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# Training and utilization of midwives for rural health services in Myanmar

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One of the key categories of basic health staff for rural health services in Myanmar is a midwife. In this review paper, the history of emergence and further development of midwives since British regime of pre-war days was traced and the important role played by midwives in Myanmar health care system currently is underlined. Without touching in-depth upon the curriculum of midwifery courses, the relevant training programme of midwives preparing for their services is explained. The evolution of a midwife from an accoucher to a "multi-purpose health worker" is also followed through. In this review, the authors attempted to look into changes that took place, in different historical contexts, in training and utilization of midwives for rural health services in Myanmar. It was observed that whenever the government health policy took into serious consideration for improving health of rural people, the role of a midwife became critical and changes in their roles took place. Inherent with these changes were the existence of some gaps in training and service utilization of midwives.

## INTRODUCTION

A midwife is internationally defined as a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualification to be registered and/or legally licensed to practice midwifery [1].

She must be able to:

- give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period; and
- conduct deliveries on her own responsibility and to care for the newborn and the infant.

This care includes preventative measures such as 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 counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.

Rural Health Sub-Center (RHSC), manned by a midwife, is the most peripheral frontline health facility located deep in the rural community in Myanmar. Midwives are posted at 1452 Rural Health Centers (RHCs) and 5,804 RHSCs all over the country. Midwife/rural population ratio: 2.89/10,000 rural population.

"Midwifery" as defined in Nursing and Midwifery Act 1990 emphasized on three key practices: antenatal care, safe delivery, and post-delivery care including care of the newly born baby. A "midwife" is referred to

a person who has been trained to perform midwifery and given a license to practice midwifery. However, the current duties and responsibilities of a midwife are not confined only to the three practices mentioned. The followings are also included:

- environmental sanitation;
- providing health education and birth spacing services;
- providing immunizations to mothers and children;
- participation in disease control activities;
- participation in nutrition promotion activities;
- providing curative care at health centers;
- supervising health volunteers, particularly auxiliary midwives (AMWs) and trained traditional birth attendants (TTBAs);
- recording and reporting;
- collaboration with local NGOs;
- participation in research activities; and
- providing duties assigned by higher authorities.

## MATERIALS AND METHODS

An exploration was made to identify how the change process took place in Myanmar as regards training and utilization of midwives for rural health services. It is a historical research and information was collected through:

- reviewing available documents and records; and
- performing informal interviews with 14 key informants which included retired as well as existing midwifery trainers, relevant managers from Departments of Health and Medical Sciences and senior as well as junior (recently graduated) midwives.

## RESULTS

*Training of midwives in Myanmar (Pre-independence Period)*

Realizing the situation of high maternal and infant mortality rates in Myanmar, Madras model of midwifery training of India was introduced in 1901 at Dufferin Hospital in Rangoon [2]. Suitable women who had passed 7th standard (middle school) were selected by Municipal and District Councils. At that time there were very few who passed 7th grade. Each training course lasted a year and after successfully completing the course, they were recruited by the respective Councils that selected them after passing the course. Salary of Kyat 40 per month was given if a midwife could deliver the assigned number of babies; if less, a deduction of Kyat 2 per baby and if delivered more, an addition of Kyat 2 per baby was given.

Burma Act No. X of 1922 was passed by the Lieutenant-Governor of Burma in Council. It was an Act for the registration and better training of midwives and nurses in Burma. Following this, an 18-month midwifery course was started in 1929 [3]. For selection, an announcement was made for applicants who passed 7th grade. The selection procedure, as described by a trainee of 1938 (now a retired midwifery tutor) was as follows:

"*The announcement said that those who wanted to apply for the midwifery training should come to the school they wanted to attend bringing along with them the following –*

- *one dozen of pink longyi (sarong);*
- *one dozen of white aingyi (traditional blouse) with clothen buttons;*
- *a white belt, a wrist watch, a thermometer and a pair of slippers.*

*"I went to Dufferin Hospital … the Matron (a British) checked the items … she asked me a few questions in English … then, I was told that I was selected to attend the 18-month midwifery course."*

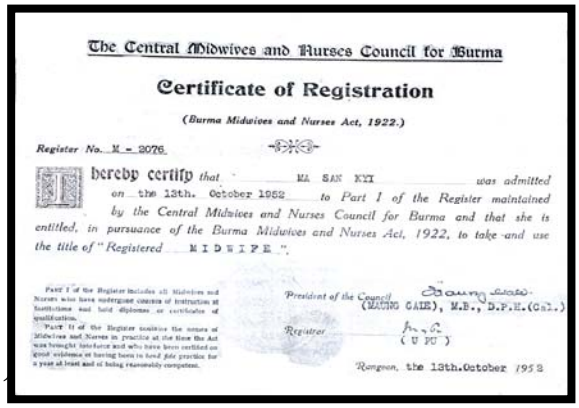
Eighteen-month midwifery training was given at Dufferin Hospital (Rangoon); Rama Krishna Hospital (Rangoon); Mandalay Hospital, and Ellen Mitchel Memorial Hospital, Moulmein. English was the medium of instruction and British nurses

were the key trainers. Midwifery training courses using Myanmar as the medium of instruction was initiated on 1-4-37 at township hospitals located in 16 townships in different regions of the country.

