FAMILY PLANNING BY PARAMEDICOS

On March 13,1969, the Family Planning Maternity and Child Health Project of HMG organised an Afternoon Seminar at the N.M.A. Building (Siddhi Sadan). About 60 doctors gathered together. Talks were given by Drs Louis Hellman, Rita Thapa, A.K. Sharma, Dibya Shree Malla, Donald Baseley, Denniston and Ralph Tenhave. There were many questions and comments from the floor. Drs. Thapa, Sharma, Malla and Tenhave provided in the panel the experience of and familiarity with the local (Nepalese) conditions.

Dr. Hellman who is Chief of obstetrics and gynaecology at the King's County Hospital New York, was currently working in New Delhi for the American College of Obstetricians and Gynaecology on the training and utilisation of para-medical personnel for delivery of Family Planning Services. He was the main speaker for the afternoon and subsequently, carried out well the task of a moderator. He set the theme of the Seminar as the Role of Paramedical persons in carrying out nationwide family planning programme under the supervision of doctors. Nurse-midwives specially trained for family planning services could carry out certain specified jobs which do not really have to be done by the doctor himself (or herself). This would ease the situation in a country where there is shortage of doctors.

Dr. Hellman described the role of Nurse-midwives in the Family Planning Clinics of King's County Hospital New York. Attendance at these clinics had increased enormously in the last four years. Therefore services of Nurse-midwives were utilized after training them and allowing them to work under supervision for 9-12 months, The training included study of demography, social structures, problems of families, psychology, gynaecology, records, screening and organisation of Family Planning Clinics. As regards the practical training, each Nurse-midwife had to make 26-50 breast examinations, about 100 pelvic examinations, insertion of twenty Intra uterine devices and five diaphragms and distribute pills to 100 clients. In the breast and pelvic examinations they were expected to distinguish the normal from the abnormal, not to find out the nature of the abnormality—this was the doctor's job. This role of nurses was acceptable to the doctors of Dr. Hellman's clinics. The clients also accepted these nurses because the Nurse-midwife had more time to listen to them and remove their anxiety. The drop out rate of clients became less. Being less confident, therefore more careful, the Nurse-midwives did better IUD insertions than the doctors—in fact the only case of perforation the clinic had was by a doctor.

Dr. Hellman concluded that similar use of Nurse-midwives could be made in Nepal.

Dr. Rita Thapa, Chief of the Family Planning and MCH Project, in her talk presented certain basic demographic data about Nepal, based on the National Health Survey. Birth rate was 54 per 1000 population and death rate 27 per 1000 population. With decrea-

sing death rate, growth is increasing and the aim of Family Planning services in Nepal is to decrease this growth rate. For this, the programme had to be extended to each district and village as soon as possible–i.e. before population growth became a problem not after it. The project aimed to achieve this through government and private organisations helping in implementing the programme through financial incentives, sale of condoms in popular bazar shops such as those selling cigarettes and matches, and also using certain paramedical personnel for certain family planning services including distribution of pills.

Dr. A.K. Sharma, FRCS, Royal Surgeon and Senior Surgeon Bir Hospital, Kathmandu, read his paper on "Surgical Aspects of Family Planning" which he had read previously in the Fourth All Nepal Medical Conference held at Birganj in Feb 1969. Even in ancient days, people had to plan their family due to scarcity of food. Crude methods were used e.g. infanticide and abortions. Commenting on the present methods of Family Planning, Dr. Sharma pointed out difficulties inherent in some of them e.g. IUD are not very popular, pills are costly for the general masses and condoms are not freely available. Quite frequently such methods of family planning are not properly understood by the users and there is carelessness in application of these methods. Dr. Sharma appealed to the Project not to sell pills at half a rupee per cycle as the market price was eight to ten rupees and if in future for some reason the cheap pills from the American aid are not available, people habituated to cheap pills will not be able to buy them at the market prices, and will stop planning their family so that if the aid could not be continued, the growth of population will no longer remain checked.

Dr. Sharma continued "while reduction in birth rate is beneficial illegal abortions are particularly a threat to the health of the mother. Induced abortions under good medical care are quite safe. Our laws allow induced abortion only when essential for saving mother's life and outside these laws a woman who needs help in ending her pregnancy must turn to illegal means. Hence I request the Family Planning bodies to take up the matter with the Judiciary and to try to legalise abortions, so that many valuable lives could be saved. Describing the Surgical aspects of Family Planning, Dr. Sharma said "we recommend surgical procedures for family planning, because these are the best and safest methods of stopping reproduction. It must however be clear that these procedures are permanent ones and the results of recanalisation cannot be guaranteed. The Surgical procedures are Vasectomy, tube ligation, salphingectomy and abortion. Vasectomy has been the most popular single method of reducing the birth rate. It can be performed in ten minutes and should be performed at the root of the scrotum.

"If sperms are present in the semen after 3-6 months have passed after operation or after ten ejaculations, the vasectomy had failed. It may be due to ligation of the wrong structure or presence of an accessory vas or helpful neighbours. A single compounder in the valley had ligated something other than the vas in four cases." Re-canalisation of vas, said Dr. Sharma, may occur through the knots tied to the divided ends of the vas or through infection of suture material. Dr. Sharma had one case of recanalisation throughthe knots. But, said Dr. Sharma, during vasectomy only a small portion of vas should be excised and the two knots

brought close to each other. Reunion of vas after vasectomy may be sought either because children, specially sons, have died or the husband has married again or he had not given careful thought before undergoing operation and has now changed his mind or because after vasectomy he is psychologically upset and has become impotent. After the operation of reunion of vas, Dr. Sharma routinely prescribed intramuscular Testosterone 25 mgm weekly for 8 weeks to stimulate spermatogenesis. Concluding his paper Dr. Sharma said he did not want to be too optimistic about the results of reunion of the vas. Phadke, the authority on the subject, quoted a success rate of just over 40%. But Dr. Sharma claimed that in his 35 cases of reunion after vasectomy, the success rate was 100%. If the two ends are patent the result of the union is going to be successful no matter how anastomosis is done. But he will certainly tell the people who come for vasectomy that the procedure is a permanent one and never temporary.

