1.3 Maternal and Child Health in Malaysia

Brief Overview of Maternal and Child Health Program in Malaysia

Health Programmes for maternal and child health in Malaysia began as far back as 1923, with the introduction of legislation for the control of practice of midwifery and the training of midwives in the Straits Settlements and subsequently in the other states of the Malay Peninsular.

Upon independence in 1957, Maternal and Child Health (MCH) services came to fore as an essential component of the National Rural Health Development Programme. Since then, extensive development of health infrastructure facilities was initiated under the Rural Health Services Scheme. Rural Health Units to serve a population of 50,000 each were organised on a three-tier system of referral for MCH Care. Dental and outpatient care were also offered at these main health centres and health sub-centres (1:10,000 population) as well as domiciliary delivery from Midwife Clinics (1:2,000 population).

The earlier 3-tier system was later modified during the mid-term review of the 2nd Malaysia Plan (1971-1975) to a 2-tier system with a Health Clinic (1:20,000 population) and the community clinic (Klinik Desa) (1:4,000 population) following a World Health Organisation (WHO) assisted Operations Research study on local health services in 1973.

The 1970s was the era where testing of the concept of an integrated multi-agency approach was put to practice through projects such as the applied food and nutrition programme, school health program, and integration of family planning into MCH services. These initiatives were

subsequently integrated into rural health and rural development programmes.

The establishment of the MCH and Health Education Unit of the Ministry of Health Malaysia in 1971, with maternal and child nutrition as one of the major service components, facilitated the implementation of programmes to reduce childhood malnutrition. It was also recognised that improving nutrition status and correcting anaemia in pregnancy improved infant survival and prevented the birth of low birth weight babies.

The organisation of MCH services give emphasis on the child growth monitoring, regularising the immunisation schedules for children, and providing nutrition education in clinics and villages contributed to reducing child mortality. The first advocacy campaign for breastfeeding in 1976 was another factor which improved infant survival.

1.3.1 Improve Maternal Health

Various specific strategies under the maternal and child health programmes have been used at all levels of health care to the better management of mothers and infants at risk.

The strategic approaches used in improving maternal health include health advocacy to empower women to have early antenatal check up and close monitoring of high risk cases for safe deliveries. Other activities are Home Based Maternal Health card for antenatal mothers so as to give better quality of care in terms of continuity and linkage to the whole health care system. Nutritional management of pregnant women include nutritional assessment, monitoring as well as provision of

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supplements (full cream milk and haematinics). Community health education on healthy eating through 'cooking demonstration' is being conducted at health clinics. Other strategies to improve maternal health are the application of the colour coding system for all pregnant women, auditing of all maternal deaths in Malaysia and the Quality Assurance Programme where indicators such as the rate of incidences of eclampsia, puerperal sepsis, neonatal tetanus, severe neonatal jaundice and immunisation coverage are used to measure the quality of care.

Strategies developed in obstetrics and perinatal services in hospitals include day care services, birthing centres, high dependency wards, obstetric Red Alert System and combined clinics to manage cases with medical problems. The introduction of teleconferencing between specialists and medical officers at district hospitals without specialist in the management of emergency cases has been implemented in some hospitals. Health clinics are also equipped with appropriate technology such as daptone, colorimeter, ultrasound, glucometer and resuscitation equipment.

Malaysian's experience in reducing maternal mortality reflects a comprehensive strategic approach to improve maternal health. The six key elements of this approach are as follows:

i. Improve access to, and quality of care of maternal health services, including family planning, by expanding health care facilities in rural and urban areas;
ii. Invest in upgrading of essential obstetric care in district hospitals, with a focus on emergency obstetric care services;

iii. Streamline and improve the efficiency of referral and feedback systems to prevent delay in service delivery;
iv. Increase in the professional skills of trained delivery attendants to manage pregnancy and delivery complication;
v. Implement a monitoring system with periodic reviews of the system investigation, including reporting of maternal deaths through a confidential enquiry system; and
vi. Work closely with communities to remove social and cultural constraints and improve acceptability of modern maternal health services.

Indicators for monitoring maternal health

Two recommended indicators for monitoring progress towards achieving the Millennium Development Goals (MDGs) between 1990 and 2015 are maternal mortality ratio (MMR) and the proportion of birth attended by skilled health personnel.

Trends in maternal mortality

The reported MMR had halved between 1957 and 1970, when it fell from around 280 to 141 per 100,000 live births. Whereas in 1991 the ratio appeared to plateau at 30 per 100,000 live births and the ratio has maintained up to the present year. The leading causes of maternal death currently are obstetric pulmonary embolism, hypertensive disorders in pregnancy, associated medical complications mainly due to heart diseases in pregnancy and postpartum haemorrhage. **(The statistics of leading causes of maternal deaths as shown in Appendix 2 – Table 1.3.1)**.

Birth attended by skilled health personnel

In Malaysia, the proportion of births attended by trained health personnel had increased markedly and in 2006, 98.3% of the deliveries conducted by trained health personnel. This is related to the rapid development and upgrading of health care services over the past decades, including the establishment of nursing and midwifery schools, led to both an increase in the number of trained health personnel and improved midwifery and obstetric skills including family planning through postgraduate and in-service training. The training of traditional birth attendants (TBAs) as partners in health care with government-trained midwives, and the utilisation of TBAs to promote the use of health facilities to women for antenatal care, delivery and post natal care, was another factor that led to an increase in the proportion of deliveries attended by trained personnel. Malaysian women were encouraged to deliver in hospitals, especially those with high risk of pregnancy complication (assigned red and yellow colour codes) during prenatal assessment. There is a shift to institutional deliveries, and currently the proportion of births delivered in hospitals, maternity homes and clinics have risen sharply that in 2006, the figure stands above 95.0%. The quality of nursing and midwifery curriculum, training and practice is regularly reviewed and governed by the Board of Nurses and Board of Midwives. Nurses and midwives have been utilised as the main providers of the maternal and child health program, with regulatory standards and practices ensuring quality maternal care. Expected mothers were advised about the importance of skilled attendance for delivery and discouraged from the traditional custom of delivering at home with the support of TBAs. **(The details on Pregnancy and Delivery as shown in Appendix 3 – Table 1.3.2)**.

Family planning and maternal health

Increasing access to family planning services and information has been an important factor in improving maternal health. It is a factor in lowering pregnancy among women known to have relatively higher risks of maternal morbidity and mortality such as those with high parity, medical conditions, childbearing ages and others. Family planning services in Malaysia are mainly provided through the Ministry of Health's facilities, National Population and Family Development Board (NPFDB) facilities, Federation of Family Planning Associations Malaysia (FFPAM) clinics and private general practitioners of private hospitals.