*Training of midwives in Myanmar (Post-independence Period)*

Re-organization of midwifery training schools took place after Independence. The schools were under the control of the Director of Women and Children Welfare Board. This responsibility was again conferred upon the Nursing Division established within the Directorate of Health Services. A Nursing Chief was appointed as head of the Division in 1953. There were only 11 midwifery training schools before 1962.

*A midwifery certificate of registration in English language (1952)*



The Central Midwives and Nurses Council for Burma

Certificate of Registration

(Burma Midwives and Nurses Act, 1922.)

Register No. M - 2076

I hereby certify that MA SAN KYI was admitted on the 13th. October 1952 to Part I of the Register maintained by the Central Midwives and Nurses Council for Burma and that she is entitled, in pursuance of the Burma Midwives and Nurses Act, 1922, to take and use the title of "Registered MIDWIFE".

President of the Council (MAUNG GALE), M.B., D.P.H.(Cal.)

Registrar (U PU)

Rangoon, the 13th.October 1952

*A midwifery certificate of registration in Myanmar language (1954)*

With an aim of improving accessibility health services to rural people of Myanmar, Rural Health Centers were opened in rural areas of Myanmar in 1953/1954. Rural Health Centers were established in rural areas and Health Assistant training began. An RHC intended to serve a population of 15,000 to 40,000 with one Health Assistant, one Lady Health Visitor, five midwives and one vaccinator. In 1959, an outstanding Myanmar midwifery tutor was sent to New Zealand to attend a 10-month midwifery training course. In 1960, local midwifery tutor course was opened with the assistance of WHO.

*Training of midwives for use in multi-purpose health work in Myanmar*

The health policy of the Government in 1962 was "to narrow the gap in health between urban and rural areas" and emphasis was paid on further enhancing rural health services operating through rural health centers. There were 16 midwifery training schools in 1976. A 4-year People's Health Plan (PHP) was drawn and implemented in 1977/1978 [4]. PHP was practical realization of Primary Health Care (PHC) concepts using Country Health Programming (CHP) methodology. One of the objectives of Primary Health Care and Basic Health Services project of PHP states:

- to improve the efficiency and effectiveness of BHS through:
  - extending the functions and roles of basic health staff to those of multipurpose health workers through in-service training and revision of basic training curricula of these categories of health workers;
  - deploying special disease control project workers (TB, Leprosy, Malaria, Trachoma, etc.) after appropriate training into BHS at the peripheral level so that they may function as multipurpose workers for all these diseases.

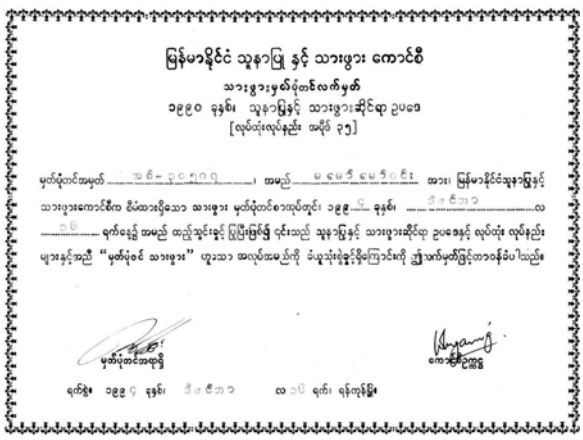
In order to fulfill the service requirements, training curriculum of midwives changed and the followings are some of the new topics included in the new curriculum:

• Community health nursing Parts I, II and III; and
• Introduction to midwifery research.

One of the learning objectives of community health nursing Part I states that the student will demonstrate competencies in knowledge, skills and attitudes (KSA) being able to: describe the health care system based on PHC approach in Myanmar. One of the learning objectives of community health nursing Part III states that the student will be able to develop KSA to allow them to function as an effective health team member, including participation with school health team and other special campaigns. During field training, students are required to complete studying special disease control programmes and their integration in the work of the RHC. In spite of the change in curricular content, training duration of 18 months remained unchanged. Total number of midwifery training schools (as of 2005) is 20, and yearly production of midwives is about 1,100.

Current practice of selecting candidates for midwifery training (since 2004) is that applications are called among those who passed tenth grade in each State/Division where the applicant passed tenth grade. Then, lists in order of merit are made in each State/Division according to the total marks of tenth grade in Myanmarsar, Mathematics and English. Finally, selection of the tops made according to the quota provided for each State/Division.

