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APPROPRIATE TECHNOLOGY FOR DELIVERIES AND MATERNAL AND CHILD HEALTH CARE IN RURAL COMMUNITIES

by

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One of the stated objectives of this meeting is to evolve specific operational procedures for the attainment of high priority goals for MCH care, amongst which are:

- improvements in data collection
- study of TBA (Dia) practices, to improve their skills.

To touch briefly on data collection, it is known that perinatal mortality studies contribute significantly to the subsequent reduction of mortality simply by identifying the problems that need to be addressed. Future comparison of the data thus obtained, should provide indications on the impact of the present day evolving technologies. One of the felt needs of countries in which the systems of birth and death registrations are not yet become functional, would be to develop some kind of perinatal information system. Even for those countries that have instituted birth and death certificates, the obtaining of perinatal and infant mortality statistics is a painfully slow process. If a viable perinatal information system can be made to work, the now general availability and use of computers would speedily help in providing better results. Since one subject area for this meeting is <u>home deliveries</u> (and referral care) we will inevitably be required to deal - theoretically at least - with perinatal information provided by midwives and dias, many of whom are illiterate; and herein lies a major problem. What possible ways are there to overcome this obstacle? There are some countries, for example Indonesia and Egypt that have devised a technologically appropriate pictorial dia (TBA) reporting form. A project in Yemen did likewise, but unfortunately its use was discontinued because it was noted that the dias, at delivery time became too involved with the correct filling-in of the cards, at the expense of care of the mother and the newborn infant.

Perhaps, however, these pictorial records and/or alternatives to them, deserve further consideration and study during the course of this meeting.

The study of dia practices, in order to improve their skills is certainly a very valid subject for discussion and exchange of information, in view of the often quoted percentages of births attended by them 60 - 80 per cent of all births in the developing world. As more countries adopt the stance that training of dias is indeed a necessity to improve MCH care, more and more information is becoming available as to the constraints inherent in this practice, and how to deal with them.

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A matter of utmost importance in the study of the practices of dias, and this must always precede any attempt to formulate a training course for them. In the developing world, the often slow acceptance of health practices and services modelled exclusively on western concepts and experience can be attributed in large measure to cultural inappropriateness. Western trainings and services embody beliefs, values and procedures which emanate from industrial societies. Thus, the juxtaposition of these so different western medical practices, and local indigenous beliefs, brought into present day relief by the many western health projects being implemented in the developing world, are or should be, a major concern of medical anthropology. In this latter discipline, much has been written about making health training and health programmes "culturally appropriate". This however has had a tendency to remain in the domain of lip-service, which is always freely given and fully endorsed by everyone, but no sufficiently acted upon in practical terms. What I am advocating is that medical as well as para-medical nurses and midwives who will be working as field personnel in public health should receive appropriate training to enable them to be mini medical anthropologists themselves; in order to assist them to formulate culturally appropriate training programmes for primary health care workers as well as for dias. In this connection it is dangerously wrong to assume that as soon as dias are given a ready made course of new knowledge and instruction, they will abandon their old convictions and follow the new set of rules. Rather every effort should be made to incorporate as much of their traditional practices into the new set of rules, as is consistent with safe perinatal practice; remembering that interventions that do not become culturally relevant will fail, no matter how correct the assessment of the causative factors, and the correctness of the intervention.

Now, to come to the specific items of appropriate technology for deliveries and MCH care in rural communities, I would like to suggest that the following items be included for study and discussion:

a) gravidograms)
b) partograms) are there any which can conveniently be used in home delivery situations in the countries of the Region

c) a baby weighing scale, which is color-coded to record ranges of birth weights, for use of illiterate dias

d) the position of the parturient mother - during the first and second stage of labour. (Discussion to be based upon Dr. R. Caldeyno-Barcia's "Physiological and Psychological Bases for the Modern and Humanized Management of Normal Labour")

e) teaching the important timed elements of delivery procedures to dias. An alternative to clock hours must be developed for illiterate persons, for example intervals between prayer calls, etc.

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f) The cutting the umbilical cord - how to overcome the dangers of the practice of not tying either the maternal or the baby's end of the cord, once cut

g) modifications of UNICEF delivery kits - given the constraints encountered with dias unable to handle forceps and scissors.

h) neonatal thermo-regulation - including the use of plastic wrappers in cold environments.

i) a workable referral system - which could be used by illiterate dias.

j) symphysiotomy - what is the opinion of obstetricians of this intervention?

To close I would like to briefly mention a concept about "appropriate technology" which I know to exist amongst some professionals in the developing world, namely the feeling that the word appropriate, as used here, carries an overtone of home-made, oversimplified, even less than optimal. While admitting that technologies which are to be applied in homes will be of necessity fairly simple devices - no matter where in the world they are used; let us remind ourselves of the often less than optimal benefits which accompany the use of highly sophisticated technologies. For example the dehumanization which can accompany the use of machines for monitoring labour; the darkly hinted rumors that babies in Europe are seldom delivered at weekends because obstetricians need their free time for golf, tennis, etc. implying that induction is used for other than obstetric reasons. In the developing world there is still excellent family support for labouring women, and there is enough patient acceptance to let normal processes take their natural course.