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INTERNATIONAL CONFEDERATION
OF MIDWIVES



UNITED NATIONS CHILDREN'S FUND

WOMEN'S HEALTH AND THE MIDWIFE

A GLOBAL PERSPECTIVE

REPORT OF A
COLLABORATIVE PRE-CONGRESS WORKSHOP

The Hague, The Netherlands
21-22 August, 1987

INTERNATIONAL CONFEDERATION OF MIDWIVES
WORLD HEALTH ORGANIZATION
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1. INTRODUCTION

The arrival of a new child into the family is, for most, a time for joy and rejoicing. In recent years, an awareness has been growing that in developing countries, for too many, the event is far from joyful. The death of the mother turns the joy to grief and mourning, accompanied by untold misery for the bereaved father and the children left motherless. Every minute of every day one woman in some part of the world dies as a result of pregnancy, abortion or childbearing. The figure of 500,000 maternal deaths is only an estimate - the real figures are unknown.

Analysis of these figures on a global basis has shown unacceptable differences between the developing and the industrialized world. Many developing countries have a maternal mortality rate 200 times greater than those of the developed countries. This is the widest disparity in all public health statistics. Over the past decades smallpox has been finally eradicated, infant mortality reduced but maternal mortality has failed to hit the headlines and remains virtually unchanged. The time has come to take urgent action and Member States of WHO have been asked to put into action strategies for the reduction of this unacceptable figure by 50% in the next decade.

Midwives from all over the world were gathering for the 21st Congress of the International Confederation of Midwives in August in the Hague, the Netherlands. This was considered to be an opportune moment to appraise midwives of the global situation related to maternal mortality. A collaborative ICM/WHO/UNICEF pre-congress workshop was planned to take place to mobilize midwives in their unique position at the forefront of activities to reduce maternal mortality.

The uniqueness of the midwife's position stems from the fact that she chose to prepare herself to be "with women" at the most crucial event of her life. She accepted through education/training the responsibility of caring for women throughout their reproductive years and to concern herself with promotive and preventive health action in families and in communities. Safe motherhood, is therefore her only concern.

The pre-congress workshop which was held in the Leyenburg Hospital in the Hague during two days immediately prior to the 21st International Congress of Midwives in August 1987, assembled 44 participants from 29 countries representing in the main, those countries whose maternal mortality is highest. Miss M. Peters (Australia) Past President of ICM agreed to chair the workshop and Mrs A. Payne (Nigeria) and Miss R. Ashton (United Kingdom) agreed to be joint rapporteurs (Annex V and VI).

2. PURPOSE AND PROCESS OF THE WORKSHOP

2.1 The Purpose

The purpose of the workshop was to commit midwives to collective action and to ensure that every midwife globally is fully conversant with the dimensions of maternal mortality. The clinical causes are well known to midwives but the psycho-social and economic implications are less evident and rarely an element of a midwife's education.

2.2 The Process

The process of the workshop was first by dissemination of information. This was done in the form of displays, handouts, reading material and presentation of papers exploring different aspects of the problem.

Participants were then encouraged to reflect on this information in the light of their own personal and/or national experience prior to the identification of factors contributing to the present state of maternal mortality from the midwife's view point. This was achieved through small group "brainstorming" sessions. To further analyse

these problems and to develop a strategy for action, the workshop functioned in four specialized small groups. These were:

- 1 Midwifery Education: basic and post basic; and training traditional birth attendants. This group dealt with issues relating to changes in education of midwives and midwifery personnel that are deemed essential if they are to learn to function more effectively with individuals, families and communities.
- 2 Midwifery Functions and the Role of Service Providers at various levels: Group 2 critically analysed present roles and functions of midwives and others participating in the care of the mother. Changes necessary in the role and function of midwives to enable them to take positive action in their local work place to reduce maternal mortality were identified.
- 3 Administration and Management of Midwifery Services. Present administrative and managerial practices related to maternal care services were studied. Recognizing that practicing midwives cannot effectively function without full support, provision of adequate equipment and supplies, an effective referral system etc., the group identified problems and proposed changes that must be made in the administration and management of services if maternal mortality is to be reduced through the activities of midwifery personnel.
- 4 Midwifery Research: This group considered implications for research, that could be undertaken by midwives at different levels in the maternity care services. Research was considered from the operational point of view, vis-à-vis information collection, compilation, analysis and interpretation to justify changes in practice, the selection of priorities etc. which could have an implication for the reduction of maternal mortality.

ICM welcomed the opportunity to use the acquired skills and knowledge of the workshop participants to draft a "Call for Action" that could be presented first to their Council and later, when amended, to the whole Congress for their committed action. A small group was charged with this responsibility. The remaining group constructed recommendations for collaborative action among midwives and for national, international and interdisciplinary support that would be needed to stimulate concerted effort in the rapid reduction of maternal mortality.

2.3 Objectives of the Workshop

2.3.1 Overall Objectives

To propose a plan for midwifery action in order to promote maternal health and to reduce maternal mortality and morbidity by at least 50% by the year 2000, as a key element of primary health care.

2.3.2 Specific Objectives

- i. To identify problems related to maternal and child health and the provision of maternal care globally.
- ii. To identify the need for changes in:
 - midwifery education; basic, postbasic; and training of traditional birth attendants (TBAs)
 - the role and function of midwives at all levels
 - administration and management of midwifery services within the health care system

- midwifery research to facilitate the reduction of maternal health problems

iii. To recommend action that might be taken professionally, nationally and internationally to implement proposed change in maternal and child health.

