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KEYNOTE ADDRESS BY YANG AMAT BERBAHAGIA DATO SERI DR SITI HASMAH BINTI HAJI MOHD ALI AT THE OFFICIAL OPENING OF STRATEGY DEVELOPMENT WORKSHOP ON TRANSFER OF MALAYSIAN SAFE MOTHERHOOD TO PARTNER COUNTRIES AT PARK PLAZA HOTEL, KUALA LUMPUR ON MONDAY, 4 DECEMBER 2000, AT 10.30 AM

Alhamdulillah, with the blessings of Allah, the Almighty, we are able to gather here within an environment of peace and harmony. I am deeply honoured to be invited to this distinguished workshop as I believe that it is through sharing of experiences and learning from each other can we spread more quickly and effectively the strategies that can improve the health of our women and children. In particular, I wish to thank the Minister of Health Malaysia, Dato' Chua Jui Meng for the support given by the Ministry of Health to the collaborating international agencies and to the participating partner countries for making it possible to realise this transfer of Malaysian Safe Motherhood experience to the selected partner countries.

2. The dawn of the new millennium has brought with it a new world of technological sophistication whether in diagnosis and management of diseases or in the way knowledge and information is made available. However, this does not necessarily mean that all countries have benefited from this progress. The World Health Report 2000 states that "in spite of all its achievements, the health systems have failed globally to narrow the health divide between the rich and the poor in the last 100 years. In fact, the gap is actually widening". This statement reflects the grim scenario of maternal mortality in developing countries when women are dying unnecessarily from complications of pregnancy and children. It is even more sad to learn that most of those deaths could have been prevented if women had access to health care; to timely

transportation and referral to appropriate and adequate health facilities; and access to opportunities for a better education, livelihood and societal status. Ninety-nine percent of maternal deaths occur in developing countries with the highest rates in Sub- Saharan Africa and South Asia while this is a rare event for women in developed countries. In this context, I am indeed pleased that we are now looking towards the South for possible answers and feasible strategies to provide for safe motherhood as we have much in common among our countries.

3. Coming back to Malaysia's experience in Maternal and Child Health (MCH), I have often been asked as to what are the ingredients of Malaysia's success in this regard. I would like to assure you that there are no magic bullets. Our experience is one of sheer hard work, dedication and commitment of all those who have contributed their services in the health and related sectors; within a guided framework of policies and strategies to improve health of women and children; backed by sound socio economic development plans; and implemented within an environment of political stability and government commitment. We are indeed blessed with this setting which has enabled us to move on progressively and incrementally without any major natural calamity or disruption.

4. We are also grateful that our health and social services sectors have been protected during times of adversity such as the financial crises of the 80's and 90's. This safety net is required as the public sector provides for preventive health and medical care of about 80 per cent of the population with free services for the rural and urban poor and disadvantaged. The most recent financial crisis has demonstrated Government's commitment towards health care where the health sector was not subjected to budget cuts, and received instead an increased allocation to cater for the greater utilisation of government health facilities by those who could no longer afford the private health sector.

5. I will briefly take you through the evolutionary process of the maternal and child health services and of our efforts to reduce maternal mortality. The earliest records on maternal and child health services in Malaysia dates back to 1923 with the First Midwifery Enactment to regulate the practice of midwifery for maternal and child survival. At the time of independence

in 1957, we inherited from the British regime six maternal and child health centres in urban towns and a few hospitals at state and district level. Through a series of consecutive Socio Economic Development Plans, beginning from 1961 with the First Malaya Plan, a comprehensive health infrastructure network was put in place with priority to the development of the rural health care delivery system. Maternal and child health as an integral part of basic health services, has always been the largest component of the public health programme.

6. The reorganisation and restructuring of the rural health services following an Operations Research Study on the Health Care System from 1976 through to the 1980's sought to provide for increased availability and accessibility of the rural population to a comprehensive range of health services for MCH care, immunization and disease control, safe water and environmental sanitation, diagnostic facilities and medical care. These services were brought nearer to homes and families through the upgrading of health centres to provide the full range of preventive and curative services with the required complement of staff and logistic support.