Dr. Ralph Tenhave, US AID Adviser to the Family Planning and MCH Project, defended the low price of the pills to be sold by the Project by pointing out that the Project would be selling the pills at the cost price. In a poor country like Nepal the Family Planning campaign would defeat itself if in order to keep par with commercial pharmaceutical firms a profit making policy was adopted. Dr. Tenhave also wondered if the medical gathering would discuss the problem of impotency after vasectomy but no discussion was forthcoming. Dr. Moin Shah questioned whether in Dr. Sharma's cases of reunion of vas, semen examinatian was carried out as a routine pre and post operatively as the criterion of success. Dr. Shah also suggested that social and legal complications would be avoided if semen examination was done as a routine after vasectomy. Unless the patients understood completely, some were likely to believe that soon after the operative procedure they would become sterile. Even after 12 or 15 ejaculations an odd case may not have got rid of all the sperms stored. Dr. L. Poudayl, Superintendent of the Central Health Laboratory said that examination of semen for presence of sperms is carried out in the Central Laboratory whenever this is requested. Dr. Narayan K. Shah, Assistant Director of Health Services, said that family planning need not be emphasised in places like Jumla where population growth was below the national rate and the problems of such areas were not relevant to family planning.

Dr. Dibya Shree Malla, MRCOG, obstetrician and gynaecologist of Bir Hospital who was a member of the panel made some pertinent comments on use of paramedical personnel in family planning and on legalisation of abortion.

Commenting on whether family planning services could in general be run in Nepal in the near future by paramedical personnel, Dr. Dibya Shree mentioned that at present there were only a few dozen qualified nurses in the whole of Nepal --hardly enough even to run those services which could not function without nurses. This acute shortage of Nurse-midwives was felt very much by all and unless their number multiplied many times, there would not be enough nurse--midwives to take up the role Professor Hellman's nurse-midwives performed in his clinics. Secondly, the qualified nurses would need a jolly good training in examining patients. How much training a qualified nurse requires to fit such a

role depends on what sort of training she has received before the qualifiying examinatio We do not know what sort of basic training the American nurse midwives have, but Nepal (and perhaps in India also), even after maternity training, nurse-m idwives do n know internal examination. Describing her own experience Dr. Dibya Shree said that in h undergraduate maternity training in India as a medical student she got the chance of doi internal examination only once. Thirdly Dr. Dibya Shree laid great emphasis on regul discussion of problems by workers in the field of Family Planning, among themselves an with experts. They will benefit much by having these discussions frequently e.g. eve fortnight.

Dr. Dibya Shree's comments on legalising abortions were pragmatic. She questione whether legalisation of abortion should be thought of before the facilities were available Since there were no facilities at present it was not advisable to approach the Judiciary about it. Morbidity should also be considered when discussing abortion, not just the morta lity. In the absence of facilities morbidity was high which was an unsatisfactory situation Let there be fulll facilities first for performing abortions on medical grounds (even if as a pilot project which will give clues about future management) before legalising abortions for socio-economic reasons. Dr. Andersen, Gynaecologist Superintendent of United Mission Medical Centre. Shanta Bhawan supported this. Dr. Andersen also made a plea that there should be comprehensive health centres all over the country which carried out, with proper emphasis, those services required for that area, instead of each service having an independent country-wide organisation.

Dr. Donald Baseley of the USAID New Delhi described experiences of his previous work in Kentucky in moutainous areas with poor transport and communication facilities and limited number of doctors. His experience of the use of paramedical persons in Family Planning services in such areas supported that of Prof. Hellman. The routine there was that the nurse-midwives distributed pills three months post-partum to those with a history of normal pregnancy, normal delivery and normal Pap. smear and followed the same criteria for the IUD with the exception that the loop was inserted 6 weeks post-partum.

Dr. Denniston, Vice-president of Population Dynamics, who has produced a film on IUD, spoke on the population problem in the USA and also discussed the loop.

Dr. Ralph Tenhave in his talk discussed the pills. He pointed out that complications due to pills were minimal. Deaths due to Thrombophlebitis in pill users were 3 in 1,00,000 whereas maternal mortality was estimated to be 300-400 in 1,00,000 births. He enumerated the contraindications for pills as Thrombophlebitis, Pulmonary Embolism, Heart disease, Hypertension, carcinoma uterus and breasts, diabetes, recurrent jaundice and migraine. Paramedical personnel could screen the cases by taking history, including that of intermittent bleeding. If the history was negative for the contraindications, they could supply the pills and if the history was suspicious, a doctor could be consulted. The distribution of pills by them provided a method of contraception (where none may be available due to circumstances thereby reducing risk of high maternal mortality) and entailed negligible risks.

Among the opinions of other participants were the following. Dr. Sarswati Padhaye of the MCH & Family Planning Project said that in her experience contraceptive pills suppressed lactation and shortage of milk created difficulties in Nepal where mother's milk is the main source of nutrition for babies.

Dr. Shankar Bahadur, Radiologist, expressed his sympathy with those who wanted to plan their families but wondered whether the long term effects of the various methods of family planning including vasectomy had been well studied. He had read an article in an American journal which showed a marked rise in the incidence of carcinoma of caecum in those who had their appendix (normal or in cases of "non-acute apendicitis") removed in the past.

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