3 PROBLEM IDENTIFICATION

3.1 Information Dissemination

For midwives to be able to support one another globally in action to reduce maternal mortality, they must all be well informed of the magnitude of the problem. This was done through:

- i) Dissemination of collected international documents on the subject including the visual and diagrammatic packets prepared for the Safe Motherhood Conference in Nairobi.
- ii) A display panel illustrating the enormous discrepancy between developing and developed countries related to the five major causes of maternal death. This also included the role of the TBA (or other auxiliaries as appropriate), the importance of family planning and the development of appropriate referral centres.
- iii) A computer programme illustrating the enormity of the problem by comparing it with the crash every four hours of every day of a jumbo jet loaded only with pregnant and puerperal women. The programme also reveals where and why these deaths take place and offers innovative suggestions based on primary health care principles for their solution.

3.2 Background papers

Three background papers were presented to sensitize participants to issues related to midwifery training and practice, to the importance of community perceptions and the potential impact of a well organized family planning service on the reduction of maternal mortality. These are abridged as follows:

3.2.1 Maternal Mortality and Morbidity - a Midwifery Challenge: Miss Joan Bentley

Since the start of the workshop an hour ago, 60 women have died as a result of childbearing. Approximately 500,000 such women die annually and unnecessarily. Ninety-nine percent of them die in developing countries where 85% of all births occur annually. Though this neglected catastrophe takes place in the third world, the developed world is not without complicity. Leaders of many health services and health training schools were trained in the developed world. Their patterns of training, of service delivery, of regulations and codes of practice have strongly influenced those in the third world to the detriment of the health of mothers and children.

The clinical causes of maternal death are similar globally, yet for the woman in the developing world the risk of death is 100-200 times greater. The women who die are rural or disadvantaged urban women; services for their care are either not available or too costly to use; they are too distant culturally from the carers, making it difficult to communicate and care is therefore unacceptable. Women are disadvantaged from birth by poor nutrition, little schooling, onerous work, early marriage, early and repeated childbearing - to produce children to provide the male with status and the family with a work-force.

The midwife could help to break this cycle and to respond to the needs of women during the reproductive years. Unfortunately she is mostly in hospitals, in towns,

where other colleagues are available and often providing care of a nature that could be delegated to other health workers. Relatively well educated and sophisticated, she is often out of touch with rural women and rarely willing to work amongst them. Having been trained in well equipped hospitals with readily available medical staff she is unable to function effectively in poorly equipped rural health units with little or no managerial or technical support.

Maternal mortality is a clinical problem with social, political, education and managerial facets. For midwives to have a major impact on maternal mortality implies that they must, by their education and training be able to function effectively in all these areas. It is imperative that midwives have skills in social and political awareness, in problem solving techniques at all levels, in communication and teaching as well as an ability to diagnose, initiate and evaluate emergency care of patients referred by community based health workers.

To reduce maternal mortality by 50% in the next decade requires improved training, deployment and service structures for midwives among the many strategies to be implemented to achieve the stated goal.

Different countries are trying different solutions based on national problems, national resources and socially acceptable and affordable strategies. They include the teaching of auxiliary maternal care personnel, including the TBA; the development of half way houses to ensure that the facilities for specialised care are more readily accessible to medium and high risk patients should they be needed; flying squads, to take expert and specialised care to a village based emergency.

More controversial approaches relate to the reorganization of training curricula based on national needs. This often means the reorganization and rationalization of midwife teacher training and the review of regulations to permit extended practice for all rural based midwives. The midwife appropriately trained to identify and quantify problems and bring her educated mind and skilled hands to the development and implementation of a rational solution involving self and others, could be the key to reducing maternal morbidity and mortality.

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By definition midwives are those trained to be "with women". As midwives, all are involved and implicated in the half million annual deaths. Associations of midwives nationally and internationally could do much as practitioners, as leaders, as lobbyists to make this tragedy more widely known: to stimulate changes in midwifery education, practice and services to give those women in greatest need, access to a fully qualified midwife capable of responding to her needs, mental, social, clinical and to find and use resources to reduce maternal deaths by 50% by the year 2000.

3.2.2 Women's Perceptions and Needs during the Reproductive Years: Dr Jane Mutambirwa

This paper presents the perceptions and views of women in the developing world since they form the main target group of women especially at risk in early, middle and later years of reproduction.

Many factors such as poor socio-economic status, lack of political will and oppressive conditioning of people, have contributed to the "silent carnage" of childbearing women in developing countries. From field experiences and studies one fundamental problem contributing to this anomaly stands out above all others. That is, most health professionals who teach and provide modern health care to third world people work among but not with the people they serve. They work apart because they are not taught to understand the people's traditional medical practices, customs, values and beliefs about health, health care and health problems.

The people to be mobilized for implementation of the new midwifery action, health information and education, are in most cases rural folk whose perceptions of illness, health, health care and health problems are based on local traditional concepts and minimally influenced by concepts of modern medicine.

In many communities or villages of developing countries, people rely on both modern and traditional health care systems for resolution of their health problems. However, the bulk of knowledge that influences their thinking and behaviour in matters relating to health, health problems and health care come from local or traditional information. The people learn effortlessly as they grow up.

