Notes from the Field

Maternal and child health in the 1950s and 1960s

Elizabeth Barton

The author reflects on her work in Bangladesh, Viet Nam and Cambodia in the early years of WHO’s existence, inventing and building the modes in which the Organization was to put its mandate into practice.

East Pakistan (Bangladesh), 1953–1958

Looking back on the years I spent in what was then East Pakistan (now Bangladesh), the lush green of the paddy fields and the golden fibre of jute are imprinted on my memory. I see the farmers cutting sugar cane or knee-deep in water planting out the rice seedlings. Women stayed closer to home, busy with the chores of fetching water, tending their vegetable gardens and caring for their numerous children. Though they generally seemed serene and smiling they were often worn out with frequent pregnancies and childbirth. WHO’s Maternal and Child Health Project certainly met a need, and eventually became an ongoing, integrated national programme. Our national colleagues then did excellent work, and their successors do so now as I discovered during a visit in 1994. The population has increased threefold since the 1950s but the overall infant mortality rate has fallen.

For the first two years I was there, and the other WHO nurse working in the project lived more or less in purdah at the Maternal and Child Health Centre. We had no male visitors apart from the occasional Christian missionary, but we did have a modest social life outside our residence. Meanwhile, the students and staff would amuse themselves with games, reading and, now and again, a party, for which some would prepare a delicious Bengali supper, and others danced or recited. Bengali dancing is the most beautiful in the world; the whole body comes into play, including the face, which can be so expressive. Such interludes came as a wonderful respite from daily work which was long and hard though mostly rewarding.

Sometimes, however, life was frustrating and shattering. I remember being called to a woman who had had no prenatal care and was in labour with twins. I and Aktar Banu, my Bengali counterpart, did all we could for her but soon realized that she should be transferred to hospital. Her husband, however, refused to let her go to an institution with male medical staff.

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Only after a great deal of persuading and at the last minute did he let her go. By this time the woman was very, very ill. She died in hospital following caesarean section. Both babies also died, and she left behind five motherless children. This tragedy caused great concern in the community, which perhaps gradually led to a change of attitudes.

**Vietnam (Viet Nam), 1958–1961**

The project in Vietnam was similar to the one in Bangladesh but wider in scope. With maternal and child health were included paediatrics, hospital obstetric care, regional programmes to develop community maternal and child health services, and the education and training of midwives, assistant midwives and paediatric nurses to staff a large new hospital. I was alone for the first year with a French doctor, but eventually a WHO team was completed, with two paediatric nurses and two nurse/midwives, each of us of a different nationality. Our common language was French. My “base” was in the Maternal and Child Health Office in the Ministry of Health, while a Swedish colleague, the late Sigrid Svensson, worked at the School of Midwifery and at the Maternity Hospital. Sigrid was a very experienced midwife who had taught in and directed a large maternity hospital in Sweden, while my experience was in community maternal and child health care, including domiciliary midwifery. We learnt from each other, and with our Vietnamese counterparts were able to achieve a number of the goals we had set for ourselves.

The status of women in Vietnam appeared higher, on the surface, than that of women in Bangladesh. They had white-collar work as well as service jobs in shops and restaurants and as clerks and receptionists. I do not remember meeting any women doctors but girls’ schools were of a high standard and run by women. Midwives had a higher status than nurses and needed three years of education at the Faculty of Medicine to qualify, after which, like their European counterparts, they were practitioners in their own right. Men, however, ruled in the home, and battered wives were not an unusual sight. Indeed, I remember one woman telling me her husband was very nice and never beat her, as if this were an unusual virtue.

The Vietnam War was going on, and in the rural areas, where much of my work was, we lived in an atmosphere of tension and uncertainty. From 1960 onwards, refugees were pouring down from the communist-controlled North, while many families fled the countryside for the relative security of the city. Meanwhile a similar exodus to the North was going on. Still, we got on with our daily round of tasks, participating in the organization and education of midwives, improving dispensaries and community health and integrating maternal and child health activities. Even in war children are born, people get sick and families need help.

The only maternity hospital in Saigon (at that time the capital of South Vietnam) was very overcrowded. It was called the Tu-Du Maternité and located on a busy street in the centre of the city. There were 100 or more deliveries a day, which took
place in a woefully inadequate labour ward. In the wards two beds were pushed together to form a double bed in which lay up to five women and five babies. There were no sanitary facilities. A bucket stood behind the door. Hygiene was poor, and the risk of infection was only stemmed by the mass administration of antibiotics. "I learned this prophylaxis in the USA," one doctor told me.

Where does one begin in such a situation? The Nursing Education Section of the United States Health Mission offered money to repair and redecorate the School of Midwifery and provide modern teaching equipment. It took much persuasion and high-level support to convince the United States authorities that the simple refurbishment of a ward and installation of hygiene facilities, where students could be taught real care in a real situation, would be far more useful than improving the midwifery school, and that the women would benefit too. So a toilet and shower were installed, and we had one mother in one bed with one baby in a bamboo cot slung over the side of the bed. We also set up a special ward for sick women needing special care. Toxaemia and eclampsia were very common in Vietnam.

