EFFECTS OF THE TRAINED MIDWIFE ON TRADITIONAL DOMICILIARY MIDWIFERY IN A RURAL MALAY COMMUNITY

PAUL C.Y. CHEN

Department of Social and Preventive Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia.

INTRODUCTION

This paper describes the method and some of the observations of a field study in a rural Malay community. The study was performed with a view to determining the effect, upon traditional practices in relation to childbirth, of the introduction into the community of midwives wholly or partly trained in modern midwifery. It was conducted in a predominantly Malay area in which a *bidan kampong* (unregistered village midwife) had been partly trained in modern midwifery 12 years earlier (1956) and a government registered midwife wholly trained in modern midwifery had been introduced two years after that (1958). The community studied comprised 128 Malay households, as the accompanying map shows, scattered over an area roughly five miles in length by one mile in width. It was situated in the state of Kedah, West Malaysia. There were also eight Chinese households and 49 other Malay households living in the same area but these were excluded from the study for reasons to be stated later.

In the 1957 Census, it was found that 57.5% of the total population of West Malaysia live in rural areas — the term urban being restricted to gazetted administrative areas with a population of one thousand or more. Of these 70% were Malays. The word *kampong* is used to describe the rural inhabited areas, which usually consist of houses scattered along a river or road. The size of a *kampong* varies considerably and may consist of half a dozen households to a hundred. The area studied included four medium sized *kampong*. The main occupations were padi and rubber farming, the average size of farms being 6.8 acres. However 38.8% of households were landless and operated as tenants on the farms of landlords. There were two very wealthy landlords who between them owned 213 acres of farmland. Padi was cultivated during the wet season while rubber was tapped all the year round. The average size of a household (extended family) was 5.8 persons. 48.4% of households had a total cash income of between (U.S.) $16.00 to $33.00 per month.

For medical care, *kampong* inhabitants, before the advent of scientific medicine in West Malaysia, were dependant upon traditional indigenous medicine, the principal exponents of which were the *bomoh* (medicine-man) and the *bidan kampong* (village midwife). Curing of disease generally requires both contact between the *bomoh* and the spirit causing the disease and the use of herbal decoctions prepared in accordance with proper ritual. However a large area of Malay medical beliefs does not come under the direct purview of the *bomoh*, but is the province of the *bidan kampong*. Like the man who becomes a *bomoh*, the woman who is to become a *bidan kampong* requires special knowledge but must first know "something" about being a *bidan* and this "something" usually comes from being associated with a mother or grandmother who is a *bidan kampong*. Although the *bidan kampong* exercises during pregnancy and for forty-four days after birth of the

child a considerable amount of spiritual prophylaxis, much of the practice of a *bidan kampong* is concerned with purely physical aspects of pregnancy and childbirth. No proper ante-natal checkups are performed. The first important ritual duty of the *bidan* is in the seventh month of pregnancy when she performs over the expectant mother the *lenggang perut*. This consists of the ritual feeding of the expectant mother with *nasi semangat* (special yellow rice) to strengthen her for her coming ordeal (Fraser, 1960). The *bidan kampong* then places her hands on the sides of the mother's abdomen to "place the child properly". At the eighth month of pregnancy, the mother of the expectant mother formally books a *bidan kampong* for her and this is called *kiriman perut*. When labour has started the *bidan kampong* is called and stays with the expectant mother until delivery is completed. Apart from the *bidan kampong*, the mother of the patient and other female relatives will usually be present. After the child is born, the *bidan kampong* is reluctant to cut the umbilical cord until after the expulsion of the placenta. This delay has been shown by McLean (1951) to add an appreciable amount of iron into the body of the child. However, before the cord is cut, it is knotted up to seven times, rubbed with ash to facilitate the cutting and then placed on a piece of turmeric "so that wind won't get in", and cut with a sharp piece of bamboo. This is probably one of the reasons for the occurrence of *tetanus neonatorum* in West Malaysia. Following the birth, a binder a foot wide and several yards long is wrapped around the woman's abdomen to provide support, prevent distension, and stop wind getting into her body. The newly confined woman is then propped up and remains in this position for three days and nights, undergoing during this period *urut-mengurut* (massage) of the body. "Hot oils" prepared by the addition of various ingredients to coconut oil are massaged into the skin. A heated stone (weighing four kilograms) wrapped in herbs is also applied to the abdomen. For forty-four days after childbirth the women observe the *pantang* (taboos) which include prohibitions on heavy work and on all sour foods and foods which "carry wind". In consequence the women restrict their diet to rice, salted fish and pepper. The *bidan kampong* is paid (U.S.) $2.00 to $8.00, and receives a chicken, three coconuts and eight pounds of rice in payment for her services. The Government of Malaysia in an effort to raise the standard of living of this rural population formulated its Rural Development Plans. An important component of the national plans was the Rural Health Plan. The principal feature of this was the establishment of a network of rural health units each rural health unit comprising a main health centre, four sub-centres, and 20 midwife stations, and serving a population of approximately 50,000. At the end of 1960, there were eight main health centres, eight sub-centres and 26 midwife stations constructed (Jayesuria, 1967). Thereafter the Rural Health Plan gained momentum, and by the end of 1968 there were 39 main health centres, 148 sub-centres and 760 midwife stations.