The power to decide when and whether or not to seek help from a modern or traditional health system depends on how well modern health concepts and views are integrated into the people's thought processes. For example in some communities women with previous caesarean section scars who attend antenatal clinic will decide to be delivered by a folk practitioner whom they believe in or view as specialized in delivering women with complications. In order to identify gaps and establish acceptable areas for integration between modern and traditional knowledge and views of midwifery, it is necessary to understand third world women's perceptions of fertility and to study their cultures' views on the perpetuation of life. In some cultures children are valued for their role as the perpetuators of life and or the family name. Implicit in the word "family", in most societies, is the concept of offspring. In some cultures the individual is viewed as not fully mature, and in others as not spiritually or morally mature until their ability to reproduce has been proved. For a couple in these cultures therefore, fertility and procreation are regarded as the most vital and intergral parts of a marriage. Conception and childbearing become the ultimate need for admission into full adulthood.

In many cultures, having a baby is viewed as part of the natural experiences in normal growth and development. The first few months of pregnancy are expected to be relatively normal. It is therefore not common for rural pregnant women to consult the formal health care system during the first trimester of pregnancy. Most childbearing women in third world countries have little knowledge of what goes on during labour and delivery. It is the traditional midwife who has the greatest knowledge about pregnancy, labour and delivery. In many countries of the third world the formal health care system is viewed as specializing in the relief of acute physical illness by the use of scientifically prepared drugs, injections and operative interventions with which the traditional health care system has little or no experience. In a comparative study conducted by the author in 1982 on traditional and modern obstetrics, all of the traditional midwives interviewed reported that if an obstetric complication is initially perceived as a spiritual health problem the patient is often referred to a folk medical practitioner after treatment at a modern health care centre. A study conducted by the University of Zimbabwe's Department of Obstetrics in 1983 established that 65% of the country's deliveries were attended by traditional midwives or TBAs and 35% by the formal health care staff. These proportions are common to many developing countries. From the above figures it would appear that women in communities of the third world prefer to deliver at home rather than in hospital.

At independence in 1980, the Government of Zimbabwe through the Ministry of Health Policy adopted the WHO global concept of Primary Health Care. This meant that the community was to be involved in the management of its own health care, supervised by health care providers whose medical and para-medical education is based on Western views and perceptions of health and illnesses. To redress this anomaly, the Government has or is in the process of implementing a number of strategies. For example - to decentralize health care services to meet health needs as they are viewed and perceived by the communities, every province has embarked on the training of traditional midwives (or TBAs). This training is carried out by District, First Referral Centre and Rural Health

Centre staff who live and work with the people. The syllabus for such training is developed by identifying needs and gaps in modern health knowledge as seen by local residents and gathered from surveys of women's knowledge, perceptions and views locally. Medical, nursing and paramedical education is being reoriented. This permits attachment of medical, nursing and paramedical students to rural health centres at various stages of their education. It requires the addition of behavioural science education starting with early patient contact in the first year of medical school; and ensuring that the syllabus provides knowledge about the patient's perception and views on presenting health problems. This is accompanied by skills for building related knowledge of modern medicine upon what people already know, can understand, visualize and practice.

3.2.3 Women's Health, Desired Pregnancies and Child Spacing:
Mrs Leticia Lorenzetti

Though it has been recognised that grand multiparity, pregnancy in early adolescence, the close spacing of pregnancies and pregnancy over the age of 35 years constitute risk factors for mothers and infants, insufficient action has taken place to allow such women the choice of not becoming pregnant.

Risks include increase in maternal mortality for women in these categories which are exacerbated by the use of illegal abortion as the only means available to them to regulate their own fertility. The outcome in terms of maternal morbidity is more difficult to measure but is "so devastating for the personal, marital and social life of women that often they would have preferred to die".

These same factors also influence child health, in particular high infant mortality rates and numerous growth and nutritional problems.

Family planning and the active participation of midwives with families, could have a measureable impact on maternal and infant mortality if effectively organized and carried out.

Using data from the South American continent, fertility rates and maternal and infant mortality were discussed, comparing them with those of the developed world. Where fertility rates are highest (Bolivia, Brazil, Ecuador, Peru) the infant mortality rates are also high and the risk of children becoming ill or dying in the first year of life are as much as seven times greater than in industrialized world.

A marked difference in maternal mortality is noted between the temperate and tropical areas of South America with respectively 3.4 and 27.5 maternal deaths per 10,000 live births in comparison with approximately 1 per 10,000 in the developed world. Between one quarter and one third of all births occur to women in the high risk groups.

Statistics presented suggested that more than half the women in Latin America have no access to family planning information or services. Undesired pregnancies lead to illegal abortion, since no country in the Region has legalised abortions. Figures showed that between 10 and 50 per cent of all maternal deaths in the Region are as a result of illegal abortion. Even so, some governments in the region consider that fertility levels in their countries are too low and in these and some others there is no government support for family planning services.

Chile was the first Government in Latin America to include family planning in its maternal health programme. Since 1965 all Government health service units, using both doctors and midwives provide information and contraceptive services free to requesting women and couples. Health posts, staffed by auxiliaries provide information only but

are backed up by regularly visiting doctors and midwives who provide contraceptive services and through supervision ensure follow up. This provision of information and family planning services as a health activity and as postpartum follow up, has facilitated the initiation and use of contraception. Between 1964 and 1985 the percentage of women of fertile age groups using contraception, rose from 3.1% to 25%. This does not include women being attended privately. In the same period, birth rates fell from 36 to 21.5 per thousand with a noticeable drop in infant mortality from 102.9 to 19.5 per thousand live births. Hospitalization as a result of abortion also fell from 30% to 11%.

It was also shown that 96% of all births were attended by trained health staff. This in turn has meant a greater number of consultations between client and doctor or midwife. Thirty-seven per cent of all client/midwife consultations related to family planning.

