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Y. A Bhg Dato' Seri Utama Dr. Siti Hasmah bte. Hj Mohd. Ali
Patron of MAMANEH

MESSAGE FROM
PRESIDENT OF MAMANEH

Greetings from Malaysia !

It is a great honour to MAMANEH to be entrusted to host the 8th World IAMANEH Conference 2003. This is the first time that this three-yearly world conference is to be held in Malaysia, and indeed, this is the first of a series of international congresses related to obstetrics and perinatology to be held in Malaysia, with the FAOPS Congress coming up in 2004 and the FIGO Congress in 2006.

The theme of this conference, "Maternal and Neonatal Health - Towards a Holistic Approach", promises a wide variety of topics not often discussed at most perinatal conferences, and a large number of outstanding and brilliant speakers from various parts of the world. Hence, it is an excellent opportunity for experts and workers in the field of perinatology to expand their horizons by attending this upcoming event. I believe that doctors, both consultants and trainees alike, and paramedics, either in obstetrics or paediatrics, will find the scientific programme fascinating. A packed four-day programme has been drawn up, consisting of six plenaries and nine parallel sessions, culminating in an expectedly heated debate on the last day of the conference.

The venue of the congress, Nikko Hotel, is situated within a five-minute walk of the world's tallest building, the Petronas Twin Towers, which houses a huge shopping complex as well as a science centre for children, and has a built-in Light Rail Transit station for ease of travel around the city of Kuala Lumpur. The Kuala Lumpur Tower with its revolving restaurant is also located nearby. In addition, a sightseeing tour has been arranged for interested delegates, and accompanying persons or families. This tour promises to cover the flourishing majestic administrative suburb of Kuala Lumpur, Putrajaya.

After the previous IAMANEH conferences in Cape Town and other places, we in IAMANEH will certainly strive hard to live up to expectations so that you will enjoy your stay here in Malaysia with its multi-ethnic culture living in harmony, exquisite cuisine, shopping bonanza, and not to forget its modern architecture. We would like to extend a very warm welcome to all of you in the Malaysian way, SELAMAT DATANG !

Best Regards

Professor Dr Nik Mohd Nasri Nik Mohd Ismail
President
Malaysian Association for Maternal and Neonatal Health (MAMANEH)

MESSAGE FROM
PRESIDENT OF IAMANEH

Dear colleagues and fellow members of IAMANEH

It is a pleasure to welcome you to the eighth International Association for Maternal and Neonatal Health (IAMANEH) conference hosted by the Malaysian Association for Maternal and Newborn Health in Kuala Lumpur.

The aim of IAMANEH, when it was founded twenty six years ago, was to improve the care of pregnant women and their newborn infants in poor countries through the formation of a federation, which could encourage closer communication between national societies and professional groups concerned with maternal and newborn well being. IAMANEH has convened seven international conferences on maternal and newborn health in developing countries between 1981 and 2000. In addition, individual national sections of IAMANEH in some industrialised countries support projects in less privileged sections while IAMANEH funding has enabled the University of Geneva to provide postgraduate training in reproductive medicine and biology to young doctors from poor countries. Many other avenues of professional assistance in perinatal care are waiting to be explored and developed.

With the ever-widening disparity in maternal and perinatal mortality rates between rich and poor communities, the need for closer co-operation between countries has never been so great. Not only do health care providers in poor countries require financial support, but help with professional training, appropriate technology, suitable management protocols and operational research is urgently required. With the use of the Internet and other lines of communication, many of these needs can be easily met, given the will and commitment of individuals. This is where the great potential benefit of IAMANEH lies; networking between groups and individuals to share ideas and experience.

It is widely recognized that most causes of maternal and perinatal mortality can be prevented with cheap, good, basic care. A clear understanding of common problems, the prevention and correct management of important complications, the provision of practical management protocols, a short list of essential drugs, and robust, simple equipment are both available and affordable. What is lacking in the ability to link those who ask for assistance and those who can supply the required knowledge and support. Often personal dialogue through non-government agencies is faster and more efficient at problem solving than formal state contacts. IAMANEH is ideally placed to provide a bridge between groups of health care workers in many poor countries and, furthermore, to connect them with better resourced colleagues in industrialized nations. Self-help training packages and distance learning courses in practical and appropriate maternal and perinatal care could be shared at minimal cost. Specific problems can be resolved by Internet communication while unsolved technical and protocol difficulties could pose research challenges for academic centres. IAMANEH has the committed members and good will to make a difference and improve the care of pregnant women and their infants in many poor countries.

On behalf of the executive board of IAMANEH I would like to wish you all a very enjoyable and productive conference.

Professor Dave Woods,
President-elect of IAMANEH

MAMANEH
COUNCIL MEMBERS 2002/2003

PATRON

Y. A Bhg Dato' Seri Utama Dr. Siti Hasmah bte. Hj Mohd. Ali

Advisor	• Datuk Dr. Raj Abdul Karim
President	• Prof. Nik Mohd. Nasri b. Nik Ismail
Vice President (1)	• Datuk Dr. Johan Thambu
Vice President (2)	• Prof. Madya Dr. Zaleha Abdullah Mahdy
Honorary Secretary	• Dr. Harlina Harlizah Hj. Siraj
Assistant Secretary	• Pn. Ng Kim Foong
Treasurer	• Pn. Fadzillah Mohd. Pilus
Ordinary Council Members	• Dr. Noor Haliza Yussoff • Dr. Ahmad Murad Zainuddin • Dr. Mohd. Nazri Yazid • Pn. Ng Chee Moy
Elected Paediatrician Co-opted	• Dr. Rohana Jaafar

ORGANISING
COMMITTEE

Chairperson	• Prof. Nik Mohd. Nasri Nik Mohd Ismail
Secretary	• Dr. Harlina Harlizah Hj. Siraj
Treasurer	• Pn. Fadzillah Pilus
Scientific Committe	• A/Prof. Zaleha Abdullah Mahdy (Chairperson) • A/Prof. Winston Yong Sin Chuen (Secretary) • Dr. Rohana Jaafar • Dr. Zarina A. Latiff • Dr. Kamaljit Kaur • Dr. Harlina Harliza Hj. Siraj • Cik Nor Rohaini Abd. Hamid • Dr. Noor Haliza Yussoff • Dr. Juriza Ismail • Pn. Ng Chee Moy • Pn. Fadzillah Pilus
Finance Manager	• Prof. Nik Mohd Nasri Nik Mohd Ismail
Publicity & Publications	• Dr. Noor Haliza Yussoff
Registration	• Dr. Harlina Harlizah Hj. Siraj • Puan Ng Chee Moy • Puan Ng Kim Foong • Mrs. Trudy Wu
Protocol & Opening/ Closing Ceremony	• Datuk Dr. Johan Thambu • Datuk Dr. Raj Abdul Karim
Social & Hospitality	• Pn. Fadzillah Pilus
Venue	• Dr. Mohd. Nazri Yazid
Website	• Dr. Ahmad Murad Zainuddin

OVERSEAS FACULTY

Dr Alan Gibson
Consultant Neonatologist
Royal Hallamshire Hospital
Sheffield
United Kingdom

Dr Alison Kesson
Head of Virology, Microbiology and Pathology
The Children's Hospital at Westmead
New South Wales
Australia

Professor David L Woods
Associate Professor and Principal Specialist
Head of Division of Neonatal Medicine
School of Paediatrics and Adolescent Health
University of Cape Town & Groote Schuur Hospital
South Africa

Mrs Imtiaz Kamal
President (Sindh Provincial Chapter)
Maternity and Child Welfare Association of Pakistan
Karachi
Pakistan

Dr Jose Guilherme Cecatti
Associate Professor
Department of Obstetrics and Gynaecology
University of Campinas
Sao Paulo
Brazil

Professor Dr Kamheang Chaturachinda
President
Royal Thai College of Obstetricians and Gynaecologists
Thailand

Professor H R Seneviratne
Professor and Head
Department of Obstetrics and Gynaecology
Faculty of Medicine, University of Colombo
General Hospital, Colombo &
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Dr Lim Meng Kin
Associate Professor
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Neurobehavioral Infant and Child Studies Lab,
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Professor Stephen Courtenay Robson
Professor of Fetal Medicine
Consultant and Head
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Royal Victoria Infirmary
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Professor Dr William Dunlop
President
Royal College of Obstetricians and Gynaecologists
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Professor Dr Zulfiqar A Bhutta
The Husein Laljee Dewraj Professor of Paediatrics
Department of Child Health
The Aga Khan University
Karachi
Pakistan

LOCAL FACULTY

Dr Ang Eng Suan
Executive Director
Federation of Family Planning Associations
of Malaysia (FFPAM)
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Professor Dr Boo Nem Yun
Consultant and Head of Neonatology Unit
Department of Paediatrics
Faculty of Medicine
Universiti Kebangsaan Malaysia
Malaysia

Mr Chia Lui Meng
Bhuddist Activist
Kuala Lumpur
Malaysia

Mrs Christine A Choong
Lactation Consultant and Childbirth Educator
Mamalink
Malaysia

Dr Christopher Lee
Consultant Infectious Disease Physician
Head of Infectious Disease Unit
Department of Medicine
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Dr Fatimah Arshad
Associate Professor
Department of Nutrition and Dietetics
Faculty of Allied Health Sciences
Universiti Kebangsaan Malaysia
Malaysia

Dato' Dr Jemilah Mahmood
President
Malaysian Medical Relief Society
(Mercy Malaysia)
Malaysia

Datuk Dr Johan A M Thambu
Consultant Obstetrician and Gynaecologist
Tawakal Hospital
Kuala Lumpur
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Dr Lee Choon Yee
Associate Professor and Consultant Anaesthesiologist
Department of Anaesthesiology
Faculty of Medicine
University Kebangsaan Malaysia
Malaysia

Dato' Dr Lim Nyok Ling
Consultant and Head
Department of Paediatrics
Hospital Selayang
Malaysia

Dr Mohd Daud Abu Bakar
Associate Professor
Ahmad Ibrahim Kulliyah of Laws
International Islamic University
of Malaysia Malaysia

Professor Dr Nik Mohd Nasri Nik Mohd Ismail
Consultant Obstetrician and Gynaecologist
and Deputy Dean
Faculty of Medicine
Universiti Kebangsaan Malaysia
Malaysia

Datuk Dr Raj Abdul Karim
Regional Director
International Planned Parenthood Federation
Kuala Lumpur
Malaysia

P S Ranjan
Advocate and Solicitor
P S Ranjan & Co
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Dato' Dr Sivalingam Nalliah
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Ms. Wong Poh Wan
Director
Services for People with Disabilities
Malaysia CARE
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Malaysia

Dr Wong Sum Keong
Consultant Obstetrician and Gynaecologist
Pantai Medical Centre
Kuala Lumpur

Dr Zarihah Zain
Deputy Director
Disease Control Division
Ministry of Health
Malaysia

PROGRAMME AT GLANCE

Thursday 21st August	Friday 22nd August	Saturday 23rd August	Sunday 24th August
0830 - 0930 Registration 0930 - 1030 Opening Ceremony	0830 - 1000 **Plenary 2** Childbirth - The Rights of A Woman	0830 - 1000 **Plenary 4** Medical Problems in Perinatology	0830 - 1000 **Plenary 6** Recent Advances in Perinatology
Coffee	Coffee		
1100 - 1230 **Plenary 1** Safe Motherhood in South & South-East Asia 1400 - 1700 IAMANEH General Assembly	1030 - 1230 **Parallel Session 1:** Perinatal Infection **Parallel Session 2:** Emergency Obstetrics and Perinatology **Parallel Session 3:** Psychosocial Aspects of Perinatology	1030 - 1200 **Plenary 5** Improving Perinatal Education	1030 - 1230 **Parallel Session 7:** Reproductive Health Issues **Parallel Session 8:** Maternal and Neonatal Health in Disaster Areas **Parallel Session 9:** Issues on Substance Abuse
	Lunch Break	Lunch Break	
	1400 - 1530 **Plenary 3** Ethical Issues Concerning the ELBW and Abnormal Baby	1400 - 1530 MAMANEH AGM	1430 - 1600 Debate
	Tea Break		Tea Break
	Parallel Session 4: Abortion Issues - A Forum **Parallel Session 5:** Community Obstetrics and Perinatology **Parallel Session 6:** Perinatal Nutrition	1530 - 1800 SOCIAL EVENT	1630 - 1730 Presidential Address and Closing
	2000 - 2230 FORMAL DINNER	2000 - 2230 **INFORMAL NITE**	

OFFICIAL AND SOCIAL PROGRAMME

• OPENING CEREMONY & WELCOME RECEPTION

DATE : 21st August 2003, Thursday
TIME : 09:30 - 10:30
VENUE : Ballroom1

Opening Ceremony will be Officiated by the MAMANEH Patron Dato' Seri Utama Dr. Siti Hasmah Mohd Ali wife of our Prime Minister. This will be followed by keynote address on Maternal and Neonatal Health - Towards a Holistic Approach.

• IAMANEH GENERAL ASSEMBLY

DATE : 21st August 2003, Thursday
TIME : 14:00 - 17:00
VENUE : Ballroom1

The annual IAMANEH general assembly will be held for IAMANEH members. All delegates are invited to attend and observe.