The study area was located in the state of Kedah, West Malaysia, and was part of the total area served by a rural health unit based at the town of Jitra. It had at its border a sub-centre $5\frac{1}{2}$ miles from the main centre at Jitra. The government employed public health personnel at the sub-centre included a public health overseer (sanitarian), an assistant nurse and a registered midwife. There were no registered midwives in solo practice in the study area. Registered midwives receive a two-year training course in modern midwifery—both hospital as well as domiciliary. However in the early stages of the establishment of rural health units in the area, short courses of training for the

bidan kampong were conducted by sister tutors and doctors, who inculcated the principles of hygiene as applied to midwifery including the cutting of the cord. It did not include diagnosis of presentation either by palpation or auscultation, nor of the degree of dilatation of the *os* by manual examination. On completion of the course each *bidan kampong* was given an accouchement bag that included, among other things, a pair of scissors and a pair of artery forceps both of stainless steel. From thence on the *bidan kampong* went to the main centre (or the nearest sub-centre) once a month for a check-up of the contents of her bag and of the record of the confinements she had conducted including their results. Her new role enhanced her status in the eyes of the people by virtue of her "government training and inspection". There was in the study area one such *bidan kampong* who had had this training. This paper examines the effect, upon traditional practices in relation to childbirth, of the introduction of the above two midwives.

PROCEDURE

Terminology

In this paper the term midwife means any person who is directly involved in the delivery of babies, including both regular midwives such as the registered midwife and the unregistered *bidan kampong* and extempore midwives. The term approved *bidan kampong* means an unregistered village midwife who has been given a three months course of weekly classes by sister tutors and doctors in the principles of hygiene as applied to midwifery including the cutting of the cord, but not including the diagnosis of presentation or of the degree of dilatation of the *os*, and who is then placed under the monthly inspection of public health personnel. To the villager this implies government approval of that particular *bidan kampong*. The term non-approved *bidan kampong* conversely means one who has not received the above training and implied approval. The duties of the *bidan kampong* can be divided into two distinct sets, the delivery itself, and attendance to the mother and child after birth. A *bidan kampong* might perform either or both these sets of duties. The term masseuse *bidan kampong* (known locally as *bidan pelihara*) means an unregistered village midwife who attends to the mother and child after birth, but rarely attends at deliveries. She usually attends on the first three days after birth, and performs the *urut mengurut* on the mother, bathes the mother and child, and washes soiled linen. The term extempore midwife will be used to cover a relative or any other person who effects a delivery in the absence of a regular midwife. It should be noted that in the study carried out by the writer, such persons delivered only one infant each, and thus should be distinguished from regular midwives. The term household means a group of persons (usually related by blood or marriage) who contribute toward and eat from a common cooking system. The term index-case refers to the youngest child in a household with at least one child born in 1958 or later.

Study area and population

A rural area with the following characteristics was located:

(i) Three varieties of *bidan kampong* (approved, non-approved and masseuse) practising therein.