Between 1976 and 1984 with the help of Government and Aid agencies, 300 doctors and midwives were trained in family planning education and methods. They have been used as the national "core" to teach others in their own country and to develop similar nuclei of trained personnel in other countries of the region.

In 1980 under the sponsorship of the Pathfinder Fund the Midwives' College of Chile met with directors of Schools of Midwifery in South America (Bolivia, Brazil, Ecuador, Paraguay, Peru, Uruguay) to help integrate the theoretical and practical aspects of family planning into all midwifery curricula.

This link between the Chilean Association for the Protection of the Family (APROFA), Government and professional groups and associations has shown how midwives can collaborate with others to make acceptable family planning services accessible to clients. The resulting reduction in maternal mortality from 283 to 50 per 100,000 live births shows what can be done by well prepared midwives working in collaboration with and supported by others.

3.3 Discussion

Having confronted participants with a barrage of information, discussion added national experiences about maternal mortality, the delivery of maternal care services and the preparation of midwifery personnel. It highlighted frustrations felt by midwives who recognized the need for change but were inappropriately prepared or placed to effect any of the real changes needed.

3.3.1 Issues related to Community level

Participants were aware that midwives needed much more contact with communities during training. Having to work with people, to appreciate their perceptions, views and needs could only be achieved in this learning environment.

Since few countries could afford to deploy fully qualified midwives in each community, their training and practice should in the future include identification, training, further education and support to those willing to be extension workers and acceptable to the women as care providers. This includes traditional birth attendants and those who had once received training but are now resident in communities and not using their skills.

It was recognized that only when such extension services had been improved could one expect to achieve early identification of high risk women in communities. Participants felt they were inadequately prepared to work with some high risk groups such as adolescents, socially and economically disadvantaged families etc.

In many countries, both developed and developing, the maternal health services have become increasingly hospital centred and high technology focussed. There was a growing awareness among all participants that in such situations sensitive care of a culturally acceptable and low cost nature geared to the needs of individual mothers was almost impossible to achieve. A service in which clients' needs, perceptions and understanding based on scientifically acceptable methods were the focus of care, and delivered at a site as close to the families as the mother's condition would allow was seen as more important than the convenience of health service providers and care practitioners. It was also considered likely that such a focus of care would encourage more women to use the services more readily and thus help in achieving safer motherhood.

3.3.2 First and Second Referral Level Issues

Participants felt that this is the crucial level for effective intervention by well prepared midwifery personnel. It was thought imperative that the midwife at this level must possess skills greater than those of community based workers and is equipped with facilities to enable her to initiate life saving care. On her would fall the responsibility for training, supervision and maintenance of standards of community maternal care providers. It was recognized that globally, not enough well prepared staff were available at this level and without incentives to encourage such placement it is unlikely that such positions will ever be adequately filled.

3.3.3 Tertiary Care Issues

Participants believed that while some learning experiences in such centres may have relevance for future practice, tertiary care centres are not in general appropriate places for basic midwifery education/training.

High technology care itself was thought to be not without risk, and inappropriate transfer of such technologies to developing countries distorts training, and may act as a barrier to women needing care at this level.

3.3.4 National Level Issues

Participants believed that weaknesses in policy making, in planning and management of education and services for maternal care was due in large part to the inadequate representation at this level of those who are specially trained to provide the majority of this care. They recognised that midwives, because they are few in number and spread wide, find collaborative action to provide a strong voice at national level, difficult to achieve. Participants had personal experiences of policies which conflict with real needs affecting maternal mortality (for example non recognition of the value and potential of traditional birth attendants: refusal to concede to pleas by midwives to allow them to expand their role particularly to cope with maternal emergencies in the absence of medical staff). It appeared to participants that they needed strong support from updated not outdated regulations including codes of practice, if they are to participate fully in the reduction of maternal mortality and morbidity.

3.3.5 Other issues

Participants expressed a growing concern at the inadequacy of their preparation to undertake simple or complex epidemiological studies and operational research essential to problem identification and solving at all levels of service. Such training would develop self critical abilities and promote evaluation of practice and services.

It was stated that many midwives were unused to and often ineffective in collaborative activities with other professionals inside and outside health services. Without further development of such skills including wider leadership skills, midwives may lose opportunities to maximise their influence on issues relating to maternal mortality and morbidity.

Finally, a significant barrier to achieving overall improvements in national mortality and morbidity in the context being discussed in the workshop was the lack of awareness of the problem which existed. Such lack of awareness should particularly be addressed in the developing countries. The particular way in which developed countries can offer/utilize their skills to improve outcomes of pregnancy globally should be addressed.

The workshop should consider not only the preparation of a plan of action, but also how associations and representatives can be assisted in formulating and implementing strategies for change.

4. IMPLICATIONS FOR CHANGE

Using the process of brainstorming, many problems were identified by the workshop participants, as being contributory to the present state of maternal mortality, viewed from the point of view of the midwife. Annex I shows how this list was used to identify the implications for change by each of the four groups (see page 2).

The interrelationship of listed problems was immediately recognised by all working groups. Solutions proposed therefore, covered more than one problem. Time constraints made it impossible to deal with each problem/solution separately. The outcome reflects priorities for action which when implemented could bring about the desired improvement in maternal care and the reduction of maternal mortality.

4.1 Educational change

The group considered basic and post basic education to prepare midwives to function effectively at all levels. Continuing education was also included in the discussion.

The term midwifery personnel has been used to ensure that all providers of maternal care services, whether the grandmother, the TBA, the auxiliary midwife, the MCH nurse, the midwife are all included.