Priority admission to the "new ward" was given to those who attended for prenatal care, but we always hoped that finance would become available so that the model could be copied throughout the hospital. For this to be done we had first to reduce the number of women giving birth there, so we began to set up a small maternity room in each suburban dispensary around the city, and completed nine in four years. The Midwife in Charge was given extended training in management and updating of skills, and the centres served as field training sites for student midwives. The cooperation of the Vietnamese midwives with us and with one another was excellent. They were enthusiastic about the changes and made many good suggestions and innovations for improvement. At the Training Centre for Accoucheuses Rurales (assistant midwives), which was combined with the Centre for Midwife Teachers, many midwives showed a real gift for teaching and management.

The programmes went from strength to strength. Our principal counterparts in all these endeavours were three people: Mlle Phong, the Chief Midwife at the Ministry of Health; Mme Bong, the Director of Midwifery at the Tu-Du Maternité; and Mme Dong, the Director of the School of Midwifery. I kept mixing up their names, which caused great amusement to all concerned. The war gradually encroached on our activities, and working in rural areas became more and more difficult. After my departure, much of what we had set up was destroyed and, regrettably, those who were most active in the programme, the well-qualified and experienced leaders, left the country after 1975, escaping to Canada, France and the United States. Still, the potential remained, and no doubt continues to bear fruit. I remember the Vietnamese as intelligent and hardworking people, and Vietnam as a beautiful country with a marvellous coastline set against a backdrop of blue mountains rising from red earth. I loved it.
Cambodia, 1961–1966

Perhaps the largest slice of my heart was left in Cambodia, a country which tried hard to remain neutral while the rest of Indo-China was engulfed in war. Until the late 1960s it was an oasis of peace. I was the only WHO worker with the Maternal and Child Health Programme based at the Ministry of Health. My closest colleague was Sok Yon, the Chief Midwife, and we made long visits to the provinces together to work in rural hospitals and health centres and in the community. We enjoyed working together. I also spent much of my time working with counterpart staff in many parts of the country.

Much of the first year was spent travelling widely in an effort to observe and evaluate the general situation regarding community health and maternal and child health in particular. It was during these visits that we would meet with groups of enterprising traditional birth attendants of which there are many in Cambodia. Maternal and infant mortality rates were, and still are, unacceptably high. It was often a traditional birth attendant who saved lives. They would tell us of their difficulties, especially lack of transport to evacuate a woman requiring emergency care.

In most developing countries at that time, training programmes for traditional birth attendants were established, and their training, management and supervision were an integral part of midwifery education programmes. They were a valuable resource, but they could be dangerous too. In one place, we found the attendant dozing comfortably with her foot gently pressed against the perineum of the recumbent mother so that the pressure of the baby’s head on her foot would alert her when birth was imminent – a most ingenious technique but one whose hygiene left much to be desired. In cases where labour did not progress, all kinds of potions and manipulations would be applied, sometimes leading to obstetric tragedies. Infant and maternal mortality is still far too high in many areas of the world, but much can be done to save lives with prenatal care, identification of women at risk and requiring special care, early referral to hospital and improvement in general health and nutrition. This amounts simply to making full use of the services available, however limited they may be. Above all, training and supervision of personnel can bring about change. Health workers in rural areas are especially vulnerable and need help and support.

In Cambodia WHO-assisted projects sometimes worked closely together. A good example of this was a rural education and training programme at An-Long Romniet, a village some 70 km from Phnom Penh. It included an active maternal and child health programme which was integrated with the work of the village dispensary and a home visiting service.

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Funds were obtained to build a students’ hostel and accommodation for the Midwife in Charge. The building was simple but functional, and included latrines, the first ever constructed in the village. Money did not run to installing a shower, however, and we performed our ablutions at the village pump. Once this part of the programme was established we were
joined by teachers from the School of Midwifery, and together we devised appropriate practices and techniques which the resident midwives could use and students could learn while assigned to An-Long Ronniet for rural experience. This was a most rewarding time for all of us, WHO, national and local staff alike, as

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well as for the village community. We worked well together and participated in village festivities. Contrary to the usual complaint, that no one wants to work in the rural areas, our students were usually reluctant to return to the city. The project soon became an ongoing programme and an integral part of midwifery education.

The sad subsequent history of Cambodia no doubt eroded most of the activities of that time. But who knows what seeds planted then might one day blossom among the flowers of peace?

In general

Travelling in rural Asia could be quite adventurous. We used every form of transport: a small Renault 4, a Russian jeep that had no springs (the effects of which are felt to this day), boats, army aero-

planes, ferries, rickshaws, buses, taxis and once, in the hills during the monsoon rains, an elephant, a never to be forgotten experience. On one occasion in Cambodia we waded waist high across a river, carrying our goods on our heads. We made it to the other side and dried out in the sun while eating a delicious meal cooked by a Chinese man who lived in a small hut among the trees. Life was full of surprises!

All three countries in Asia described here have been scarred by conflict. This has brought irrevocable changes, but during a brief return visit to all three in 1994 I found much that was enduringly the same. People still chatted and laughed and sat around in cafés or outside their houses in the evening. Children played and rice was being planted and harvested as before. Cities were being modernized and there were more vehicles on the road, but bicycles and scooters still prevailed as well as bullock carts and mules, especially in rural areas.

Reading the literature of various aid groups, it would seem that the kind of programmes we were involved in in the 1950s and 1960s are still being set up and meeting a need. The difference now appears to be that there are more qualified people available within the countries concerned, and there is less demand for international participation. Perhaps we achieved what we set out to do, and “worked ourselves out of a job”.

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