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EVALUATION REPORT

INTERNATIONAL CONFEDERATION OF MIDWIVES (ICM)

LONDON, ENGLAND

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Evaluation Team:
Anne Aarnes, PHA/POP/IE&C
Constance Collins, PHA/POP/MI
William S. Lefes, PHA/PRS/Evaluation

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A.I.D.
Reference Center
Room 1656 NS

Aarnes, Anne; Constance Collins; and William S. Lefes

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The strengths of the International Confederation of Midwives (ICM) are inherent in the credibility of the organization in LDCs and in its unique association with the International Federation of Gynecology and Obstetrics. These qualities permit the ICM to gain access to leading LDC obstetrical/gynecological physicians and to policy level officials in Ministries of Health. The ICM has demonstrated some capability in organizing working parties and attracting the medical and midwifery leadership of the region. The working parties have been used successfully to introduce the concept of family planning as an integral part of Maternal Child Health (MCH) to midwives from LDCs. ICM success at the country level, however, has been uneven. Within the grant objectives the ICM has succeeded in: (1) introducing the idea of family planning as a midwifery responsibility; (2) stimulating discussion on the recognition and use of Traditional Birth Attendants; and (3) identifying major barriers to effective family planning service delivery by midwives in LDCs. The evaluators made several recommendations including: (1) AID and ICM need to negotiate the means for strengthening ICM's contribution to AID's total family planning training program; (2) ICM's project administration should be strengthened; and (3) the ICM grant should be continued.

AN EVALUATION OF INTERNATIONAL CONFEDERATION OF MIDWIVES (ICM)

October 1974

I. Introduction

The International Confederation of Midwives (ICM) representing approximately 100,000 midwives from 42 countries works towards greater international cooperation in the professional practice of midwifery and assists other organizations in improving standards in maternal and infant care including family planning.

An important tenet of ICM is its belief in the fundamental right of freedom of choice for individuals to shape their family life according to their aspirations. Its goals are improvement of the quality of child birth, lowering of infant and maternal mortality and morbidity rates, reducing birth defects, spacing children, conservation of maternal strength and increased family social and economic security.

A grant in the amount of $675,000 was given to ICM for a period of 13 months commencing in May 1972. The scope of the grant indicated that ICM could conduct a triennal congress in 1972 with program emphasis on family planning and organize at least five regional working parties in developing countries. The working parties were to analyze needs, resources, and potentials for expanding midwife capacity in the region to support the promotion of family planning, develop recommendations on how to integrate family planning into midwife training and practice, and plan action to put resultant recommendations into effect at national and local levels.

It was anticipated that ICM would take actions to assure that returned delegates take the necessary steps to implement in their own country recommendations adopted by the working party and time would be provided in the program for the delegates to establish a plan of action for each such implementation. These plans would detail how the delegates would organize follow-up, including workshops, seminars, or similar meetings.

The International Confederation of Midwives has undertaken collaborative measures with the International Federation of Gynecology and Obstetrics (FIGO) to continue the improvement of maternal and child care through the inclusion of family planning as a part of its services provided by midwives of all categories. It carries out these collaborative programs through a Joint Study Group composed of members from each

organization. The purpose of the joint study group is to provide a forum for professional obstetricians and midwives to examine the situation in their own area. It is anticipated that suggestions appropriate to the conditions of the area will emerge from these proceedings.

II. Purpose of Evaluation

To determine the extent to which the grantee, ICM, has achieved the purpose of the grant, to provide a framework for midwives to enable them to influence population/family planning policy, training curricula, legislation, and delivery of services, the effectiveness of its implementing actions, and the efficiency with which it carried out the provisions of the grant.

III. Summary of Findings and Recommendations

A. Findings

The strengths of the ICM are inherent in the credibility of the organization in LDCs, and in its unique association with FIGO. These qualities permit the ICM to gain access to leading LDC obstetrical/gynecological physicians and to policy level officials in Ministries of Health.

The ICM has demonstrated some capability in organizing working parties and attracting medical and midwifery leadership of the region. The working parties have been used successfully to introduce the concept of family planning as an integral part of MCH to midwives from LDCs. This approach is necessary in countries where family planning policies require its integration with health services. The working parties introduce ideas to LDC participants as to who shall deliver family planning services (midwives, traditional birth attendants (TBAs), auxiliaries) and ways in which governments can be approached to initiate or improve services.

The working parties and subsequent follow-up visits, while not exploited fully thus far, appear as reasonable vehicles for bringing together the midwifery profession of a given region and of each country in support of family planning as an important continuing responsibility for all midwives. This function, which ICM as the international midwifery body is uniquely qualified to perform, is useful even in countries in which many midwives are already trained and permitted to provide

family planning services. It reinforces awareness of the role of family planning in MCH, and encourages them to become more active in providing family planning information and education as well as family planning services. ICM working parties particularly in the Caribbean and in East Africa, have largely succeeded in stimulating this awareness and enthusiasm at the regional level.

ICM success at the country level, however, has been uneven.

Within the grant objectives the ICM has succeeded in:

a. Introducing the idea of family planning as a midwifery responsibility.

b. Stimulating discussion on the recognition and use of Traditional Birth Attendants (TBAs).

c. Identifying major barriers to effective family planning service delivery by midwives in LDCs.

The midwives in the areas involved in the project so far have proven to be positive about family planning, eager to learn the required clinical techniques, and willing to begin integrating the services in MCH programs. The ICM, however, has been less successful in field follow-up with returned midwives.

Another finding is that the grant objectives seriously underestimated the bureaucratic obstacles in LDCs which prevent rapid implementation of both training curriculum changes and integration of FP services with other health services delivered by midwives. Legislative and policy restrictions concerning midwifery practice, lack of adequate training facilities, and the lack of priority by LDC governments in providing training and materials for family planning programs impede progress and dampen enthusiasm of both midwives and supporting physicians.

Another finding is that ICM's modest staff and current table of organization contribute to its administrative difficulties.

The ICM staff that devotes its efforts to this project consists of the director of ICM (part time), a part time field director, a full time professional coordinator, part time professional nurse-midwife administrator and three clerical staff.

It is modest by most standards and is highly personalized in the character of the Executive Secretary. The planned retirement of the Executive Secretary in December 1975 is a significant factor in the future planning of this project.

The A.I.D. grant provided for a separate staff to operate the project. The project staff is now headed by the Executive Secretary of ICM, who serves in a dual capacity. Prior to the A.I.D. grant, the ICM was essentially managed by the Executive Secretary who maintained the strength and prestige of the organization through her single minded devotion to the excellence of midwifery practice and professionalism. While this has been essential in holding the ICM together and in building the organizational prestige which enables ICM to be effective in its work with LDC governments, this method of operation is not appropriate for the project. In addition, the Executive Secretary has not fully appreciated the scope of the project activity and the need for an overall plan of action to meet specific project targets.

A major finding is the realization that ICM's principal strength appears to be its motivational capabilities and as such this project appears to lend itself well to coordination with several other A.I.D. projects that involve nurse-midwives. Substantial improvements in the administration of the project would be helpful and would not significantly increase the capabilities because of the basic nature of the organization. Even in the area of motivation the ICM is somewhat limited because once the interest in family planning and especially clinical training is raised the opportunities for obtaining the training are extremely limited. A.I.D. must be prepared to back up these motivational activities with training programs or the effort will be wasted.

Africa, for several reasons, has the greatest potential for developing midwife delivery services in FP. The professional nurse midwives are respected and have traditionally carried out all normal MCH services. The African medical establishment is increasingly accepting contraceptive delivery as a part of MCH and there has not been a problem of physician hostility found

in Asia and LA. As most African governments are now permitting family planning with the context of MCH, the climate should be very favorable for working through the midwives.

Plans are now being firmed up for a LA working party in January 1975. The status of midwives is confused in LA, and there is some doubt that midwives from the different countries in LA will be able to establish a cooperative climate necessary to begin exploring FP. There is also strong opposition from the LA medical establishment to expand the midwife's role. The ICM therefore, may have very limited influence in LA because of these problems. There are similar problems in Africa and Asia, although the political climate there is at least favorable to FP. The ICM is planning working parties in Asia in 1975.

While the LA working party will have to be carried out since it is now in the final planning stages, the Asian activities may be reconsidered at this time.

B. Recommendations

1. That A.I.D. and ICM determine ICM's future role within A.I.D.'s population policy framework. A.I.D. and ICM need to negotiate the means for strengthening ICM's contribution to A.I.D.'s total family planning training program for nurses, midwives and other medical personnel around the world.

2. That ICM project administration be stengthened, assuming the grant is continued for another period.

Specifically this includes:

a. The designation of and assignment of a new project director no later than July 1, 1975, to provide continuity in view of the prospects that the incumbent director is retiring in December, 1975.

b. In order to implement the provisions of the grant the new director should be a qualified nurse-midwife with an understanding of FP and with experience in LDCs. Priority should be given to locating an LDC nurse midwife with these qualifications. If at all possible the new director of the project should be from outside of ICM London staff and the British Central Midwives' Board.

c. ICM should be required to prepare plans that identify explicit activity targets and indicators of achievement of the purpose of the grant.

d. More efficient use needs to be made of personnel both in the London office and in the field. The London staff, which could be increased by one full time nurse midwife if the project were to operate at optimum level, should be more actively utilized in planning and organizing working parties to ensure smooth functioning and effective use of consultants. The London staff should also be available to travel and consult regularly with Regional Field Staff. The field personnel are not being used efficiently due to a lack of understanding of the objectives of follow-up visits and lack of direction from the London staff.

e. An effort should be made to enlist the collaborative support of international organizations such as WHO, PAHO, and IPPF. The participation of these agencies in the project is desirable realizing, however, their policies in certain countries may not always permit them to collaborate with ICM. ICM should assume leadership in planning and organizing activities under the A.I.D. grant.

f. An effective follow-up evaluation system is needed for ICM to monitor actions by returning working party participants. The present questionnaire used is more appropriate to national Ministries of Health. It is difficult for individual nurse-midwives to obtain the requested statistics or provide meaningful answers for the current questionnaire.

g. ICM should increase its utilization of the FIGO affiliation to strengthen relationships between the midwives and the medical profession in LDCs.

h. Since national midwifery associations are important in enabling midwives in a country to work together to improve training and practice standards and to integrate into the profession new responsibilities such as family planning, provision should be made in any future grant for developing explicit action plans for the organization of local midwifery associations or for strengthening existing ones. This includes helping the organizations, with the assistance and cooperation of the medical profession, develop realistic standards of practice and legislation.

i. That ICM prepare and publish a standardized policy for all categories of its personnel and to implement the policy.

3. That the ICM grant should be continued providing PHA/POP can successfully negotiate a new grant agreement that strengthens and rationalizes the tactical operations of ICM, but that will not adversely affect the ICM character.

4. That ICM tactical plans for the next two years focus on reinforcing its activities in some of the areas already explored in preference to initiating new working parties.

For example, the ICM should postpone its tentative plans to move into Asia in 1975. It should carry out the IA working party and follow-up, then concentrate on Africa, the Caribbean, and Central America to assist with needs as defined in the initial working parties. In Africa this would mean establishing closer working relationships with other contractors.

Due to the problems in LA and Asia, it is suggested that the ICM concentrate efforts in Africa where the chances of success are more promising. It should also be noted that the ICM will be having its triennial congress in 1975. A.I.D. should encourage the ICM to again stress FP in the program and to encourage Asian midwives attendance to the congress rather than African midwives. These contacts with Asians could be utilized for planning working parties in Asia in 1976.

IV. Program Goal

A. Statement of Goal

The program goal in the population area is the reduction of fertility rates in LDCs. Clearly we are interested in the long term impact this project will have in reducing fertility rates in countries in which ICM midwifery activities take place under the grant. The extent to which ICM affects fertility rates in the long term is difficult to assess at this time.

While reducing fertility rates appears as a reasonable goal over the long term, the nature of the grant with ICM requires a more circumscribed view for a near term goal. A reasonable interim goal for the project is perceived as follows:

Development of an adequate system, in developing countries, for delivery of information/education about population and family planning together with delivery of family planning services.

B. Findings

The project has not progressed as rapidly as it was envisioned at the outset, therefore, its impact on the achievement of the sub-goal is not significant at this time. The effects of the grant in this area are not expected to be readily measurable in the immediate future. Evidence to date indicates that while midwives generally understand the adverse effects of high fertility rates on the health and welfare of mothers and children and are willing to take actions that will ameliorate the situation, it will be many years before they will be permitted to enjoy the status and authority required to enable them to effectively influence family planning programs in developing countries.

