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National nursing and midwifery legislation in countries of South-East Asia with high HIV burdens

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Abstract

This paper analyses nursing and midwifery legislation in high HIV-burden countries of the World Health Organization (WHO) South-East Asia Region, with respect to global standards, and suggests areas that could be further examined to strengthen the nursing and midwifery professions and HIV service delivery. To provide universal access to HIV/AIDS prevention, care and treatment, sufficient numbers of competent human resources for health are required. Competence in this context means possession and use of requisite knowledge and skills to fulfil the role delineated in scopes of practice. Traditionally, the purpose of professional regulation has been to set standards that ensure the competence of practising health workers, such as nurses and midwives. One particularly powerful form of professional regulation is assessed here: national legislation in the form of nursing and midwifery acts. Five countries of the WHO South-East Asia Region account for more than 99% of the region's HIV burden: India, Indonesia, Myanmar, Nepal and Thailand. Online legislative archives were searched to obtain the most recent national nursing and midwifery legislation from these five countries. Indonesia was the only country included in this review without a national nursing and midwifery act. The national nursing and midwifery acts of India, Myanmar, Nepal and Thailand were all fairly comprehensive, containing between 15 and 20 of the 21 elements in the International Council of Nurses Model Nursing Act. Legislation in Myanmar and Thailand partially delineates nursing scopes of practice, thereby providing greater clarity concerning professional expectations. Continuing education was the only element not included in any of these four countries' legislation. Countries without a nursing and midwifery act may consider developing one, in order to facilitate professional regulation of training and practice. Countries considering reform to their existing nursing acts may benefit from comparing their legislation with that of other similarly situated countries and with global standards. Countries interested in improving the sustainability of scale-up for HIV services may benefit from a greater understanding of the manner in which nursing and midwifery is regulated, be it through continuing education, scopes of practice or other relevant requirements for training, registration and licensing.

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Keywords

HIV/AIDS; India; Indonesia; legislation; Myanmar; Nepal; nurses' act; nursing; South-East Asia; Thailand

INTRODUCTION

HIV/AIDS remains a serious global health issue, as evidenced by its contribution to the global burden of disease and by global commitments to expand access to prevention and treatment services.[1,2] The World Health Organization (WHO) South-East Asia Region is second only to the African Region in the number of people of all ages living with HIV and the number of deaths due to AIDS.[3] With the exception of Thailand, which at 78% coverage has nearly achieved the target of universal HIV treatment access, overall coverage of antiretroviral treatment (ART) in the WHO South-East Asia Region is still far below the target of 80%.[4,5] Coverage rates for prevention of mother-to-child transmission of HIV in the region are low and slow to improve.[5] However, Member States of this Region have committed to expand ART access and eliminate new HIV infections in women and children.[6]

To provide universal access to HIV/AIDS prevention, care and treatment, sufficient numbers of competent human resources for health are required.[4,5] In this context, competence means that health workers, particularly nurses, who form the majority of professional health workers in the countries reviewed, have and utilize the requisite knowledge and skill to fulfil their roles as delineated in scopes of practice. In all five countries included in this review, the density of nurses is greater than that of physicians, suggesting that nurses are probably providing a larger portion of health-care services – especially in countries such as Indonesia and Thailand, which have the highest densities of nurses and lowest densities of physicians in the Region. The importance of nurse-initiated and -managed ART education, policy, regulation and practice for scaling up HIV treatment in east, central and southern Africa has already been discussed in the literature.[7] Additional research suggests that, to provide ART to 1000 patients, between one and two physicians and between two and seven nurses are required.[8] However, in the WHO South-East Asia Region, there is a severe shortage of physicians and nurses (the latter averaging fewer than 2 per 1000 patients); the distribution of these professionals within countries is skewed towards urban areas; and many nurses and midwives lack the clinical skills to adequately respond to health-care demands.[9–13] Legislation can establish mandates; authorize issue of regulations; and allocate resources to address deficiencies in the numbers of health workers, their distribution and clinical capacity. In many low- and middle-income countries, nurses are in greater supply than physicians and a growing body of evidence suggests that the quality of nurse-led ART initiation and management services is not inferior to that provided by physicians.[14–16] These studies have noted the importance of high-quality training and supervision to ensure quality of care,[14–16] and professional regulation can facilitate both.