7. Similarly the midwife clinics which have the most peripheral health facilities were upgraded to community clinics (klinik desa) with the midwives converted to community nurses. These professional auxiliary health workers now known as 'jururawat desa' were retrained to improve their basic midwifery skills including prenatal and post natal care. The training was expanded to prepare them for child health care including assessment of growth and development, provide immunization, advice and support on breast feeding and nutrition, oral rehydration, family planning and treatment of minor adult ailments. Supportive supervision and monitoring by staff nurses trained in post basic midwifery and public health nursing and backed by a functioning referral and feedback system enables the 'jururawat desa' to function effectively. It also enables women and children to be referred promptly to the health centre for designated routine check-ups, for problem and priority cases, or to hospitals in the case of serious and emergency conditions.

8. While the decades of the 1960's and 70's were dedicated to development of infrastructure and basic health services, the decade of the 80's focused on approaches to cover underserved remote and difficult to reach areas and population groups as well as strategies to address major preventable causes of child and maternal mortality. This period also saw the integration of major components of MCH such as family planning, nutrition, health education and school health into the fast expanding MCH programme. In child health care, our early preventive programmes led to a reduction of the traditional childhood killers of tuberculosis, malaria, diphtheria, tetanus, diarrhoea and malnutrition, which were the major problems in the 60's and 70's when I was a District Medical Officer of Health and later on the State MCH Officer in Kedah.

9. With improved population coverage of health facilities and trained personnel, we were able to implement child survival strategies to further reduce infant and below five year child mortality. Immunization programme was expanded to include measles, Rubella and Hepatitis B for newborns; staff retrained in management of childhood diarrhoeas and oral rehydration with diarrhoeal diseases and a Nutrition Surveillance system put in place for early detection and rehabilitation of children with nutritional deficiencies. With the reduction in postnatal and under five child mortality, current efforts are increasingly focussed on perinatal and neonatal interventions to reduce mortality during this period.

10. A strong point in Malaysia's MCH programme has been due to the fact the "M" in MCH has never been neglected; but in fact has been a major part of our continuous strive to improve health of women and avoid the tragic deaths of pregnancy and childbirth. We believe that every woman has a right to quality health care to safeguard her health and life and that her children need her for their own survival and for the well being of families. Hence from the inception of the rural health programme in the 60's, we have worked on various approaches to ensure the availability of skilled attendants for prenatal care, delivery and postnatal care. I understand that this is now a very topical focus of discussion in the search of effective Strategies for Safe Motherhood and that Skilled Attendance at Delivery has been highlighted as the most important strategy.

11. In Malaysia, during my early working life, and more so in Kedah, we did not have sufficient trained midwives and nurses nor health facilities. TBAs were actively conducting deliveries and women preferred them to our trained midwives as they would provide for care not only of the pregnant women but also for the newborn child and family. Moreover, the community were bound by strong socio-cultural traditions, taboos, beliefs and preferences which favoured their choice for TBAs. A decision needed to be made - do we allow TBAs to conduct more than 60 per cent or 70 per cent of the deliveries and result in women dying from complications arising from their harmful practices, or do we train them to handle deliveries safely and hygienically?

12. In Kedah, we made a decision to train TBAs to conduct clean and safe deliveries and by 1971, a national registration system for TBAs was undertaken to facilitate their training through UNICEF support. Later, in the 1980's, based on a study on the TBAs as part of the Risk Approach Study, a nationwide system was implemented to retrain TBAs to detect danger signs of pregnancy and delivery, to refer pregnant women to health facilities and to work together with our midwives in the care of the mother and newborn. The fostering of this partnership has been effective in reducing our unsafe deliveries and in deaths from delivery complications notably postpartum haemorrage, obstetric trauma and infection, while at the same time not depriving TBAs of their much needed income and respect. Today 99 per cent of our deliveries are attended by trained personnel as compared to less than 30 per cent during the 60's.

13. I have spoken of our TBA experience as an illustration of how we have worked through a strategy to achieve a win-win situation for the benefit of all concerned - professionals, TBAs and women and families. I realise this is still a debatable issue today and many of your countries are faced with similar situations.