• FORMAL DINNER

DATE : 22nd August 2003, Friday
TIME : 20:00
VENUE : Nikko Hotel Ballroom

Highlight of the 4-day conference where delegates get together at a formal sit-down dinner. A special entertainment will entertain you.

• MAMANEH AGM

DATE : 23rd August 2003, Saturday
TIME : 14:00 - 15:30
VENUE : Ballroom1

This is the assembly of the local or Malaysian Maternal & Neonatal Health Association followed by election of new commitee members for 2003/2004

• IAMANEH 2003 SOCIAL EVENT

DATE : 23rd August 2003, Saturday
TIME : 15:30 - 18:00

A time of leisure where delegates can relax and get to see the city sights or go shopping

• INFORMAL NITE

DATE : 23rd August 2003, Friday
TIME : 20:00
VENUE : Nelayan Titiwangsa Restaurant, Taman Tasik Titiwangsa

An opportunity for delegates to get together and mingle in an informal setting.

PROGRAMME SCHEDULE

THEME: Maternal and Neonatal Health - Towards A Hollistic Approach

DAY 1 (THURSDAY, 21ST AUGUST 2003)

0830-0930 **REGISTRATION**

0930-1030 **OPENING CEREMONY & KEYNOTE ADDRESS** ***(Venue: Ballroom 1)***
Maternal and Neonatal Health - Towards a Holistic Approach - by Dato' Seri Utama Dr. Siti Hasmah bte. Hj Mohd Ali

Coffee Break

1200-0130 **Plenary 1** **Safe Motherhood in South & South-East Asia** (Chairperson: Prof. Nik Nasri)
(Venue: Ballroom 1)

1. Safe Motherhood in Thailand (Prof Kamheang)
2. Safe Motherhood in Sri Lanka (Prof Seneviratne)
3. Safe Motherhood and Maternal Mortality (Datuk Dr. Raj Abdul Karim)

1400-1700 **IAMANEH General Assembly** ***(Venue: Ballroom 1)***

DAY 2 (FRIDAY, 22ND AUGUST 2003)

0830-1000 **Plenary 2** **Childbirth - The Rights of A Woman** (Chairperson: Dr. Milton Lum)
(Venue: Ballroom 1)

1. The Right to Request for Induction of Labour (Prof Dunlop)
2. The Right to Home vs Hospital Delivery (Datuk Dr Johan Thambu)
3. The Right to Labour Pain Relief (Assoc Prof Lee CY)

Coffee Break

1030-1230 **PARALLEL SESSIONS**

Parallel Session 1: **Perinatal Infection** (Chairperson: Assoc Prof Yasmin Abdul Malik)
(Venue: Bunga Raya Room)
Keynote 1: Screening for HIV in Pregnancy (Dr Alison Kesson)
Keynote 2: Anti-retroviral Therapy in Pregnancy - An Update (Dr Christopher Lee)
Keynote 3: The HIV Positive Baby (Dr Alison Kesson)
(3 Free Papers + 3 Posters of the Day)

Parallel Session 2: **Emergency Obstetrics and Perinatology** (Chairperson: Prof Neera Agarwal)
(Venue: Lotus Room)
Keynote 1: PPH Management - An Update (Prof Seneviratne)
Keynote 2: The Non-Reassuring Fetal Status (Prof Robson)
Keynote 3: Neonatal Resuscitation - What's New (Prof Boo NY)
(3 Free Papers + 3 Posters of the Day)

Parallel Session 3: **Psychosocial Aspects of Perinatology** (Chairperson: Dr Katsuyuki Takahashi)
(Venue: Ballroom 1)
Keynote 1: Adolescent Pregnancy (Prof Cecatti)
Keynote 2: Impact of the Premature Baby on the Family (Dr Alan Gibson)
Keynote 3: Community-based VLBW Care - A Pakistani Model (Prof ZA Bhutta)
(3 Free Papers + 3 Posters of the Day)

Lunch Break

1400-1530 **Plenary 3** **Ethical Issues Concerning the ELBW and Abnormal Baby** (Chairperson: Prof David Woods)
(Venue: Ballroom 1)

1. Ethical Issues Surrounding Higher Multiple Births (Prof Dunlop)
2. ELBW - To Resuscitate or Not to Resuscitate (Dr Alan Gibson)
3. Termination of Pregnancy for Fetal Anomaly - The Ethics (Prof Robson)

Tea Break

1600-1800 **PARALLEL SESSIONS**

Parallel Session 4 : **Abortion Issues - A Forum** (Chairperson: Prof Omar Hasan Kasule)
(Venue: Ballroom 1)
Keynote 1: Civil Law - Where do Obstetricians Stand? (Mr PS Ranjan)
Keynote 2: The Islamic Perspective (Assoc Prof Dr Mohd Daud Abu Bakar)
Keynote 3: Abortion in the Eyes of Other Religions:

- Christianity (Dr Wong Sum Keong)
- Buddhism (Mr Chia Lui Meng)
- Hinduism (Assoc Prof Dr Subramaniam Aiyar)

Parallel Session 5: **Community Obstetrics and Perinatology** (Chairperson: Assoc Prof Nik Safiah Nik Ismail)
(Venue: Bunga Raya Room)
Keynote 1: Midwifery Care - Then and Now (Mrs Imtiaz Kamal)

Keynote 2: Community Support for Special Babies (Ms. Wong Poh Wan)
Keynote 3: Influence of Cultural Practice on Maternal & Perinatal Health (Mrs Imtiaz Kamal)
(3 Free Papers + 3 Posters of the Day)

Parallel Session 6: **Perinatal Nutrition** (Chairperson: Dr Irene Cheah)
(Venue: Lotus Room)
Keynote 1: Nutritional Needs for the Lactating Mother and Her Infant (Prof. Fatimah Arshad)
Keynote 2: The Baby Friendly Initiative - What has been achieved (Dato' Dr Lim NL)
Keynote 3: The Insufficient Breast Milk Syndrome (Mrs. Christine Choong)
(3 Free Papers + 3 Posters of the Day)

2000-2200 **CONFERENCE DINNER** ***(Venue: Nikko Hotel Ballroom)***

DAY 3 (SATURDAY, 23RD AUGUST 2003)

0830-1000 Plenary 4 **Medical Problems in Perinatology** (Chairperson: Assoc Prof Muhammad Abdul Jamil MY)
(Venue: Ballroom 1)
1. Heart Disease in Pregnancy (Dato'Dr Sivalingam)
2. Outcome of Growth Restricted Babies (Prof David Woods)
3. Neonatal Infections (Prof Z A Bhutta)

Coffee Break

1030-1200 Plenary 5 **Improving Perinatal Education** (Chairperson: Datuk Dr Johan Thambu)
(Venue: Ballroom 1)
1. The Role of the RCOG in Promotion of Perinatal Health in Developing Countries (Prof Dunlop)
2. Expanding Trained Midwifery Services to Rural Areas (Mrs Imtiaz Kamal)
3. The Impact of Distance Learning on Maternal and Newborn Care (Prof David Woods)

Lunch Break

1400-1530 **MAMANEH AGM** ***(Venue: Ballroom 1)***

1530-1800 **SOCIAL EVENT** ***(City Tour)***

2000-2230 **INFORMAL NITE** ***(Venue: Nelayan Titiwangsa Restaurant, Taman Tasik Titiwangsa)***

DAY 4 (SUNDAY, 24TH AUGUST 2003)

0830-1000 Plenary 6 **Recent Advances in Perinatology** (Chairperson: Dr Ong Hean Choon)
(Venue: Ballroom 1)
1. Perinatal Diagnosis - What's New (Prof Robson)
2. NIDCAP (Prof. Boo N Y)
3. Steroids in Pregnancy (Prof Nik Nasri)

Coffee Break

1030-1230 **PARALLEL SESSIONS**

Parallel Session 7: **Reproductive Health Issues** (Chairperson: Assoc Prof Siti Zawiyah Omar)
(Venue: Bunga Raya Room)
Keynote 1: Sex Education - Who, What, When, Where and How? (Dr Ang Eng Suan)
Keynote 2: The "Optimal" Family Size ? (Datuk Dr Johan Thambu)
Keynote 3: The Non-Hormonal Contraceptive Pill (Prof Nik Nasri)
(3 Free Papers + 3 Posters of the Day)

Parallel Session 8: **Maternal and Neonatal Health in Disaster Areas** (Chairperson: Dr Musa Mohd Nordin)
(Venue: Ballroom 1)
Keynote 1: War and Disaster Around the World - Lessons Learned (Assoc Prof Dr Lim MK)
Keynote 2: Children of War - An Analysis (Prof Z A Bhutta)
Keynote 3: Serving Women in War (Dato'Dr Jemilah Mahmood)
(3 Free Papers + 3 Posters of the Day)

Parallel Session 9: **Issues on Substance Abuse** (Chairperson: Assoc Prof Dr Khadijah Shamsuddin)
(Venue: Lotus Room)
Keynote 1: The Effects of Tobacco on Women's Health (Dr Zarihah Zain)
Keynote 2: Substance Abuse - Effects on the Newborn (Dr Alan Gibson)
Keynote 3: Maternal Drug Abuse in South-East Asia (Prof Kamheang)
(3 Free Papers + 3 Posters of the Day)

Lunch Break

1430- 1600 **DEBATE "Caesarean Section at Request is a Woman's Right"** (Chairperson: Prof Nik Nasri)
(Venue: Ballroom 1)
Proposer : Prof Cecatti
Opposer : Dato'Dr Sivalingam

Tea Break

1630-1730 **PRESIDENTIAL ADDRESS AND CLOSING** ***(Venue: Ballroom 1)***

SPEAKERS
ABSTRACTS

SAFE MOTHERHOOD IN THAILAND

KAMHEANG CHATURACHINDA, THAILAND

Thailand is a developing country of 62 million people situated in South East Asia. Each year there are approximately 600,000-700,000 births; and 200-300 maternal deaths.

The birth rate has continued to decline due to better education and good access to family planning services. Maternal and Perinatal mortality have also greatly declined during this last decade.

Maternal Health has many determinants ranging from internal factor such as genetic to external factors such as socio-economic, politic, climate, geographic, lifestyle, health care system and technology.

Changes in these external factors in Thailand In the last decade contributed markedly to the Improvement of maternal and perinatal safety with the resulting decline in maternal and perinatal mortality

More work, both medical and social need to be done to reduce further the maternal mortality and morbidity and to improve maternal and perinatal health to the level attained in the developed nations.

"SAEE MOTHERHOOD IN SRI LANKA"

PROFESSOR HARSHALAL R SENEVIRATNE, MBBS DM FSLCOG FRCOG FACULTY OF MEDICINE, UNIVERSITY OF COLOMBO, SRI LANKA

The ruling Monarchs in ancient times and then the colonial rulers established a series of measures to introduce good medical services to the people of Sri Lanka. Maternity care came into focus with the donation in 1879 of the DeSoysa Maternity Home. Subsequently the commencement of the domiciliary / field midwifery service, free education in 1338 and introduction of Family Planning in 1953 ensured progress in saving maternal lives. In 1997 Sri Lanka changed to comprehensive Reproductive Health (RH) Care.

Maternal mortality records available from 1880 now show a maternal mortality rate of 1.5 per 10,000 live births. Approximately 180 maternal deaths occur annually. Sri Lanka's success was the triad of social enhancement, healthcare development and family planning services linked together to thrust the safe motherhood concept forward. This same triad is expected operate to enhance maternal safety still further.

Male and female literacy rates have reached 94% and 88% respectively. The need for expanding the RH awareness in general and providing RH education and services to school leavers in particular is a priority. With the increased literacy rate utilization of maternity services has shifted to the specialist hospitals while home deliveries have increased. Needs for adequate management of resources for health care where by the hospitals manage the appropriate pre defined level of case is very much felt.

While Sri Lanka is unique in its achievement in family planning the country has a regrettable prevalence of illegal abortions. The adverse effect of a high literacy rate along with the unmet needs for spacing and limiting pregnancy are areas needing urgent attention of policy makers. Sri Lanka therefore needs to re-direct its program for Safe Motherhood to ensure that the momentum gained in the past is maintained.

The recent evaluation of provision of emergency obstetric care in the country showed that while coverage by basic and advanced services was adequate serious lapses are present because of malutilization of facilities, inadequate management of services etc. The maternal death audit conducted annually has done much to focus on the causes such as medical disorders, service lapses, public compliance etc. Based on such data Sri Lanka is due to embark on the implementation phase of the new safe motherhood programme using strategies very different to those adopted in the past century.

HOME VS HOSPITAL DELIVERY

DATUK DR JOHAN THAMBU, KUALA LUMPUR, MALAYSIA

The right to Home vs Hospital delivery must be viewed in the context of the International Conference on Population and Development (ICPD Cairo 1994), programme of action document [C (b)] ... "Ensure that the reduction of maternal morbidity and mortality is a health sector priority and that women have ready access to essential obstetric care well equipped and adequately staffed maternal health care services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher level of care when necessary, postpartum care...."

Over the years health care providers in their effort to reduce maternal mortality and perinatal mortality and morbidity have moved births from Homes to Hospitals. This concept Is being challenged in the context of the reproductive rights of women.

"Home birth a real option and the wishes of women to have home birth must be viewed" - Cumberiedge Report (London HMSO 1993).