V. Project Purpose

A. Statement of Purpose

To provide a common framework for midwives in as many countries receiving A.I.D. assistance as possible, to enable them to influence population/family planning policy, midwifery training curricula, legislation, the delivery of services and to provide information.

B. End of Project Conditions

1. Midwives associated with ICM working parties accept individual responsibility to promote family planning and seek opportunities to make family planning a part of their regular professional work.

Progress-to-Date

Evidence from questionnaires and field visits by ICM regional coordinators indicate that most midwives are unable to participate fully in implementing family planning action programs because of the absence of proper facilities in their working environment and the lack of encouragement by supervisory personnel. While midwives attend the eight day working parties and express their support for them, they obtain very little in the way of technical skills in the family planning area. The purpose of the working party is focused primarily at provoking thought among midwives to plan and carry out education, information and action programs.

Recommendation

That key supervisory and educational personnel involved in curriculum development and policy and program planning also be invited to attend working parties to broaden the base of persons who can contribute to FP information and education programs. While ICM does not hand pick delegates to its workshops, steps need to be taken to influence the calibre of person that attends these workshops.

2. Returning delegates from working parties are taking actions to implement the recommendations adopted by the working parties and whose capability is to provide the delivery of family planning services and information is recognized.

Progress-to-Date

Most of the actions of returning midwives center around the strengthening of indigenous midwifery organizations and ad hoc representation of views to Ministry of Health officials. None of the returning delegates have prepared action agendas either at the working parties or following the conferences for implementation, therefore, little in the way of action programs is evidenced by returning delegates.

Following are summaries of the five working parties held thus far:

a. Caribbean Working Party - Barbados

ICM conducted its fifth working party under the A.I.D. grant, in Barbados, May 17-24, 1974 for midwives and obstetricians from Caribbean countries and territories. Twenty-six delegates attended from Barbados, Belize, Grenda, Guyana, Haiti, Jamaica, and Trinidad and Tobago, as well as the territories of Antigua, Dominica, French Guiana, Montserrat, St. Kitts, St. Vincent and St. Lucia. Fifteen others--consultants, observers and ICM staff--attended the working party. IPPF provided funds to enable the delegates from the territories and Guyana to attend the meeting. All other country delegates were funded through the A.I.D. grant. See appendix A for list of delegates and observers.

The working party program focused on defining priorities for MCH/family planning services for the participating countries, and on defining the roles, functions, status and training of all categories of midwives in MCH/FP. The participants also gave extensive consideration to the need for identifying and training traditional birth attendants to take a larger role in MCH/FP. See appendix B for working party objectives and recommendations.

Seventeen of the twenty-six participants, representing nearly every country and territory attending the meeting, returned the ICM questionnaire concerning their efforts following the working party to convince their governments to implement

the working party recommendations. The ICM regional field director for the Caribbean also gathered information on these efforts during her follow-up work in Jamaica and Belize. Although only six weeks had elpased between the working party and the time the delegates replied to the ICM questionnaires, there is evidence that a majority of working party delegates have taken some action to influence their respective governments to accept and implement the recommendations.

(1) Jamaica

The obstetrician and midwives attending the working party from Jamaica met with the Minister of Health, the Principal Nursing Officer and other Ministry of Health officials to discuss the working party recommendations. The obstetirican delegate also discussed the working party recommendations with officials of the environmental control agency and National Family Planning Board. The midwife delegates to the working party discussed the working party recommendations with the midwifery training schools, with medical and maternity staff at Victoria Jubilee Hospital and with the senior medical officer and public health nurses of the Kingston area. Other actions include the adoption of the theme "Role of the Midwife in Population Dynamics" by the Jamaica Midwifery Association for its annual summer seminar in June 1974. Its program included reports of the working party and papers on population dynamics and midwives' responsibilities in population/family planning. Although family planning is already being integrated with midwifery training in Jamaica, the working party and follow-up discussions by the Jamaican participants are thought to have strengthened and speeded the integration.

(2) Guyana

The two midwives from Guyana participating in the working party have discussed the working party recommendations with the Minister of Health, medical officer, and obstetrician for MCH, and have sought their help in implementing the recommendations applicable to Guyana. They have also approached midwifery training schools to discuss an increase in family planning in the curriculum. One delegate reported holding a seminar for her staff on the working party. Both delegates are involved in family planning activities. Apparently as a result of the working party, one of the delegates now participates actively on the Committee for Responsible Parenthood, and works to motivate those already trained in family planning to disseminate their knowledge to their colleagues and to the community.

(3) Barbados

The working party recommendations have been forwarded to the Minister of Health. Both midwives who participated in the working party report that they are engaged in teaching family planning to midwives. Family planning is already included to a limited extent in the midwifery curriculum.

(4) Belize

The obstetrician participant reported working party recommendations to the chief medical officer, who in turn reported to the Minister of Health. As a result, the Minister agreed to include family life education in the basic midwifery training curriculum. The ICM regional field director visited Belize to assist with the curriculum revision program.

(5) Grenada

Working party participants from Grenada presented the working party report to the Minister of Health and other Ministry of Health officials. They are now awaiting cabinet approval for the report. The participants also distributed copies of the working party report to the medical and nurses' associations, MCH services, family planning association, and midwifery training schools in Grenada.

(6) Trinidad and Tobago

Working party participants have discussed the recommendations of the working party with the principal nursing officer and other Ministry of Health officials. They are soliciting the support of the medical and nurses' associations, MCH services, family planning association, and midwifery training schools, in implementing working party recommendations. The midwives attending the working party report that they encourage midwives and pupil midwives to be aware of family planning, are planning to include family planning in in-service programs for domiciliary midwives, and have included family planning in plans for basic midwifery training

(7) Haiti

One midwife delegate to the working party discussed the working party recommendations with the Director of the Family Hygene Division, University of Public Health and Population, and with the Family Planning Association.

(8) Territories

Midwives who attended the working party from St. Kitts, St. Lucia, St. Vincent, Dominica and Antigua also reported meeting with their Ministers of Health to obtain support in implementing working party recommendations. These participants also held a variety of other meetings--e.g., with the nurses' associations, midwifery training institutions, and family planning associations--to obtain support for implementing recommendations.

Findings

Reports from delegates to the Caribbean working party indicate that many have begun to fulfill the expected outcome of the project of influencing their governments to implement working party recommendations. Belize is an example where high Government official action may have been influenced directly by the midwife and obstetrician who attended the working party. Their efforts have resulted in government approval of plans to integrate family life education with midwifery training.

It appears likely that working party participants in other countries may begin to see evidence of success of their follow-up actions, particularly if they are assisted by the ICM regional field director. Only Jamaica has a midwifery association to support working party follow-up, although the working party itself stimulated a great deal of interest among other delegates to form associations in their respective countries.

b. Central American Working Party - Costa Rica

ICM conducted the Costa Rica working party September 13-21, 1973 for midwives and obstetricians from Central America and Panama. Seventeen delegates attended the meeting, as well as twenty other persons including observers, speakers and resource persons. See Appendix A for a list of participants and observers.

Group discussion and recommendations from the working party centered on definition, training and legislation for different categories of midwives. Family planning was considered a part of midwives' duties in MCH. Therefore, it did not receive a great deal of separate attention. The working party participants emphasized the importance of strengthening the number of midwives in the region and ensuring proper utlization of their skills. See Appendix B for working party objectives and recommendations.

Delegates from all countries included in this working party have reported actions they have taken to influence their own governments to implement working party recommendations. However, conclusions based on these reports are tentative as information about the work of all delegates is not complete. The regional field director had contacted about one half of the delegates, and only six of the 17 delegates completed the ICM questionnaire.

In general, the delegates' attempts to influence their own governments were limited largely to meeting with several leaders in government and Family Planning Organization officials, to acquaint them with the working party recommendations and to urge support for their implementation.

Delegates from all six countries appear to have focused their attention on MCH departments and nursing directors in ministries of health, and to national nurses' associations and training institutions. Delegates in Guatemala solicited the cooperation of both the midwifery and obstetric associations, and the Panama delegates contacted the national medical assocation. Delegates from El Salvador reported contacting the Minister of Public Health and Social Welfare.

In Costa Rica a group of nurse midwives including the working party delegates is planning to set up a committee to study the working party recommendations.

Participants from Nicaragua and Honduras reported that their actions show some progress in implementing the working-party recommendations. In Nicaragua the Minister of Health expressed support for the recommendation to conduct an MCH seminar to include elements of family planning, for nurses and national

health auxiliary personnel working in various health centers. In Honduras, the midwife participants' discussions with nursing authorities are reported to have led to a revision of the MCH program, beginning of a survey by the nursing division of the MOPH to identify nurse midwives in maternal and child care.

Although the working party participants from each country reported that midwives now work in and receive training in family planning, they did not indicate whether these activities are related to the ICM project. No further evidence has been received that the delegates from the other countries in this working party have yet succeeded in influencing their governments to implement recommendations from the working party.

Findings

Two aspects of midwifery in Central America and Panama--its generally weak and unifluential situation, and its opposition by doctors and nurses--have significantly hindered the working party participants' attempts to affect their governments. First, professional midwives and nurse-midwives are not numerous in most countries of this region. Basic midwifery training programs have been eliminated in every country except Costa Rica, although plans are underway in the other five countries to revive this training. Midwives in the region generally have low status, and the ICM regional field director mentioned that a primary reason for the participants' slowness in achieving results is that they are often not in positions of influence to enable them to promote the recommendations by themselves. No country in this region except Guatemala has a national midwifery association.

Second, doctors and nurses in this region generally oppose expansion of midwifery training and practice. Nurses in these countries are also a low status group, but often compete with midwives. With the exception of Costa Rica and Panama, doctors in the region are sufficiently influential to limit midwives in providing family planning information and services, even though this may be formally allowed by the governments.

These two important aspects of midwifery in this region were not considered in planning the grant and in formulating the end-of-project conditions, but must be taken into account in any evaluation of the achievements of this working party.

Recommendations

1. That follow-up work in this region include actions designed to influence medical professionals as well as government officials to accept and implement working party recommendations.

2. ICM, through the Joint Study Group--particularly the International Federation of Gynecology and Obstetrics (FIGO)--should assist the regional field director and the midwife delegates to gain the cooperation of the ministries of health and the national medical and obstetric associations. ICM and FIGO should also encourage obstetrician delegates to the working party to assist in country follow-up.

3. The regional field director should take an active role in assisting delegates to influence their governments.

c. Francophone West Africa Working Party - Yaounde

The Francophone working party was held in Yaounde, Cameroon, September 28-October 6, 1973. There were 33 participants from The Cameroons, Republic of the Congo, Gabon, Chad, CAR, Madagascar and Zaire. Participants included midwives and physicians. The working party was conducted in French. See Appendix A for a list of participants and observers.

The recommendations of the working party do not emphasize family planning but rather the need for more midwifery schools, and/or improved midwifery curricula, the need for national health policies and legislation for health as well as regulations for the practice of midwifery. Family planning, however, is mentioned as an essential subject in a comprehensive midwifery curriculum. See Appendix B for working party objectives and recommendations.

A report from an A.I.D. observer at the working party reveals that the official recommendations do not reflect the emphasis of FP in the workshop. The observer also noted a perceptibly positive attitude change at the end of the session toward FP which is not reflected in the report or recommendations.

Post working party questionnaires which have been received from participants reflect the FP emphasis and support the observer's comments. Five questionnaires (5 countries out of 7) were received. This is a very low return rate (5 participants out of 33). As of late July 1974 the Francophone Regional Field Director has made only one follow-up visit due largely to delays in the confirmation of her appointment. Further follow-up visits were planned for late 1974.

The questionnaire responses are as follows:

(1) Gabon

The Government of Gabon remains Pronatalist in its population policy making it difficult to even approach the subject at the ministerial level. The midwife participant believes that assistance from International organizations such as the ICM in educating government officials concerning desirable births will be helpful. The establishment of a private FP organization would be helpful if it were approved by the government. This midwife has had one seminar in Zaire but no clinical instruction. She is teaching postpartum mothers about FP methods that can be obtained from private doctors (pills), rhythm, coitus interuptus and douching.

(2) Madagascar

The MD participant has sent the recommendations of the working party to the Minister of Social Welfare, and has presented a report of the working party at a National Health Planning Seminar held in December, 1973. The MD in his own practice teaches the rhythm method.

(3) Republic of Central Africa

The midwife participant has sent a report with the recommendations to the Minister of Health and has contacted the director of the school where she serves as midwifery instructor. As of October, 1974, family planning will be included in the midwifery curriculum as 36 hours of theory.