Traditionally, the purpose of professional regulation has been to set standards (such as pre-service and continuing education requirements, and scopes of practice) that ensure the

competence of practising health workers, such as nurses and midwives.[17] In countries around the world, health professionals are regulated through national or subnational legislation (such as a nursing act) that establishes a regulatory body or council and authorizes it to issue regulations pertaining to education and practice. Common regulatory functions of nursing and midwifery councils include accreditation of training institutions, registration and licensing of qualified nurses and midwives, implementation of continuing education requirements, delineation of scopes of practice, and enforcement of professional codes of conduct.[18,19] Thus, nursing and midwifery acts aim to ensure the quality of nursing and midwifery services, to protect the public from harm, and to advance the professions.

While health professional legislation varies from country to country, international nongovernmental organizations such as the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM) have issued global standards for nursing and midwifery legislation and regulation.[20–22] The ICN Model Nursing Act outlines 21 standard elements (seven structural and 14 functional) that are encouraged for inclusion in national nursing acts.[21] Thus, international guidance can be used as a benchmark to evaluate the content of national nursing acts. WHO urges countries to regularly review and strengthen their legislation governing health professionals and to ensure that nurses and midwives give their optimum contribution to the community.[23] The contribution of nurses and midwives need not be limited to delivering health services. For example, to promote community outreach, they may be called upon to supervise other nurses, midwives and community health workers.

Although nurses are the largest health professional group in the WHO South-East Asia Region,[3] to date there has not been an examination of the nursing and the midwifery legislation in Member States of this Region. In light of global and regional commitments to increase access to life-saving HIV services, and the previously cited clinical weaknesses in the nursing and midwifery professions in the Region, a review of nursing and midwifery legislation and its alignment with global normative guidance would add to existing knowledge concerning health professional regulation. The purpose of this paper is to analyse nursing acts in high HIV-burden countries of the Region with respect to global standards, and to suggest areas that could be further examined to strengthen the nursing profession and the critical role it plays in addressing HIV specifically, and primary health care more broadly.

METHODOLOGY

Countries were selected for inclusion in this review according to a 2010 global report on HIV-related disability-adjusted life years (DALYs), a common measure used to quantify disease burden.[1] Five countries of the WHO South-East Asia Region account for more than 99% of the Region's HIV burden: India, Indonesia, Myanmar, Nepal and Thailand.[5] The rank of HIV/AIDS DALYs and statistics on nurse and physician densities for each of the five countries are presented in Table 1.[24] DALYs are a measure of both morbidity and mortality due to a particular cause and are, therefore, widely used to quantify disease burden for comparative purposes. India has the highest number of HIV/AIDS DALYs in the Region by far (more than eight times the second highest country), in part due to the substantially

greater national population of India. The contribution of HIV to total DALYs varies by country, with HIV contributing three times more in Thailand (5.6%) than in India (1.8%). All countries have a combined workforce density below the WHO-recommended minimum of 2.3 health professionals per 1000 people.[25] Available data from each of the five countries indicate their population density of nurses and midwives is greater than the density of physicians. Thailand and Indonesia have the highest densities of nurses and also the lowest densities of physicians.

The most recent nursing and midwifery legislation from these five countries was obtained by searching the online legislative archives of ICN, the International Labour Organization, national regulatory bodies and governments, from May to October 2013. Advanced search terms used were “nurses’ act”, “nursing act”, “nurses and midwives”, “health professions act” and “legislation”. As necessary, the regulatory body or the national nurses’ association was contacted via email, to request the latest national nursing legislation.[26] Other countries of the Region not selected for this review, owing to lower HIV burdens, are Bangladesh, Bhutan, Democratic People’s Republic of Korea, Maldives, Sri Lanka and Timor-Leste.

The national nursing and midwifery acts of India, Nepal and Thailand were retrieved from online sources.[27–29] The legislation from Myanmar was obtained from the Nurse and Midwife Council in June 2013;[30,31] Indonesia does not have national nursing legislation.[32] The four nursing acts were reviewed to understand how each of the councils was established and the extent to which the 21 elements recommended by the ICN Model Nursing Act[21] were included in the acts. Additionally, the acts were reviewed in greater depth to understand the professional scopes of practice of regulated nurses and midwives. The purpose of the review was not only to explore what actions and procedures nurses and midwives were legally permitted to perform, but also to reveal whether performance of HIV/AIDS-related tasks in these countries was addressed in their respective legislation.