4.1.1. The community must be involved in the development of strategies for its own health care. Care personnel must be aware of perceptions and needs as seen by the community. This can only be achieved if all midwives are exposed to communities and a considerable part of their education takes place there.

4.1.2. Midwives are in short supply. If their skills are to be used to best advantage to cover large populations, they must be

(i) adequately prepared to train, support and supervise other community based maternal care providers ensuring, as far as possible, coverage of the entire population.

(ii) able to effectively deal with all emergency maternal health situations being referred by community based health care providers.

It is therefore imperative that her training includes educational skills and additional technical skill and knowledge to deal with life saving midwifery action.

4.1.3 In view of the importance of the caring function in midwifery it is essential for midwifery training to prepare the students for fostering a relationship of mutual respect between care giver and recipient. In evaluating trainees, this capacity should be given greater importance.

- 4.1.4 In order that these radical changes can be implemented, midwife teachers themselves and those training them must be exposed to the realities of this extended midwifery function to enable them to construct realistic learning experiences and select appropriate places for this learning to take place. The form of qualifying examination should also reflect these innovations.
- 4.1.5 Since midwife teachers are also in short supply, the careful selection, preparation and use of well experienced peripherally based midwives as clinical teachers should be explored.
- 4.1.6 Additional resources will be required for these changes. A case must be made to present the issues to national governments for increased resources, supplemented by international, inter-professional and non-governmental help to prepare curricula and learning aids.

4.2 Changes in roles and functions of midwives

If the burning issues of maternal mortality and morbidity are to be seriously addressed, changes must take place in the present role and function of the midwife. It was appreciated that this would have major implications also for education/training and for administrative and management of services.

Traditionally, the midwife's training has reflected independent practice as a promoter of health, an identifier of high risk problems for referral, a practitioner of normal pre, intra and postnatal care. Increasingly in many countries her role has been in hospitals providing care where medical specialists are also available to deal with many of the problems for which earlier the midwife took responsibility.

Reduction of maternal mortality where it is most serious, can only be effected if the midwife is facilitated to be accountable for her own actions and assume the role of specialist when life-saving care is to be performed in the absence of any specialised medical staff. District and sub district levels are the most appropriate places for her to work in the developing world.

Changes seen as necessary are:

- 4.2.1 The midwife must have an educational role in preparing and supporting other personnel assigned to (or traditionally a part of) the maternal care system (eg nurses, auxiliary nurse/midwives, TBAs), helping communities in general and women's groups in particular to participate in the reduction of maternal mortality and defining and implementing local strategies to achieve this.
- 4.2.2 The five major causes of maternal mortality require immediate action locally if lives are to be saved. It is imperative that the midwife, situated closest to the problem be permitted and trained to undertake safely the following activities until the woman's condition is such that transfer to a secondary or tertiary care centre is safe or no longer necessary:
- manual removal of placenta/retained products
 - prescribe and use antibiotics to arrest or prevent infection
 - initiate and monitor:
 - replacement of fluid essential in the treatment of severe haemorrhage
 - intravenous administration of medicaments
 - sedate and monitor the woman with severe pre-eclampsia or eclampsia

- 4.2.3 One of the functions of every midwife must be to provide up to date factual information: to those for whose health she is responsible in order to generate community support and action; to those in authority over her and her practice area to obtain facilities and support in the setting of priorities and the solving of exposed problems as rapidly as possible.
- 4.2.4 The midwife's role in helping families to ensure that each child is a wanted child implies that her ability to function as a counsellor of family planning services is insufficient. She must also be able to prescribe, initiate and monitor contraceptive activities that have been selected by the family as most appropriate to its situation.
- 4.2.5 Where there is no doctor she must function as a reliable referral agent, selecting the appropriate place for care according to the severity of the condition with which she is dealing.

4.3 Administrative and Managerial Changes

Many of the problems identified relate to present weaknesses in administrative and management practices. The inadequacy of preparation of midwives at policy making level, was noted but emphasis was given to lack of any real support structure from top to bottom of the services.

- 4.3.1 The most important managerial and administrative change that needs to occur is in the attitudes of senior personnel. They need a much greater awareness of their responsibilities for finding and allocating resources to ensure that all workers at other levels can function effectively to reduce maternal mortality. This has implications for their education as well as for changes in their job description.
- 4.3.2 More midwives must be made more accessible to the women in greatest need and as problem solver to auxiliary personnel including TBAs. Changes therefore need to be made in:
- job descriptions, to rationally distribute all the tasks to be performed in preventive, promotive and curative maternal health commensurate with the training and experience of each worker.
 - incentive schemes to facilitate the deployment of midwives to areas where their skills are most needed. This would include appropriate living and working quarters.
- 4.3.3 Administrators and managers need to recognise more clearly AT EACH LEVEL their role in providing the support necessary in terms of equipment and supplies, to facilitate maternal care, and ensure a regular supply to meet the demands of the service. Decentralization is a useful strategy allowing maternal care providers at all levels to find and develop resources in addition to those centrally provided, to extend service to the fullest.
- 4.3.4 Managers need to recognise more clearly at all levels their responsibility for continuing education and maintenance of standards of practice for workers for whom they are responsible. More specific information systems to enable a variety of problems to be identified, would facilitate more realistic continuing education.

- 4.3.5 Administrators need to review laws, regulation and codes of practice relating to maternal care to ensure that the extending role and function of the midwife essential to the reduction of maternal mortality, is in no way restrained by outdated regulations.

4.4 Midwifery Research

The term research was much debated - some wanted to retain it, others to replace it by data collection, analysis, interpretation and use, making it applicable to each level of midwifery functioning as appropriate. It was recognised that education in simple studies and more formal research methodology was at present inadequate to the midwife's need.