(4) Zaire

The nurse participant has contacted the Minister of Health and given him the recommendations of the working party. The Minister was pleased and promised future implementation. As a nurse instructor in the "desirable births" center she is encouraging instructors of nurses to send students for training to the center. She has also utilized the monthly meeting of the Zaire Nurses Association to report on the working party. The Nurses' Association is requesting integration of FP training in basic curriculum.

(5) Cameroon

The physician participant responded that he has discussed FP with the MOH which is in favor of establishing the services as a part of MCH. This physician states that he inserts IUDs and prescribes contraceptives in his private practice. Midwifery students are not receiving FP training at present but the training is proposed for 1975. Several Cameroonian midwives have been sent to the U.S. for FP training in 1973-74.

Findings

The Cameroon West African working party emphasizes some of the problems encountered by midwives and physicians in introducing FP.

Five of the African countries represented rank high among the least developed and most strongly pronatalist in all of Africa. While the participants of the working party agreed that child spacing is a part of MCH and that midwives should receive training in FP, the degree to which these recommendations can be implemented is uncertain without governmental cooperation.

As experienced previously, changes in governmental attitudes can occur rapidly but almost certainly in the initial stages sanction for FP services would be permitted only in the context of MCH care. The participants of the working party recognize that without greater numbers of midwifery personnel, both auxiliary and professional, government sanction of FP would not help the rural women since there are neither health facilities or trained personnel in these areas.

The ICM was able to educate the participants in the need for FP as preventive health care and to stimulate some of the participants to approach their governments with the recommendations.

To date the only specific evidence of implementation of the recommendations comes from the CAR where the midwife participant has been granted permission to begin teaching FP to midwifery students in October, 1974.

d. East Africa Working Party - Kenya

The East African working party was held in Nairobi, Kenya, November 29,-December 8, 1973. Twenty-eight participants (midwives and physicians) from Kenya, Uganda, Zambia, Lesotho, Botswana, Tanzania, Ethiopia, Mauritius, and Swaziland attended plus observers. See Appendix A for list of participants and observers.

A report from an A.I.D. nurse midwife observer, who had attended the first working party in Accra, stated that the Kenya party was better organized and conducted than the West African Anglophone meeting in Accra. Family planning was discussed in almost every paper. The observer felt that this party met the objectives of the ICM Grant in its emphasis on family planning. See Appendix B for working party objectives and recommendations.

Twenty-eight participants completed evaluation forms at the end of the working party. All of the participants stated they believed the aims of the working party had been met. Twenty-two participants listed the sessions on the role of the traditional birth attendant(TBAs) as the most interesting and some stated they had not thought much about the TBAs previously but were now more aware of her role. One participant felt there was too much interference in discussion groups by ICM leaders, another felt background papers needed to be distributed and changes in program kept to a minimum. One major problem in the party was the lack of materials, which had been mailed but did not arrive in time.

The Kenyan Nurse-Midwifery Association (an ICM affiliate) held its annual meeting soon after the working party and "Family Planning as a Nurse-Midwifery Responsibility" was a major topic.

Questionnaires were mailed to working party participants after their return home to determine what actions had been taken to promote family planning. Seventeen questionnaires from eight countries were returned. Participants from Kenya, Lesotho, Tanzania, Ethiopia, Swaziland, Maruitius and Uganda reported that either through personal interview or letter, they had presented the recommendations to the Minister of Health. In Botswana the recommendations were given to the chief nursing officer and in Zambia to the MCH physician specialist.

Ethiopian and Ugandan participants expressed reservations that any action would be forthcoming from the MOH, although the others were optimistic that the recommendations would be acted on.

All of respondents were either involved in family planning clinical services or teaching family planning in nurse midwifery training programs.

Follow-up visits were made to Kenya, Tanzania, and Ethiopia by the East African Regional Field Director, and to Botswana, Swaziland, and Lesotho by the Field Director and the ICM professional coordinator. No visit is planned to Uganda due to the political situation. The Field Director visited Mauritius the week of July 22 and subsequently planned to visit Zambia.

Findings

Situations differ in each country but all share common problems of too few staff especially for rural areas and insufficient training facilities for both professional and auxiliary nurse midwives. Most of the countries are involved in extending rural health programs especially MCH services but resources are limited. The Director and Coordinator noted that in Botswana, Lesotho, and Swaziland there was no hard evidence

of any effect of the ICM working party. No one visited had received the report of the working party or the recommendations or at least remembered it. Information and literature on FP was requested but no direct assistance asked. In Ethiopia there was interest in FP services and the nurses and midwives are prepared to offer this assistance but progress is impeded by lack of government support. In Tanzania, the government gives support to FP but few nurse midwives are clinically trained and the FP Association has limited space for training.

Although Zambia has not had a follow-up visit, as a result of the working party a seminar was organized for 60 midwives, nurses, physicians and government officals to discuss improvement of health services, including family planning. At the request of the Zambian Health officials the Honorary President of the ICM was invited as key speaker for the seminar. Her participation was influential in developing seminar recommendations for the inclusion of FP in MCH.

e. Anglophone West Africa Working Party - Accra

The working party was held December 8-15, 1972 in Accra, Ghana. Sixteen participants from five countries and WHO attended. Also present were 9 observers from WHO, A.I.D., ICM and IPPF. In addition, 14 speakers attended the 8 day conference. See Appendix A for a list of participants and observers.

Working party recommendations included the integration of FP and MCH seminars, the training needs of traditional birth attendants, common standards for midwifery qualifications among several countries within a region, incentives for rural midwives and the need for increased numbers of midwives. See Appendix B for working party objectives and recommendations.

(1) Ghana

Three trained participants were assigned to conduct FP training at Korle Bu Maternity Hospital, however, the program was terminated by the government and the midwife tutors entered the private health services sector. The obstetrician delegate who is teaching at the medical school in Accra, provides lectures on FP to midwifery students.

Two midwife tutors were sent to the U.S. for training and a committee was formed to work out details for traditional birth attendants training. However, FP is being taught in the current midwifery training curriculum. Clinical contraception, however, is absent from the training except for the theory.

(2) Liberia

Midwifery school is closed at this time pending the outcome of a controversy as to the status of midwifery and FP training in the country. There is general agreement among midwives, however, that FP training is necessary. Another problem in Liberia is the absence of midwife tutor diplomates who are necessary to teach midwifery and FP courses.

There is no national family planning program at this time, however, the GOL has requested the U.S. for assistance in FP and purports to give this high priority. The midwifery association in Liberia is inactive at this time and has taken no specific actions to implement the recommendations of the working party as yet.

(3) Sierra Leone

The Ministry of Health wants to integrate FP and MCH services. GOSL does not have an explicit anti-natalist policy, but generally does not encourage FP activities. However, the working party report was shared with the Minister of Health.

There is an active Midwifery Association with the status of a Trade Union. The association has formed a subcommittee to press for the implementation of working party recommendations as reviewed and modified by the association.

While the MOH accepts the role of Midwives in teaching FP in midwifery school and in providing services, it refuses to provide explicit sanction to these activities. Very few midwives are currently engaged in teaching contraception methods in Sierra Leone.

(4) The Gambia

The ICM regional director has initiated action to organize a midwifery association in The Gambia. The question of integrating both midwives and nurses in one organization is temporarily holding up progress.

The MOH has no nusring or midwifery post although there are over 100 midwives in the country today. One midwife delegate now teaches FP in The Gambia School of Nursing and Midwifery as well as to a class of TBAs and to rural field workers for the family planning association. FP theroy is currently included in the midwifery training curriculum.

The working party report and recommendations were shared with the Chief Medical Officer, Medical and Health Department of the Ministry of Health and with personnel at the school of Nursing and Midwifery. While the MOH does not appear to fully understand the implications and importance of FP programs it nevertheless provides some encouragement to voluntary organizations by allowing them the use of health clinics and in releasing midwives for external training as scholarships become available. There are currently no midwives trained to insert IUDs in The Gambia.

(5) Nigeria

There is an active midwives association in Nigeria with a National Board, now separated from the National Nurses Board. Midwives from the private sector, church missions, teaching hospitals and Government are cooperating in joint programs.

The Western States of Ibadan and Benin City, Kaduna in the North, Benue and Port Harcourt in the East have FP programs integrated in the health service system to some degree. Kano, Sokoto (both in the North) and Maiduguri, Enugu and Calabu in the East have very little in the way of FP and few trained midwives.

The ICM Regional Director visited all of the states in Nigeria and culminated her visit with a press conference with the Media about Family Planning. The press asked why Africans needed to control their population. The Director emphasized the health needs of mothers and children and the need to space children.

Findings

The Regional Director completed her follow-up visits to the West African countries with dispatch and with enthusiasm. Unlike other regions, three of the countries visited had midwifery associations through which explicit actions can be taken to implement working party recommendations and one new Midwives' Association was being organized.

It appears this region has prospects of achieving success in implementing FP programs in teaching institutions. However, intensive follow-up visits are needed.

3. Midwifery organizations are active in support of sound population policies and family planning programs within the population policy of their governments.

Progress-to-Date

Most of the countries represented at the regional working parties do not have midwifery organizations. Some actions are currently underway to establish such organizations in some of the countries and to strengthen those in other countries. The ICM project activities--the ICM Congress, working parties and preliminary and follow-up visits--have encouraged midwives in many countries to begin organizing national midwifery associations and to apply for membership in ICM. It is not yet clear how many new associations will actually be formed and become ICM affiliates as a result of this project. See Appendix C for a list of affiliate ICM Midwifery Associations.

VI. Outputs

1. Arrange and conduct the 1972 International Conference of Midwives Congress in October 1972 in Washington, D.C., on "New Horizons in Midwifery" and prepare and distribute a report on the Congress.

Progress-to-Date

The ICM arranged and conducted the 16th Triennial Congress in October, 1972, in Washington, D.C. Under terms of the A.I.D. Grant, the ICM received funding of $103,650 ($83,650 from A.I.D. and $20,000 from HEW) for the Congress. This funding was to be used to support program efforts for the promotion of family planning in developing countries. These efforts included simultaneous translation, visual aids, and materials, speakers, consultants, clerical services, meetings, and the preparation of a report of the Congress to be published in three languages.

Recognizing that LDC nurse/midwives would not be able to attend in significant numbers because of the expense, A.I.D. provided a grant to The Pathfinder Fund to finance African midwives and PAHO was permitted to utilize A.I.D. funding for Caribbean and Latin American participation. The ICM received funding from UNDP to bring at least one midwife from each of 70 LDC's to the Congress. Development Associates, an A.I.D. Contractor working in Latin America, also funded some delegates.

In addition, A.I.D. released funds through contractors to provide training sessions in MCH and FP for LDC nurse/midwives. Three courses were offered prior to the Congress: A Francophone program for African nurses at Meharry Maternal Child Health and FP Research Center, Nashville, Tennessee; an Anglophone program for nurse/midwives from Asia and Africa at the Baltimore Planned Parenthood Training Center; and a Spanish language program at Johns Hopkins conducted by PAHO.

The Congress' Report provides details of the programs and other information relating to the organization of the Congress.

Through the combination of A.I.D. and UNDP funding 188 LDC midwives attended the Congress, and 121 received some MCH/FP training from A.I.D. sources before or after the Congress.

The mechanics and actual effort involved in brining these participants fell to A.I.D. (see report) and the contractors involved in the training. It is doubtful, however, that the cooperation from LDC ministries and USAID Missions and Embassies in many countries could have been obtained without the ICM Congress umbrella.

The Congress activity was probably most successful in attracting African and Latin American nurse/midwives. At the time of the Congress, FP was an extremely sensitive subject in most areas of Latin America and Africa and many of the participants would not have been permitted to come for the training had not the major purpose of the trip been the ICM Congress.

The Congress provided the first meaningful break through in Francophone Africa and at least two midwives attended from each country. As a result of the interest in FP as an MCH component

generated by the Congress, twenty Francophone midwives have been trained in a special US program in 1973-74, with a waiting list for additional courses.

The Congress also provided valuable contacts for LDC midwives with the ICM and has resulted in applications from local midwifery organizations to join the ICM.

Prior to the Congress a few LDC midwifery organizations were affiliated with the ICM but these were mainly located in former British Colonies. Interest in joining ICM requires that midwives first form a local association if none exists. The local organizations have stimulated professional interest in FP and Population matters.

The Congress also gave ICM the opportunity to meet LDC midwifery leaders and inform them of the working parties planned for the remainder of the grant. These contacts have been valuable in selecting participants and in planning the working parties.