*A midwifery certificate of registration (1994)*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များနှင့်အညီ "မှတ်ပုံတင် သားဖွား" ဟူသော အလုပ်အမည်ကို ဆောင်ရွက်ခွင့်ရှိကြောင်းကို ဤစာတမ်းဖြင့်တာဝန်ခံပါသည်။

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*Prospects and perspectives of midwives*

The career prospects of a midwife nowadays can be considered not so poor. She can become a nurse and work in a hospital setting, or can remain in public health work after becoming a Lady Health Visitor and then a Health Assistant. A nurse can also become a Health Assistant. The next steps for a Health Assistant are Health Assistant-1 and Township Health Assistant. The career ladder of a midwife is shown in Fig.1. Among the rural health team human resources for health, midwives constitute the only category having a demand from the private sector. Attrition rate for midwives is about 3% in 2004.

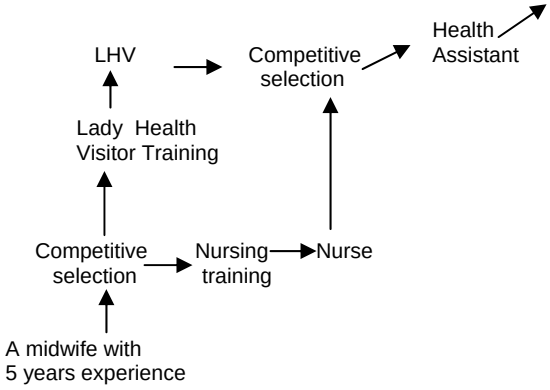


Fig.1. The career ladder of a midwife

The new organizational set-up of Subcenters with 1 midwife and 1 PHS-2 was introduced in 1988. As of 2005, there are 1337 RHCs still with the old staffing pattern (Fig. 2).

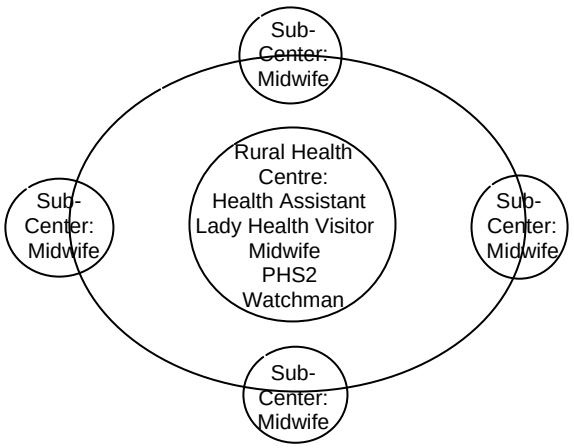


Fig. 2. Staffing pattern of a rural health centre

We would like to make a few quotes of some midwives interviewed as regards their

opinions on their jobs. These quotations reflect existence of some gaps in training and service utilization of midwives for rural health services. This situation has also been elicited in other studies [5, 6].

*"I am quite happy with what I am doing … we have been trained for disease control activities when we were students, so we regard these as our duties and responsibilities. However, I want to become a Nurse and I will try for it."* (a new graduate recently posted to a Rural Health Center in Hlegu Township)

"*We want to pay more attention to MCH works … we can keep the UCI duties as these are very much linked to MCH care … other responsibilities for disease control should be handed over totally to PHS-2.*" (a senior midwife from Bago Township)

"*While I was a student, 80% of our training was on midwifery and 20% on other health care services …. After joining the service I came to realize that only 20% of our work is on midwifery and 80% on other health service activities.*" (a midwife of 10-month service from a Sub-center in Sittway Township)

## DISCUSSION

In this review, we attempted to look into changes that took place, in different historical contexts, in training and utilization of midwives for rural health services in Myanmar. It was observed that whenever the government health policy took into serious consideration for improving health of rural people, the role of a midwife became critical and changes in their roles took place.

Two major impacts on training and utilization of midwives for rural health services in Myanmar:

- implementation of rural health centers in 1953/1954
- implementation of National Health Plan in 1977/1978

During the last few decades several projects had been implemented in Myanmar according to the main programmes of PHC had significantly increased the workload of the RHC staffs over the whole country. Some activities were new to the RHC staffs and a series of training had to be given to the implementers. Following, programme managers are concerned with the huge amount of workload borne by the RHC staffs, particularly midwives. There were complaints that midwives being over-burdened with various project activities so much so that they have not sufficient time to perform their main task of MCH care. Midwives complained that they would prefer MCH services including immunization rather than doing disease control jobs. The new idea to place a midwife and a PHS-2 in duo at Sub-centers can be a possible solution for transferring some of the midwives' workload to the shoulders of PHS-2. What is more important than increasing numbers of any category of human resources for health (HRHs) is the ways these HRHs are being managed. Management and supervisory practices at township levels should be critically reviewed and appropriate revisions be made**.** Another important point is that long-term solutions like increasing the numbers of production and employment are, in general, resource-based. Without actually changing staff numbers, an effective staff increase can be achieved by changing personnel and operating policies that lead to higher productivity, efficiency and motivation of rural health staff. These are the considerations to be made in future policy formulations in attempting to improve rural health services of Myanmar through rural health teams in which midwives are members**.**

## ACKNOWLEDGEMENT

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