14. In our effort to reduce maternal mortality we have conducted field research and implemented a multi strategy approach. Using Krian District as our field test district which in

the early 80's was the district with the highest maternal mortality in Peninsular Malaysia, an in-depth study and analysis of the major causes and contributory factors of maternal mortality was conducted. The evidence available formed the basis of formulating strategies to overcome traditional and socio-cultural barriers to access and utilisation of health care; to upgrade midwifery life saving skills and competencies of midwives, nurses and doctors; to strengthen district hospitals to provide for essential and emergency obstetric care; to implement a practical, functioning and well equipped referral system; to improve cooperation between health and hospital sectors; and to mobilise community resources and participate to provide information, transport and family support. These among others are the major strategies of the Risk Approach which has been devised as a Systems Approach providing continuity of care and specially for those with pregnancy complications. A major outcome of this approach is the Risk Colour Coding System, which is a system for prenatal assessment to accord each pregnant woman the appropriate level and category of health personnel she needs for a safe pregnancy and delivery. I am sure you will have a chance to discuss these nationwide strategies further during your workshop and field visit over this week.

15. With the Risk Approach in place, Malaysia moved on to further refine and monitor these strategies, to strengthen district ownership and encourage local initiatives. The Safe Motherhood Initiative was thus developed from 1989 starting with six districts and utilising the District Team Problem Solving approach (DTPS) to identify local problems and solutions. I am pleased to note that some states with high maternal mortality such as Kedah and Terengganu have expanded this initiative to the whole state and their experiences will also be shared.

16. These ongoing maternal reduction strategies are strengthened by the Quality Assurance Programme which has identified both public facility and hospital facility obstetric related indicators. These serve as indicators reflective of quality of care and has undergone several improvements since the system started in 1986. In addition, the system of Confidential Enquiry of Maternal Deaths (CEMD) implemented since 1991 provides for a continuous confidential "no blame" monitoring of each maternal death to identify any "substandard" care or practice and for remedial or corrective measures.

17. The road towards our success has not been easy. Perhaps the most complex and difficult has been in evolving strategies and approaches sensitive to community needs and perceptions; be they social, cultural, traditional or religious. This is an essential ingredient in planning and organisation of health services to meet the needs of our multi ethnic and multi religious society. Realising that health programmes need to be considered within a developmental approach, we have in place a system of multisectorial and intersectorial collaboration including education and poverty alleviation; inter agency partnerships; and linkages between the public, private and non-governmental sectors. We have built upon our strengths; tried to reduce the equity gaps; and bring closer to communities and families an affordable, comprehensive and acceptable package of comprehensive health care.

18. The results of Malaysia's consistent and sustainable policies, strategies and programmes have yielded results. Our maternal mortality ratio has been reduced from 570 in 1957 to 20 per 100,000 live births in 1998 through Vital Registration System and 40 through the Confidential Enquiry system. Infant mortality rate has fallen from 75 to 9 per 1,000 live births during the same period.

19. I would like to stress the need to sustain this reduction especially in the wake of HIV/AIDS which has resulted in a reversal of the declining trends of maternal and child deaths in many of the countries represented here. We in Asia have to learn from the experience in Africa as to how to prevent the fast spread of the pandemic especially among youth, women in active child bearing years and transmission from mother to child. It is in this spirit of understanding each other's needs, problems and aspirations can we engage in a more frank and open discussion of sharing of our experiences and learning from each other what has worked and what has not.

20. I support this initiative of South to South Cooperation and Collaboration in the transfer of country program experiences. I congratulate all the agencies involved in making this possible, namely Partners in Population and Development, IPPF ESEAOR and CARE

International and especially the Ministry of Health Malaysia in this sharing and transfer of the Malaysian Safe Motherhood experience.

21. I sincerely hope this collaboration will continue and I look forward to the third phase of this programme. We in Malaysia will do whatever possible to facilitate this process and we are ready to share our experiences and learn from yours. You have a big challenge ahead, and with the strong commitment of your governments, professionals and the society, you can achieve similar results. I wish you every success in meeting this challenge and to give every woman her right to live and to make pregnancy and childbirth the joyful event it deserves.

22. On that note, I now have great pleasure to officially declare open the Strategy Development Workshop on Transfer of Malaysian Safe Motherhood to Partner Countries.

Thank you.

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