"Home birth safe in selected women and with adequate infrastructure and support - BMJ No7068 Vol 313, Editorial Nov 1996.

In Malaysia, the MCH Division and now the Family Health Division of the Ministry of Health has over the years evolved an excellent system starting from Primary Care Level to the Hospital using obstetric risk assessment protocol for client selection, monitoring and obstetric and perinatal care with very effective referral system coupled with client education and with staff skills building.

The right for Home or Hospital delivery is made on an individual basis following a process of informed selection.

1. Meticulous selection of clients for Home Birth
    - Use of risk management strategy and protocols
    - Use of colour code for high risk obstetric screening
        - code red - immediate hospital admission
        - code yellow - referral to O&G specialist clinic
        - code green - referral to medical officer of Health
        - code white - to midwives for home birth.
2. Infrastructure for Home safe birth
    - Home, privacy/room, light, clean water, bed, telephone and clean environment
    - Maternity clinics
    - Alternative birth centers
    - Low risk centers
3. Protocols for Home visit
4. Protocols for
    - Ante Natal care
    - Intrapartum care
    - Post Natal care
    - Manual for perinatal care
5. Client accessibility to Government clinics and alternative birth centres.
6. Communication / consultation / referral to Hospital
7. Ambulance transportation

"Home births accounted for only 1.8% of all deliveries. The perinatal mortality rate for all home births is 7.8 per 1000 live births, that for hospital delivery 8.9 per 1000 live births." (Office for National Statistics, London 1994)

The Malaysian Hospital, midwife clinic, altemative birth centres and Home births percentages are shown as below:

	Peninsular Malaysia		Sabah		Sarawak	
Year	1985	2001	1985	2001	1985	2001
Hospital Birth	53.6%	96.0%	53.8%	70.3%	67.1%	88.8%
Government clinics/ alternative birth centres	NA	1.9%	NA	5.2%	NA	9.1%
Home births	46.4%	2.1%	46.2%	24.5%	32.9%	2.1%

The reproductive rights are NOT Home vs Hospital BUT a holistic approach for rights to Home and Hospital Births.

THE RIGHT TO LABOUR PAIN RELIEF

LEE CHOON YEE, KUALA LUMPUR, MALAYSIA

When the anaesthetic effects of ether and chloroform were discovered in the mid-1800s, the British clergy argued that "human intervention in the miracle of birth was a sin against the will of God". The practice of limiting labour pain gained wider acceptance when Queen Victoria used "blessed chloroform" during labour. Various analgesic techniques - ranging from non-pharmacologic ("natural" childbirth) techniques in various forms, parenteral opiates, transcutaneous electrical nerve stimulation (TENS), inhalational anaesthetics, and loco-regional blocks - were advocated and became part of modern day obstetric practice. Not only is effective analgesia during labour indicated on humanitarian grounds, It is also important to overcome the deleterious effects of pain on various organ systems both in the mother and the fetus.

Epidural analgesia is without doubt the most effective means of pain relief during labour. However, despite its efficacy and overall safety, it is still being regarded with suspicion by some obstetricians and nursing staff, the public, and even among some non-obstetric anaesthetists themselves. Controversies abound regarding the effect of epidural analgesia on the progress and outcome of labour, together with uncertainties about its possible side-effects and complications both immediate and long-term, Meta-analyses and systematic reviews may not represent the true picture because of heterogeneity in both obstetric and anaesthetic management protocols In different centres and over the years. It cannot be ruled out that changes in obstetric anaesthetic practice - the use of more dilute solutions of newer local anaesthetic agents (ropivacaine, levobupivacaine), supplementation with opioids (fentanyl, sufentanil), the combined spinal-epidural (CSE) technique and practice of ambulatory ("walking") epidural - may have effects on labour progress and outcome.

Other issues to be considered include antenatal education for the expectant mothers, (mis) information from the immediate family, relatives, friends and the media, the availability of anaesthetic staff to provide round-the-clock obstetric anaesthesia coverage, recompensation issues and refusal of medical insurance coverage in certain countries.

The American College of Obstetricians & Gynaecologists stated in a 2002 ACOG practice bulletin "...In the absence of a medical contraindication, maternal request is a sufficient Justification for pain relief in labour."[1] Although it is true that every woman has the right to labour pain relief, all the factors enumerated above will influence the ultimate decision whether the parturient gets to enjoy a comfortable birthing process on one of the most important occasions in her life.

Reference

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SCREENING FOR HIV IN PREGNANCY.

ALISON KEESON, NEW SOUTH WALES, AUSTRALIA

Screening for HIV in pregnancy has three main aims. 1) to optimise the medical management of HIV infection in the woman, 2) to try and prevent horizontal transmission to her sexual partner and 3) to reduce the risks of vertical transmission to the infant. The initial consideration about HIV screening Is who to screen and how the population at risk of having HIV infection will be identified. Consideration needs to be given to the prevalence of HIV infection in the screened population as this will Impact on the false positive rate of any screening program.

The important complementary issue with screening for HIV in pregnancy is counselling of the women being screened and those women identified as HIV infected. The counselling needs to consider 1) the psycho-social and economic environment of the woman, 2) methods to prevent horizontal and vertical transmission and 3) issues of parenting. The counsellor needs to be Fully aware of the women's cultural background and expectations as well as their own cultural and moral values because counselling is not straight forward and the line between clinical recommendations and value judgements can be ambiguous. When an HIV positive woman is identified the role of anti-retrovirals or caesarean section in decreasing vertical transmission needs to be fully discussed BS well as the risks of HIV transmission to the infant from foetal monitoring during labour and delivery and breast feeding.

ANTIRETROVIRAL THERAPY IN PREGNANCY

CHRISTOPHER LEE, KUALA LUMPUR, MALAYSIA

Antiretroviral (ARV) therapy during pregnancy has become the cornerstone of medical interventions to reduce maternal-fetal HIV transmission. Since the landmark study of ACTG 076 published in 1994, numerous clinical trials using various ARV agents / combinations at different phases of pregnancy have been studied. Generally, most of the trials have concluded with positive results in favor of ARV therapy when compared with placebo, Which ARV treatment / combination and which timing permutation is considered the best is however less certain. Various treatment regimens will be discussed during the presentation. It is now clear that the choice of ARV treatment offered to reduce mother-to-child transmission (MTCT) in any setting must be based on various factors; the level of maternal-child health services, the profile of the mother esp. with regards to possible ARV drug contraindications, the accessibility of Highly Active Antiretroviral Therapy (HAART) to the mother as well as the cost of the particular therapy. The option chosen ultimately must not only be effective but also affordable, practical and achievable based on the available local resources. If possible, it should also have minimal impact on the future ARV options for the mother. It is now clear that besides ARV therapy, other interventions are also important to address MTCT. These include the option of elective caesarean section as well as replacing breast-feeding with formula feeding. Counseling is also another important component in MTCT; not only in supporting the mother-father pair through the pregnancy but also to address the issue of future pregnancies and/or contraception.

THE HIV POSITIVE BABY

ALISON KEESON, NEW SOUTH WALES, AUSTRALIA

Diagnosis of the HIV positive baby requires a very different approach to diagnosis In an older individual as the presence of maternally acquired HIV antibodies interfere with the normal diagnostic tests. The management of an HIV exposed or infected baby requires a multidisciplinary approach. The method of staging HIV infection in infants and children is different to that used in the management of HIV-infected adults and careful consideration needs to be given to commencing and choice anti-retroviral therapy. There is a significant risk of death from Pneumocystis carinii infection during the first year of life therefore introduction of prophylaxis for opportunistic infections are a critical Issue. Care and attention needs to be paid to risk of recurrent bacterial infections as well as the routine vaccination schedule. Additional vaccinations may be indicated in these patients. Growth and development can also be impaired in HIV positive infants and early identification and intervention with developmental problems or nutrition may impact on well being and outcome.

"MANAGEMENT OF POST PARTUM HAEMORRHAGE: An Update"

HARSHALAI R SENEVIRATNE, COLOMBO, SRI LANKA

Advanced technology introduced over the past century has failed to prevent maternal deaths due to post partum haemorrhage (PPH). Treatment needs to be designed to save lives as well as conserve endocrine functions and fertility. Often treatment of post partum haemorrhage is too little and too late. An objective review of the medical, surgical, organizational and training resources is timely so that individual cases could be dealt with effectively.

Identification of high risk pregnancies and pre-treatment is vital for minimizing mortality and "near miss" situations due to PPH. Check lists for this purpose are standard tools in the provision of maternity care. PPH occurring unexpectedly tests the skills of maternity care providers at all levels. Primary and specialist care providers should be equally competent in recognizing and appropriately managing PPH. While supportive measures continue individual treatment depends on identification of the cause. Very early recognition of trauma as the cause is mandatory in commencing effective surgical treatment.

PPH due to uterine atony is sometimes predictable, often preventable and in most instances treatable. Addition of prostaglandin analogues to the range of traditional "oxytocics" has enhanced medical treatment. Applicability of oxytocics in a wide range of clinical situations and levels of care has now increased.

Primary causes leading to PPH from bleeding disorders need to be identified early. While long standing abnormalities of coagulation and bleeding due to medication could be evaluated and managed on a preplanned protocol those arising acutely in the peri-partum period need more urgent as well as focused treatment.

In PPH of non traumatic origin surgical treatment is reserved as a last resort. The uterus has a quadruple blood supply. Several techniques ranging from the time tested ligation of the Internal iliac arteries to more recently suturing of the uterus have been used. There are however instances still where hysterectomy is the last resort for saving maternal life. The decision to use it needs foresight and experience.

For effective treatment of PPH physical resources, well trained staff and efficient management systems appropriate for each level of care need to be In place. High risk evaluation for PPH should be routine at all stages of pregnancy and labour. All pregnancies are considered to have a potential for developing PPH until the puerperium is completed.

IMPACT OF THE PREMATURE BABY ON THE FAMILY

ALAN T. GIBSON, SHEFFIELD, UK

When a preterm baby is suddenly, and unexpectedly born, family life becomes centred in the strange and alien world of the neonatal intensive care unit. Weeks later the parents return to their "normal" world - a world that has been permanently changed by recent events. The impact of this on the families cannot be underestimated

We have assessed this by sending questionnaires to 100 sets of parents -10 from each of the last 10 years. Fifty-eight were returned but a number of parents apologised because they could not complete the form because of the distress they felt at the questions raised.

When asked to describe the range of feelings they experienced, most parents expressed negative emotions, with fear being commonest. Most parents felt that they had coped well with the experience and most felt well supported during their time on the neonatal unit. The majority felt they had been adequately prepared for discharge but a significant proportion felt that more could have been done to help. At the time of discharge, the majority of parents felt happy that their baby was going home but many also felt frightened and worried about the implications. After discharge most parents initially felt well supported but became concerned as the level of support diminished over the first year.

Almost all parents felt that they worried about their child because of the preterm birth; much more than they worried about other children born at term. Most of these parents continued to worry. Almost half had experienced nightmares about their time on the neonatal unit and in some cases these had continued for many years. Sleep disturbance was common. Feelings of guilt were extremely common amongst parents and continued, many years later, in almost half. Many parents felt that their employment and financial situation had been affected and a large proportion felt that their personality had significantly altered. Many couples felt that their premature baby had permanently altered their relationship and changed their plans for future pregnancies.

The vast majority of parents admit to long lasting psychological problems as a consequence of having a premature baby. The long-term morbidity experienced by these parents should concern us and persuade us to explore the means by which the support we provide can extend far beyond the walls of the neonatal units where the problems began.

PROFILE AND OUTCOME OF A HIGH-RISK VERY LOW BIRTH WEIGHT COHORT IN A DEVELOPING COUNTRY: EARLY DISCHARGE & COMMUNITY MANAGEMENT

ZULFIQAR A. BHUTTA KARACHI, PAKISTAN

The survival and care of very low birth weight (VL8W) infants poses unique challenges in developing country settings. While a large proportion of such infants may not survive, others pose enormous drain on scanty material and human resources, with high rates of morbidity. Although there are reports of successful management of VLBW infants in community settings with kangaroo care and thermoregulation, most of these refer to stable VLBW survivors and largely exclude those with significant post-natal problems.

We prospectively evaluated the admission profile, complication rates and outcome of all very low birth weight (VLBW) infants in a birth cohort at AKUMC (1987-2001), VLBW infants (n=528) represented 1 1.7% of all live births (n=30,538) with a overall mortality of 24%. The sequential mortality at discharge for the periods 1987-1990, 1991-1994 & 1995-97 and 1998-2001 were 34%, 32%, 24% and 29% respectively.

In order to reduce costs of care and rates of nosocomial infection, we instituted a program of active involvement of the mother in the routine nursing and respiratory care of VLBW infants in 1993, leading to early discharge from hospital. This was facilitated through the creation of a high-step down mother and baby unit where the mothers learnt and performed basic neonatal procedures under supervision. After discharge a system of outpatient follow up and a hot line were provided to parents. There has been a significant reduction in the average time to discharge
for VLBW survivors over the last 10 years and the mean weight at discharge has remained between 1284-1288 g over the last 8 years. Overall 44 (8%) of VLBW infants so discharged required readmission during the neonatal period and most mothers were able to manage at home with exclusive breastfeeding in the majority (86%). The overall rates of handicap at a year of age were low. Nine infants among 380 survivors died at home after discharge and the overall rates of handicap at 12 months follow-up were low (significant development delay 7%, hydrocephalus 3%, bronchopulmonary dysplasia 15% retinopathy of prematurity 4%).