RESULTS

The national nursing and midwifery acts of India, Thailand, Myanmar and Nepal were reviewed to understand how their councils and council memberships were established (*see* Table 2). In each case, the act created the council as the entity mandated to regulate nurses and midwives. Each council was established as a new, regulatory entity; the number of members on each council ranged from 11 to 33. In broad terms, council membership across these countries is structured to enable participation from government, the health professions themselves and the private sector. Thailand’s act created a Council Committee of 33 members to function as the council’s decision-making body while extending council membership to all nurses and midwives regulated by the act. In the acts of India, Thailand and Nepal, a mix of election and appointment is used to select council members, in contrast to Myanmar where all members are appointed. Respective appointments are made by the Central Government of India, Thailand’s Minister of Public Health, Myanmar’s Minister of Health and the Government of Nepal. All acts call for government representation on the council, often from the ministry of health. The councils include representation from multiple sectors. However, only Thailand’s act calls for a private non-profit member to be represented on the council; India’s act is the only one to explicitly include a medical

representative; and Nepal's is the only one to include a representative from the consumers' group. Nepal's council is the only one of the four that does not include a representative from the midwifery sector. All councils have authority granted by the legislative acts to establish committees, as needed, to implement their mandates. Professions regulated by the acts include nurses and midwives of various types, including auxiliaries, assistants and aids.

The acts from India, Thailand, Myanmar and Nepal were reviewed to determine whether or not they addressed each of the 21 elements included in ICN's global standard (*see* Table 3).[21]

Structural elements

Each act included the title of legislation and the most recent year of amendment, and defined key terms. India was the first country to enact its nursing legislation (1947) and Nepal was the most recent (1996). All acts have been amended; the least recent was in 1996 (India) and the most recent were in 2002 (Myanmar and Nepal). The purpose and composition of the council was described in each act. Similarly, all acts established specific committees or authorized the councils to establish them.

Functional elements

Registration of nursing and midwifery professionals was comprehensively addressed in each act, including creation of the position of registrar, requiring the establishment and maintenance of registers, and setting specific criteria for registration. Two of the three recommended elements for pre-service education and training were present in each act: educational standards and authority to approve training institutions. However, a requirement for continuing education after registration was not included in any act. Elements pertaining to fitness to practise were present in each act except for India's. Neither India's nor Thailand's act established an appeals process for disciplinary procedures. The Indian Nursing Council was the only council with full autonomy to make and approve rules and regulations; other acts allocated rule-making authority among the councils and one or more governmental entities. All acts included provisions to recognize foreign-trained nurses, and all acts regulated the midwifery profession in addition to nursing. Three acts (all but India's) addressed funding of the councils. Overall, of the 21 structural and functional elements, Myanmar's and Nepal's acts each addressed 20; Thailand's addressed 19; and India's addressed 15.

The review of scopes of practice provision revealed that brief definitions of the terms "nurse", "midwife", "nursing", and "midwifery" exist in Thailand's and Myanmar's acts *(see* Table 4*)*. Similarly, only those two acts provided general scopes of practice, elaborating on the brief definitions. Since none of the acts included a more detailed, task-oriented scope of practice for the nurse or midwife, it was unclear whether specific HIV-related tasks, such as initiating HIV treatment, were encompassed in the more general scope of practice. Thus, the interpretation of terms from these general scopes of practice, such as "diagnosis", "care" and "treatment", may make a significant difference to the involvement of nurses in HIV service delivery and other health tasks. This further delineation or interpretation of scopes of

practice may occur when councils and ministries of health issue rules, regulations or other policies to implement their legislative mandates as set out in the acts.

DISCUSSION

This study compared existing national nursing and midwifery acts in the countries of the WHO South-East Asia Region with the highest HIV burden to the ICN global standard,[21] and reviewed the scopes of practice in each act. India, Thailand, Myanmar and Nepal each had over 70% of the 21 elements recommended by ICN; Indonesia was the only country in the review without a national nurses' and midwives' act. Since enacted, all acts have been amended, albeit not recently (between 13 and 19 years ago). This suggests that countries may benefit from reviewing their national nursing acts to take into consideration current health-care needs and global guidelines. Revisions to nursing and midwifery acts, or permissive interpretation of existing legal and regulatory scopes of practice, could expand the workforce for health services such as ART. This is particularly relevant because nurses greatly outnumber physicians in the countries profiled, and globally.