In summary the Congress served to:

a. Introduce the concept of family planning as an integrated part of maternal child health care to LDC nurse/midwives.

b. Inform LDC nurse/midwives of current contraceptive methods.

c. Provide an acceptable means for introduction of FP to nurses and midwives from LDCs with pronatalist policies.

d. Stimulate interests of LDC nurse/midwives to obtain more training in FP and to begin integrating these services in MCH.

e. Educate AID/W personnel and officers in Missions abroad about the role of the nurse/midwife and her potential for the delivery of contraceptive services.

The awareness of the role of the nurse/midwife in FP by Mission officers was evidenced by larger numbers of nurse/midwives being sponsored for training by A.I.D. Missions. The Downstate and Meharry programs which had previously had difficulty filling N/M training slots began to receive larger numbers of applicants and by mid-1973 were training at optimum capacity with waiting lists.

The Congress Report New Horizons in Midwifery available in English, French, and Spanish is a collection of papers on the Congress by midwives and other MCH experts from both LDCs and Western countries.

While there are separate textbooks and publications on fragmented aspects of maternal child health care there are very few materials on the newly expanded comprehensive role of the nurse/midwife. The Congress report emphasizes the expanded role and as such will be a welcome addition to nurse/midwifery libraries. It should also serve as a source of information for allied professions in understanding the role and potential of the nurse/midwife both in the US and in LDCs.

2. The ICM arrange and conduct at least five regional working parties each consisting of representatives from eight or nine developing countries and/or neighborhood clusters. The working party participants analyze the needs, potentials, and necessary resources for midwives to participate actively in family planning services.

Progress-to-Date

ICM's organization of working parties conducted under the A.I.D. grant includes preliminary headquarters and field work, and arrangements for the administration and program substance for the working parties. ICM begins preparations by requesting approval for the working party from the ministry of health in the country in which it hopes to hold the meeting. In making these contacts, ICM stresses that the working parties will be sponsored by the Joint Study Groups of ICM and FIGO, rather than by ICM alone. ICM explains the working parties to other governments in terms of the Joint Study Group's aim and objectives, which differ in focus from, although they do not contradict, the purpose and outputs of the A.I.D. grant.

ICM stresses its close relationship with FIGO throughout all project activities when it will help to encourage the cooperation of ministries of health and the medical profession.

Following these initial contacts, the ICM field director travels to the country to secure an invitation from the government and to make preliminary arrangements for the meeting. The field director's principal duties during these visits are: (1) to explain the purpose and procedure of the working party, and secure a letter of approval and invitation from the minister of health; (2) to recruit a regional field director to organize the meeting; (3) to identify possible meeting sites and costs, and establish a local committee responsible for hospitality. ICM provided little direction and support to the regional field directors and other local representatives, in organizing the first three working parties, but provided much more assistance in the last two meetings.

ICM has relied heavily on assistance from PAHO in making these initial visits in Latin America, and seeks advice from WHO offices in planning project activities in other areas of the world. ICM believes that no project activities can succeed without the guidance and approval of PAHO-WHO. Although PAHO's advice has been generally useful, ICM's heavy reliance on PAHO-WHO has had several disadvantages. PAHO and WHO policies, particularly at the country level, sometimes vary from those of A.I.D. In following PAHO-WHO guidance, ICM may then follow policies that are at best not productive in terms of the A.I.D. grant. In addition, several key PAHO officials have questioned the need and appropriateness of ICM's reliance on their advice and assistance. The Ministeries of ealth have ultimate authority over country MCH/FP programs, and PAHO and WHO are advisors to those entities. Although it seems advisable for ICM to continue to coordinate project activities with other organizations, ICM, with FIGO's help as needed, appears to have sufficient status to arrange these visits independently.

ICM staff visits each country invited to the working parties, to meet with ministry of health officials to explain the purpose of the working party and follow-up, and to enlist their cooperation. For the first three working parties, the ICM field director conducted these visits with some assistance from other staff and consultants. Preliminary visits for the East African and Caribbean working parties were conducted by other project staff and consultants.

Among the important functions of these visits, besides eliciting government cooperation, are arranging for delegate selection, collecting information on the current status of midwifery and family planning in the country, considering how to arrange the working party program to meet the needs in each country, and contacting the national midwifery association and/or midwifery leaders. These tasks were included during staff visits for the last two working parties, although they were not usually covered during visits for the first three working parties.

The A.I.D. grant anticipated that, in conducting the working parties, ICM would arrange for adequate conference facilities, MCH/family planning materials for participants, and adequate staff to cover administrative detail and provide leadership for the meeting. Conference facilities for the five working parties have been generally adequate, although the Ghana and Cameroon working parties had some weaknesses in organization. No materials were provided at these two working parties, and very few at the working parties in Costa Rica and Kenya. ICM did provide a large and extremely useful collection of materials at the Caribbean working party, however a library of materials for future working parties has been established at ICM headquarters.

Adequacy of ICM's management and substantive leadership of the working parties has varied from one working party to another. According to the reports of A.I.D. observers, not enough ICM staff, including field staff, were present at the first three working parties to cope adequately with both administrative detail and leadership of the program. In Ghana and Cameroon, limited planning time and the difficulty of recruiting a regional field director prevented ICM from orienting the regional field directors adequately to their responsibilities at the working parties. At the working parties in Kenya and Barbados, work was divided unevenly among the staff so that some were overburdened while others had few responsibilities and did not contribute equally to running the working party. As a result of the inadequate number or organization of the staff, substantive leadership and focus of the working parties were often left to participants or observers from international organizations. As the ICM finance administrator suggested, it might be helpful for a conference organizer or administrator to be designated for each working party to take responsibility for all administrative detail, freeing other ICM staff to concentrate on the substance of the meeting. In any case, all project staff attending a working party should have clear responsibilities and assist fully in running the meeting.

ICM develops the program for each working party after a pattern used for every working party. Although such a pattern is useful in ensuring that working parties meet the grant objectives, ICM should continue to develop specific agendas for each working party that are appropriate to the situation and needs of midwives in the countries included in the meeting.

Few speakers, consultants, and resource persons have been invited to assist with the working parties thus far, although ICM has begun to ask speakers and consultants to the last few working parties.

Findings

ICM's supervision and support to regional field directors, particularly in organizing working parties, is generally weak and informal

Recommendations

That preliminary country visits by ICM staff include a substantive study of the entire range of activities necessary for the prepraration of working parties, and follow-up. ICM should consider developing a stematic approach to its organizational visits in which details of the working party session are developed and formally approved by country representatives as well as ICM central office.

3. Working party recommendations on licensing of midwives and revision of midwifery training to include family planning. The following is a summary of these recommendations by Party.

a. Barbados Working Party Recommended that:

(1) FP be included in curriculum content of all categories of midwives including TBAs.

(2) FP should be an integral part of all health services of Governments in Caribbean area.

(3) Midwives be included in planning and policy making at the highest levels of health and FP.

b. Costa Rica Working Party Recommended that:

(1) FP be a part of nurse/midwifery duties.

(2) Nursing, Midwifery, and Medical organizations establish updated regulations for obstetrical practice and work for legislation in these areas.

(3) All nurses or midwives be required to produce a diploma for registration to practice.

c. Yaounde Working Party Recommended that:

(1) National legislation to regulate and protect the practice of professional, auxiliary, and indigenous midwives be developed.

(2) Family Planning be included in the training of all professional midwives and in post graduate courses.

d. Kenya Working Party Recommended that:

(1) FP be included in family health programs.

(2) FP be taught in basic midwifery curriculum.

(3) Legal definitions of auxiliary and professional midwives be developed and utilized to determine levels of practice.

e. Accra Working Party Recommended that:

(1) FP be integrated into all MCH services and in basic curriculum for midwifery training.

(2) Refresher courses in family planning be given to practicing midwives of all levels.

(3) TBAs be identified, supervised, and trained in MCH/FP.

(4) Governments in the region support FP.

Findings

Recommendations regarding the inclusion of FP in training curricula were generally universal. However, the attention given to these matters varied considerably. Most working parties were concerned with the definition of the function and training for each category of midwife which included the regulation and licensing of practice.

Recommendation

Working party recommendations need to be explicit and reasonably actionable.

4. In cooperation with ICM, all working party participants to agree on a plan of action to make every effort to put into effect the recommendations made at local and national levels.

Progress-to-Date

The working party participants did not develop individual country plans at the conferences for sub-segment implementation. The working parties agreed on certain resolutions that were presumably appropriate for local and national consumption. Some of the delegates organized other midwives in their country and promulgated resolutions to improve midwifery training.

There is some evidence to indicate that local midwifery organization programs are changing midwifery training program curricula to include family planning as an integral part of the course of instruction. However, most reports of action are from responses to a mail questionnaire, therefore, specific actions are not clearly delineated.

Recommendation

ICM Field Staff needs to follow-up with all delegates and to prepare specific action agendas that are supported by local midwifery organizations and midwives. Subsequent country visits should deal with follow-up on the action agenda. Field staff reports should monitor progress in completing the action agenda.

5. ICM prepares and distributes reports of each working party to working party participants, ministries of health in the region, and other interested organizations and individuals.

Progress-to-Date

ICM has prepared and distributed approximately 200 copies of the report of the working party in Ghana, and approximately 500 copies each of the reports of the working parties in Kenya and The Cameroon. The reports were distributed, as required, to working party participants, ministries of health, WHO, IPPF, UNICEF, the International Pediatrics Association, and working party observers. A French version of the report of the Cameroon working party has not yet been completed. The report of the working party in Barbados is now being printed. The report of the Costa Rica working party is being prepared by ICM and will be translated and printed in Costa Rica.

Findings

The three working party papers prepared thus far have been received with interest. However in two cases the list of working party participants and observers and accounts of working party sessions have been incomplete and were late in publication.

Recommendations

ICM should employ professional editorial consultants, as provided in the grant, to prepare reports within 90 days after each working party, and to ensure that the reports are well-organized and complete.

6. Regional field directors arrange follow-up visits to each participating country to assist in implementing recommendations of the working party and to report on the progress of implementation.

Progress-to-Date

Regional field directors have not identified specific objectives for their visits nor have they planned work schedules for their site visits. Visits were scheduled randomly largely at the convenience of the field directors. There is also a diversity in the amount of travel that was done. The Central America Coordinator, for example, visited all of the countries represented at the Costa Rica Conference, the Caribbean director visited two countries (within a matter of six weeks after the Conference). The Francophone Africa representative visited only 1 country, the Anglophone East Africa representative visited all but one country and the Anglophone West Africa representative visited all of the countries.

The field visit reports are filed as required with ICM headquarters. Some of the reports were generally detailed and instructive while others were sketchy.

Findings

The lack of preplanned agendas for follow-up prohibits a systematic review of the results of working party recommendations. In many cases the reports reveal the difficulty that midwives encounter in obtaining favorable consideration of plans to include Family Planning in Midwifery training courses. Government officials are reluctant to make changes in training courses, particularly for subject matter that may be controversial.

This is not true for all the countries, but it is safe to say that this attitude prevails in the majority of the countries represented in working conferences thus far.

Recommendations

That all field visits by regional and ICM representatives be preplanned with specific objectives and that all subsequent visits follow-up specific agendas. Reports, therefore, need to be structures so that they provide progress data on planned actions for each country.

7. The ICM, through working parties, to encourage professional midwives, obstetricians and pediatricians, and through them, individual governments to identify traditional birth attendants and incorporate them in the MCH services including family planning. To encourage professional personnel to give training and supervision to traditional birth attendants in the interests of maternal and child health and to incorporate family planning motivation/services in the training of traditional birth attendants.

Progress-to-Date

The working parties in Costa Rica, Kenya and The Cameroon focused on the role of the traditional birth attendant (TBA) in family planning. There seems to be a general awareness of the role of TBAs, but according to working party reports, very little definitive action emerged in the way of recommendations.

A discussion of the role of the TBA in MCH and FP was included in the agenda of every working party except the one held in Costa Rica.

The discussions revealed that LDC physicians and professional midwives are reluctant to acknowledge the practice of TBAs and for the most part have not considered working with them. The ICM has encouraged the identification, training, and utilization of TBAs in MCH/FP programs through the working party discussions. The LDC professionals have been urged to consider TBAs as potential auxiliaries in MCH/FP programs. These discussions led to resolutions being formed in the working parties (Kenya, Yaounde, Accra, and Barbados) to identify, train, and utilize the TBA for the present until better trained personnel are available.