Our data suggest that despite high morbidity, it is feasible to provide modified basic newborn care to VLBW infants in a developing country with early-discharge to domiciliary care. Training mothers in the care of VLBW infants after discharge is both feasible and cost-effective.

THE EXTREMELY LOW BIRTHWEIGHT INFANT - TO RESUSCITATE OR NOR TO RESUSCITATE

ALAN T GIBSON, SHEFFIELD, UK

Many factors must be considered when the decision is made as to whether an extremely immature infant should be resuscitated. No single set of rules apply in all circumstances and different units serving different populations must generate their own guidelines. What questions should be asked?

Gestational age or birthweight? Both factors are relevant. Gestational age is the most important discrimant factor for survival, and birthweight alone should not be used to determine care. A baby born with a weight of 60O grams may be very immature and normally grown, or relatively mature but growth impaired - outcome may be very different. At any gestational age growth impaired babies have increased mortality and morbidity and both factors should therefore be taken into account.

What gestational age? Survivors are very uncommon below 23 weeks and many would regard this as the limit of viability. Above 22 weeks mortality decreases sharply and data suggest a marked increase in survival over the last decade.

What morbidity is acceptable? Improved survival at extreme immaturity is associated with Increased morbidity The majority of infants born at 25 weeks or below will develop chronic lung disease and many will require long-term oxygen therapy. Retinopathy requiring treatment is commoner. Approximately 50% will have some degree of neuro-developmental impairment and in around half it will be severe. A significant proportion of infants will have long-term educational and behavioral problems. The decision as to what level of morbidity is acceptable will depend on the culture, financial resources and follow-up support available.

When should morbidity be assessed? Evidence suggests that early assessment of morbidity may overestimate adverse outcome. A cohort of extremely premature infants assessed at 6 years had significantly lower rates of neurodevelopmental morbidity than predicted by assessment at 2.5 years.

How much resuscitation? Data suggest that outcome is likely to be far worse if aggressive resuscitation is required. Use of resuscitation drugs rarely results in acceptable outcomes

Is such care financially justifiable? Provision of care for extremely premature babies consumes a large amount of resources, both acutely and following discharge - sometimes for many years. If resources are limited it is difficult to justify such care and resource should be utilised for the greatest good of the greater number. If resources are unlimited ethical, legal and moral issues dominate discussion

To resuscitate or not? A difficult dilemma

MIDWIFERY THEN AND MIDWIFERY NOW

IMTIAZ T. KAMAL, KARACHI, PAKISTAN

How does one define the, "THEN" of midwifery? It would date back to the first birth of a baby assisted by the, "With Woman". The art of midwifery has been practiced since time immemorial. The documented history of midwifery is two thousand years old. The, "NOW" of midwifery is a very interesting phenomenon because there is no uniform situation of the present picture. What was THEN in many countries is the NOW in many. Sweden managed to gradually replace the Traditional Birth Attendant by the trained and state supported midwife in the middle of the 18th century. Many countries of Africa and Asia are still struggling to achieve that goal. Midwifery's acceptance has had its highs and lows with the midwife in and out of fashion and back in. In almost all the developing countries acceptance of the midwife as a specialist in normal obstetrics is going to take a long time because many of the elements of effective midwifery practice are missing e.g. many countries do not have any regulatory mechanisms for the practice of midwifery. Training and proper utilization of the licensed midwife is a challenge, which faces many nations of the world even today.

Key Words: Acceptance. Training. Challenge.

COMMUNITY SUPPORT FOR SPECIAL BABIE5

WONG POH WAN, KUALA LUMPUR

When parents are given the devastating news that their child has a disability, their whole world falls apart. Everything becomes a daze, unreal, a nightmare. There will be a period of shock, grief, anger, blame and even denial. This is followed by the process of coming to terms with the child's disability, seeking for information to understand more and for help to develop their child. It is therefore crucial that parents are fully supported at this point, so that they will come through the process well, adjusting themselves to having a special needs child, taking on a positive outlook and getting the whole family to work together to help their special child.

IAMANEH is therefore to be applauded for including the topic 'Community Support for Special Babies' into their conference and for addressing this issue, which brings so many changes and challenges to the lives of families who are affected.

Malaysian CARE has been supporting families with special needs children through our Early Intervention Programmes and Parent Resource Centre/Toy Library for the past 15 years. Our primary focus is on children with developmental delays/intellectual disabilities.

It is a well established fact that early identification and intervention brings about better outcomes for children with disabilities or who are at risk of having disabilities. There are many approaches to intervention and multidisciplinary approaches are now in practice.

Our early intervention programmes are centre-based educational programmes that are child-centred and family focused. It provides for children from birth to 6 years of age. Although most of our children would come to the centre, we do support new parents through home visits, until such time when they are able to bring their child in.

Presently, Malaysian CARE manages SPICES (Support for Parents, Infants and Children through Early Services), an early Intervention centre based in Wangsa Maju, Kuala Lumpur. SPICES is also our base for programme development, staff training and resource development. Our Parent Resource Centre/Toy Library is attached to SPICES, and membership is open to all parents, regardless of whether they attend SPICES or not.

INFLUENCE OF CULTURAL PRACTICES ON MATERNAL AND PERINATAL HEALTH

IMTIAZ T. KAMAL, KARACHI, PAKISTAN

Culture is the pattern of thinking and behaviour of social group(s), which they learn, create and share. Influence of culture on health in general and maternal and neonatal health in particular is evident in any society. In the developing countries the health seeking behaviour and health practices are a complex mixture of tradition, religious beliefs, attitudes and values. These are peculiar mixture of knowledge and ignorance, mysticism and science, faith in the healing power of "the needle", prayer and the para-normal, hold of tradition and exposure to and acceptance of change. Availability, accessibility, affordability and acceptability of health services play an important role. Only recently the practitioners of modern medicine have been sensitized to the holistic dimensions of health care delivery. Many programmes failed because they did not take into account the cultural aspects of communities' needs. To initiate change in the curricula is a challenge for the planners and the faculties of the institutions preparing health care personnel. Technological advances are affecting cultural patterns more rapidly than ever before. A change is being experienced by the communities and the health systems. This needs to be studied scientifically particularly in the traditional societies so that policy and programme development can be addressed accordingly.

Key Words: Culture. Faith. Change.

THE BABY-FRIENDLY HOSPITAL INITIATIVE

DATO' LIM NYOK LING, SELAYANG, MALAYSIA

The WHO/Unicef Baby-Friendly Hospital Initiative (BFHI) inspired by the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding throughout the world was launched in 1991. Since then the programme has supported training courses in breastfeeding counselling, improving hospital practices and drafting of legislation to implement the International Code of Marketing of Breastmilk Substitutes.

Operational targets of the declaration stated that by the year 1995 all governments should have

1) appointed a national breastfeeding coordinator and established multisectorial national breastfeeding committee 2) ensured that every facility providing maternity services fully practises all ten of the 'Ten Steps to Successful Breastfeeding, 3) taken action to give effect to the principles and aim of the international Code on Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions and 4) enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

The 10 steps of BFHI, being based on science rather than opinions gained popularity and by 1 September 2000 there were more than 15,000 Baby-Friendly Hospitals in 140 countries. During the 1990s the rate of exclusive breastfeeding for the first 4 months increased from 42% to 46%. Even though success of the BHFI varies between countries it has managed worldwide to institutionalize support for breastfeeding, reduce the pressure from the marketers of breastmilk substitutes and facilitated the adoption by ILO of a now convention on Maternity Protection which included extension of maternity leave to 14 weeks. Another notable progress was the extension from 4 to 6 months to an absolute minimum of 6 months as the global recommendation for exclusive breastfeeding.

In some areas especially in sub-Saharan Africa, there is a dramatic slowdown in the implementation of the BFHI mainly due to the complexities involved in infant feeding with the HIV/AID epidemic. Observance of the Code remain a challenge in many countries. Nevertheless while many hospitals have yet to achieve the BFHI status, others have started implementing reassessment and monitoring tools to ensure that appropriate policies and practices remain in place to support breastfeeding in hospitals.

As breastfeeding is known to be of unparalleled benefit for children, providing them with the best physical, emotional and cognitive start in life, emphasis is now to extend baby-friendliness beyond hospital and Including breastfeeding as a central component in the integrated early childhood development approach of UNICEF.

THE INSUFFICIENT BREAST MILK SYNDROME

CHRISTINE A CHOONG, KUALA LUMPUR, MALAYSIA

This talk will consider both perceived insufficient milk supply & causes of actual insufficient milk supply

1. A mother may consider her milk supply to be insufficient due to any of the following:
- Frequent feeds
- Sudden increase in frequency of feeds
- Fussy, unsettled baby.
- Baby taking supplements after a breastfeed.
- Short feeds.
- Soft breasts.
- Mother not aware of milk ejection reflex.
- Inability to express large quantities of milk
- Breast refusal.
- Poor milk transfer triggered by maternal factors such as pain, stress, lack of confidence.

2. Low milk supply due to maternal and infant feeding bahaviours such as:
- Delayed initiation of breastfeeding.
- Restriction on frequency and / or length of feeds.
- Poor attachment at the breast.
- Weak suck due to illness, abnormality or prematurity in the infant.
- Inappropriate use of complementary feeds.

3. Low milk supply due to maternal conditions such as:
- Previous breast surgery
- Breast injury.
- Hormonal contraception.
- Retained products of conception.
- High intake of alcohol or drugs.
- Smoking.
- Maternal illness / malnutrition.
- Insufficient glandular tissue in the breast.

Management is dependent on ascertaining whether insufficient milk supply is real or perceived and if real identifying actual causes. A history should be taken including the birthing & breastfeeding experience, maternal medical history, maternal nutrition, social conditions & baby's health & behavioral patterns. A complete breastfeed should be observed and If appropriate the breasts should be examined. In the case of perceived breastmilk insufficiency the mother should be reassured & should be given information re: the normal infant behaviour & natural features of lactation.

In instances where there is found to be insufficient milk the mother should be provided with the appropriate advice & management. This may include assistance with positioning & attachment, advice on frequency & duration of feeds to stimulate increased milk supply, dietary changes, & techniques to aid stimulation of the let down reflex.

In the rare instances where there is true breastmilk insufficiency the mother should be provided with appropriate advice on complementary feeding.

In all instances it is vitally important to encourage, praise & promote confidence in the mother.

CAN A STRATIFIED APPROACH BE TAKEN IN THE MANAGEMENT OF HEART DISEASE IN PREGNANCY IN DEVELOPING COUNTRIES?

DATO' DR. SIVALINGAM NALLIAH, KUALA LUMPUR, MALAYSIA

Cardiovascular diseases are encountered in about 0.5-4 % of pregnant women. In most general hospitals in Malaysia with a delivery rate of about 10000 a year, heart disease in pregnancy is seen in 5.4 per 1000 . The most common disorders are mitral valular disease due to rheumatic heart disease (55%), congenital heart disease (30%), cardiac arrhythmias and peripartal cardiomyopathy.

Since the inception of the Confidential Enquiries into Maternal Deaths (CEMD) in 1991, reliable data is available pertaining to heart disease deaths in the country. It remains the common non-obstetric cause of maternal mortality in Malaysia accounting for 10% of all deaths (1991-2000).

Rapid technological developments in the diagnosis of heart disease has presented a situation of 'practising first world medicine in third world countries.' This paper will address the feasibility of a stratified approach in managing heart disease utilising morbidity and mortality data available against compounding factors of inadequate patient management, socio--cultural issues, prevalent remediable factors in maternal mortality and clinic care given in health facilities.

In referral government hospitals in Malaysia only non-invasive cardiology services are available with government cardiac centres located in the Klang Valley, Penang, Johore Baru and Kuching . Cardiac disease in pregnancy is managed by resident obstetricians and general physicians with selective referral to cardiac centres for consultation and confirmation if appropriate facilities are not available in such centres. In Ipoh Hospital for example, the common cardiac lesions managed are mitral valve disease, ventricular septal defect and atrial septal defect . In 2001-2001, of a total of 108/18718 cardiac disease cases , 90% of the patients were in NYHA Class I. Most patients were managed in the hospital as outpatients without the need for admission till delivery. There were 18.4 % primigravida, 65.3% multiparous (G2-5) and 16.3% grandmultiparous`s women. Nearly 96 % took their pregnancies beyond 35 weeks gestation with 78 % achieving vaginal births. The perinatal mortality was low (1 death). There was one maternal mortality due to complications of prosthetic valve and cardiac failure.

Against this background data, there were 26 maternal deaths in Malaysia in 1996 (CEMD) accounting for 11 % all maternal deaths including direct and indirect deaths. Rheumatic heart disease (predominantly mitral stenosis), Eisenmengers' Syndrome peripartal cardiomyopathy were the common causes. The CEMD Identified several remedial factors in the management of such cases. Failure to diagnose and inadequate management of heart disease in diagnosed cases, Inadequate documentation of a clear management plan and remoteness from referral hospitals were noted .