While functional regulatory elements relating to registration and pre-service education were well represented in all acts reviewed, none of the acts required continuing education after initial registration. Continuing education or continuing professional development (CPD) ensures that nurses and midwives update their knowledge and skills to maintain congruence with the rapid evolution of medical research, science and technology.[33] Continuing education also helps to ensure that health workers sustainably provide high-quality health-care services.[34] Thus, the absence of a CPD requirement in all of the acts reviewed is noteworthy.

Only two acts (Thailand and Myanmar) included a general scope of practice, which elaborated on the brief definitions provided. However, none of the acts included a detailed, task-oriented scope of practice for nurses or midwives, making it difficult to interpret how the terms in the general scope of practice, such as "diagnosis", "care" and "treatment", might relate to HIV-specific tasks, such as diagnosing HIV and initiating ART. How general or how specific a scope of practice should be is not a question this study sought to answer, as strong arguments can be made for both approaches. General scopes of practice can provide greater flexibility for health professionals to respond to changing needs with new technologies and skills, whereas specific scopes of practice can provide greater protection for, and direction to, health professionals, as authorized tasks are explicitly delineated in writing. In the absence of specific scopes of practice, the ways in which Thailand's and Myanmar's general scopes of practice are interpreted and implemented may well make a significant difference to the involvement of nurses and midwives in HIV service delivery. General scopes of practice could be made more specific, to provide further guidance to providers and their employers about what tasks nurses and midwives are authorized to undertake. Specific scopes of practice could include HIV-related tasks, such as nurse-initiated and -managed ART, as recommended by WHO to include prescriptive authority for nurses.[15] Means of reform could include legislative amendment or issue of rules or regulations. Further delineation or interpretation of scopes of practice may occur when councils and ministries of health issue rules, regulations or other policies to implement their

legislative mandates as set out in the acts. However, assessing whether these countries have issued such rules or regulations or other policies is outside the scope of this review.

All the acts created councils as new entities, but with clear influence from the countries' governments. For example, all councils had government representatives as members that were either appointed or elected by government: some council members in India are appointed by its central government; in Thailand, the minister of public health appoints the council members and is the special president; in Nepal, the government appoints the chairperson and some council members; and in Myanmar, the minister of health appoints all council members, including its chairman.

In terms of financing, both Thailand's and Nepal's acts explicitly allowed councils to receive funds from sources beyond fees charged for services, such as registration. Such funding provisions create opportunity for those councils to receive funds from external sources, including domestic government support and, potentially, external donor funding.

Comparing nursing acts in countries of the WHO South-East Asia Region to the ICN Model Nursing Act[21] can assist national governments and regulatory bodies to identify areas of regulation to review and strengthen in order to improve the nursing profession and its contribution to the national health system. Though the connection between national law and local health-care practice is not a direct one, it is certainly plausible that national legislation may have a major impact on both the quantity and quality of nursing and midwifery services for HIV prevention, care and treatment, and for primary health care in general. The intent of nursing and midwifery acts is to set standards for these professions, thereby facilitating quality of care. Furthermore, as noted earlier, evidence suggests that health workers undergoing continuing education are able to provide higher-quality health-care services. For example, strengthening health policies for continuing education on HIV care and treatment may lead to improvement in the quality of HIV service delivery. Additionally, better delineation of scopes of practice to align with WHO guidance (for example ART initiation including prescribing authority for nurses) may facilitate sustainable scale-up of health services, including ART coverage. The role of nurses and midwives in HIV/AIDS care is paramount in South-East Asia and elsewhere. This is due to the greater density of nurses and midwives compared with physicians, and to their placement on the front lines of health care, often in facilities lacking physicians. In short, nurses and midwives are critical to HIV/AIDS care. Therefore, those interested in improving the sustainability of scale-up for HIV services may benefit from a greater understanding of the manner in which nursing and midwifery is regulated, be it through continuing education, scopes of practice or other relevant requirements for training, registration and licensing. Indonesia, which lacks a nursing and midwifery act, may consider all findings relevant to its ongoing legislative process to develop such an act.