Every midwife, at whatever level she practices has a need to collect, analyse and interpret data to enable her to convince others of the need for stronger joint action in problem solving. Operational research at community level, epidemiological studies at secondary and tertiary levels would enable limited resources to be channelled to areas where maternal mortality is greatest. It would also facilitate evaluation of services and the skills of service providers and ensure the planning and implementation of realistic corrective strategies.

5. RECOMMENDATIONS

1. To enhance the health of mothers and children and to promote knowledge about the current status of maternal morbidity and mortality, it is recommended that practising midwives be encouraged to meet in groups or in formal associations to explore, document and disseminate this information and in collaboration with others, develop national strategies for safe motherhood.
2. Since resources are limited, and it is unlikely that a midwife will be available to each community in the foreseeable future, it is recommended that all qualified midwives acquire skills to assist each community to be self sufficient in identifying its own high risk groups and help them to take action to ensure that high risk mothers are treated at the appropriate level of care, at the appropriate time.
3. To make midwifery skills available to every community, it is recommended that each midwife is made capable, through basic and continuing education, of training carefully selected community members to undertake the care of identified low risk women, in their own community.
4. It is strongly recommended that a midwife's education be expanded to include the knowledge, skills and attitudes necessary to enable her to function effectively to:
 - be sensitive and react to individual and community perceptions and needs;
 - promote an awareness of maternal health status;
 - prevent pregnancies too early, too close, too many and too late;
 - save life in emergency situations.
5. It is recommended that laws and regulations including codes of practice, be reviewed to ensure that midwives can be prepared to undertake emergency care that may be needed to save a mother's life and to provide legal protection for such action.

6. Since the above recommendations require an improvement in the quality and quantity of midwives, it is recommended that the training of midwife teachers be reviewed: national or regional centres be developed for this purpose and an exposure to community problems and research methodology, adaptable to each level of midwifery care be included in curricula which must include the development of leadership and managerial skills.
7. It is recommended that all midwives be assisted through basic, post basic and continuing education activities to undertake operational research relative to the needs of their own level of functioning. The only purpose of such research is to identify problems and implement proposed change to improve services to reduce maternal mortality and morbidity.
8. The holding of national, regional and interregional workshops to develop a core of midwives in each country capable of teaching research methodology appropriate to each level of maternal care services and to work in collaboration with other professionals and researchers to expose the extent of problems and implement strategies for change to reduce maternal mortality.
9. Groups other than midwives are also actively concerned in the reduction of maternal mortality. It is recommended that collaborative activities be promoted between national midwives, nurses, obstetricians/gynaecologists, paediatricians, etc., and internationally between interested organizations (eg. WHO, UNICEF, UNFPA) and non governmental organizations and professional associations (eg. FIGO, ICN, IPPF) in action to achieving this common goal.

6. CONCLUSION

Workshop participants were made acutely aware of the dimensions of maternal mortality and the efforts needed to bring about changes in the present status of maternal health globally.

Among the participants were members of national midwifery associations and members of ICM's executive committee. The recommendations of the workshop were taken and moulded into a "call for action" (later amended by Council to an Action Statement) to all midwives which was presented and adopted by the ICM's Council before being presented to the whole congress in a plenary session on the final day (Annex II).

It has been agreed that at the 22nd ICM congress to be held in Kobe, Japan in 1990, maternal mortality and morbidity would be more widely discussed and the impact of the "Action Statement" receive its first evaluation.

7. ACKNOWLEDGEMENTS

Thanks are expressed to the President of the ICM Congress Mrs N. F. Lugtenburg and the Secretary, Mrs C. Lems, for making the arrangements for the venue of the workshop. The management of the Leyenburg Hospital in The Hague are thanked for the free disposition of their excellent facilities. Mr C. J. C. Delissen and Mr C. Olij are especially thanked for their support throughout the workshop. Miss Joan Bentley, Mrs Jane Mutambirwa, Mrs Leticia Lorenzetti prepared papers and wrote the Pre-Congress Workshop report. Their contribution is gratefully acknowledged. Invaluable assistance was given by Miss Joan Bentley for the preparation of the final draft. Gratitude is accorded to the overall chairmanship of the workshop to Mrs Margaret Peters, and to the two rapporteurs of the plenary sessions, Miss Ruth Ashton and Mrs Lola Payne.

PROBLEMS BRAINSTORMED

PROBLEMS BRAINSTORMED	IMPLICATIONS FOR			
	Midwifery Education	Midwife's Roles and Functions	Administration and Management of Midwifery Services	Midwifery Research
Deployment of maternal care personnel	x	x	x	x
Status of women	x			x
Attitudes of health care providers	x		x	
Inadequate training for midwives	x	x		x
Female illiteracy	x			
Lack of technical support	x	x	x	
Poor basic supplies to do the job			x	x
Community perception and involvement	x	x		x
Need for continuing education for midwives	x		x	
Poor data collection and use	x			x
Limited research capability of midwives	x			
Transport needs to extend coverage			x	
Midwives rules and codes of practice			x	x
Outdated laws and regulations			x	
Difficulty of access to primary and secondary health services		x	x	
Increasing rates of obstetric interventions				x
Poor cooperation between health professionals			x	x
Limited available finances			x	
Birth customs may be dangerous	x			x
Harmful practices affecting health of women and girls	x			
Population coverage for care			x	

