

International Partnerships

WHO in the 1970s and 1980s – a user's view

Raj Karim

The author reflects on 24 years of involvement in WHO activities, and their effect on her own life and on the maternal and child health services in Malaysia.

On being asked to write about my personal experience with the World Health Organization, I recalled a myriad of faces, countries and situations. The name itself of the Organization is one I have held in respect since the early days of my career, and this feeling is shared by many colleagues around the world.

My first encounter with WHO was as a participant in a WHO course on maternal and child health and family planning, held in Warsaw, Poland, in 1974. Visiting a socialist country from Malaysia at that time involved being interviewed by the Special Branch of Police, which added to the excitement. The course was briskly and efficiently run, with lectures by prominent textbook authors, and study tours at the weekends. As it happened, I had to leave the course early because of an injury, but the care I received then from WHO staff also helped to forge strong and long-lasting friendships.

Two years later I met Dr Angele Petros Barvazian, whose name was well known to me as she was the Director of Family Health at WHO's headquarters in Geneva. She was at the WHO Regional Office in Manila at a Regional Consultation to which I had been invited. She contributed greatly to my feeling that WHO was a deeply humane organization providing valuable services to its Member States. The consultation provided an excellent opportunity for establishing contact with WHO staff and national counterparts. These links played a very important part in mobilizing resources and providing technical support for our work.

The 1970s and 1980s were exciting years for the building up of maternal and child health and family planning services in Malaysia and in many other developing countries. There was a great deal of interaction with teams from WHO and other international agencies, and sharing of information which could save many lives. This was the era of experimentation with integration, introducing new combined programmes such as one on family planning, nutrition, immunization and health

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education. Our chief concerns were maternal deaths caused by haemorrhage and infection in home deliveries, infant deaths caused by preventable diseases, and toddler deaths caused by undernutrition, diarrhoeal diseases and respiratory infections.

The Alma-Ata Conference started to draw the attention of governments and policy-makers to the importance of primary health care and a set of essential health

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services in all parts of the country. As the responsible officer in Malaysia for maternal and child health and family planning, I had many opportunities to work with WHO staff and consultants in building the infrastructure to provide these services. The WHO consultants who came to help us were recruited mainly from academic institutions in the West, and it often took them quite a while to develop a practical working knowledge of local beliefs, customs and perceptions. A typical difficulty would be for a nutrition expert to recommend strongly a "cheap and good" source of protein which was out of the question because of religious taboos.

These situations became rarer as time went on and the importance of acceptability became more widely recognized by scientists and doctors. Also, consultant assignments became shorter and focused more on a particular task such as starting a programme or introducing a particular method or technology. This seemed to be more productive, as it added intensity and

accountability, both for the consultants and for the national staff they were working with.

Dr Petros Barvazian visited Malaysia in 1976 to get a first-hand view of our maternal and child health and family planning services. We trudged through many rural areas and kampongs to health centres and midwife clinics, and talked to health workers and traditional birth attendants about how they understood their activities. I was heavily pregnant at the time, and Angele kept casting anxious glances at me, in fear of being confronted with an emergency situation. However, the visit ended without mishap, and Malaysia, together with Cuba and Turkey, was selected for a collaborative project on improving the care of mothers and children by using the risk approach.

I was proud to be involved in the work of WHO in this way. The project involved me in meetings in Geneva to set the agenda with my counterparts on the WHO staff and from the other two countries. I remember listening to Harvey Goldstein and others explaining the fine points of assessing risk on a scientific basis, while I tried not to be distracted by the unreality of overworked nurses and midwives in rural clinics juggling numbers to calculate a risk score for every pregnant woman. These exercises taught me that theories, hypotheses and models may look good and be scientifically correct on paper but they may not be suitable for application on the ground. Before using the risk approach we needed to train more health personnel and to modify practices, attitudes and beliefs in the community.

The discussions in Geneva set the agenda for a five-year research project on the risk approach as a "methodological tool".