(ii) A registered midwife who had been based in a sub-centre in the area for about 10 years.

(iii) A population with a minimum of geographical mobility.

The map, Fig. 1, depicts the study area which was located along a five-mile stretch of laterite road lying between the 14th and 19th mile-stones from Alor Star, the capital of Kedah State. As shown in the map, the registered midwife was based in a sub-centre at the 14th mile-stone end of the area, the approved *bidan kampong* was located at the 19th mile-stone end, while in a cul-de-sac in between them was located the non-approved *bidan kampong*. For ease of presentation, the study area has been divided into four areas designated as "A", "B", "C" and "D".

The study covered the period from the introduction of the registered midwife in 1958 to the end of 1967. The study area had a total population of 1007 persons distributed amongst 185 households.

Of the 185 households 57 were excluded from the present study. These 57 households were made up of 40 Malay households with no children born during or after 1958, 9 Malay households with children born outside the study area, and 8 Chinese households since the study was concerned with rural Malays only.

Data collection

The data were collected by the writer assisted by a trained interviewer. Three methods were utilized in data collection, and this served as a cross-check in respect of several of the items.

Interviews with key persons

Key persons such as the various midwives, local leaders (*penghulu*, members of the village committees) and public health personnel were interviewed. The interviews were unstructured. Where possible, the interview was recorded on tapes.

Questionnaire

A pre-tested list of questions in Malay was utilized in the house-to-house interviews. The interviews were conducted in Malay and were with the housewife.

Secondary sources

Secondary sources were available and used. Records kept by the registered midwife and the approved *bidan kampong* for inspection purposes, antenatal cards and child health cards kept by housewives, were examined and relevant information extracted.

TYPES OF MIDWIVES

In the study area, the homes of the following midwives were encountered:

A registered midwife;
An approved *bidan kampong;*
A non-approved *bidan kampong;*
A masseuse *bidan kampong;*
Five extempore midwives.

The registered midwife

This was a 33-year old married Malay woman with an adopted child. She had undergone a two-year course in hospital and domiciliary midwifery, and passed the terminal examination, and consequently was a registered midwife. By village standards she was well educated and in view of her salaried position in the government was considered financially well-to-do. The degree to which she had been accepted by the people was based mainly on the fact that she was a government-trained and registered midwife.

The approved bidan-kampong

Although there was only one approved *bidan kampong* in the study area as indicated in Fig. 1, her practice was limited to areas "D", "C" and "B". Area "A" came under