PROBLEM BRAINSTORMED	IMPLICATIONS FOR			
	Midwifery Education	Midwife's Roles and Functions	Administration and Management of Midwifery Services	Midwifery Research
Career development prospects			x	
No strategies to improve life and work conditions for rural health workers			x	
Overuse of technology				x
Midwives not influencing health plan so therefore inadequate provision for service	x		x	
Lack of confidence of young midwives in community settings	x	x	x	x
Community participation not perceived	x			x
Maldistribution of midwife resources			x	
Real needs not identified	x		x	x
No incentives for rural practice			x	

ANNEX II

ACTION STATEMENT BY THE INTERNATIONAL CONFEDERATION OF MIDWIVES

THE INTERNATIONAL CONFEDERATION OF MIDWIVES AT THE COUNCIL MEETING held on 25th August 1987, adopted the following recommendations from the joint ICM/WHO/UNICEF PRE-CONGRESS WORKSHOP, held in the The Hague on 21st - 22nd August 1987:

- that in countries, where there are none, midwifery associations should be formed, in order to enhance the health of mothers and babies, by sharing of information, the support of individual midwives, the analysis of the situation in their country and to develop appropriate strategies to achieve the goal of "Safe Motherhood"

- that ICM, WHO, UNICEF, in collaboration with and where possible FIGO, ICN, IPA, IWC, IPPF, WCC, CICR and others "in the team" hold joint regional workshops within the next triennium, in order to assist in achieving the goal of "Safe Motherhood"

- that the midwives of the developed countries express their full support for and solidarity with midwives in developing countries, where the maternal mortality and morbidity is greatest, in their efforts to achieve "Safe Motherhood" for the families of their nations.

THE INTERNATIONAL CONFEDERATION OF MIDWIVES AT THE COUNCIL MEETING held on 25th August 1987, adopted the following action statement arising from the joint ICM/WHO/UNICEF PRE-CONGRESS WORKSHOP, The Hague on 21st - 22nd August 1987:

recognising:

- that half a million women die from conditions associated with pregnancy and childbirth each year throughout the world and that for each of these deaths it is estimated, that another 10 to 15 women are handicapped in one way or another.
- that 99% of the deaths occur in developing countries.
- that 50% of the women who give birth in the developing world, do so unattended by a trained health worker.
- that material and human resources are limited and unlikely to improve dramatically in the near future.

believes:

- that the goal to reduce maternal mortality and morbidity by 50% by the year 2000 can only be realised by the strengthening of care and participation at the community level.
- that the midwife has the primary responsibility for developing and supervising this extension of the maternal and child services in collaboration with other sectors in achieving the goal of "Safe Motherhood" world-wide.
- that community education must form a part of the education/training and practice of midwives.
- that this goal can only be achieved by the adoption of the following strategies.

In education

- By 1990 students from all midwifery education/training programmes should have acquired the necessary skills to determine the communities perceptions on family planning, maternal and child health and the ability to develop strategies to respond to that community's educational needs.
- midwives must be committed to take the lead in identifying, training, supervising and supporting the required number of health care workers at that primary level, to ensure a minimum of 3 antenatal examinations for each pregnant woman.
- midwives with the appropriate support of international, governmental and nongovernmental organisations will develop educational materials appropriate for the various levels of training in maternal and child health according to the respective country's needs.
- Midwifery curricula should be adapted to train the various categories of midwifery personnel to the level required to improve maternal and child health including the evaluation of appropriate technology.
- midwives will collaborate with other professional groups in the setting of education/training objectives for primary health care workers.

- national professional associations and/or statutory bodies shall undertake continuing education programmes where they do not already exist, for all categories of maternal, child health and family planning workers.

In role and functions

- midwives will act as advocates in their countries to promote adolescent health, women's health, nutrition and family life education.
- the midwives' role will be expanded to include a service necessary to prevent pregnancies too early, too close, too many and too late.
- midwives will identify and appropriately refer women at risk of complications during pregnancy and childbirth in order to reduce maternal mortality and morbidity.
- in order to reduce maternal mortality and morbidity midwives must be educated/trained to carry out life-saving midwifery functions. For example:
 - administration of antibiotics for prolonged rupture of membranes
 - sedation in cases of severe pre-eclampsia and eclampsia
 - intravenous administration of drugs/medications
 - blood-loss replacement with appropriate fluids
 - manual removal of the placenta and evacuation of retained products of conception.

In administration and management of services

- midwife managers must be developed and all must equip themselves to identify priorities and propose budgetary allocations required to reduce maternal mortality and morbidity.
- national midwifery associations and/or statutory bodies should appraise critically their maternal and child health/family planning services and training needs. They should evaluate the national capacity for meeting the objectives of lowering mortality and morbidity.
- midwives in administration and management should appraise the human resources situation and the distribution thereof in order to make proposals for a more equitable coverage.

In research

- each midwife must be able to collect, analyse and interpret information at the level at which she/he functions.
- the basic study of epidemiology and statistics must be incorporated into educational programmes. Practising midwives should acquire such skills through workshops and other activities.
- the holding of workshops to equip midwives to learn about the methodology of operational research and to undertake research initiatives, in order to reduce maternal mortality and to improve maternal and child health services.

- midwives must be motivated by midwifery organisations and supported by ICM/FIGO, to develop interest in evaluating their own practice through seminars and workshops with the goal of raising their awareness of the issues concerning "Safe Motherhood"
- by 1988 all organizations should have arranged seminars
- by 1989 activities reported back to ICM headquarters in preparation for a pre-congress workshop in Japan 1990

The Hague, 26th August 1987

BACKGROUND DOCUMENTS

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Women's Perceptions and Needs during the Reproductive Years: Dr Jane Mutambirwa
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Herz B. and Measham A. R.; Safe Motherhood Initiative. Proposal for Action. World Bank, Washington, 1987.