Malaysia selected maternal mortality as the outcome indicator, and the northern district of Krian as the field laboratory for testing various interventions, as it was the district with the highest maternal mortality ratio. Field use of the risk strategy led to the development of a system based on colour coding and "risk tagging" rather than numerical scores. Eventually, successes in the Krian district were used as the basis for a National Risk Approach Strategy, and the colour coding system has evolved into a national system for the screening, assessment, referral and management of pregnant women. Being part of a pioneering cooperative project of this kind gave us the insight and the motivation to work continually on improving service quality. Field visits by consultants and WHO staff over the years, together with technical meetings and workshops, greatly enriched our experience at the national and local level.

One of the staff members who knew us well was Dr Eilif Liisberg, who helped us prepare for using the risk approach. He was adventurous and adaptable, and agreed without hesitation to get acquainted with the more difficult features of the Krian district. We crossed paddy fields and rivers to visit a solitary midwife in a remote area, talked to community groups who were hostile to modern health care because of deeply rooted traditional inhibitions, and went to the homes of traditional birth attendants who were held in high regard in the village. On one occasion, while we were engrossed in an account by a traditional birth attendant of how she would bind the abdomen to push the baby out, a cat drew our attention to a python that was neatly coiled under Eilif's chair. Fortunately, he got away from it safely. Incidents of this kind leave strong memories, and have helped to build up

trust and friendship between WHO and local health workers.

Partly as a result of the work done in Malaysia, WHO launched the Safe Motherhood Initiative in 1987 as a call for international commitment to reducing maternal mortality in developing countries. Dr Robert Cook, from WHO's Family Health Division in Geneva, came to Malaysia to introduce us to the concept of "confidential enquiry into the causes of maternal deaths" as a method for improving the quality of maternal and obstetric care. The idea caught on, and has been in use nationally since 1992.

With the help of Robert's personal dedication and sense of urgency, Malaysia embarked on a research and development strategy for Safe Motherhood in six of the districts in which maternal mortality was high. At about the same time, Dr Steve Sapiirie, also from WHO's headquarters, was promoting the "district team problem-solving" approach to management training, and this was combined with the safe motherhood project. These activities have since been extended to other districts, and the lessons learnt from them are being

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applied in national interventions. Robert passed away in 1995, but his work remains very much alive, as does the memory of him for all those who knew him.

In 1993, Malaysia introduced a National Safe Motherhood Award and launched a

Safe Motherhood Research Fund. The first recipient of the Award was Dr Siti Hasmah bte. Haji Mohd ali, whose efforts and achievements have taught us a great deal. She has played a leading part in training midwives, community nurses and

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traditional birth attendants, and educating rural people on the advantages of modern health care and safe delivery.

As can be seen, the expansion and improvement of maternal health services in Malaysia have been greatly enhanced by our collaboration with WHO. Today the relationship is mutually beneficial, since

Malaysians act not only as participants and counterparts but as WHO temporary advisers and consultants in other countries. A special feature of our success has been in combining a number of different strategies to deal with selected priority areas.

The years of collaboration with WHO have been rewarding both for our health service and for me personally. I have learnt a great deal from the interaction of ideas and experiences, and from finding out how to apply "universal", "broadbased" strategies to national and local settings. Often, national and international objectives are the same but the way to achieve them may be quite different. Ultimately, the country itself has to decide on its priorities and strategies. WHO provides valuable support for doing this through its advocacy, technical guidance, training and normative functions. ■

Complementary shifts in education and health care

In the search for lower cost and greater value, the health care and education sectors are looking for new approaches. Health care is broadening its action to include disease prevention and health promotion. Similarly, education is widening its focus from formal teaching to a renewed interest in the participatory process of learning, both inside and outside school. The shifts in emphasis from treating illness to promoting health, and from a teacher-centred to a learner-centred approach, are parallel and complementary developments. Both of these movements shift the emphasis from the professional to the individual in the community. Empowerment, local expertise and community participation are integral elements of health promotion and learner-centred education.

- *Creating supportive environments for health. Stories from the Third International Conference on Health Promotion, Sundsvall, Sweden. Geneva, World Health Organization, 1996: 35.*