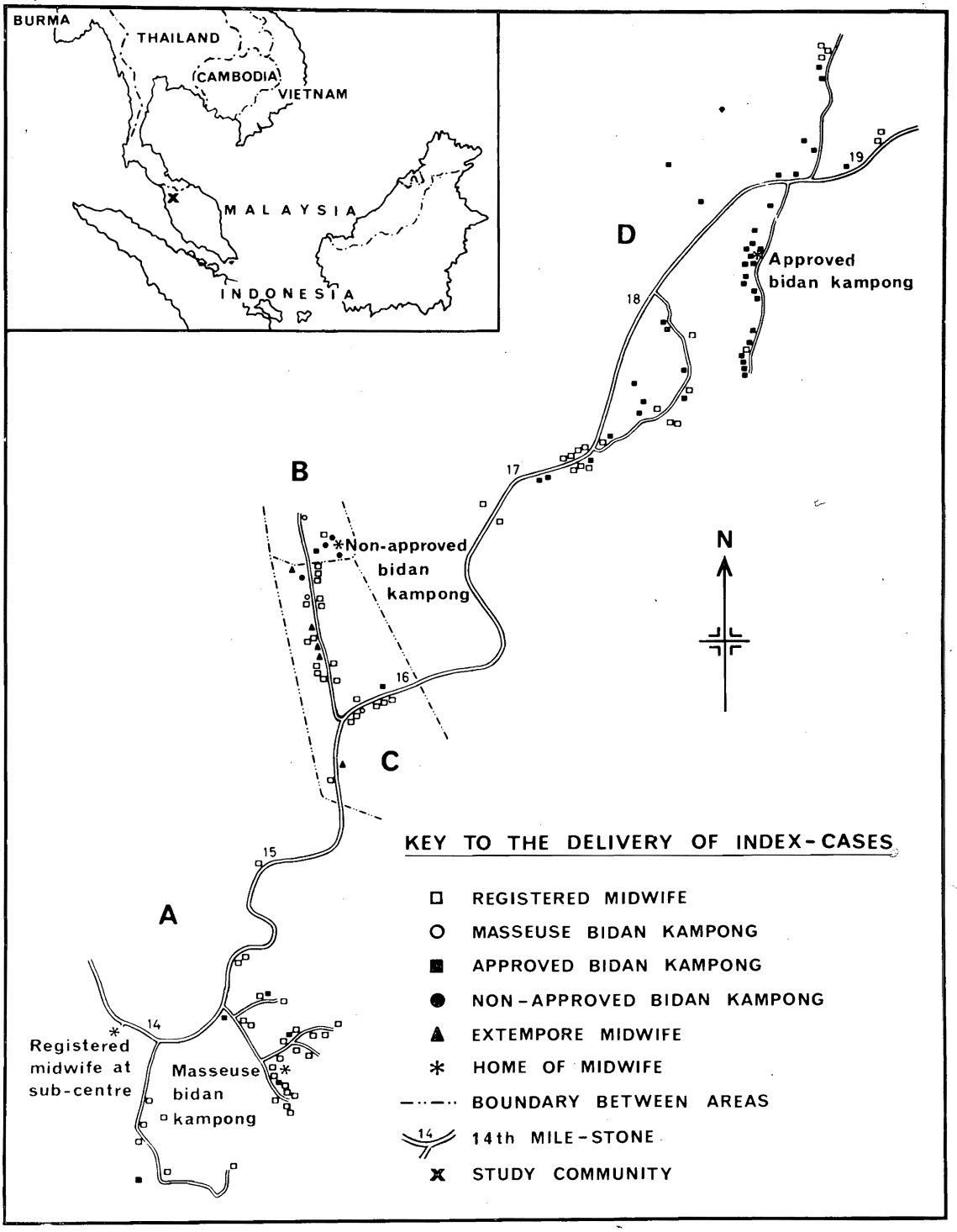

Fig. 1—Map showing the location of 128 Malay households, in each of which an index-case was delivered, and the type of midwife who delivered the index-case.

the influence of a second approved *bidan kampong* who lived two miles away from the study area, and who was responsible for the delivery of five index-cases in area "A" as indicated in the table.

The one who lived in the study area was a 47-year old Malay grandmother who was reputed to be descended from a line of *bomoh*. Her own father, who had been one of the great *bomoh* of the past generation, was famous for his cures. Her own mother had been the *bidan kampong*. When her mother died, the position fell to a cousin; when the cousin died, the position became hers. She pointed out that she expected one of her two daughters to take up the position upon her death.

Her own training had been largely one of apprenticeship, to her mother and later to her cousin. Nevertheless, she was particularly proud of the three-month course of weekly classes given by the public health personnel of the Government Rural Health Training School in Jitra in 1956. The course had been one mainly in the elements of hygiene and asepsis but had given her the privilege of government approval. After the course she reported once a month to the public health personnel who noted the number of confinements she had conducted and their outcome, and inspected her accouchement bag.

This regular inspection was known to the villagers and served to enhance her status among them. To the villagers the main difference between the registered midwife and this approved *bidan kampong* lay not in their professional skills but in the method of payment—one was salaried while the other worked on a fee-for-service basis.

The non-approved bidan kampong

This was a 38-year old Malay grandmother who had only a few deliveries to her credit. She had acquired her skills in midwifery in a haphazard manner and by apprenticeship. She had never received any training at all from any public health personnel and was also not inspected. Hence she was recognised by the villagers as lacking approval from the government. Her practice, carried out in the traditional fashion, was small and restricted to the cul-de-sac in which she lived. She was reluctant to discuss midwifery practices as social approval of her activities was considerably restricted.