A G E N D A

Friday, 21 August 1987

- | | |
|-----------------------|---|
| 08.30 hrs - 09.00 hrs | Registration of Participants |
| 09.00 hrs - 09.30 hrs | OPENING SESSION |
| | Chairman: Mrs N. Filippa Lugtenburg (President ICM) |
| | - Opening Address |
| | - Address by Dr Angèle Petros-Barvazian,
Director, Family Health, WHO/HQ |
| | - Address by Mrs Marjorie Newman-Black,
External Relations Officer, UNICEF, Geneva |
| | - Introduction of Participants |
| | - Objectives of the Workshop, Dr Barbara Kwast, MCH/HQ |
| | - Nomination of Chairman, Vice-Chairman and Rapporteurs |
| 09.30 hrs - 09.45 hrs | TEA BREAK |
| | PRESENTATION OF PAPERS |
| 09.45 hrs - 10.15 hrs | - Maternal Mortality and Morbidity - A Midwifery
Challenge, Miss Joan Bentley |
| 10.15 hrs - 10.45 hrs | - Women's Perceptions and Needs during the
Reproductive Years, Dr Jane Mutambirwa |
| 10.45 hrs - 11.15 hrs | - Women's Health, Desired Pregnancies and Child
Spacing, Mrs Leticia Lorenzetti |
| 11.15 hrs - 12.00 hrs | - Plenary meeting for further information to clarify
questions. |
| 12.00 hrs - 13.00 hrs | LUNCH |
| 13.00 hrs - 13.15 hrs | - Small groups (4) to identify needs and problems |
| 13.15 hrs - 13.45 hrs | - Plenary meeting to combine needs and problems |
| 13.45 hrs - 14.30 hrs | - Plenary meeting to group needs and problems into area
of education, policy formulation, management of
services, research. |
| 14.30 hrs - 15.00 hrs | TEA BREAK |
| 15.00 hrs - 17.00 hrs | SMALL WORKING GROUPS (4):
Action for change |

Saturday, 22 August 1987

08.30 hrs - 10.00 hrs	Working Groups
10.00 hrs - 10.30 hrs	TEA BREAK
10.30 hrs - 12.00 hrs	Reports of Working Groups 1 and 2
12.00 hrs - 13.00 hrs	LUNCH
13.00 hrs - 14.30 hrs	Reports of Working Groups 3 and 4
14.30 hrs - 15.30 hrs	- Drafting of Recommendations
15.30 hrs - 16.00 hrs	TEA BREAK
16.00 hrs - 17.30 hrs	- Drafting of final workshop recommendations to be reported to ICM Congress
17.30 hrs	CLOSURE OF WORKSHOP

ANNEX V

LIST OF GROUP MEMBERS INCLUDING RAPPORTEUR AND CHAIRMAN

Chairman of the Workshop: Mrs Margaret Peters
Rapporateurs of plenary sessions: Miss Ruth Ashton
Mrs A. O. Payne

WORKING GROUPS

GROUP I - Midwifery Education including TBAs

Dr J. Mutambirwa (facilitator)

Mrs N. Al-Hakimi		Yemen
Miss R. Ashton		United Kingdom
Mrs K.C.A. Betts	(Rapporateur)	Sierra Leone
Dr A. Bharadwaj		India
Mrs M. Newman-Black		UNICEF, Geneva
Mrs I. Acevedo		Chile
Mrs N.G. Munyenyembe		Malawi (2nd day only)
Mrs M. Ngui	(Group leader)	Sarawak
Mrs S. Martosewoyo		Indonesia
Dr A. Petros-Barvazian		WHO (Geneva)

GROUP II - Midwifery Functions and Roles

Dr B. Kwast (facilitator)

Miss M. Abela		Malta
Ms M. Barker	(Group leader)	Barbados
Ms R.A. Daw El-Beit		Sudan
Mrs E. Ismail		Egypt
Miss M. Brain		ICM (Wales)
Mrs Munakarmi		Nepal
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Ms L. Saxill	(Rapporateur)	Canada
Mrs A.N. Senyimba		Kenya

GROUP III - Administration and Management Midwifery Services

Mrs Lorenzetti (facilitator and group leader)

Mrs N.I. Abdalla		Sudan
Ms H. Owusu		Ghana
Mrs F. Dauphin		France
Mrs M. Goubran	(Rapporateur)	ICM Secretariat
Ms Z. Bendjelida		Algeria
Mrs N. Kabil		Egypt
Mr D. Kumar		India
Mrs A.O. Payne		Nigeria
Mrs Z. Pritchard		Burundi
Mrs H. Morrow		ICN Geneva

GROUP IV - Midwifery Research

Ms J. Bentley (facilitator)

Mrs M. Bennett		Pakistan
Miss K. Christiani		ICM Secretariat (Sweden)
Mrs R. Dugan		Ghana (2nd day only)
Ms S. Houd	(Rapporteur)	Denmark
Prof. C. Nohno	(Group leader)	Japan
Ms H. Mapondera		Zimbabwe
Prof. T. K. A. B. Eskes		Holland (FIGO)
Mrs E. S. Mbawa		Malawi (2nd day only)

ICM/WHO/UNICEF PRE-CONGRESS WORKSHOP ON
WOMEN'S HEALTH AND THE MIDWIFE - A GLOBAL PERSPECTIVE
THE HAGUE, THE NETHERLANDS, 21-22 AUGUST 1987

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