Findings

Because the patterns of TBA practice differ even within countries, identification and training must be done on a localized basis. In this situation, the ICM can only utilize the working parties to stimulate MCH professionals to recognize that although the TBA may not meet the desired qualifications for assistance in MCH services, she is now and for the immediate future the only source of obstetrical care most LDC women will have and realistically must be brought into health care systems. The deputy field directors can offer assistance to individual countries as a part of follow-up in beginning identification and training of TBAs.

8. The ICM to provide teaching materials, manuals and popular publications in the local language to the extent possible, to equip and assist midwives of all categories to promote family planning.

Progress-to-Date

Very little was done on this during the first 20 months of the grant. However, beginning in January 1974 a systematic effort began to collect and distribute literature on midwifery, and family planning to working party participants and others involved in the project.

VII. Inputs

ICM/USAID

Project Budget from 1 September 1973 to 31 August 1975

	Expended up to 31 August'73	Half Year to 28 Feb 1974	Half Year to 31 Aug 1974	Half Year to 28 Feb 1975	Half Year to 31 Aug 1975	Total Grant Requirement
SALARIES & FRINGE BENEFTS						
Project Manager		$ 6,875	$ 7,000	$ 7,300	$ 7,600	
Field Director		6,000	7,000	8,000	8,500	
Deputy Field Directors		8,000	15,000	24,000	30,000	
Administrative Assistant		3,600	3,800	4,000	4,200	
Financial Administrator		3,600	3,800	4,000	4,200	
Professional Co-ordinator		4,500	8,500	9,000	9,500	
Secretaries (3)		5,000	7,000	7,500	8,000	
Temporary Assistance (peak periods)		1,000	1,000	1,000	1,000	
Fringe Benefits		3,925	5,400	6,200	7,000	
Working Party Staff (Secretariat)		-	2,500	5,000	4,000	
	$71,480	$42,500	$61,000	$76,000	$84,000	$334,980
TRAVEL&PER DEIM						
Core Staff		$20,000	$22,000	$18,000	$15,000	
Working Party Participants		15,000	30,000	30,000	20,000	
Subject Matter Specialists		3,000	6,000	6,000	6,000	
Regional consultants		5,000	15,000	20,000	15,000	
	$24,906	$43,000	$73,000	$74,000	$56,000	$270,906
CONSULTANTS		4,000	10,000	15,000	15,000	44,000
EVALUATION STUDY				3,000	9,000	12,000

VII. Inputs (Cont.)

ICM/USAID

Project Budget from 1 September 1973 to 31 August 1975

	Expended up to 31 August'73	Half Year to 28 Feb 1974	Half Year to 31 Aug 1974	Half Year to 28 Feb 1975	Half Year to 31 Aug 1975	Total Grant Requirement
DIRECT COSTS						
Rent & Maintenance		$ 3,750	$ 3,750	$ 3,750	$ 3,750	
Office Supplies		2,200	2,200	2,200	2,200	
Telephones/Telegrams		2,000	2,000	2,000	2,000	
Postage		1,000	1,500	1,500	1,500	
Equipment		1,500	1,000	1,000	500	
Bond						
	22,734	10,450	10,450	10,450	9,950	64,034
WORKING PARTY COSTS						
Reports		2,000	2,000	2,000	4,000	
Editorial		2,000	2,000	3,000	5,000	
Translations		2,000	3,000	5,000	8,000	
Miscellaneous		1,000	2,000	2,000	3,000	
		7,000	7,000	12,000	20,000	46,000
PUBLICATIONS	200	2,000	8,000	12,000	10,000	32,000
H.E.W. Grant	12,887	4,113	6,000	6,000	11,000	40,000
USA CONGRESS (Incl. H.E.W. Grant)	103,650					103,650
TOTALS	$235,857	$113,063	$175,450	$208,450	$214,950	$947,770

APPENDIX A

LIST OF PARTICIPANTS

Appendix A

List of Participants

1. Anglophone West African Working Party -- Accra, Ghana, December 7-16, 1972

Representatives

Country	Midwives	Doctors
Gambia	Ms. A. Lusack Ms. O. Roberts	
Ghana	Ms. P. Acolatse Ms. L. Osei-Kofi	Dr. K. K. Korsah Dr. S. De Graft-Johnson (IPA)
Liberia	Ms. B. Barmadia Ms. I. Faulkner	Dr. D. Collins
Nigeria	Ms. R. O. Sosanya Ms. K. Delano	Dr. A. Akinkugbe
Sierra Leone	Ms. K. G. A. Betts Ms. E. Smith	Dr. Belmont Williams
WHO		Dr. R. H. O. Bannerman

Observers

Ms. Elizabeth Barton, WHO Regional Office, Brazzaville
Ms. E. Johnsen, USAID, Washington, D. C.
Ms. Marie Kirby, USAID Regional Office, Ghana
Dr. G. Roane, Director, USAID Regional Population Office, Ghana
Dr. R. T. Sai, IPPF, London
Ms. A. Kennedy, WHO Regional Office, Nigeria

Project Director: Ms. M. Bayes, ICM
Field Director: Mr. R. J. Fenney, ICM
Deputy Field Director: Ms. Comfort Akrofi, ICM

Speakers

Ms. P. Acolatse, Ghana
Dr. A. Akinkugbe, Nigeria
Dr. A. A. Ampofo, Medical Faculty, Korle Bu Medical School, Ghana
Dr. R. H. O. Bannerman, WHO
Ms. B. Barmadia, Liberia
Dr. Belmont Williams, Sierra Leone
Ms. K. G. A. Betts, Sierra Leone
Dr. D. S. Collins, Liberia
Ms. W. Ebans, USAID, Liberia
Dr. K. K. Korsah, Ghana
Dr. G. A. Reindorf, Medical Faculty, Korle Bu Medical School, Ghana
Ms. J. Samarasinghe, Senior Public Health Nurse Tutor, Ghana
Ms. R. O. Sosanya, Nigeria

2. Central American Working Party --
San Jose, Costa Rica, September 13-21, 1973

Representatives

Country	Midwives	Doctors
Panama	Ms. Marina Lopez de Ambula Ms. Margarita de Ortiz	
Nicaragua	Ms. Thelma Medina de Cortes Ms. Adela Saballos de Hernandez	Dr. Clemete Guido
Honduras	Ms. Beverly A. Taylor Ms. Norma Iris Fiallos de Gonzalez	
Guatemala	Ms. Bianca Lemus de Paniagua Ms. Maria Graciela Cruz	Dr. Carlos Enrique Rodas Dr. Otto Guillermo Retana
El Salvador	Ms. Ana Maria Alfaro de Sanchez Ms. Maria Luisa Martinez	Dr. Ramiro Martinez Perez
Costa Rica	Ms. Miriam Esquivel de Fernandez Ms. Vilma Curling de Anderson	Dr. Jose Joaquin Chavez Quesada

Observers

Dr. Jorge Luis de Leon R., Paediatric Resident, General Hospital, Guatemala
Dr. Jose Manuel Alvrado Obando, No. 1 Programmatic Region, Ministry of Public Health, San Jose
Ms. Ana Teresa Cruz Castro, Nurse-Midwife, No. 2 Programmatic Region, Ministry of Public Health, San Jose
Ms. Maria Cristina Garita V., Nurse-Midwife, No. 2 Programmatic Region Supervisor, Ministry of Public Health, San Jose
Ms. Luz Maria Rivas C., Nurse-Midwife, "Carlos Luis Valverde V" Hospital, General Director for Socio-Medical Welfare of San Ramon, Costa Rica
Ms. Anne Tinker, USAID, Washington, D. C.

Speakers

Dr. Enrique Napoleon Diaz, Paediatrician, Ministry of Public Health, Guatemala
Dr. Gloria Moreno de Lopez, Obstetrician, Santo Tomas Hospital, Panama
Ms. Hilda de Eastmond, Nurse-Midwife, University of Panama

Speakers (continued)

Dr. Manuel Villa Crespo, WHO/PAHO Representative, Ministry of Public Health, Costa Rica
Ms. Liliana Picado de Corrales, Instructor at the School of Nurses of Costa Rica
Dr. Armando Carrasco, Gynaecologist, Family Planning Programme Supervisor, Costa Rican National Health
Ms. Elisa Maria Barqueo de Alpizar, Nurse-Midwife, Nurse Advisor on Hospital Planning, Costa Rican National Health
Dr. Max Teran Torrens, Obstetrician-Gynecologist, Obstetric Service's Assistant, San Juan de Dios Hospital, San Jose.

Resource Personnel

Ms. Lucille Woodville, Nurse-Midwife, Vice Chairman FIGO/ICM Joint Study Group, Washington, D. C.
Ms. Mable Zapenas, Nurse-Midwife, WHO/PAHO Nurse and Obstetric Regional Advisor, Washington, D. C.
Mr. Roger J. Fenney, ICM/FIGO Joint Study Group, Director, England
Ms. Ligia Carranza R., Training Department Director, Ministry of Public Health, San Jose, Costa Rica, Interpreter
Ms. Haydee Gomez de Badilla, Supervisor, Mother and Child Nursing, Ministry of Public Health, San Jose, Costa Rica, Deputy Field Director
Lic. Damaris Visconti de Quesada, Legal Advisor, School of Nurses of Costa Rica

3. Francophone West African Working Party
Yaounde, Cameroon, September 28-October 6, 1973

Representatives

Country	Midwives	Doctors
Cameroon	Mme. A. Mimbang	Dr. P. C. Mafiamba
	Mme. J. Lobe	Dr. Nasah
	Mme. H. Jipguep	Dr. C. Ngango-Ottou
	Mme. C. Moyebe	Dr. S. Tonye
	Mme. J. Biya	
	Mr. E. Elle	
	Mme. S. Mpouli	
	Mme. M. Nike	
	Mme. D. Mouniom	
	Mme. S. Hoch	
	Mlle. A. M. Nicole Lekund	
	Sr. Evelyne	

Representatives (continued)

Country	Midwives	Doctors
Congo (Brazzaville)	Mme. Ebaka Mme. E. Manima	Dr. P. Mobengo
Gabon	Mme. J. Biyogho Mme. A. Oliveira	
Chad	Mme. A. Gossigar Mlle. F. Blondeau	Dr. W. N. Ngoidi
Central African Republic	Mme. B. Njiengui Mlle G. Diouf	Dr. V. M'Barindi
Madagascar	Mme. I. Gastel Mme. R. Ramiliarifara	Dr. Randrianalimanana
Zaire	Mlle. Kangala-Ngenje Mlle. Tshiebue Mutombo	Prof. Ngandu-Kabeya Dr. Mbiye Kamuma

Observers

Mr. Gustave Harcourt, France
International Planned Parenthood Federation, Kenya

Advisors and Consultants

Mr. R. I. Fenney, Field Director, ICM, England
Mme. Kone-Diaba, Regional Field Director, Dakar, Senegal
Mme. Pouvreau-Romilly, France
Mme. I. Stillmann, Carolina Population Center, University of North Carolina, Chapel Hill, N.C.
Mlle. E. Hilborn, AFR/OS, A.I.D., Washington, D. C.