The masseuse bidan kampong (bidan pelihara)

The duties of a *bidan kampong* can be divided into two distinct sets, the delivery itself, and attendance to the mother and child after birth. A *bidan kampong* might perform either or both these sets of duties. Unlike the two *bidan kampong* previously described, the masseuse *bidan kampong* chose to confine her practice to attendance of the mother and child after birth. She was a 60 year old Malay grandmother whose mother, now deceased, had been a *bidan kampong*, while her father, now living in the next district was a famous *bomoh*. Although she had delivered several children in the past, she rarely effected any deliveries nowadays. She limited her practice to the first three days after delivery when she would *urut-mengurat* the mother, bathe both mother and child, and wash soiled linen. For her services she received from (U.S.) $1.00 to $4.00 as well as eight pounds of rice and a coconut. Her new role as the *bidan pelihara* had arisen as a result of her combination with the registered midwife to form a team, each playing a complementary role to the other.

The extempore midwives

The final category of women who effected deliveries in the study area were five women who, due solely to circumstances, came to deliver an infant each. In all instances they were relatives who had come to assist in a time of need. None were regular midwives. Four of them were the mothers of the women in labour, while the fifth was an elder sister of the woman in labour. The parturient women were all multiparous and living in area "C" as indicated in the map.

AREA AND SIZE OF PRACTICE

Division into home and intermediate territories

By plotting on a map (Fig. 1) the midwife who effected the delivery of each of 128 index-cases, it became clear that a majority of the index-cases was delivered by each of the three types of midwives in the territory immediately adjacent to her. Thus in area "A", the home territory of the registered midwife, 29 of the 34 index-cases were delivered by her; in area "B", the home territory of the non-approved *bidan kampong*, three of the six index-cases were delivered by her; and in area "D", the home territory of the approved *bidan kampong*, 38 out of the 59 were delivered by her.

Area "C" can be described as an intermediate territory lying between the home territories of the above three midwives. It exhibited the following features which seems to suggest that it was not the home territory of any of the three.

(i) It was the only area where five women in labour had to be delivered by their own relatives. The home territories did not exhibit this feature, even when various midwives encrouched into the territory of one another.

(ii) Further, it was the only area in which two or more midwives, other than the masseuse, were summoned to attend to the same delivery. Five such instances were recorded amongst the index-cases of "C".

(iii) It was the only area in which all five types of midwives effected at least one delivery each as indicated in the map and table.

(iv) Out of the total of 128 deliveries of index-cases only four did not include the customary *urut-mengurut*. Of these four, three were from area "C".

Distribution of the 128 index-cases by type of midwife in attendance and location of house.

Type of midwife	No. of Index-cases in area				Total
	A	B	C	D	
Registered midwife	29*	1	20	21	71 (55.5%)
Approved *bidan kampong*	5***	1	1	38*	45 (35.2%)
Non-approved *bidan kampong*	–	3*	1	–	4 (3.1%)
Masseuse *bidan kampong*	**	1**	2**	–	3 (2.3%)
Extempore midwives	–	–	5	–	5 (3.9%)
Total	34	6	29	59	128 (100%)

* home territory of the midwife.
** area of operation of the masseuse.
*** five index-cases delivered by an approved *bidan kampong* who lived 2 miles beyond the study area.

The size and geographical limits

In the last section, the observations on home and intermediate territories were presented. It is obvious that each midwife was the chief midwife within her home territory but it is also clear that her practice stretched beyond her home territory into the intermediate territory and perhaps even into the home territory of other midwives. The sociological implication of such encrouchments will be discussed later. However, the present section will deal with the extent of such encrouchment and the size of each practice.

Of the four midwives living in the study area, the registered midwife was the only one who carried on a practice outside the study area. Her practice stretched a further three miles along the laterite road towards Alor Star, the capital of Kedah State. Confining further remarks to the study area, it will be obvious from both Fig.1 and the table that her practice covered all the four divisions of the study area. Of the total of 341 children born during or after 1958 in the study area, she was responsible for the delivery of 182 (53.4%), the 182 being made up of 71 index-cases (55.5% of all index-cases) and 111 other children (52.2% of other children). It is also obvious that the size of her practice dropped from 85% in her home territory to below 36% as she encrouched on the home territories of the two *bidan kampong* (approved and non-approved).

