The role of nurse-midwives in a family planning program is described. Details are given on the program, the training of nurse-midwives to function in it, and its expansion to foreign countries with AID assistance.

The Nurse-Midwife as a Family Planner

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The recently enacted Family Planning Act of 1970 appropriates financial support, but does not make available the medical personnel to carry out the act . . . to deliver family planning services to 5,000,000 medically indigent women. The situation in the United States is that there are not sufficient physicians who can be induced or found to render these services, especially to the medically indigent in the ghettos and rural areas. The situation in the less developed countries of the world is even more severe because of the more adverse doctor/patient ratio.

Therefore, it is essential that persons other than physicians be given considerable responsibility in the delivery of family planning services, here and elsewhere in the world. Otherwise the services will not be made available to the people who desire them. New and expanding programs must compete with already established operations for scarce personnel. This problem is not solved by borrowing from "Peter to pay Paul." Rather, we must exert our entire influence toward the expansion of schools of medicine, nursing, and midwifery so that the additional personnel needed, will be available in the foreseeable future.

The Downstate Medical Center, specifically its Department of Obstetrics and Gynecology, became committed to nurse-midwifery training because of Doctor Louis Hellman's concern about the availability of a sufficient quantity of physicians to render needed and anticipated obstetrical care. It was because of our involvement in a basic nurse-midwife training program of eight months' duration and the subsequent six months internship, that nurse-midwife interns were available in our department at the time that our Family Planning Clinic operation expanded dramatically.

Some may recall that it was our department which "fought the good fight" with the "political powers" of New York in 1958. The result of this encounter was that family planning services were made available to the clients of the city hospitals for "Medical Indications." Subsequently the indications were broadened to "demand." This coupled with the availability of more acceptable and more reliable methods of contraception, led to a marked expansion of the demand for services.

It was in this setting that Mrs. Shirley Okrent, then a nurse-midwife intern, volunteered to help me in the Family Planning Clinic. Much to my satisfaction, she soon demonstrated herself to be a better dispenser of family planning services than I. We then included other nurse-midwife personnel in the dispensing of family planning services. Since then, we have employed nurse-midwives on a full time basis in this capacity.

The nurse-midwife is enthusiastically accepted by patients to perform all tasks associated with the delivery of family planning services. Because of her background in midwifery, the nurse-midwife is easily taught the techniques of vaginal examination, use of the uterine sound, and the insertion of IUDs. The other techniques employed in family planning were already a part of her armamentarium. The nurse-midwife is especially well-equipped emotionally and philosophically to administer counseling in the area of human sexuality, an area presently not included in all family planning services.

Integration of all postpartum services (post-hospitalization) has been achieved in our institution. The patients receive an introduction into family planning during the prenatal and hospitalization periods and comes to her postpartum or postabortal examination already having received information concerning methods of contraception. A significant number of patients leave the hospital with IUDs already in place or already on oral contraceptives. This is especially so for our abortion patients. There are approximately 12,000 patients delivered or aborted at the Downstate Medical Center each year. These patients, plus those referred from other sources, comprise an adequate base for a large training program.

In 1966, with the financial assistance of The Population Council, The Ford Foundation, and The Rockefeller Foundation, we began to provide training in the delivery of family planning to nurse-midwives and certified midwives from the less developed countries. This educational activity reflected the Foundations' and our concern with the necessity for such services in the less developed countries and their shortage of physicians to deliver such services. Also, it reflected appreciation of the fact that family planning services should be part of the continuum of obstetrical care regardless of who provides such care. Since April, 1971 this program has been supported by a grant from the Agency for International Development.

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*Deceased September 10, 1971.

With the advent of AID support, a five-year grant, the program has been expanded. While three training sessions per year of twelve weeks duration have been maintained, the number of trainees has been increased from ten to twenty per session. Secondly, the grant provides for the establishment of similar training centers in the less developed countries. It is anticipated that ten such centers can be established during the first three years of the grant. Provision has been made for adding the staff necessary to carry out this responsibility. The centers are to be established with appreciation of, and with adaption to the peculiarities of the individual countries, their needs and their resources. The programs will be local ones which we will support and assist, but the emphasis will be on local involvement and needs. We are confident that the result obtained in the pilot program in Ghana, a year and a half ago, under Ford Foundation support, will be replicated elsewhere.

At the time of his death in September, Doctor Gregory Majzlin was assisting in the establishment of another training center in Afghanistan.

The training programs for nurse-midwives in family planning include:

1. Comprehensive instruction in all phases of family planning.
2. Understanding of the basic concepts of the anatomy and physiology of the reproductive systems.
3. Complete indoctrination in the accepted methods of family planning and exposure to the experimental methods being investigated by us and others.
4. Attention to the development of proper methodology by each trainee.
5. Accurate record keeping and follow-up of patients.
6. Instruction in demography and the economics of family planning.
7. Orientation into social service problems of family planning.
8. Clinic planning and management.

At the outset of the course, our nurse-midwife staff evaluates each trainee's gynecological knowledge and skills. All trainees must become efficient in performing pelvic examinations. In order to properly care for patients medically, and in order to adequately prescribe family planning methods, the trainee must learn to:

1. Determine position, size and shape of the uterus and adnexa.
2. Determine the direction of the cervical canal.
3. Sound the uterus.
4. Recognize gross pelvic pathology.
5. Properly take vaginal and cervical smears for neoplasia detection.