Two limitations of the study should be discussed. First, section seven of the Indian Nursing Council Act[27] was not included in the version available on the council's website, nor were requests for it fulfilled, thus it was not reviewed. It is possible that particular section addresses one or more of the aforementioned elements from the ICN Model Nursing Act.[21] The second limitation lies in the nature of the review carried out. National acts are a

primary, but by no means the only, form of regulation of nursing and midwifery. Therefore, this type of review provides important though limited information on how nations regulate nursing and midwifery. For example, state or territorial level health legislation may also play an important role, as in India.[35] Future research should explore the implications of nursing acts and their implementation on nursing professionals and the public, such as whether the lack of legislative provisions requiring continuing education affects the quality of services delivered.

CONCLUSION

The national nursing acts of India, Thailand, Myanmar and Nepal were all fairly comprehensive, containing 15–20 elements of the 21 elements in the ICN Model Nursing Act.[21] Continuing education was the only element not included in any act. Given the importance of continuing education to quality of practice in HIV care and other areas, this is a problematic finding; however, the study did not assess whether continuing education is required through means other than the act (such as regulations). Requirements for continuing education can help health workers maintain and improve upon training received prior to entry to service, thus facilitating quality patient care. None of the acts included a scope of practice specifically listing HIV-related tasks. Without explicit and specific directions concerning which tasks a nurse or midwife may undertake within their scope of practice, some nurses and midwives may hesitate to practise to their full scope, for fear of exceeding it. However, general language in scopes of practice may potentially be interpreted by domestic authorities to include such tasks, without necessarily listing each one. Thus, the lack of specific scopes of practice is not necessarily a barrier to task sharing of HIV services. Indonesia was the only country in this review without a national nursing and midwifery act. Countries without a nursing and midwifery act may consider developing one, in order to facilitate professional regulation of training and practice for HIV specifically, and for primary health care more broadly. Countries considering reform to their existing nursing and midwifery acts may benefit from comparing their legislation with that of other similarly situated countries and with global standards. This review may assist countries in the WHO South-East Asia Region, and beyond, to evaluate and improve their nursing and midwifery legislation and regulations as part of efforts to strengthen their national health systems and increase coverage of HIV and other primary health-care services.

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Table 1

HIV burden and health workforce in select countries of the WHO South-East Asia Region

Country	National population in 2012[25]	HIV/AIDS DALYs in thousands in 2010 (rank in Region)[1]	Physicians per 1000 people in 2005–2012[3]	Nurses and midwives per 1000 people in 2005–2012[3]	Nursing legislation enacted?
India	1 236 686 732	9265.13 (1)	0.65	1.00	Yes
Thailand	66 785 001	1123.30 (2)	0.30	1.52	Yes
Myanmar	52 797 319	1098.67 (3)	0.50	0.86	Yes
Indonesia	246 864 191	650.61 (4)	0.20	1.38	No
Nepal	27 474 377	217.74 (5)	0.21	N/A	Yes

N/A: data not available.

Table 2

Composition of the councils established by the national acts

Composition or membership of nursing councils	India	Thailand	Myanmar	Nepal
Council members appointed	Yes	Yes	Yes	Yes
Council members elected	Yes	Yes	No	Yes
Number of council members established	11	33 on Council Committee	11	15
Council members appointed or elected from various sectors	Yes	Yes	Yes	Yes
Ministry of health or equivalent	Yes	Yes	Yes	Yes
Private non-profit	No	Yes	No	No
Nursing	Yes	Yes	Yes	Yes
Midwifery	Yes	Yes	Yes	No
Medical	Yes	No	No	No
The public	No	No	No	Yes
Training institutions	Yes	No	No	Yes
Criteria set out to select chairperson or president of council	Yes	Yes	Yes	Yes
Council is created as a new, separate entity	Yes	Yes	Yes	Yes
Committees of council are established	No	Yes (Council Committee)	No	No
Council is authorized to establish its own committees	Yes (executive committee and others, as needed)	Yes (ethics and others, as needed)	Yes (as needed)	Yes (as needed)
Professions regulated	Nurses; midwives; auxiliary nurse-midwives; health visitors; public health nurses	Nurses (first and second class); midwives (first and second class); nurse-midwives (first and second class)	Nurses; midwives; nurse-midwives; nurse-aids	Nurses; midwives; assistant nurse midwives