Considering an overall low rate of maternal deaths, socio-economic problems of transfer to cardiac centres (and inability to access to cardiologists) and documented favorable outcome of management of heart disease in general hospitals with predictable good outcome without the need for interventional cardiology in most cases, there appears to be a role for a stratified approach in managing heart disease in pregnancy. In Ipoh Hospital a majority of patients were in NYHA Class I with less than 5 % having complicated heart disease.

OUTCOME OF GROWTH RESTRICTED BABIES

DAVID L WOODS, CAPE TOWN, SOUTH AFRICA

The frequency of low birth weight infants in many developing countries remains a major cause of neonatal morbidity and mortality. Many of these small newborn infants are born underweight for their gestational age due to intrauterine growth restriction and soft tissue wasting. While maternal illness and complications of pregnancy can result in slow fetal growth, most underweight for gestational age infants from poor communities are born to short, low weight women with uncomplicated pregnancies.

In a study of primigravid mothers from an indigent community in Cape Town, South Africa, we demonstrated that maternal weight, weight for height and skin fold thickness, rather than stature, were important determinants of both fetal and placental growth. Therefore, growth restricted infants are usually born to underweight rather than short women. This observation suggests that a woman's lifetime nutritional experience rather than her genetic height potential determines fetoplacental growth rate.

As most of these infants were born symmetrically underweight for gestational age at term, their size at term suggested prolonged slow fetal growth from early in pregnancy. The low nutritional demands of the fetus at this stage of gestation makes it unlikely that inadequate nutrients were restraining fetal growth. Rather, the fetus appears to be growing slowly as an intrauterine adaptation to prevent starvation towards the end of pregnancy when fetal energy needs are high and the risk of starvation greatest.

In a follow up study to five years of age, this pattern of slow growth rate was shown to continue after birth although mental development was similar to a control group of infants. It is proposed that the ongoing restricted growth in the infants born underweight for gestational age at term may also be an appropriate means of adapting to the extrauterine environment in poor communities, with small individuals having lower nutritional needs.

When these underweight for gestational age infants were assessed at twenty years of age, the pattern of underweight, short stature and thinness during childhood tended to continue. As a group, they had higher blood pressures, raised serum lipids and more insulin resistance. Of interest was the observation that these complications were common in adults with a higher body mass index but uncommon in individuals who remained underweight. Adult height was not a predictor of these problems. A combination of fatal growth restriction and obesity in adulthood therefore is associated with to risk factors for chronic illness.

It is concluded that fetal growth restriction may be an appropriate adaptation to, rather than a complication of, a deprived nutritional environment. In addition, later exposure to a more privileged diet in these individuals with a 'thrift phenotype~ may be detrimental and result in adult illness. These findings have implication in making recommendations for nutritional supplements and dietary advice to both children and adults who were growth restricted at birth. Improved nutrition of children and pregnant women and the prevention of obesity in adults are recommended.

NEONATAL INFECTIONS IN DEVELOPING COUNTRIES

ZULFLQAR AHMED BHUTTA, KARACHI, PAKISTAN

Despite major advances in antimicrobial therapy, neonatal infections still account for considerable morbidity and mortality in the developing world. Each year over 10 million children under 5 years of age die In the third world, and six countries account for almost half of these deaths. It is also recognized that almost 23% of all deaths among children under 5 occur in the first week of life and almost 36% with the neonatal period. In longitudinal follow-up of birth cohorts and verbal autopsy surveys in India and Pakistan, over 50% of all first week deaths were found to be related to serious infections.

Any interventions aimed at reducing the severity and improving the outcome of perinatal infection, require a close understanding of predisposing factors and pathogenesis of these infections. Although a relationship of perinatal and intrauterine infections with preterm births has been shown, their exact contribution to the burden of perinatal infections in developing countries is unclear, as is the case with group B Streptococcal (GBS) infections. In contrast to GBS infections, early-onset gram negative sepsis is commonly described from developing countries and has been attributed to vertical transmission from the maternal genital tract. It is also likely that given the high rates of microbial contamination, that a number of these early-onset infections also represent acquired infections from the environment. The risk of such infections may increase several folds with inappropriate early feeding. The important role of breastfeeding in the prevention of neonatal sepsis and infections during the early neonatal period has been highlighted in several recent studies. This may be especially relevant to the risk of nosocomial infections in developing countries. An important global issue in relation to nosocomial neonatal Infections is the recent emergence of multidrug resistant organisms, which are of particular importance in developing countries.

Given the relative contribution of preterm births and low-birth-weight (LBW) to neonatal mortality and infections, one of the most important preventive strategy for perinatal infection in the developing world context, is prevention of LBW. This entails the provision of basic maternal antenatal care and recognition of the high-risk pregnancy. Apart from a clean, uncomplicated delivery with minimal intervention, the single most effective preventive strategy for preventing neonatal infections is exclusive breastfeeding and avoidance of prelacteal feeds, although this may be problematic in areas with high rates of perinatal HIV infections.

The major challenge is the reduction of morbidity due to neonatal infections in settings where facilities for care may be rather limited. A major advance in this regards is recent information from rural India Indicates that it is possible to reduce neonatal mortality due to sepsis by 76% using domiciliary administration of antibiotics by trained community health workers. These exciting new interventions clearly indicate the potential for prevention and improving neonatal survival from neonatal infections in developing countries.

EXPANDING TRAINED MIDWIFERY SERVICES TO RURAL AREAS: A CASE STUDY

IMTIAZ T. KAMAL, KARACHI, PAKISTAN

In Pakistan 80% of the babies are born at home. Only 5% of these are delivered by skilled birth attendants. Maternal and perinatal death rates are unacceptably high. A mission hospital in a small town, bordering a desert in southern Pakistan was alarmed by the number of cases of ruptured uteri coming from a certain rural district. Investigations led them to a situation where mothers were dying because of no trained midwife in the area. Many partners joined hands and an MCH Center cum Birthing Station was established, It was staffed by a very experienced midwife. It proved an uphill task but within two years mothers stopped dying. Four ingredients contributed to the success i.e. community involvement and ownership of the project; registered and experienced midwife available round the clock; modest resources to run the Center; and back up support to the midwife of the community and of the Kunri mission hospital for EmOC. The model is being replicated In another similar situation. After half a century of a one woman crusade to promote midwifery the government has started to pay attention to training community midwives.

Key Words: Partnership. Midwife. Services.

THE IMPACT OF DISTANCE LEARNING ON MATERNAL AND NEWBORN CARE

DAVID L WOODS, CAPE TOWN, SOUTH AFRICA

In many developing countries, the maternal and perinatal mortality rates remain unacceptably high. The health professionals providing primary care are nurses and medical officers who do not have easy access to continuing education. Traditional in-service training of knowledge and skills in centralized, tertiary institutions is often inappropriate and not applicable in poorly equipped smaller hospitals and clinics. Due to the expense, the needs of their families, and the demands of the local health services, most rural doctors and nurses cannot make use of such educational opportunities. As a result, the standard of practice in rural areas progressively falls.

In South Africa, neonatologists, obstetricians and midwives have developed a Perinatal Education Programme (PEP) to meet the training needs of both urban and rural health care workers. The aim is to improve the standard of perinatal care in all communities in Southern Africa by providing a self-study training course at minimal cost. The PEP is presented in the form of two written manuals (Maternal Care and Newborn Care), which teach the cognitive knowledge, clinical skills and correct attitudes. This self-instructional course uses a problem-orientated, patient-based approach and a question-and-answer method of learning. Case studies, flow diagrams, illustrated skills and multiple choice tests are also used. Participants find this method of learning simple, easy and enjoyable.

Groups of students study the Programme together. The course material from one unit at a time is studied by each participant at home and then discussed at group meetings, thus Introducing the concept of peer tuition. Group members encourage, support and teach each other in a spirit of cooperative learning. Participants complete and mark their own multiple-choice tests. The responsibility of learning is, therefore, placed squarely on the shoulders of each participant. Participants buy their own manuals at 150 SA rand (approximately 15 USA dollars) each but are refunded on successful completion of the course. Because each group takes ownership of their course, the pride and sense of achievement is theirs.

Currently, more than 35 000 PEP manuals have been distributed and over 10 000 certificates awarded to midwives, medical practitioners, and undergraduate nursing and medical students who have successfully completed the course in Southern Africa. Two prospective controlled trials of the Maternal Care and Newborn Care manuals of PEP have documented a significant improvement in cognitive knowledge, clinical skills, attitudes and patient care practices of nurses in South Africa.

Supplementary manuals on perinatal HIV/AIDS, primary newborn care, and saving mothers and infants have recently been added to the basic course while further manuals on other important topics are being developed. This simple yet highly effective means of self-education offers exciting training opportunities for all health care professionals and promises a cost-effective method of improving health care in the most needy commonties. Further information on PEP, and some of the training material, can bo obtained from the PEP website (www.pepcoursa.co.za).

THE OPTIMAL FAMILY SIZE

DATUK DR JOHAN THAMBU, KUALA LUMPUR, MALAYSIA

The concept of an optimal family size varies in different countries and is determined by the place of residence, educational level, ethnic and socio- cultural norms.

Data from studies conducted by the National Population and Family Development Board and the Malaysian Population and Family Survey (MPFS 1994) - the fertility of urban women irrespective of ethnicity showed urban fertility was lower than of rural women. Woman with higher education tended to have less children. Those who married early (in their teens) had an average of 6 births compared wlth those who married after 25 years had an average of 3 births. The 1991 census reported that both men and women were marrying later, the age of first marriage for women was 24.7 and for men was 26.6

The family planning services provide the information and comprehensive contraceptive services so that the wife and the husband can make a responsible informed decision on the number and spacing of their children to achieve their desired optimal family size. In the context of the reproductive rights of the women, the women have an equal say in their desired family size.

The strategies adopted by some countries to reduce rapid population growth with mandatory restrictive numbers for the optimal family size with slogans 'stop at one', 'two is enough' goes against the reproductive rights of women and families.

The International Conference on Population and Development, Cairo 1994, programme of action stated that 'couples to decide freely and responsibly the number, spacing and timing of their children'.

In Malaysia, the strategy has always been to provide the right of access to a Comprehensive Family Planning and RH Services so that every child is a planned and wanted child, every mother a healthy mother, every father a caring father and every family a happy family so that the child is brought up healthy, educated and imbued with good moral and ethical values.

The total fertility rate (TFR) Is one of the most important measures, which answers the question 'How many children are women having nowadays?' The TFR for Malaysia is 3.1 {or year 2000. The TFR for selected countries and Malaysia 1996 (UN Data Sheet 1997) - Malaysia 3.3 higher than Japan 1.5, Singapore 1.7, China 1.8, Thailand 1.9, Indonesia 1.9 but lower than India 3.5 and Bangladesh 3.6. The TFR by regions of the world - Europe 1.4, North America 1.9, Asia 2.9, Africa 5.6 and the world 3.0.

The Malaysian family planning strategy is not too early, not too late and not too close and the married couples decide on the optimal family size.

WAR AND DISASTER AROUND THE WORLD - LESSONS LEARNED.

LIM MENG KIN, SINGAPORE

It is a sad indictment on the history our species that although marked by a proud record of technological achievements, it Is marred by the dark stain of Internecine wars. And we seem to have learned little, or nothing, from our experience. Indeed, humanitarian emergencies have become more urgent and increasingly more complex -- as the technology of killing and maiming becomes more sophisticated, and the civilian populations more concentrated and exposed to harm. There are now an estimated 40 million refugees and displaced persons worldwide due to armed conflicts and natural disasters. There is a need to intensify international efforts to provide relief and protection to the vulnerable populations, especially women and children.

At the same time, there is a need to increase the effectiveness of such efforts through a better understanding of the scientific and technical basis of disaster management.

WAR AND CHILDREN

ZULFIQAR AHMED BHUTTA, KARACHI, PAKISTAN

Given their vulnerability, it is no surprise that around 2 million children are estimated to have died as a result of armed conflict in the last decade. In Mozambique alone, between 1981 and 1988, armed conflict caused 454,000 child deaths, while In Somalia, according to WHO, crude mortality rates increased 7 to 25 times. In Afghanistan alone, where a civil war of sorts has been continuing for the past 25 years, around 300,000 to 400,000 children have died out of total population of 20 million.

It is questionable if mortality rates are the best indicators of the impact of war on children, and it may be better to use multiple indicators of health and morbidity in addition. Since 1990, the most commonly reported causes of death among refugees and internally displaced persons during the early influx phase have been diarrhoeal diseases, acute respiratory infections, measles and other infectious diseases such as tuberculosis. The effects of these illnesses are heightened during conflicts, partly because malnutrition is likely to increase the risk of infection.

For children, one of the most dangerous implications of this breakdown of health services during conflict is the disruption of rural vaccination programmes. During Bangladesh's struggle for independence in 1971-1972, childhood deaths increased 47 per cent. Smallpox, a disease that had virtually disappeared prior to the conflict, claimed 18,000 lives. By 1973, in Uganda, immunization coverage had reached an all-time high of 73 per cent. After the fighting started in that country, coverage declined steadily until, according to WHO sources, by 1990, fewer than 10 per cent of eligible children were being immunized with BCG, and fewer than 5 per cent with other EPI vaccines.