The second largest practice in the study area was that of the approved *bidan kampong* who effected the delivery of 40 (31.3%) of the 128 index-cases. Her practice was largely confined to her home territory where she was responsible for 38 (64%) of the 59 index-cases. However, she did venture out to the intermediate territory and to the home territory of the non-approved *bidan kampong*, in each area of which she delivered one index-case. A similar *bidan kampong* who lived two miles beyond the study areas was responsible for five index-cases in area "A".

The non-approved *bidan kampong* was responsible for three index-cases in her home territory and one in the intermediate territory. Her home territory was very small and consisted of the households immediately around her home.

The masseuse *bidan kampong* avoided deliveries as far as was possible. She attached herself to the registered midwife but confined her practice to areas "A", "B" and "C". In the home territory of the approved *bidan kampong* the registered midwife ventured alone without the masseuse. The masseuse delivered two index-cases in area "C" and one in area "B".

Thus not only were there a variety of midwives in the study area, but also a division of the area into home territories, in each of which one midwife was clearly the chief, and an intermediate territory in which every variety of midwife operated. Each midwife operated within given areas and had a different size of practice.

MODUS OPERANDI

Each of the several types of midwives had her own modus operandi. However, one common feature stood out in the case of the three main types of midwives, namely, the registered midwife located at "A", the non-approved *bidan kampong* at "B", and the approved *bidan kampong* at "D". It was observed that in their own home territories each was paramount and was assisted in her practice by some other midwife.

The registered midwife and the masseuse bidan kampong

In her own territory of "A" as well as in the intermediate area of "C", the registered midwife was prominent, delivering the majority of index-cases. She was assisted during her attendance at labour as well as during the postpartum period by the masseuse *bidan kampong* from "A". This masseuse carried out the customary *urut mengurut* of the mother, bathed the mother and child, and washed the soiled linen during the first three days after delivery. The customary *urut mengurut* was performed on all but four of the 128 mothers by the various *bidan kampong* and it would appear that by teaming together, the registered midwife and the masseuse complemented each other. Without the masseuse performing the customary *urut mengurut* the registered midwife would have been unable to satisfy an important customary requirement; on the other hand, without the registered midwife, the masseuse would have lacked approval.

Their team-work was apparent even during labour. In a majority of instances, the masseuse was called at the onset of labour pains and stayed at the woman's side until delivery had been effected. Here again, her role complemented that of the registered midwife and must have endeared her even more to the registered midwife. The writer was privileged to have recorded a birth attended by the registered midwife during the time the study was underway and will describe it briefly as an example of the team-work that existed between the two midwives. The woman in labour was a primigravida who had sought and received antenatal care on two occasions. With the onset of labour pains, the masseuse was summoned and stayed beside the woman in labour, together with the woman's mother, an elder sister, and a cousin, for a total of 35 hours. As soon as delivery appeared imminent, some 28 hours after she had been initially called, the masseuse arranged to have the registered midwife summoned. Four hours later, the child was born. Delivery was normal. During those 35 hours, the masseuse took her food and rest in the patient's home. For the next three days, both the midwives arranged to visit the home together, the registered midwife giving a lift to the masseuse on her bicycle. Fig.2 shows the two midwives on their rounds. The masseuse avoided delivering any babies whenever she could. However, she served as a standby midwife on those occasions when the registered midwife arrived late. As indicated previously, she effected the delivery of two index-cases in area "C", and one in area "B".

The registered midwife, in addition to attending to 53.4% of all births in the study area, was the only midwife in the area to provide antenatal care. Out of the 128 index-cases, 122 (95%) of the mothers exchanged one or more antenatal visits with the registered midwife. The average number of antenatal visits per mother was 4.8 for all index-cases, and 5.5 for the 71 effected by herself. During these antenatal visits the mothers were examined and given advice on diet as well as mothercraft. In addition, the registered midwife visited the mother and bathed the new-born baby, of all births she herself had effected, on the first 10 days after delivery and again on the 20th and finally the 40th day after delivery.