The trainees are taught a minimum of laboratory techniques:

1. Hematocrit or hemoglobin determinations.
2. Trichomonas smears.
3. "Pap" smears.
4. Pregnancy test.

Each trainee is required to perform these tests whenever indicated on her patient. This is carried out under the direct supervision of her instructors. In addition to the clinical instruction, the trainees receive didactic instruction in:

Demography
Psychology of family planning
Ecology
Endocrinology of the ovulatory cycle and oral contraceptives.
Disorders of menstruation

After the third week of the course, the trainee begins to insert IUDs under very close supervision. After the sixth week, she is usually capable of doing this on her own. When she is ready to begin to work alone she has learned to perform as follows:

1. Secure and record an accurate history.
2. Perform a physical examination consisting of blood pressure determination, breast examination, thyroid palpation, and search for signs of circulatory problems, especially in the lower extremities and vulva.
3. Perform bimanual vaginal, recto-vaginal and speculum examinations, "Pap" smear and sounding of the uterus.

After carrying out the above, the patient and trainee are ready for a definitive selection of a method of family planning.

Our 139 trainees have performed 16,220 pelvic and 13,637 breast examinations. They have fitted 668 patients with diaphragms, have inserted 3,373 IUDs without a single perforation of the uterus, and have prescribed oral contraceptives for approximately 13,000 patients.

They have participated in the supervision of continuing patients. Thus, in addition to the training in starting patients on family planning, the trainees receive instruction in the more difficult—keeping the patient an active family planner.

Our own clinic operation is carried out by our nurse-midwife staff and their trainees. The medical staff is present for supervision and consultation. The nurse-midwife staff is charged with the responsibility for clinical instruction of medical students and diploma and baccalaureate nursing students.

It is the responsibility of colleges of medicine and colleges and schools of nursing to select and prepare personnel for such training as detailed above, and to provide the training for domestic as well as foreign personnel. Until passage of the Family Planning Act of 1970, there was governmental support only for foreign training under AID. The National Center for Family Planning Services is now planning to extend such training programs to include domestic personnel. The Center has already made some support available and is planning to expand its activities. We, who are experienced in this field, both as providers of service and teachers of providers should inform the Center of our evaluation of our domestic needs. Further, we should suggest methods of meeting these needs.

The 139 nurse-midwives and certified midwives whom we have thus far trained have come from the areas shown in Table 1.

The Course Outline is shown in Table 2

How have our nurse-midwives and their trainees discharged their technical responsibilities in relation to the insertion of IUDs? Table 3 presents the answer.

We have maintained annual contact with our trainees and find that the majority of them are actively engaged in dispensing family planning services and/or are

Table 1—State University of New York Downstate Medical Center Family Planning Trainees 1966—1971: Total Trained—139

Residence			
North America - 58			
Alaska	2	St. Lucia	1
Canada	1	Grenada	1
U.S.A.	40	St. Vincent	1
Virgin Islands	2	Trinidad	2
Puerto Rico	1	Barbados	2
St. Kits	1	Jamaica	4
Africa - 29			
Kenya	4	Liberia	2
Ghana	1	Ethiopia	1
Uganda	1	Nigeria	7
S. Africa	12	Mali	1
Asia - 48			
Afghanistan	3	South Vietnam	8
Pakistan	2	Thailand	14
Iran	5	Malaysia	1
Jordan	1	Nepal	4
India	10		
Europe - 2			
Holland	1		
Belgium	1		
South America - 2			
Guyana	1		
Brasil	1		

Table 2—Current Course Outline Family Planning Trainees

	hours
1. Demography, Population Statistics	4
2. Motivation for Personnel and Patients	2
3. Cultural Patterns and Life Styles of Population Served	2
4. Principles of Interviewing	2
5. Anatomy and Physiology of Reproduction	4
6. Endocrinology of Menstruation and Chemistry of the Pill	6
7. IUD - Physiology, Theory, Application of Techniques	4
8. Cervical and Vulvo-vaginal Pathology	2
9. Pelvic Inflammatory Disease	1
10. Genetics in Family Planning	4
11. Microbiology (Gyn) and Therapy	1
12. Sex Education and Sexuality	3
13. History of Contraception	1
14. Development of Nurse-Midwifery in the U.S.	2
15. Present Day Methods of Contraception and Counseling	18
16. Physical Examination, Breast and Pelvic Examinations, Pap Smears, Referrals, Personal Hygiene	8
17. Marital Problems and Choice of Contraception	2
18. The Teenager and Problems of this Group	2
19. Lab Work, Pregnancy Test, Hct. Urine-Hanging Drop	3
20. Organization and Administration of Clinic	2
21. Statistics, Record keeping and Follow-up	2
22. Teaching Aids, Films, Field Trips	40
23. Roundtable conferences, Case Presentations, Projects	60
24. Obstetrical and Gynecological Conferences	10
Total	185
Clinic Sessions - 84 (3 hours each)	252

Table 3—State University of New York Downstate Medical Center Family Planning Clinic

Events and Closures for 3,687 Majzlin Springs Inserted 1967—1970

	Events	Closures
Accidental pregnancy	74	74
First expulsions	167	116
Later expulsions	8	6
Removals for medical reasons	560	552
Removals for planned pregnancy	72	72
Removals for personal reasons	109	105

Estimated continuation at twelve months after first insertion: 75 - 80%

teaching this subject matter to other nurses, nurse-midwives or certified midwives.

The acceptance of the AID announcement of the program has been most gratifying. It appears that the expanded program at the Downstate Medical Center will be filled and that our staff will be spending an appreciable amount of time learning about the Less Developed Countries first hand.

Dr. Kohl is Professor, Dr. Majzlin was Lecturer, Dr. Burnhill, Dr. Jones, and Dr. Solish are Associate Professors, Ms. Okrent and Ms. Pendleton are Instructors, Department of Obstetrics and Gynecology, Downstate Medical Center, State University of New York. This paper was presented before the Maternal and Child Health Section of the American Public Health Association at the Ninety-Ninth Annual Meeting in Minneapolis, Minnesota on October 13, 1971.