4. East African Anglophone Working Party
Kenya - Nairobi, November 29-December 8, 1973

Representatives

Country	Midwives	Doctors
Botswana	Miss Marion Peter Mrs. Margaret Kobue Miss Claudette Baily	Dr. N. N. Mashalaba
Ethiopia	Mrs. Kassech Essaias Miss Mulunesh Waldeghiorghis Miss Sara L. Rush	Dr. Ghermai Berbe
Lesotho	Mrs. Rosalia Khuluse Miss J. N. Rankhethoa	Dr. J. L. Molapo
Mauritius	Miss Francine Auchet Mrs. Jaunky Raynooka	
Swaziland	Mrs. Abegail J. Dlamini Mrs. Elizabeth Mdiniso	
Tanzania	Mrs. Grace Mtawali Miss Monica B. Mwakatika Miss Salome Wendeline	Dr. David Lisasi
Kenya	Mrs. Lydia W. Cege Miss Louisa Ongaya	Mr. J. Mati Dr. S. Mathai Prof. N. O. Bwibo
Uganda	Miss Faith B. N. Lutu Mrs. Sellinah Kebbie Sewanyana	Prof. Frederick M. Bulwa
Zambia	Miss Namukolo Lishomwa Miss Rose M. Noahi	Dr. Machupe Mphahlele

Observers

Miss Evelyn Johnsen, Nurse Midwife Advisor, Office of International Health, Public Health Service
Mrs. Maria Kirby, USAID, Accra, Ghana
International Planned Parenthood Federation, Nairobi, Kenya
Family Health Advisor, WHO/Geneva
WHO Nursing and Midwifery Advisors, Cameroon

Advisors and Consultants

Miss Marjorie Bayes, Executive Secretary, ICM
Mr. Roger Fenney, Field Director, Central Midwives Board London, England
Mrs. Perpetua W. Kanyoko, Regional Field Director, IPPF, Nairobi
Dr. Keith Masters, Consultant to Working Party, England
Miss Kate Torig, ICM, London
E. Schenkel, Zurich, Switzerland
Dr. Abbas, Consultant
WHO Advisors - Ms. Elizabeth Barton
Mlle. Lise St. Hilaire
Mme. Ivenka Markovic
Mlle. Stanislava Stachura
Mme. Stephonaia Hoch

5. Caribbean Working Party
Barbadoes, May 16-24, 1974

Representatives

Country	Midwives	Doctors
Antigua	Mrs. Louise Pilgrim, S.R.N., S.C.M.	Dr. G. T. Cummins, M.B., Ch.B., F.R.C.O.G. F.A.C.O.G.
Barbados	Miss Elayne Scantlebury, S.R.N., S.C.M. Miss Carmen E. Blackman, S.R.N., S.C.M., B.T.A., R.S.I. Ward Admin. Lond., M.T.D.	
Belize	Mrs. Belle Lovell	Dr. Lionel A. Clare, M.B., B.S.
Dominica	Miss Virginia Austrie	
Grenada	Miss Marian Williams, SRN/SCN Certificate in Advanced Nursing Education (UWI) Mrs. Beverley D. St. Paul	Dr. Desmond Noel, M.R.C.O.G.
Guyana	Miss Byrnece R. Browne, SRN, SCM, MTD. Mrs. Enid Hall, RN. RM.	

Representatives (continued)

Country	Midwives	Doctors
Guyane Francoise		Dr. Claudine Francois-Endelmond, Obstetrician-Gynaecologist
Haiti	Mrs. Antoine Cesar Stenschke, RN, Midwife Mrs. Georgette Malebranche, Nurse-Midwife	Dr. N. R. Jean Cadet, Obstetrician-Gynaecologist
Jamaica	Mrs. G. Omphroy-Spencer, S.R.N., S.C.M. Mrs. Hazel Sinclair Registered Midwife	Dr./Mrs. A.Wynante Patterson, M.B.B.S., M.R.C.O.G., F.AC.O.G.
Montserrat	Mrs. Marjorie Joseph	
St. Kitts-Nevis	Mrs. Sylvia Garnette, S.R.N., S.C.M./F.P.	
St. Lucia	Miss Emelia Augustin, Staff Nurse/Midwife	
St. Vincent	Mrs. Lilius Lawrence, Nurse/Midwife	
Trinidad & Tobago	Miss Helen Christian, S.R.N., S.C.M., M.T.D. (Scot.)	Dr. Andrew Bhagwansingh M.B., M.R.C.O.G.

Observers

Barbados Local Committee Chairman, Mrs. Perletta Hinds, S.R.N., S.C.M.
Mrs. Anne H. Aarnes, PHA/POP, USAID, Washington
Miss Evelyn Johnsen, Nursing Midwifery Adviser, Office of International Health, Department of Health, Education and Welfare, Washington, D. C.
Dr. Willard Boynton, Deputy Director, PHA/POP, USAID, Washington, D. C.

Consultants and Advisors

Miss Anna Nowakowska, R.N., S.C.M., M.P.H., Family Planning International Assistance
Miss Grace Allman, Nurse-Midwife Advisor PAHO/WHO Barbados
Miss Mabel Zapenas, C.N.M., R.N., M.S.N.E., Regional Advisor in Nursing and Midwifery, PAHO
Miss Marjorie Bayes, M.B.E., S.R.N., S.C.M., Executive Secretary, ICM
Miss Barbara Patterson, S.R.N., S.C.M., P.B.N., H.V., ADM., MTD., Regional Field Director, ICM, Jamaica
Mr. Roger Fenney, C.B.E., Field Director FIGO/ICM Joint Study Group
Miss Kate Lorig, Professional Coordinator, ICM

APPENDIX B

WORKING PARTIES

Appendix B

1. Caribbean Working Party - Barbados, May 16-24, 1974

Recommendations

(a) The ideal Maternal and Child Health/Family Planning (MCH/FP) Program should start before pregnancy with family life education, in order to secure and inform target populations. This should help to avoid too early pregnancy and ensure adequate management whenever pregnancy does occur. The future mother would therefore be well nourished and would attend prenatal services early in pregnancy. The incidence and the complications of social diseases would also be reduced. Another result would be to encourage a responsible and co-operative attitude amongst the future fathers - thereby leading to responsible parenthood at all stages.

(b) The process of communication and education should go forward and rapport is therefore established. This may be supplemented by informative pamphlets which may have to be the main means of communication and education.

(c) The essential task of the obstetrician/midwife team is to ensure a safe delivery under optimum circumstances. The birth should be notified and registered in order to secure statistics and to guarantee a continuation of supervision.

(d) This is the optimum time to educate the patients and recruit them for family planning. Suitable arrangements should be made for follow-up. Appointments for routine postnatal care including family planning and a Papanicolau smear should be made. Arrangements should be made to follow-up defaulters.

(e) Curriculum content for training all categories of midwives for their expanded roles include family planning, child care and nutrition for Traditional Birth Attendants.

(f) Professional midwife - basic training should include the following to the basic curriculum if it is not already included, family planning, child care and nutrition.

(g) Post basic training of the Midwife in family planning, child care, nutrition and family life education.

(h) Since Traditional Birth Attendants already exist in some communities, it is recommended that they be identified, recruited and trained.

(i) Where necessary midwives should be prepared to teach and supervise Traditional Birth Attendants in all aspects of Maternal and Child Health.

(j) In the basic course midwives should be taught about the presence, purpose and usefulness of Traditional Birth Attendants and the role Traditional Birth Attendants play in communities where midwives do not exist. Traditional Birth Attendants should be brought in for discussions.

(k) Schools of midwifery should have adequate libraries and students taught how to use them.

(l) Research should be included as part of the midwives' expanding role.

(m) That all Governments in the Caribbean area should introduce family planning as an integral part of all health services. N.B. (one delegate from Belize voted against this recommendation.)

(n) That Governments should make sure that the program of immunization of children be completed before entrance to primary school.

(o) Governments should introduce the "co-operative" antenatal cards containing essential clinical information for each pregnant mother. These should be a type which could safely be carried by the mother herself.

(p) The professional advancement for midwives should be regularised in view of the fact that they will be acquiring expanded roles and functions.

(q) Personnel following specialized training should be allocated in such a way as to make use of their newly-acquired skills.

(r) Midwives should promote their profession by every means available especially through their organizations, mass media - e.g., radio, television, newspapers.

(s) Practicing midwives should be included in planning and policy making at the highest levels.

(t) That midwives should be invited to participate in all medical meetings dealing with Maternal and Child Health/Family Planning.

(v) Stimulation should be given to the organization of a professional body for midwives in each territory. These should be so constituted as to be able to seek recognition and affiliation with the International Confederation of Midwives.

(w) As soon as possible delegates should report on the Working Party deliberations and recommendations to:

a Their immediate staff

b Their Ministers of Health

c. Midwifery Tutors
d. Pupil Midwives
e. Staff Senior to themsleves
f. Local Midwifery and Nursing Associations and Councils

(x) Regular meetings of this nature should be held on a regional basis at intervals between one and two years.

(y) That the Regional Field Director of the Caribbean Working Party should visit the countries periodically to discuss the implementation of the recommendations with all members of the Health Team involved in Maternal and Child Health/Family Planning Services.

(z) The Regional Field Director should keep in close touch with all participants through correspondence.

(aa) A report should be sent by each country and territory advising the International Confederation of Midwives how they are progressing towards implementation of the recommendations.

(bb) The possibility of members of the Maternal and Child Health Team making inter-territorial visits should be explored.

(cc) Representatives of the Caribbean Working Party should attend Working Parties in other parts of the world and vice-versa.

(dd) At future Working Parties, field visits should be included in the program.

2. Central American Working Party - San Jose, Costa Rica September 13-21, 1973

Recommendations

The working party made up of Nurse-midwives, midwives and Doctors from Central America and Panama, aware of the Mother and Child Health problems in the area and of the aims fixed by the Ministers of Health of both Americas to be reached in the present ten years, is pleased to present to the Governments, Professional Associations and their International Bodies the recommendations issued from discussions of the different subjects. The members of the working party consider the recommendations most adequate to the present in our countries and judge that it would be appropriate to implement them.

(1) The Governments through their Ministries of Health and the Professional Associations to continue using the terms "Enfermera Obstetrica" or "Obstetrica".

(2) To accept the ICM definition of the Midwife or Nurse-Midwife with a short attachment, as follows: - "A Midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be officially registered to practice midwifery legally during the Mother and Child Care Cycle".

(3) The Governments, through their Ministries of Health and professional organizations to acknowledge the necessity to establish and keep the following categories of nurse-midwifery personnel involved in the Mother and Child Care team, and family welfare:

a) Nurse-midwife or Midwife
b) Professional Nurse
c) Auxiliary Midwife
d) Traditional Birth Attendant

(4) The countries using any other kind of nursing personnel such as Nursing Technician and others to determine a definite role for them within the services for Mother and Child Care and Family Planning.

(5) The Governments through their Ministries of Health and Professional Organizations to accept the following functions:

a) Nurse-midwife or Midwife: Integral direct assistance through the maternity cycle during pregnancy, childbirth, post-partum, childhood (0 to 14 years) adolescence and Family Planning including the continuous education of the family unit. Also the detection and referral to a doctor of pregnancies, childbirths and high risk children, assuring also the continuity of nursing care to all mothers and children. Other functions include: administration, supervision, education, research and leadership of programmes related to mother and child. (Reference: Conference on nursing-obstetrics education in Latin America. Nursing Report, No 14. Washington PAHO/WHO, 1969)

b) Professional Nurse: Direct assistance through maternity cycle, within the limits of her competence as nurse in accord with the legal definition and under the regulations for service. Other functions include: administration, supervision, education and research. (Reference: PAHO/WHO Experts Committee on training of Mother and Child nursing in Nursing Schools in Latin America. Scientific Publication No. 260. Washington PAHO/WHO 1973

c) Auxiliary Midwife: Direct care of mother and child within the limits of her competence as such in accord with the legal definition and under the regulations for service.

d) Traditional Birth Attendant: Direct care of mother and new born under her own responsibility within the limits stated in legislation and with the co-operation of the health services, under supervision of the mother and child care team. (Reference: Guide for orientation and supervision of Traditional Birth Attendants. Reports on Nursing No. 12. Washington PAHO/WHO, 1969

(6) The International Bodies ICM/FIGO to speak of "different levels of personnel working in Obstetrics" when referring to people working in the field of Obstetrics in Central American and Panama.

(7) The professional organizations and each member in particular and the institutions which employ them to recognize the internationally approved duties of each level in order to make better use of them according to the needs of the MCH care within the limits of the local regulations and the regulations of the institutions employing them:

a) The nurse-midwive and the Midwife - Their duties and degree of responsibility in the MCH services have more depth and scope than those of the general nurse, because she specializes in obstetrics which includes attendance at deliveries on her own responsibility in accordance with the legislation of the country and collaborating with doctors.

Direct Care: She takes responsibility - with medical advice - of the MCH care through the whole period of family life under normal conditions. This involves: the diagnosis of every physical, emotional, social and mental need of the mother and young child; the undertaking and use of a plan to meet these needs; the procurement of medical help in abnormal conditions of the maternity cycle and the application of urgent measures when needed. Planning: She initiates, develops and realizes plans which are under her province in the care of the patient and the educational programmes. Education: She promotes a natural approach to pregnancy and normal childbirth through health education of every group. She provides the right environment for a happy, personal maternity experience for both the mother and father. She also acts as a technical resource, giving advice on the implications attached to the establishment of realistic aims in the daily nurse-obstetric care. She takes part in the educational activities for health professional or allied students inside or outside the clinic unit. Organization: As a leader she is responsible for the continuity of the services provided to mother, child, family and community and takes the necessary measures to improve the nurse-midwifery integral assistance with the human and material resources available in the health team. Coordination: She communicates and works with other members of the health team providing them with guidelines on nurse-midwifery assistance to improve the mother and child care. Evaluation: She has a specific part in the evaluation of the nurse-midwifery care in order to determine those provinces in need of improvements. Administration: Her role is perhaps a key one in the implementation of the mother and child assistance in capacity of supervisor. In areas with shortage of professional personnel or under cultural pressures, the traditional birth attendant, the auxiliary midwife or even a member of the family provides care during childbirth. The supervision of this non-professional personnel is essential to reduce the possibilities of infection and accidents during the maternity cycle particularly during delivery. As an educator she has an important position in the teaching of the mother and child care through family life. She can do so in Nursing Schools, in programmes for training of Nurse-Midwives and Traditional Birth Attendants Reference: Conference on Nurse-Midwifery Education in Latin America. Cali, Colombia, November 3-12, 1969

Her specific duties are as follows:

Antenatal Care:

Evaluates the health and socio-economic situation.
Takes measurements of uterine height.
Makes vaginal and rectal examinations.
Determines the fetal heart rates.
Makes gyno-obstetric examinations and evaluates findings.
Makes obstetric diagnosis.
Gives information, including family planning, to the woman.
Prescribes some drugs according to establish regulations.
Makes the Papanicolau test.