The approved bidan kampong

She was paramount in her home territory "D", but did not carry out any antenatal visits in the fashion that the registered midwife did. She expected and entertained an antenatal visit from the relatives at the eighth month of pregnancy, during which, the *kiriman perut*, a ritual tantamount to a contract whereby she was booked as the midwife, was performed. Nevertheless, 36 (95%) of

Fig. 2—The registered midwife followed by the masseuse *bidan kampong* on their way to visit a mother who had her child delivered by the registered midwife the previous day.

the 38 index-cases that she delivered received antenatal care from the registered midwife, the average number of visits being 3.4 visits per mother. It would thus appear that in the home territory of the approved *bidan kampong* the registered midwife assisted the former by providing antenatal care for a group of women who had already indicated their preferred midwife by a customary ritual.

Her accouchement bag, which had initially been given to her on completion of her short course of training in 1956, contained the following items, as shown in Fig.3:

> Three enamel basins, a pair of stainless steel scissors, a pair of stainless steel artery forceps, sterile soap, sterile cord ligature, surgical spirits, "dettol" anti-septic, cotton wool, nail brush, soap, and an enema pump.

During the course of labour, she would perform a number of vaginal examinations, after washing her hands with soap and water and using antiseptic "dettol". After the birth, she was responsible for washing linen soiled with discharge and for performing the customary *urut mengurut*.

Twenty-one of the 59 index-cases in area "D" were delivered by the registered midwife. Of these 21, all but one received the *urut mengurut* from the approved *bidan kampong*. However, unlike the masseuse *bidan kampong* who assisted the registered midwife in the other areas, this midwife never attended at the same time as the registered midwife. The

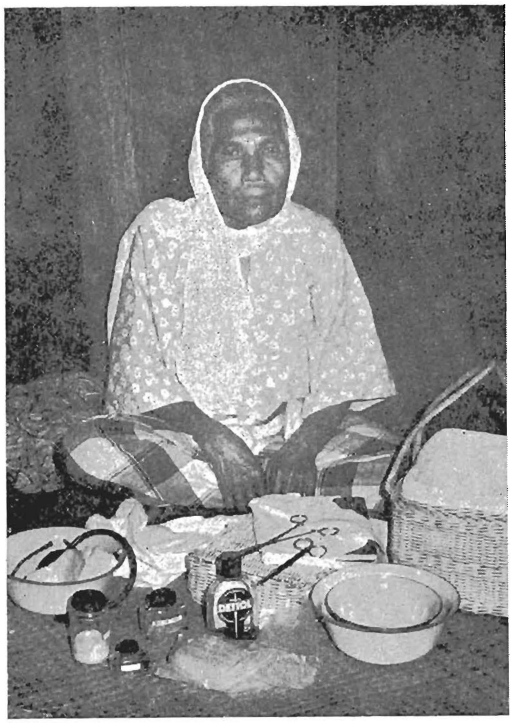

Fig. 3—The approved *bidan kampong* and the contents of her accouchment bag.

urut mengurut was done on the basis of independent arrangements between the relatives and the *bidan kampong*. Only in one respect did the approved *bidan kampong* concede her pre-eminence in her own home territory, namely that all complicated labours were beyond her and deserved the attention of doctors in the general hospital. In this respect, she did not hesitate to summon for help the moment labour appeared prolonged. For example, on one occasion, she summoned the registered midwife when the caput appeared at the vulva but there was no progress in labour for six hours. The registered midwife arranged to have the patient removed by ambulance to the nearest general hospital 19 miles away.

The non-approved bidan kampong

She was confined to the area immediately around her home. Nevertheless, all the mothers of the four index-cases that she attended to, received antenatal care from the registered midwife, each exchanging between five to ten antenatal visits with the registered midwife. In spite of this, when labour began, the four women chose the non-approved *bidan kampong*. Her method of midwifery as described earlier can be said to be traditional and crude, weak in respect of asepsis, but strong in some other respects. For example, in the tradition of all *bidan kampong*, she always stayed at the bedside of the woman in labour until delivery was completely effected. She did not leave the woman unattended even in the earlier stages of labour. Further, she always performed the *urut mengurut*.