In most instances mothers and children are affected together by the travesty of war and conflict. A survey of Afghan refugee women and children in Quetta in 1992 indicated that over 80% were unregistered and thus ineligible for assistance. Of the 112 women interviewed, the child mortality was an incredible 31% (112/366 births). In addition, of the surviving children 67% were severely malnourished with a trend for Increasing malnutrition with age.

Clearly the most important strategy for the protection of women and children in war is prevention of war, which may be utopian. However, there is a dire need for protection of women and children in conflict situation through regulations and international agreements, especially on recruitment of child soldiers. Although the psychological trauma of war on children has been described as permanent, others have also highlighted that children respond rapidly to the onset of peace with remarkable adaptation. Although the evidence-base for effective interventions ameliorating the effect of war on children is small, there is a growing body of literature on strategies that help.

SERVING WOMEN IN WAR

DATO' JEMILAH MAHMOOD, MALAYSIAN MEDICAL RELIEF SOCIETY (MERCY MALAYSIA)

It is hard to imagine a world without war. Inevitably, women become victims of horrific atrocities and injustices in conflict situations. As refugees, internally displaced persons, heads of household and community leaders, as activists and peace builders, women and men experience conflict differently. Women rarely have the same resources, political rights, authority or control over their environment and needs that men do. In addition, their caretaking responsibilities to their families limits their mobility and ability to protect themselves.

Health care, even basic, is lacking for women in conflict situations. In this paper, the author will share the experiences of a young Malaysian NGO in serving women in conflict situations in particular, Afghanistan. The provision of health care and nutrition in acute conflict and in the rehabilitation phase will be presented. MERCY Malaysia currently has projects serving the people in Afghanistan, Iraq, Cambodia and Sri Lanka. It will expand its services soon to Include Lao and Indonesia.

THE EFFECTS OF TOBACOO ON WOMEN'S HEALTH

ZARIHAH ZAIN, MINISTRY OF HEALTH MALAYSIA

The tobacco epidemic that was once exclusively limited to men is now advancing to seize the female population. While smoking rates for men in developed countries are showing slow decline, the raise in global smoking uptake among women and girls is a cause for grave concern. Also, even in the present context where smokers are still primarily men, women and children are unkindly left as passive or involuntary smokers, a clear violation of human rights that is often ignored.

Scientific evidence has conclusively proven that smoked and smokeless tobacco cause fatal and disabling health problems throughout the human life cycle, regardless of age or gender. If women smoke like men, they will suffer and die like men. There are distinct increases in risks of numerous cancers, particularly lung cancer, heart disease, stroke, emphysema and other fatal conditions; and if one chews tobacco, one will risk developing oral cancer.

Studies have also shown that women who smoked are more likely to experience dysmenorrhea and early menopause. Smoking is linked to sterility in both sexes. The likelihood of primary and secondary infertility as well as delayed conception is Increased among women smokers compared to non-smokers. Smoking during pregnancy may cause ectopic pregnancy, abruptio placentae, placenta previa, spontaneous abortion (miscarriage), intrauterine growth retardation, premature rupture of membranes and preterm labour. Infants born to smoking mothers frequently have lower average weights when measured against their gestational ages and are at higher risks of stillbirth and perinatal mortality.

Secondhand smoke (SHS), i.e. side-stream smoke released from a burning cigarette plus exhaled smoke from a smoking spouse, for example, also has negative impact on a woman's reproductive health and may cause serious complications during pregnancy, such as low birth weight babies.

Many of these problems affect not only the health of the foetus, but also that of the mother. Especially in poor countries, for instance, a miscarriage with bleeding may be fatal particularly where health facilities are poor or non-existent.

Smoking parents are most likely to expose their children to second-hand smoke thus endangering them of chest inflections and long term effects on growth / development - besides being poor role models that influence children to become smokers too.

There is absolutely no room for complacency now. The apparently low levels of female smoking prevalence in many Asian countries, including Malaysia. i.e. 3.5% in 1996, are by no means an indication of adequate level of health awareness, but rather due to traditions and low social and economic status. However, in recent times, many previously conservative communities, like Japan, have undergone major changes. Cultural and religious constrains that have kept female smoking rates low, are now breaking down. Affluence and high education attainment of females had unfortunately brought on the smoking behaviour, as a symbol of emancipation. Manipulation of this sentiment by the tobacco industry through aggressive and deceitful cigarette promotions has certainly worsened the situation.

A global health treaty, named the Framework Convention on Tobacco Control (FCTC) has just been adopted by the World Health Assembly in May of this year and is currently open for ratification by member states. The FCTC contains provisions that addresses the gender needs for international tobacco control. Each one of us here has a role in tobacco control and must strive to curb this growing public health threat now before it gets irrepressible.

MATERNAL SUBSTANCE ABUSE - THE EFFECT ON THE NEWBORN CHILD?

ALAN T GIBSON, SHEFFIELD, UK

The incidence of substance misuse in pregnant mothers appears to be increasing. It is actually quite possible that the incidence is not rising - but increasing awareness of the problem and open support for pregnant women who consume illicit substances, may be resulting in an increase in reporting. Anonymous testing has suggested that between 5 and 10% of pregnant women have taken some illegal substance during pregnancy. This figure is almost ten times higher than the number who admit having done so. The figures for legal but still potentially dangerous substances - alcohol and nicotine - are substantially higher.

Animal studies have clearly shown alterations in cerebral neurotransmitter levels and neural pathways following intrauterine exposure to drugs, and both short-term and long lasting effects could be anticipated. Some studies have suggested very high withdrawal rates when opiates are involved, but, as reporting rates increase, the apparent incidence of withdrawal appears substantially lower than initially predicted. The relationship between dose and withdrawal is not straightforward. Some babies exposed to high doses have no problems while others withdraw on much lower doses. withdrawal is more likely following multiple drug use, particularly involving benzodiazepines, and may be both delayed and protracted. Subtle disturbances in behaviour, sleeping pattern and feeding are more common than frank withdrawal.

Although the potential for long-term problems is high the evidence that they happen is conflicting. Studies have suggested that children exposed to opiates in utero may have lower psychomotor and mental development scores on the Bailey Scales, while other studies have demonstrated identical scores to control children. Some studies have shown that cocaine exposure in-utero is associated with increased behavioral disturbance while many can find no such association. Alcohol is one drug over which there is no doubt and in some countries a significant proportion of all poor educational, behavioural and mental performance and cerebral palsy are attributed to the effects of alcohol on the fetus.

Although long-term effects on the fetus are debatable, the medical, psychological and sociological consequences for the mother are not, and are far more important. Problems in pregnancy and labour, poor parenting and failure to cope are frequent and the infant may suffer seriously as a consequence. If the child remains in that family, and family behaviour has not changed, the child's chance of following in mother's footsteps is very high - should they survive long enough to do so.

MATERNAL DRUG ABUSE IN SOUTH EAST ASIA

KAMHEANG CHATURACHINDA, THAILAND

Maternal drug abuse is becoming an increasingly important public health problem, The abuse of substance took various form, from abuse of alcohol to other CNS stimulant drugs. The form of substance used depends on the availability of the drug, In Thailand the main substance abuse is methamphetamine. The effect on the mother and her baby, including the diagnosis and after care will be discussed.

FREE PAPER
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FP01 **ACCURACY DIAGNOSTIC BETWEEN A SIMPLE EXAMINATION (COMBINATION OF pH, AMINE TEST AND WHIFF TEST) VERSUS A MICROSCOPIC EXAMNINATION ON THE CAUSE OF VAGINITIS**
Sofie Rifayani Krisnadi, Boy Abidin, Ida Parwati
Department of Obstetrics and Gynaecology Padjajaran University, Bandung, Indonesia

POSTER PRESENTATION

FP02 **ISOLATION OF PROTEUS MIRABILIS FROM SEVERE NEONATAL SEPSIS AND CENTRAL NERVOUS SYSTEM INFECTION WITH EXTENSIVE PNEUMOCEPHALUS : A CASE REPORT**
Zainab Kassim (1), Azian Abd. Aziz (2), Humairah A S Cheung (2), Quazi M Haque (3)
(1) Department of Paediatrics, (2) Department of Radiology, (3) Department of Microbiology, Kulliyyah of Medicine, International Islamic University Malaysia, Kuantan, Pahang, Malaysia

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ORAL PRESENTATION

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[1]Japaraj RP, [2]Sivalingam N, [3]Kamaljit K, [3]Ng KY
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FP04 **BIRTH INJURIES ASSOCIATED WITH INSTRUMENTAL DELIVERIES IN HOSPITAL UNIVERSITI KEBANGSAAN MALAYSIA**
Nor Azlin MI[1], Rohana J[2], Boo NY[2], Jamil MA[1],
(1) Department of Obstetric & Gynaecology, (2) Department of Paediatrics, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

POSTER PRESENTATION

FP05 **OBSTETRIC EPIDURAL SERVICE IN HOSPITAL UNIVERSITI KEBANGSAAN MALAYSIA - FIVE YEAR EXPERIENCE**
Choon Y. Lee
Department of Anaesthesiology & Intensive Care, Faculty of Medicine, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

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Nik Hazlina NH[1], Norliza M[2], Che Hasanah CI[3], Shariful Bahari[2]
Department of Obstetrics and Gynaecology, [2]Department of Family Medicine, [3]Department of Psychiatric School of Medical Sciences, Universiti Sains Malaysia, Kubang Kerian, Kelantan.

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1) Kelana Jaya Health Clinic, Kelana Jaya, Selangor. 2) Puchong Health Clinic, Puchong, Selangor. 3) Petaling District Health Office, Kelana Jaya, Selangor. 4) Selangor Health Department

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Department of Paediatrics, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

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Dept. of O&G*. Dept of Microbiology**, Universiti Sains Malaysia, 16500 Kubang Kerian, Kelantan.

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Department of Obstetric and Gynaecology, Hospital University Kebangsaan Malaysia.

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Neera Agarwal[1], Amita Suneja, [1]Ruchika Garg, [1]K M Prabhu[2]
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Zainab Kassim (1), Burhanudin Busu (2), Zainurrashid Zainudin (3), Siti Noor Ali Shibramulisi (1)
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FULL ABSTRACTS

FP01 ACCURACY DIAGNOSTIC BETWEEN A SIMPLE EXAMINATION (COMBINATION OF pH, AMINE TEST AND WHIFF TEST) VERSUS A MICROSCOPIC EXAMINATION ON THE CAUSE OF VAGINITIS

Sofie RIifayani Krisnadi, Boy Abidin, Ida Parwati Department of Obstetrics and Gynaecology Padjajaran University

OBJECTIVE: To find out the relation of the accuracy diagnostic value between combination of the pH examination, amine test and whiff test versus microscopic examination on the causes of vaginitis .

METHOD: Cross sectional diagnostic test by pH examination, amine test, whiff testing and microscopic examination

PLACE AND PERIOD OF STUDY: Family Planning Clinic, Dr. Hasan Sadikin Hospital Bandung (from November 2000 to April 2001).

MATERIAL AND METHOD: A total of 300 patients with leucorhea, who fulfilled the inclusion criteria sampling by consecutive series. They underwent pH examination, amine test and whiff testing of their vaginal discharge to diagnose clinically based on the uses of vaginitis (candidosis vulvovaginal, vaginal trichomoniasis, bacterial vaginosis). Microscopic examination was conducted as gold standard then sensitivity and specification values were determined.

RESULT: The sensitivity value for vulvovaginal candidosis was 84.4 %, vaginal trichomoniasis 85.7 % and bacterial vaginosis 87.1 %. While the specification value-for vulvovaginal candidosis was found 92.8 %, vaginal trichomoniasis 91.1 % and bacterial vaginosis 85 2 %.

CONCLUSION: The sensitivity and specification values, of the combination, pH examination, amine testing and whiff testing in comparison with the microscopic examination was quite high, more than 80 %.

KEY WORDS: Vaginitis, pH examination, amine testing, whiff testing and microscopic examination.

FP02 ISOLATION OF PROTEUS MIRABILIS FROM SEVERE NEONATAL SEPSIS AND CENTRAL NERVOUS SYSTEM INFECTION WITH EXTENSIVE PNEUMOCEPHALUS: A CASE REPORT

Zainab Kassim (1), Azian Abd. Aziz (2), Humairah A S Cheung (2), Quazi M Haque (3)
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BACKGROUND: In neonates and infants, Proteus *mirabilis* is encountered worldwide as an uncommon aetiological agent in sepsis and infections of the central nervous system (CNS), often as a mixed infection.

METHOD: A 5-day-old term baby girl was admitted to our neonatal intensive care unit with history of jaundice, poor feeding and lethargy. Her mother was a 28-year old well primigravida. On admission the baby was dehydrated and hypotonic. The clinical progression, investigation results and management plans will be discussed. CT brain scan with extensive pneumocephalus replacing the substance of the frontal and temporal lobes will be shown.

CONCLUSION: A fatal case of pure P. *mirabilis* meningitis complicated by extensive pneumocephalus demonstrated on brain CT is presented. We recommend that early institution of third generation cephalosporin combined with an aminoglycoside and CT brain are warranted in neonates with neurological sepsis caused by this organism.