Childbirth:

Supervises the uterine mechanics and progress of labor.
In normal cases: She also supervises the high risk mother.
Manages normal deliveries.
Makes and repairs episiotomies
Attends twin and breech delivery in low risk mother in doctor's absence.
Examines the cervix of the uterus.
Repairs first and second degree rupture of perineum.
Prescribes and administers analgesic, certain oxytocic drugs in the third stage of labor and certain anaesthetics according to the established regulations.
Evaluates the well being of the new-born.

Post-Partum:

Evaluates the health of the mother.
Makes post-partum examinations.
Gives health eudcation including lactation.
Prescribes drugs according to the regulations.

Family Planning:

Promotes responsible parenthood.
Evaluates the health conditions of the woman.
Prescribes and distributes oral contraceptives.
Places the IUD.
Makes the Papanicolau test.

3. Francophone West African Working Party
Yaounde, Cameroon, September 28-October 6, 1973

1. Host Country

The Francophone African Working Party held in Yaounde suggests:

a. That there be collaboration between the host country and the International Organizations present in the country, in order to ensure a better organization of the seminar.

b. That the programs arranged for a visit to health centers, maternity hospitals, MCH, etc., and a visit of cultural interest.

c. That the administrative formalities be made easier for the participants.

2. To the Participant Countries

a. The participating countries appoint their delegates early enough to allow for a better preparation of seminar material.

b. The seminar's recommendations must be communicated to the participants and to their Ministries of Health in order that these may be forwarded to the relevant departments.

3. Training of the Midwives

The Working Party participants in Yaounde recommend:

a. The establishment of professional and auxiliary midwives training schools in each of the countries represented.

b. That each country identifies its public health needs and determines the midwives's tasks in relation to these needs.

c. That a comprehensive professional midwifery training include: public health, nutrition, health education and family planning.

d. That a good practical training be provided by efficient senior staff and that reports be issued on individuals at the end of each training course.

e. The organization of educational exchanges between teachers and students from different African countries.

3. Training of Midwives (continued)

f. That a training program be established within schools and each country has the opportunity to refer to the training syllabus agreed at the Yaounde Working Party.

g. That the traditional birth attendant be allowed to gradually disappear due to the training of a sufficient number of professional and auxiliary midwives.

h. The establishment of national legislation for the protection of mother and child primarily, but also to regulate and protect the practice of the professional and auxiliary midwives and the traditional birth attendants.

i. That the promotion prospects of the professional and auxiliary midwives be revised for the level of each country.

j. That a professional internal seminar be arranged.

Objectives

In order to fulfill the Working Party AIM seven objectives were developed for the participants.

1. To exchange information on the present situation in relationship to Maternal and Child Health Services to include the practice and training of midwives of all categories.

2. To exchange information on the place of family planning in Maternal and Child Health Services and training and practices of personnel involved.

3. To determine what are the minimum needs of mothers and babies in maternal and child care including family planning.

4. To define the role of midwives of all categories in providing for these needs.

5. To consider the training necessary for midwives of all categories in providing for these needs.

6. To consider the necessary legislative framework.

7. To consider future actions to implement recommendations.

4. Anglophone East African Working Party--
Nairobi, Kenya, November 29-December 8, 1973

Recommendations

Future Action

1. That those countries who have not accepted family planning into family health service programmes, should include in the training programme of midwives/nurse-midwives.

2. That family planning services where existing should be incorporated into Maternal and Child Health services.

3. That comprehensive clinics be provided to deal with all aspects of maternal and child care simultaneously.

4. That as a short term solution to the existing problem of shortage of staff, training of basic maternal and child health assistants whould be encouraged.

5. That mothers' waiting houses should be provided near hospitals to aid all health personnel in referring high risk cases.

6. That the terminology concerning midwives be amended because both enrolled and registered are considered as professional midwives.

7. That countries should make the registration of births and deaths compulsory.

Regional Field Director

1. That Field Directors acquaint themselves with country needs and progress by regular correspondence and visits.

2. That a newsletter including progress reports be circulated to all countries.

3. That followup should be through the Ministries of Health in cooperation with the delegates who attended the Working Party.

Objectives

In order to fulfill the working party aim several objectives were developed for the participants:

1. To exchange information on the present situation in relationship to Maternal and Child Health Services to include the practice and training of midwives of all categories.

2. To exchange information on the place of family planning in Maternal and Child Health services and training and practices of personnel involved.

3. To determine what are the minimum needs of mothers and babies in maternal and child care including family planning.

4. To define the role of midwives of all categories in providing for these needs.

5. To consider the training necessary for midwives of all categories in providing for these needs.

6. To consider the necessary legislative framework.

7. To consider future actions to implement recommendations.

5. Anglophone West African Working Party--
Accra, Ghana, December 7-16, 1972

Recommendations

1. That family planning should be an integral part of MCH services and that it should be included in the syllabus for midwifery training of all categories including the Traditional Birth Attendant.

2. a. That immediate consideration should be given to the Traditional Birth Attendant, who still provides care for most births in the area.

   b. That a well designed study of the methods used by the TBAs, the strength and defects of such methods should be undertaken by a group including obstetricians, sociologists, midwives and health administrators.

3. That the midwife (including the TBA) in the West African context is an appropriate person to act as a motivator, educator and counsellor for family planning.

4. That there is need for flexibility of training programmes, to suit different circumstances of practice and the conditions in the part of the country where the trainee is to work.

5. That appropriate measures should be considered by health authorities for the services of private midwives to be fully utilized and for them to be regarded as part of the entire maternity service.

6. That it is desirable to consider common standards for midwives in neighboring countries to permit reciprocity in licensure and common practices.

7. That for efficient discharge of the duties of the midwife, in the interest of the public, accommodation, good communication and other social amenities should be provided for the midwives and some form of incentive worked out for the midwife in rural areas.

8. That consideration should be given to the feasibility of including education for family life in the general education system at all levels.

9. That there is an urgent need for a large increase in the number of training institutions for midwives and measures should be taken to effect this.

10. That it would be an advantage if family planning programmes were supported by Government in each country.

AIM and Objectives of the International Confederation of of Midwives (ICM) in cooperation with the International Federation of Gynaecology and Obstetrics (FIGO)

AIM: To continue the improvement of maternal and child care, and the quality of maternal and child life through the inclusion of family planning among the services provided by midwives of all categories in their expanding role.

Objectives:
1. To identify the present situation in each country.
2. To suggest practical improvements for the immediate future in each country.
3. To agree to intermediate and long term guidelines suitable to the particular groups of countries under survey.

Means of Obtaining Objectives

1. Discussion and exchange of information.
2. Research into existing demography.
3. A series of questionnaires submitted to individual countries, as follows:
   a. Are there training programmes controlled by public or professional bodies for appropriate grades
      i. Professional midwives
      ii. Auxiliary midwives
      iii. Traditional Birth Attendants?
   b. i. Who provides the maternity service at present, including support and care as well as delivery?
      ii. Who provides care of the infant during the first 28 days of life?
   c. Is there any public or professional control of these people (cf. b. supra)?
   d. Is there a family planning programme in existence?

e. Are the individuals who provide the maternity service at present, including support and care during delivery, all known or recorded by public or professional bodies?

f. If a family planning programme is in existence, are the individuals who operate the programme regularly all known and recorded by public or professional bodies?

g. If the answer to e. and f. is no, is some licensure envisaged to give the present practitioners some status and control over the entry of future practitioners?

APPENDIX C

MEMBER COUNTRIES

INTERNATIONAL CONFEDERATION OF MIDWIVES

MEMBER COUNTRIES

Executive Secretary: Miss Marjorie Bayes, to whom all communications should be addressed

Headquarters: Albany House,
47 Victoria Street
London SW1H 0EQ

Argentina (2)	S	Japan (2)	E
Australia	E	Kenya	E
Austria	E	Korea	E
Belgium	F	Liberia	E
Brazil	S	Luxembourg	F
Chile	S	Netherlands (2)	E
Czechoslovakia	E	New Zealand	E
Denmark	E	Nigeria	E
Ecuador	S	Norway	E
Finland	E	Peru	S
France (2)	F	Philippines	E
Germany (DBR)	E	Republic of China (Taiwan)	E
Ghana	E	Republic of Ireland	E
Greece	E	Sierra Leone	E
Guatemala	S	Spain	S
Hong Kong	E	Sweden	E
Iceland	E	Switzerland	F
Indonesia	E	Turkey	E
Iran	E	United Kingdom	E
Italy	F	United States of America	E
Jamaica	E	Uruguay	S

(2) Countries having TWO Associations, both of which are members of the ICM
E: English speaking countries F: French speaking countries
S: Spanish speaking countries

APPENDIX D

CURRICULUM VITAE

CURRICULUM VITAE

Name:	Marjorie Bayes, MBE, RSCN, SRN, SCM
Present Position:	Executive Secretary, International Confederation of Midwives (ICM) and Project Manager ICM/AID Projects
Education:	State Primary School
	High School for Girls - Educational Standard Reached - University Entrance
	Two years Specialized Sick Children's Training
	Four years General Nurse Training - University Teaching Hospital
	One year Midwifery Training
Experience:	Part time at Marie Stopes Family Planning Clinic
	Sister-in-charge of (a) 12 bedded Infant Ward and (b) 40 bedded Children's Ward - three years
	Sister-in-charge Gynaecological Ward-two years
	Administrative Sister - One and a half years
	Sister - Hospital Midwifery - one year
	Sister - District Midwifery - five years
	Assistant Secretary, Royal College of Midwives - ten years
	Deputy General Secretary, Royal College of Midwives and Part-time Executive Secretary ICM - Seventeen years
	Full-time Executive Secretary ICM - five years
	Since 1961, Secretary of the Joint Study Group of ICM and International Federation of Gynaecology and Obstetrics - Responsible for publication of "Maternity Care in the World: and all other reports.

Experience: (continued) Nursing Advisor to WHO since 1966

Member of WHO Expert Committee No. 331

Honorary Member of Royal College of of Midwives since 1969

Honorary Member of many overseas Midwifery Associations

Member of British Family Planning Association

President of Local Branch (Southend-on-Sea), Royal College of Midwives

Senior Member of the Midwives Chronicle Board

President of Essex and Counties Housing Association

Member of the Board of Scandinavian Homes

Honoured by Her Majesty the Queen with the Most Noble Order of Member of the British Empire

French Medical Honor for International Work

CURRICULUM VITAE

Name:	Florence Margaret Hardy, SRN, SCM, MTD, DN (London University)
Present Position:	Deputy Executive Secretary, ICM
Education:	Private School 3 years Elementary School 3 years High School 7 years General Certificate of Education with Matriculation Exemption, i.e., University Entrance in: English Language English Literature German Geography History Botany Physics Chemistry Zoology Mathematics Religious Knowledge Chelsea College of Science and Technology leading to first degree of Bachelor of Medicine General Nursing - Guy's Hospital London, 4 years Midwifery Training - General Lying-In Hospital and South London Hospital for Women, 1 year Midwife Teachers Diploma - Royal College of Midwives Diploma in Nursing - London University in Physiology Bacteriology Social and Preventive Medicine Social Psychology History of Nursing Obstetric Nursing Family Planning course - Family Planning Association, London Top-Line Management Course - Glacier Institute of Management

Experience:

Head Nurse - Guy's Hospital, London
- Obstetrics
- Ear Nose and Throat
- Surgery

Matron - Czech Refugee Hospital

Staff Midwife - Radcliffe Infirmary, Oxford

Midwifery Sister - General Lying-In Hospital, London

General Nursing Duties at Leigh Memorial Hospital, Norfolk, Virginia 1946-50 and 2½ years in charge of Obstetric Department

Education Officer, Royal College of Midwives, 14 years

Publications:

Practical Nurse (USA) - Assistant Nursing in the U.K.