DISCUSSION

Of the various members of the public health team in a government rural health unit, the registered midwife stands out as unique for several reasons. In most instances she is peripherally located in relation to the health centres, and lives solo amongst the rural people away from other members of the public health team. Further, she has a counterpart in the local community, the unregistered *bidan kampong*, whom she tends to displace in order to establish her own practice. As she establishes herself and introduces modern midwifery practices, she will bring about a modification of indigenous midwifery practices. These modifications will be reflected both among the established *bidan kampong* as well as among the residents of the rural community she enters.

The introduction of the registered midwife into a rural Malay community necessarily results in the displacement of the established *bidan kampong*, who not only must seek new roles and statuses but also must re-establish for each of themselves a re-adjusted area and size of practice. Thus in the study area, the *bidan kampong* from area "D", by virtue of

having been given a short course in the principles of hygiene as applied to midwifery and being placed under monthly inspection, established for herself a new role - that of an approved *bidan kampong*. In the process she acquired, in the eyes of the rural community, a status no less than that of the registered midwife. The main difference between the two, in their eyes, was merely that the registered midwife was salaried and hence never charged a fee while the approved *bidan kampong* worked on a fee-for-service basis. The approved *bidan kampong*, on her part, compromised by limiting the bulk of her practice to area "D", having in the past practised over a very wide area. This entailed a decrease in the size of her practice. For example, during 1957 she effected 32 deliveries while ten years later during 1967, she effected 14 deliveries. She also submitted herself to government inspection but this also served to confirm the approval she had from the government.

A second *bidan kampong* established for herself a different but equally new role - that of a masseuse, known locally as a *bidan pelihara*, who in a very neat manner complemented and aided the role of the registered midwife. By endearing herself to the registered midwife she acquired a new status and found herself a new geographical area for practice. The size of her practice naturally was directly related to that of the registered midwife and increased as the registered midwife gradually established her own practice.

A third *bidan kampong* who lived in area "B" did not develop a new role but tried to retain the traditional role of the *bidan kampong* as best as she could. As a result she lacked the approval that the two previously mentioned *bidan kampong* acquired in their new roles. Consequently, her practice was very limited and restricted to the cul-de-sac in which she lived.

Among the three main types of midwives, namely, the registered midwife, the approved *bidan kampong* and the non-approved *bidan kampong*, it was observed that within their own home territories, each was paramount and was assisted in her practice by some other midwife. It was also observed that between the three home territories was located an intermediate territory that exhibited features, not seen in the home territories, which seems to suggest that it was not the home territory of any of them. In terms of social status, the registered midwife was highest and she practised in all four territories. The approved *bidan kampong*, who was the next highest, practised in all territories other than the home territory of the registered midwife. The masseuse *bidan kampong* was the third highest in social status and ventured into the home territory of the non-approved *bidan kampong* and not into that of the approved *bidan kampong*. The non-approved *bidan kampong* had the lowest social status among the four regular midwives and ventured only into the intermediate territory being confined largely to the households immediately around her home.

SUMMARY

For domiciliary midwifery, the rural Malay, before the introduction of modern midwifery into rural Malay communities, was dependant upon the traditional *bidan kampong* (unregistered village midwife). This paper presents the results of a study that examines the effects of the introduction of the trained midwife on traditional domiciliary midwifery in a rural Malay community. With the introduction of modern midwifery into the study community, three established *bidan kampong* had not only to seek new roles and statuses but also to re-establish for each of themselves a readjusted area and size of practice. One, by virtue of a short course

in modern midwifery, established herself as a socially and legally approved *bidan kampong;* a second, by readjusting as a masseuse who performed the customary postpartum *urut mengurut* (massage), complemented and aided the role of the new registered midwife; a third, who tried her best to retain her traditional role, found herself lacking social and legal approval, and consequently restricted to a very limited practice.

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