FP03 PERIPARTUM HYSTERECTOMY: A COMPARISON STUDY OF TOTAL VS. SUBTOTAL HYSTERECTOMY

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BACKGROUND: Subtotal hysterectomy has usually been promoted as the method of choice when peripartum hysterectomy is required, as previous studies have shown this method to be simpler, faster and less complicated when compared to total abdominal hysterectomy. Our objective was to compare the value of two methods of peripartal hysterectomy in combating obstetric haemorrhage in a large tertiary hospital.

STUDY METHODS: We analyzed fifty nine cases of emergency peripartal hysterectomy which were performed at Maternity Hospital Kuala Lumpur (MHKL) from Jan 2000-Dec 2002 (3 years). Indications for peripartal hysterectomy, complications at and following surgery, clinical morbidity and mortality were evaluated and compared between total hysterectomy and subtotal hysterectomy. SPSS V 11.0 was used for statistical analysis.

RESULTS: There were 56,893 deilveries during the three year period giving an incidence of peripartal hysterectomy of 1.07 per 1000. Forty two of the hysterectomies were total abdominal hysterectomies, the rest (17) were subtotal hysterectomies. The most frequent indications for the hysterectomies were placenta accreta (48%, 26 with previa and 2 without previa), uterine atony (32%) and uncontrollable bleeding secondary to an extended tear during Cesarean section (10%). Thirteen patients (22%) needed internal iliac artery ligation as an added procedure to control intraoperative haemorrhage. The most common intraoperative complication was bladder injury (8.5%). There were no significant differences (p>0.05) in terms of mean blood loss (5053ml vs. 4929ml), mean amount of blood transfused (9.2 vs. 8.2 pints), mean intraoperative time (148 vs. 150 minutes), operative complication rates (31% vs. 12%) and mean length of hospital stay (7 vs. 5 days) between total and subtotal hysterectomy.

CONCLUSION: Subtotal hysterectomy does not seem to offer any significant advantages in the surgical management of postpartum haemorrhage compared to total hysterectomy. Total abdominal hysterectomy is generally preferable in the presence of placenta previa accreta and there is a trend towards placenta previa accreta as being the main indication for peripartum hysterectomy.

FP04 BIRTH INJURIES ASSOCIATED WITH INSTRUMENTAL DELIVERIES IN HOSPITAL UNIVERSITI KEBANGSAAN MALAYSIA

Nor Azlin M[1], Rohana J[2], Boo NY[2], Jamil MA', (1) Department of Obstetric & Gynaecology, (2) Department of Paediatrics, Universiti Kebangsaan Malaysia, Kuala Lumpur' Malaysia.

OBJECTIVES: The study was conducted to determine the incidence of instrumental related birth injuries and to identify risk factors associated with it.

METHODS: This was a prospective observational study of all deliveries in Hospital UKM over a four- month period (between 1st November 2001 and 28th February 2002) where instrumentations were attempted. This included patients in whom instrumentations were attempted but failed and subsequently delivered via Caesarian section or spontaneous vertex delivery. The demographic, antenatal and intrapartum details of the patients were recorded. The paediatric doctors examined all infants at birth to detect any injuries.

RESULTS: There were 1418 deliveries during the study period. Instrumentation was attempted in 83 (5.8%) patients. Vacuum was used in 47/83 (56.6%) patients while forceps was used in the other 36 (13.4%) patients. All patients delivered via the attempted method except one in whom she delivered via spontaneous vaginal delivery after failing vacuum. Instrumentation resulted in 21(25.3%) moderately severe injuries (sub-aponeurotic haemorrhage, muscle haematoma) and 1(1.2%) severe injury (skull fracture, intracranial haemorrhage). Vacuum assisted deliveries were associated with a higher rate (31.9%) of moderately severe injuries when compared with forceps deliveries (19.4%). When deliveries that resulted in moderate/severe injuries were compared with deliveries associated with mild or no birth injuries, there was no significant difference in the level of experience of the accouchers. There was also no difference in the mean age and parity of the patients. Nineteen (22.9%) infants required admission to neonatal intensive care unit (NICU) with mean hospital stay of 4.5 (SD: 5.1) days.

CONCLUSION: Vacuum-assisted deliveries were associated with a higher rate of moderate and severe injuries when compared with forceps-assisted deliveries. We recommend that when instrumentation is indicated, forceps should be considered as the instrument of choice whenever possible.

FP05 OBSTETRIC EPIDURAL SERVICE IN HOSPITAL UNIVERSITI KEBANGSAAN MALAYSIA- FIVE YEAR EXPERIENCE

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The obstetric epidural service in Hospital Universiti Kebangsaan Malaysia (HUKM) was started in April 1998. During the five-year period from May 1998 to April 2003, 4673 labouring women were given epidural analgesia. The epidural rate increased steadily from 2.8% in 1998 to 26.0% in the first four months of 2003 with the overall rate at 23.8%. During this period the predominant analgesic technique has shifted from conventional lumbar epidural analgesia to combined spinal-epidural analgesia (CSEA), ropivacaine has become the sole local anaesthetic drug used for obstetric analgesia, while a more dilute local anaesthetic solution (0.0625% ropivacaine with 2 µg/ml fentanyl) is now used for maintenance of analgesia. No major morbidity associated with epidural analgesia was reported, common complications being pruritus, shivering, inadequate analgesia and epidural catheter-related problems. The overall instrumental delivery rate was 12.2% and Caesarean section rate was 22.7%, compared to 4.5% and 25.2% for parturients not receiving epidural analgesia. Postpartum mothers were interviewed to obtain their feedback regarding the epidural service. The comments were generally favourable, 93.4% expressed satisfaction and 89.3% wished to receive epidural analgesia for their next delivery. The anaesthetist is also involved in conducting regular antenatal education classes where the various options of pain relief during labour are discussed. Continuing medical education sessions are also held regularly for anaesthetic and obstetric trainees in the hospital.

FP06 A PRELIMINARY REPORT OF A STUDY ON THE PSYCHOSOCIAL IMPACT AND THE USE OF ALTERNATIVE MEDICINE PRACTISES (HOMEOPATHY AND TRADITIONAL) ON THE INFERTILE FEMALE.

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Society views infertility as a sign of inadequacy, identity and role failure and it is a major life crisis. Women usually experience a greater psychosocial distress.

OBJECTIVE: The aims of the study were to determine the socio demographic characteristics, the used of alternatives medicine (traditional and homeopathy) and to assess the psychological impact on the female couple.

METHODOLOGY: A cross sectional study was conducted on 96 females who attended the fertility augmentation clinic Hospital USM. The data on the alternatives practices and the psychological impact were assessed by using a self-administered questionnaire and the further information regarding the infertility problems were obtained through the patient's folder. Result: The study found that the age of the patients were between 20 to 43 years old with mean of 32.0 years old. Fifty nine percents of them had an education up to secondary level. Sixty one percent were having primary infertility. The mean duration of infertility was 5.61 years and mean duration of marriage was 6.63 years. Sixty three percents chose traditional medicine and only fourteen percents preferred homeopathy as their alternative medicine. The psychosocial impact was assessed using a score. Ninety seven percents of female had psychosocial impact with 32.3% was mild, 50% was moderate and only 14.6% was severe. Statistical analysis showed there were no significant association between the psychosocial impact and age, education, type of infertility, duration of marriage, duration of infertility and the use of homeopathy medicine However there was a significant association between the psychosocial impact and the use of homeopathy with p= 0.036.

CONCLUSION: Majority infertile female had psychosocial impact and those who practice a traditional medicine had higher psychosocial impact. Therefore it is very important to consider the psychosocial aspect in the infertility management and counselling.

FP07 EXPERIENCES AND PERCEPTION OF FATHERS DURING CHILDBIRTH IN HUSM.

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OBJECTIVE: To describe how fathers who are present during childbirth experience the event, what they feel during childbirth, what are their perception towards support from healthcare professionals, and to identify the needs of the fathers during labour and delivery.

DESIGN: Survey using structured close-ended questionnaires was carried out over one month period. This study was conducted in the labour suite of Hospital Universiti Sains Malaysia, Kubang Kerian, Kelantan. A convenient sample of 40 fathers, 15 primid and 25 non-primid fathers who were present at the birth of their baby were selected for the study.

RESULT: Almost all out of 40 fathers said that they became fearful of the outcome (95%), and most of them (75%) found that as labour progressed the level of stress experienced increased. Most of them, regardless of parity (72.5%) reported feeling helpless during labor. However, all of them were pleased at being present and giving support to their partner during labor and delivery and share the experience of childbirth. Regarding the perception towards healthcare professionals, most of the fathers reported as not being received any guidance or methods in helping their partner during the event from doctors and nurses. Most of them also believed that they received inadequate information concerning care of their wives'. However, most of them agreed, being given information regarding progresses of the labor. Almost all of them, reported need an antenatal classes as preparation in becoming a supporter to their partner during childbirth.

CONCLUSION: Fathers should be included in labor management plans and need support for their role as labor partners.

FP08 A PILOT STUDY TO COMPARE THE EFFECTIVENESS OF HOME VERSUS HOSPITAL PHOTOTHERAPY FOR TERM INFANTS WITH UNCOMPLICATED HYPERBILIRUBINAEMIA IN PAHANG STATE, MALAYSIA

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BACKGROUND: The objective of this study is to determine the difference in the reduction of total serum bilirubin in infants who had phototherapy at home versus the inpatient hospital phototherapy.

METHOD: This is a comparative study in which 18 infants with unconjugated hyperbilirubinaemia who conformed to the selection criteria (based on the Committee on Fetus and Newborn of the American Academy of Pediatrics (AAP) guidelines for Home Phototherapy with some modifications) were included in the mobile phototherapy unit (Bluelite) placed at home. A control group of 18 infants with the same criteria had phototherapy (wooden unit) in the hospital . The infants were matched for race, initial total serum bilirubin level, birth weight and age at initiation of therapy.

RESULT: The mean daily decrease in total serum bilirubin concentration was significantly more in the home group as compared to the hospital group ($P < 0.05$). The mean duration of treatment was also significantly less for the home group as compared to the hospital group ($P<0.05$). None of the infants who had home phototherapy were rehospitalised. Phototherapy related complications were comparable in both groups.

CONCLUSION: The result suggests that home phototherapy is safe and perhaps more effective in reducing the concentration of total serum bilirubin for term babies with uncomplicated hyperbilirubinaemia .

FP09 REDUCTION OF BBA AND UNSAFE DELIVERIES IN PUCHONG - YEAR 2002

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BACKGROUND: The number of BBA cases increased drastically from 10 cases in 1999 to 44 cases in the year 2000 and remained high in the year 2001. As a result, the rate of unsafe deliveries in Puchong increased from 0.40 in 1999 to 1.73 in the year 2000 and further increased to 2.02 in the year 2001. The main objective of this study is to reduce the number of BBA cases hence reducing the rate of unsafe deliveries in Puchong government clinics to 0.8 or less.

METHOD: The study was conducted in two phases at Puchong Government Health Clinics. Phase 1 was a retrospective study to retrieve information on all cases of BBA that occurred from 1.1.2000 to 31.12.2001. The antenatal cards of all BBA cases in that period were collected and the information was recorded in a BBA Registry. Information that was not available in the antenatal cards was obtained during interviews. Demographic data and reasons for BBA were obtained and interventional strategies formulated. Phase 2 was a prospective study whereby the interventional strategies were carried out from 1.1.2002 to 31.12.2002.

RESULTS: Phase 1: A total of 84 cases were recorded of which 65.5% were foreigners. The majority of BBA cases were unbooked or had antenatal checkups at private clinics . 90% of unregistered cases were foreigners. The midwife was called after delivery in 81% of cases. Phase 2: Following intervention, the number of BBA cases dropped to 13 cases.

CONCLUSION: The majority of BBA cases were foreigners who did not have any antenatal visits. The interventional strategies that were undertaken were successful in reducing the number of high risk home deliveries. Hence the rate of unsafe deliveries reduced from 2.02 in the year 2001 to 0.61 the following year; well below the target rate of 0.8.

FP10 NORMALLY FORMED MACERATED STILLBIRTH - EXPERIENCE IN NEGERI SEMBILAN

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BACKGROUND : All normally formed macerated stillbirths (NFMSB) cases occurring in Negeri Sembilan were studied in 2001.

METHOD: Retrospective studies looking at the antenatal cards and the hospital notes. This report describes the socioeconomic, ethnic differences in that cohort and the possible contributing factors to the fetal death.

RESULTS: The overall stillbirth rate was 8.15 per 1000 (124/15095) births. The normally formed macerated stillbirth rate was 5.89 per (89/15095) births. Most of these macerated stillbirth were NFMSB and accounts for 45.9%. Malays constitute of 68% of the cases. There was a high mortality rate among male fetuses. As expected, a higher fetal mortality rate 67 (75.3% %) was found in the group with birth weight (less than or equal to 25009) than in the group with birth weight greater than 2500g 22(24.7%). Although a high incidence of low birth weight, gestational age at delivery and antenatal history of Hypertensive Disease In Pregnancy contributed greatly to fetal mortality, maternal age, ethnic group, parity, gravidity, place of antenatal care (health center vs hospital) and number of fetus did not seems to be the significant influence on the risk of normally formed macerated stillbirth.