Obstetric Nursing (Nursing Times 1962)

Antenatal Care

Management of Labour - Nursing Aspects

Subsequent Care of Mother and Baby

Co-Editor "Maternity Care in the World"

Appendix D

CURRICULUM VITAE

Name:	Kate R. Lorig
Date of Birth:	January 6, 1942
Present Position:	Professional Coordinator
Education:	1960-64 Boston University, Boston, Massachusetts - B.S. Nursing
	1967-68 University of California/San Francisco Medical Center - M.S.
	Fall 1964 Michigan State University, East Lansing, Michigan - Community Development, Latin American Studies, Spanish
	1967 University of California Extension - Statistics
	1968 University of California School of Public Health/Berkeley - Health Education
	1969 Ohlone Community College, Fremont, California - Spanish
	1970-73 Foothill Community College, Los Altos, California - French
	1972 University of California Extension/ Santa Cruz - Certificate (17 Q.U.) International Maternal and Child Health
Experience:	1964 & 1967 Charge Nurse St. Francis Hospital, Colorado Springs, Colorado Several months of each year were spent working on a medical-psychiatric unit.
	1964-1967 Peace Corps Volunteer Nurse working for the National Health Service of Chile as a public health nurse and clinical instructor for the Austral University in Valdivia, Chile.
	Summer 1967 Camp nurse for the Arizona-Cactus-Pine Girl Scout Council

Experience: (continued) 1968-1970 Training coordinator for the Alviso Family Health Center, Alviso, California. In charge of curriculum and training for dental assistants, clerical assistants and community health workers. Also clinical and Public Health practice. Working with community colleges to create health career ladders.

1969-1974 Instructor West Valley Community College, Campbell, California of Health Education, Sociology, and related subjects.

1970-1971 Instructor Department of Community Medicine, Stanford University School of Medicine

1971-1974 Community Development Specialist, University of California Extension/Santa Cruz. Responsible for curriculum development in human services, liaison work with community colleges, teaching courses on training, supervision and community development; educational development in the Model Cities area of San Jose; training community health workers in rural areas, supervision; management training for neighborhood health centers, Management Training for City and County clerks.

1973-1974 Program coordinator West Valley College - analysis of the community health worker role, designing CHW curriculum, training tools and setting up regional training centers in California community colleges.

1974-Present Professional Coordinator International Confederation of Midwives, London, England. Responsible for coordinating and followup of International Working Parties - conferences for midwives and obstetricians on Maternal and Child Health/Family Planning; coordinator of a worldwide MCH/FP literature and information distribution service.

License: Registered Nurse - California, Colorado Arizona
California Public Health Nurse Certificate
California Vocational Teaching Certificate

Professional Organizations:
American Nurses' Association
American Public Health Association
Northern California Public Health Assn.
Sigma Theta Tau - National Honor Society of nursing
Sigma Theta Rho-Tau Kappa Alpha - National forensics honor society

Languages: Read, write and speak English and Spanish
Presently studying French

Publications: "Consumer Controlled Nursing Service" Nursing Outlook September 1970

Comprehensive Health Services Career Development Technical Assistance Bulletin Vol. 1 3, December 1969

"Training New Careerists in a Service Setting" Nursing Administration. January 1972

Special Professional Interests:
Training/curriculum development for community health workers/National and International
Community participation in health planning
Alternative curriculum models for Nursing Education
Nursing and health education in developing nations
Supervision/management for health and other human service systems

CURRICULUM VITAE

Name: Harry Smith

Age: 40

Present Position: Financial Advisor

Nationality: British/English

Education: Wolstanton County Grammar School

Cambridge Certificates of Education in: Mathematics, English Language, English Literature, History, Geography, German

Postgraduate Studies:

Two year full time course leading to the passing of the final examinations of the Association of Certified and Corporate Accountants

Two year full time course leading to the passing of the final examinations of the Institute of Chartered Secretaries and Administrators

Two year full time course leading to the passing of the final examinations of the Institute of Cost and Management Accountants.

One year course leading to the passing of the final examinations of the Institute of Taxation

Six month course in Methods Study and Work Measurement at the Work Study School Shrivenham (non-examination course)

Qualifications held:

Member of the Association of Certified and Corporate Accountants. (Certified Accountant) (Holder of the Associations Public Practitioners' Certificate)

Associate of the Institute of Cost and Management Accountants

Associate of the Institute of Chartered Secretaries and Administrators

Associate of the British Institute of Management

Associate of the Institute of Taxation

Fellow of the Institute of Directors

Member of the Association of Lecturers in Accountancy

Current Appointments and Career Details - Concurrently since 1971:

a. Managing Director of Scandinavian Homes Ltd., Construction Company, turnover One Million Pounds.
b. Chairman of a "Data Processing Services" corporation.
c. Director of two Public Quoted Corporations.
d. On the Board of Directors of four other corporations.
e. Partner in one Public Accountancy Practice and sole practitioner in another.
f. Partner in a publishing company.
g. Author of three books: (1) A Taxation textbook (2) A Corporation Law textbook (3) A textbook on "The Law and Conduct of Meeting".
h. Appointed Financial Adviser to the ICM and to ICM/FIGO Joint Study Group in 1971.

Early Career Details

1951-1971 Ministry of Defence (Royal Army Pay Corps)

Locations: United Kingdom, Korea (UN), Japan, Hong Kong, Philippines, Borneo, Malaya, Singapore, Australia, Aden, Cyprus (UN), Libya, Holland, Germany, Italy, France

Appointments: Unit Paymaster; O.C. Offices Inspection Team
O&M Assignments Officer
Lecturer in Management, Economics, Office Management, and Statistics
Local Audits Officer;
Management Auditor and Financial Evaluator.

For the last five years before voluntary retirement on retired pay: - responsible for training senior officers in accountancy and administration. Also assigned to special evaluations, e.g., Royal Military Academy, Sandhurst, Military Prison Colchester, Military Hospitals at Aldershot and Colchester, and Civil Service organizations.

Appendix D

CURRICULUM VITAE

Name:	Kone Diabi Aissatou
Age:	Born 19 June 1937 in Dakar
Present Position:	Francophone Africa Regional Director
Nationality:	Senegalian
Religion:	Moslem
Marital Status:	Married
Education:	Primary School Dakar 1949 CEPE
	Secondary School - College Moderne de Jeune Filles 1953 BEPC
	Seconde, Lycee Van Valhenvoven of Dakar, 1953-54
	Admitted at the State Midwives School in 1956. Midwives School from 1956 to 1959 Laureate of the mixed Faculty of Medicine and Pharmacology of Dakar in June 1959
	Since 1969 Baccalaureat in Philosophy with mention A good
	June 1973, Certificate in African nutrition (optional)
	For the last four years, medical studies at the University
Experience:	From 1960 to 1963, Head Midwife at the Maternity Hospital in Donka, Conakry (Republic of Guinea)
	From 1963 to 1966 Head Midwife responsible to the Mother and Child Protection Centres in Conakry's peripheric suburbs (Coleah, then Colewoundi).
	Replacements at several private maternity hospitals and semi-private companies' departments in Dakar - 1967

Experience: (continued)	In 1968, agreed Midwife at the Municipal Medical Centre (Dispensary's P.M.I. No. 1) Dakar Since 1969, Midwife at the "Maternite du Repos Mandel"
Other Activities:	For the last few months, concluded a study on urral maternity hospitals in Senegal for UNICEF. Started a study on intra-uterine devices inside the family planning programme at the "Clinique Croix Bleue" in Dakar.

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CURRICULUM VITAE

Name:	Haydee Gomez De Badilla
Date of Birth:	6 July 1926
Present Position:	Central America Regional Director
Marital Status:	Married
Education:	Nurse-Midwife Degree 27 December 1947 Licensed by Medical School of the College of Doctors and Surgeons of Costa Rica Nursing in Public Health with special attention to Maternal and Infant Care. University of Syracuse, N. Y. - 1 year Course in Epidemiology for Nurses, 3 mos. Louisiana State University Course on Dynamics of Population and Family Planning, 2 weeks, University of Costa Rica Course on Sexual Education for Nurses, one month, University of Costa Rica
Experience:	Nurse at a Pediatric Doctor private consultation (one year) Nurse in a General Hospital in rural area with special dedication to assistance in deliveries (18 months) Supervisor Nurse in the Maternal and Infant Programme from 1950 until now. During this period of time have had permission from the Ministry to fill several different posts in the following institutions: WHO: Short term consultant, detached in Uruguay to give a course in Public Health and Obstetrics. Instructor of the Obstetrics Post-graduate course during its organization in 1954

Experience: (continued)	Chief Instructor of the same course from 1958 to 1961
Other Activities:	Participation to several working parties and National and International Congresses with subject: Maternal and Infant Care and Midwifery Nursing. Study trips about maternal and infant care.

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CURRICULUM VITAE

Name:	Perpetua Wanjiru Kanyoko
Age:	35 approximately
Present Position:	East African Regional Director
Nationality:	Kenyan
Marital Status:	Married
Education:	Elementary and two years secondary education
	General Nurse Training, West London Hospital (Medical School)
	Midwifery Training, Leeds Maternity Hospital and British Hospital for Mothers and Babies
Other Qualifications:	Diploma in Mothercraft taken at the Institute of Public Health, London
	Family Planning Training, 4 months at Downstate Medical Centre, New York
Experience:	Ward Sister, Maternity Hospital, Nairobi
	Following Family Planning Training appointed by Ministry of Health Nairobi organizing Family Planning Clinics
	18 months Senior Training Officer with IPPF Regional Office, Nairobi

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CURRICULUM VITAE

Name:	Amy Barbara Hyacinth Patterson
Date of Birth:	June 8, 1930
Present Position:	Caribbean Regional Director
Nationality:	Jamaican
Education:	Private preschool, Chapleton, Jamaica 1933-1935 Primary School, Sav-la-mar, Jamaica 1936-1941 Secondary Schools: The "Manse", Falmouth, 1941-43 St. Hughs High, Kingston, 1943-46 Kingston Technical School, 1946-49 (Home economics, Art, etc.) Durham Commercial College, Evening Classes 1947-48
Certificates:	Senior Cambridge: Grade I (English, English Literature, Maths, Physics, Geography, Spanish) Credit x 3; Distinction x 2; Pass x 2. Higher School Certificate: 5 subjects (Maths, Biology, English, English Literature, Spanish) Distinction x 3, Pass x 2. Royal Society of Arts: Manufactures and Commerce London. English Education Department Jamaica: Domestic Science subjects: Cookery, Laundry work, Housecraft, and Needlework. Commercial: Typing and Shortnand
Nursing:	State Registered Nurse: University Hospital and Kingston Public Hospital, Jamaica, May 2, 1949-July w4, 1952 State Certified Midwife: Central Midwives Board, England. December 31, 1955: No. 142545. Training Schools (a) St. Helier Hospital, Carshalton Surrey England - Part I; (b) Bristol Maternity on the Downs, Bristol - Part II.

Nursing (continued)

Midwife Teacher Diploma: Central Midwives Board, England, July 1959

Premature Baby Certificate: United Bristol Hospitals, Bristol Maternity Hospital, November 28, 1955-February 29, 1956

Courses Attended:

Triennium Congresses International Midwives

Advanced Nursing and Midwifery Education-Course 3/52 1972 U.H.W.I.

Top Level Management Couse - Part time Basis 10/9/73 -21/10/73, U.H.W.I.

Preschool and Basic School Regional Seminar Interdisciplinary, U.W.I. Campus November to December 1973 for 2/52

Experience:

Staff Nurse U.H.W.I. July 1952-54 Casualty Department, Jamaica

S/Midwife, United Kingdom: Bristol Maternity Hospital and St. Helier Hospital 1955-57

Ward Sister Maternity Unit: St. Helier Hospital 1957-59

Midwifery Educator, U.H.W.I. 1960, January-October 1972.

Principal Midwifery Educator, October 1972 to present time.

Professional Activities:

President of Jamaica Midwives Assn.
Member of Nursing Council for Jamaica
Member of Nursing Committee (U.H.W.I.)
Member of Inservice Education Programmes

Other Activities:

Member of Voluntary Organization for Under-priviledged Children West End Kingston

Church Activities co-ordinator.