Table 3

Comparison of national nursing acts with the ICN Model Nursing Act[21]

ICN Model Nursing Act elements	India	Thailand	Myanmar	Nepal
Structural elements				
Part I. General				
Title of legislation	Indian Nursing Council Act (1947)	Professional Nursing and Midwifery Act (1985)	Law relating to the Nurse and Midwife (1990)	Nepal Nursing Council Act (1996)
Most recent year of amendment	1996	1997	2002	2002
Key terms defined	Yes	Yes	Yes	Yes
Part II. Council and committees				
Name of council	Indian Nursing Council	Nursing and Midwifery Council	Myanmar Nurse and Midwife Council	Nepal Nursing Council
Purpose of council set out	Yes	Yes	Yes	Yes
Composition of council specified	Yes	Yes	Yes	Yes
Committees established or authorized for establishment	Yes	Yes	Yes	Yes
Functional elements				
Part III. Registration				
Registrar position	Yes	Yes	Yes	Yes
Establishment and maintenance of register	Yes	Yes	Yes	Yes
Criteria for registration	Yes	Yes	Yes	Yes
Part IV. Education and training				
Education standards specified (curricula)	Yes	Yes	Yes	Yes
Authority to approve training institutions	Yes	Yes	Yes	Yes
Continuing training required	No	No	No	No
Part V. Fitness to practise				
Code or standards of conduct/ethics	No	Yes	Yes	Yes
Disciplinary procedures	No	Yes	Yes	Yes
Part VI. Appeals				
Established process	No	No	Yes	Yes
Part VII. Regional harmonization				
Recognition of foreign-trained professionals	Yes	Yes	Yes	Yes
Part VIII. Midwifery				
Encompasses midwifery	Yes	Yes	Yes	Yes
Part IX. Offences				
Offences/penalties listed	No	Yes	Yes	Yes
Part X. Miscellaneous				
Making and approval of rules or regulations	Yes (Council)	Yes (Minister of Health and Council Committee)	Yes (Ministry of Health, Government and Council)	Yes (Council and Government)

ICN Model Nursing Act elements	India	Thailand	Myanmar	Nepal
Funding of council	No	Yes (fees and other sources)	Yes (fees)	Yes (fees and other sources)
Total number of elements addressed	15	19	20	20

Table 4

Scopes of practice provisions in the nursing acts

Provisions	India	Thailand	Myanmar	Nepal
Nurse defined	No	Yes	Yes	Yes
Nursing defined	No	Yes	Yes	No
Midwife defined	No	Yes	Yes	Yes
Midwifery defined	No	Yes	Yes	No
General scope of practice	No	Yes[a]	Yes[b]	No
Specific scope of practice (tasks)	No	No	No	No

[a] "Professional Practice of Nursing means practice of nursing to individual, family and the community in the following actions: (1) to provide education, advice, counseling, as well as solving health problems; (2) to act and assist individuals physically and mentally, including their environment, in order to solve problems of illness, alleviate symptoms, prevent dissemination of diseases and provide rehabilitation; (3) to provide treatment, as mentioned in primary medical care and immunization; (4) to assist physicians to perform treatments. These actions shall be based on scientific principles and the art of nursing in performing health assessment, nursing diagnosis, planning, nursing intervention and evaluation."[29]

"Professional Practice of Midwifery means practice of midwifery to pregnant women, postdelivery women, their newborns and families in the following actions: (1) to provide education, advice, counselling, as well as solving health problems; (2) to act and assist pregnant women, postdelivery women, and their newborns physically and mentally, in order to prevent complications during pregnancy, delivery, and postdelivery; (3) to provide physical examinations, delivery of the baby and family planning services; (4) to assist physicians to preform treatments. These actions shall be based on scientific principles and the art of midwifery in performing health assessment, diagnosis, planning, intervention and evaluation."[29]

[b] "Nursing Profession means a profession capable of rendering physical, mental, social nursing care needed by a sick person and also health care, mental and social needs of the family and relatives of such sick person. This expression includes rendering services in respect of better health care and disease preventive measures to the healthy persons."[30–31]

"Midwife Profession means rendering pre-natal care to pregnant women before delivery, and rendering safe delivery at the time of birth. This expression includes rendering care to mother and new born baby."[30–31]