CONCLUSION: Normally formed macerated stillbirth is a common problem in Negeri Sembilan. Further research and continuous intervention is required to overcome this problem.

KEYWORDS: Normally formed macerated stillbirth

FP11 THE QUALITY OF ANTENATAL CARE AMONG PREGNANT WOMEN IN SEREMBAN

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OBJECTIVES: 1. To assess the understanding and awareness about the importance of antenatal care 2. To evaluate the quality of antenatal care services

METHODS: A prospective study, using standard and structured questionnaires, carried out on a representative sample of 390 pregnant women, who had visits to Obstetrics and Gynaecology Department, Hospital Seremban and Antenatal Clinic, Klinik Kesihatan Seremban from 1st July 2002 to 30th October 2002.

RESULTS: Our results revealed 46% were primigravida, majority booked in the 1st trimester. 72% mothers had attended antenatal classes and 99% of them agreed that the classes were important for them. 92% mothers were satisfied with information and explanation given by the staffs. However, only 62% mothers knew the methods available for relieving labour pain. Only 8% heard about epidural pain relief. Overall the mothers find that the attitude of the doctors (85%), nurses (82%) and medical attendants (82%) good. The level of professionalism was noted as good.

CONCLUSION: By providing good antenatal care followed by delivery by a skilled or trained birth attendant at a maternity center with essential obstetric care facilities, any pregnancy can be made safe.

FP12 THE ATTITUDE AND LEVEL OF KNOWLEDGE OF BREAST FEEDING AMONGST MEDICAL STUDENTS FROM CLINICAL SCHOOL OF INTERNATIONAL MEDICAL UNIVERSITY (LMU)

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BACKGROUND: It was not long ago since the government introduced baby friendly hospital whereby breast-feeding was encouraged amongst mothers of newborn. One of the criteria to ensure the success is to adequately equipped health care professional with the knowledge of breast-feeding. This aspect has seldom been formally assessed in the undergraduate medical education.

AIM: To evaluate IMU clinical school medical students their attitude and level of knowledge of breast-feeding.

METHODS: A self-administered questionnaire containing 10 True-False multiple-choice questions (each questions with 5 statements) was administered to all medical students from IMU clinical school.

RESULTS: One hundred and fifty eight (73%) medical students participated in the study 99.4% of students reported they would like to have their baby breastfed in future. Only 0.1% students reported that formula milk is as good as breast milk. Of all, 97% of students were not breastfed when they were baby. The overall mean of scoring of the questions was 72.3%. Students tend to score less well in questions related to clinical practice of breast-feeding. 44.9% of students scored poorly (less than 3 statements correct) in the question, regarding sore nipple. Nonetheless, 85.4% of students scored well (more than 3-statements correct) in the question regarding concept of baby-friendly hospital. '

SUMMARY: Medical students from IMU clinical school generally are good in their knowledge of breast-feeding but should improve their knowledge particularly on the practical aspect of breast-feeding. Therefore, we feel that breast-feeding seminar or workshop should be conducted from time to time in our university.

FP13 AN UNUSUAL PRESENTATION OF MATERNAL PRIMARY HYPERPARATHYROIDISM

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BACKGROUND: Pregnant women with primary hyperparathyroidism may be asymptomatic or have subtle symptoms such as fatigue, hyperemesis gravidarum and polydipsia. It may present as transient hypocalcaemia in their newborn infants.

METHODS: This is a case report of a patient in whom primary hyperparathyroidism was diagnosed after her infant presented with seizures associated with hypocalcaemia.

CASE REPORT: A 15 day old term newborn infant presented with a 5-day history of multiple episodes of generalized seizures. There was no history of fever, vomiting, diarrhoea or poor feeding. His mother's antenatal and peripartum history was uneventful. ,Physical examination revealed no abnormalities in the infant. Blood investigation of the infant showed low levels of serum calcium and parathyroid hormone. He was treated with calcium and vitamin D supplements for about 3 months. Investigations carried out on his mother revealed the presence of hyperparathyroidism secondary to parathyroid adenoma. She also had gallbladder calculus and bilateral medullary nephrocalcinosis. She underwent surgical removal of the parathyroid adenoma.

CONCLUSION: Mothers of neonates presenting with hypocalcaemic convulsions should be investigated to exclude primary hyperparathyroidism.

FP14 PALM VITAMIN E: TERATOGENICITY EVALUATION

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Vitamin E is a generic term for tocopherol and tocotrienols that qualitatively exhibit the biological activity of alpha-tocopherol. Compared to tocopherols, tocotrienols have been poorly studied. Tocotrienols are minor plant constituents especially abundant in palm oil, cereal grains, and rice bran that can provide a significant source of vitamin E activity. Tocotrienols differ from tocopherols by possessing an isoprenoid rather than saturated phytyl side chain. This study summarizes the non-teratogenicity of palm vitamin E (25% tocopherols and 75% tocotrienols) in pregnant Sprague dawley rats. Even though vitamin E has been documented to have low toxicity, there is no data on tocotrienols. Pregnant rats were divided into 5 groups: control, dose 100mg palm vitamin E/ kg bw, 250mg/kg bw, 500mg/kg bw and 1000mg/kg bw. In this teratogenicity study, the animals were sacrificed on gestational day 13. The number of implanted embryos was observed to be between 8 to 10 embryos per mother which corresponded to the number of corpus lutea released. No significant difference was observed on the implantation rate between controls and animals treated with different doses of palm vitamin E. Toxicity in Sprague Dawley rats is exhibited as percent resorption, hence from our assessment, the control group showed the highest resorption rate (7.412%). Animals treated with tocotrienol exhibited less resorption (5.162%, 0.007%, 4.444% and 6.581% in the groups treated with doses of 100, 250, 500 and 1000 mg/kg bw respectively). Normal resorption rates in Sprague Dawley rats were between 5-7%. Therefore, it can be suggested that maternal intake of palm vitamin E up to 1000mg/kg bw does not have teratogenic effect on reproductive performance.

FP15 A STUDY ON COMMON SEXUALLY TRANSM1TTED DISEASE (STD) INFECTION IN INFERTILE FEMALE IN HOSPITAL UNIVERS1TI SAINS MALAYSIA, KUBANG KERIAN KELANTAN.

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OBJECTIVES:

1. To determine local prevalence of common organism in STD infection (Chlamydia, Gonorrhoea and Syphilis) in infertile females in HUSM
2. To determine the clearance rate of Chlamydia and Gonorrhoea infection after a course of Azithromycin 1 gram

STUDY METHOD: A prospective study involving 150 infertile females under follow up at infertility clinic HUSM between 1st of March 2002 till 28th of February 2003 . Endocervical samples were obtained to detect Chlamydia trachomatis by direct immunofluorescence, Neisseria gonorrhoea by Gram smear and culture & sensitivity. Blood samples were also obtained for VDRL testing and for Ig M antibody toward Chlamydia. For VDRL testing positive patient another blood sample for Treponema pallidum haemagglutination assay (TPHA) will be taken. In a patient with a positive Chlamydial or Gonorrhoea or both infections, she and her partner will be treated with a single dose of Azithromycin 1 gram orally. After 2 weeks of Azithromycin, the respective investigation(s) will be repeated to determine the clearance of such infection(s).

RESULTS: Chlamydia infection was present in 6 (4.0%) patients. There was no incidence of gonorrhoea or syphilis infection in the studied population. All repeated investigations after Azithromycin for Chlamydial infection showed a negative testing. The clearance rate of Gonorrhoea or Syphilis is unable to determine as there is no incidence of the infection in the studied group.

CONCLUSION: The prevalence of Sexually Transmitted Disease (Chlamydia, Gonorrhoca and Syphilis) infection in infertile female is low in our studied group. The clearance rate of Chlamydial infection by Azithromycin is good. This is not a true representation of Malaysian populations as it is a hospital-based study. A larger scale study involving a few centers is needed in order to obtain a better representation of Malaysian populations.

FP16 SACRAL RHOMBOID DIMENSIONS AS NEW SCREENING PARAMETER FOR PREDICTION OF PELVIC DISPROPORTION

- a pilot study of Indian primigravidae

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BACKGROUND: Sacral Rhomboid is a diamond shaped area at the back bounded by the posterior iliac spines, L5 vertebra and upper end of natal cleft.

OBJECTIVE: To evaluate dimensions of sacral rhomboid as predictors of pelvic disproportion(PD) in prospective study of 300 primigravid women

METHODS: Maternal height, external pelvimetry measurements, ultrasonic obstetric conjugate and dimensions of sacral rhomboid were assessed during antenatal period. 10th percentile values were taken as cut off for considering women at risk for PD . Multivariate analysis and logistic regression was carried out for individual parameters & combination models to predict women at risk for PD. Pelvic disproportion was considered when there was LSCS for contracted pelvis, nonrotation or nondescent, vacuum or forceps delivery for non progress of labor, birth trauma or intrapartum stillbirth.

RESULTS: 36 women (12%) had disproportion. Multivariate analysis showed that short maternal height (< 146.5cm.) and small transverse (TD) & vertical diagonals(VD) of sacral rhomboid were associated with PD. TD < 9.5 cm and VD < 10.5 cm were found to be most predictive and increased the relative risk by 7.5 and 2.7 times respectively. In combination they could pick 2 out of 3 women with PD. Maternal height and ultrasonic obstetric conjugate correlated well but were not superior to the dimensions of sacral rhomboid.

CONCLUSIONS: Transverse and vertical diagonals of sacral rhomboid are highly predictive, simple, safe, cost-effective measurements which can be easily mastered by the lowest level health worker & can be used as cut off markers at peripheral centres and community for timely referral of pregnant women at risk of pelvic disproportion to a higher center...

FP17 DOES TOCOLYTIC AGENT HELP ECV IN A TERM BREECH?

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BACKGROUND: To study the effect of ritodrine tocolysis on ECV success rate and assessing the role of ECV for breech at term in Hospital UKM.

METHOD: This is a prospective double blind randomized trial. All women with singleton fetus in breech presentation at 37 weeks gestation and above at antenatal clinic in Hospital UKM from 1st January 2002 until 7th February 2003 were considered for the study. They were randomized to receive either ritodrine or placebo infusion. Upto three attempts were performed.

RESULTS: A total of 60 women were recruited with 30 on each arm. Overall success rate was 36.7%. Version was successful in 15 of the 30 patients given tocolysis but in only 7 of 30 given placebo ($p < 0.032$). Thus in this study ritodrine improves ECV success rate and we were able to reduce the caesarean section rate for breech presentation by 33.5% in our center.

CONCLUSION: Ritodrine tocolysis improves the success rate of ECV in a term breech. ECV is also cost-effective by substantially reducing the caesarean delivery rate among breech presentation in Hospital UKM.

FP18 WAIST CIRCUMFERENCE, BODY MASS INDEX AND LIPID PROFILE AS EARLY PREDICTORS OF GESTATIONAL HYPERTENSION AND PREECLAMPSIA.

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OBJECTIVE: Role of early pregnancy waist circumference (WC), body mass index (BMI), Waist to hip ratio (WHR), waist to height ratio (WHtR) and serum lipids in prediction of gestational hypertension or Preeclampsia.

METHODS: A follow-up consecutive study of 325 women with singleton pregnancy between 6-16 weeks. Anthropometric measurements & fasting blood samples were taken. Outcome was noted in terms of development of hypertension & data analyzed by student unpaired t test & Fischer exact test.

RESULTS: Forty subjects were lost to follow up and 32(11.2%) developed gestational hypertension, or Preeclampsia. Mean WC, BMI, WHR, and WHtR were significantly higher in hypertensive group. Mean levels of triglycerides, cholesterol, VLDL were significantly higher in hypertensive group. HDL was not significantly different. With $>90^{th}$ percentile as cut off values, WC >80 cm, WHR >0.86, WHtR >0.54 and BMI >24.2 had RR of 6.73, 4.0, 6.73 and 4.4 respectively. Serum triglyceride, VLDL, & cholesterol had RR of 5.3, 5.28, and 2.65 respectively. Models constructed by combining two most significant factors showing highest risk were WC with WHtR and WHtR with BMI, both increasing the risk to 7.6 times.

CONCLUSION: Anthropometric measurements & ratios are promising parameters for prediction of Pregnancy induced hypertension in the community.

FP19 GROWTH PATTERN OF AFGHAN CHILDREN

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BACKGROUND: This is a descriptive study to analyse the growth pattern (weight, height and head circumference of Afghan children who reside near the Afghanistan-Pakistan border (internally displaced children).

METHODS: Anthropometric data were obtained from 169 Afghan children during the 19th Malaysian Medical Relief Society (MERCY Malaysia) Humanitarian Mission to Afghanistan in November 2002. All children aged less than 12 years old presenting to MERCY-PIMA Hospital in Spin Boldak Afghanistan during the mission period were included. Weight (recorded to the last completed 0.1kg), head circumference (recorded to the nearest 0.1 cm) and height (recorded to the last 0.1 cm) measurements were taken. All measurements were plotted on the appropriate centile charts (NCHS).

RESULTS: The mean age of the children were 3.5 years old. Almost two third of the height of the children were in the less than third centile . As for the weight, 70% were in the less than 25 centile. Only 30% of the head circumference were in the less than third centile.

CONCLUSION: A significant percentage of Afghan children were underweight and short. However, majority of them have appropriate head size.

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