDIX C

COMMENTS ON ANSWERS ON TECHNICAL ASPECTS

(Question B)

Question 1:	2 delegates gave 2 answers - Objective 1 and 3
Question 3:	2 delegates abstained
Question 4:	1 delegate did not answer as he thinks it is not necessary.
Question 5:	1 delegate gave 6 answers

APPENDIX D

(QUESTION D)

1. Information from the International Confederation of Midwives.
2. Atmosphere of informality.
3. How the expanding 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 am very pleased on the exchange in information on training and functions of all categories of midwives and TBAs.
6. The integration of Family Planning with MCH Services.
7. Discussion after reading papers.
8. Group discussions
9. Presentation of group reports and discussions
10. Organization was good
11. Good co-operation
12. Co-operation of all parties concerned
13. Much friendliness and hospitality
14. Presentation of group reports and discussions
15. Panel Presentation on legislation governing training and practices of midwives.

Note: One delegate left this question unanswered.

APPENDIX E

(QUESTION E)

1. Agenda should be sent before delegates' departure from their country.

2. Discussion should follow after presentation of each topic rather than at the end of the session after two or three topics.

3. a) Chairman & Rapporteurs were worked a little too hard.

   b) The hours were long but probably unavoidable.

   c) We have seen five countries work together in complete harmony.

4. The conference room was often too warm for concentration and discomfort was made worse by over-crowding and uncomfortable seatings of the observers.

   On the whole this Workshop has benefitted me and all is more clear in my mind, what I can do when I go back to adopt and modify the MCH & FP I.E. & C. services.

5. In developing immediate steps should be taken to register TBAs and train them as early as possible.

6. The lectures given by most of the prominent personnel were really exciting and useful.

7. To have another Seminar to evaluate the progress of each country.

Note: 9 participants did not give any additional comments.