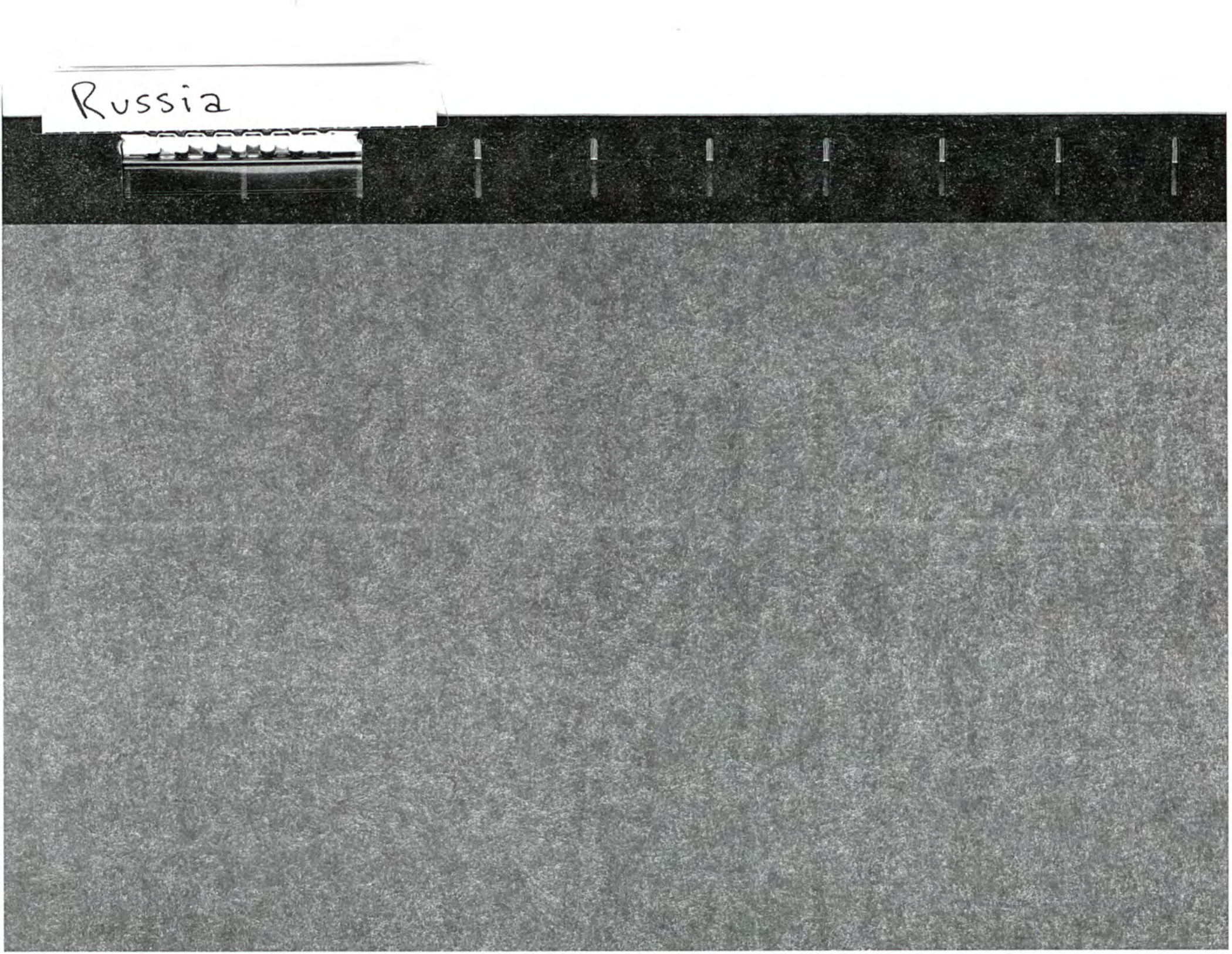
Russia

file Reinhard

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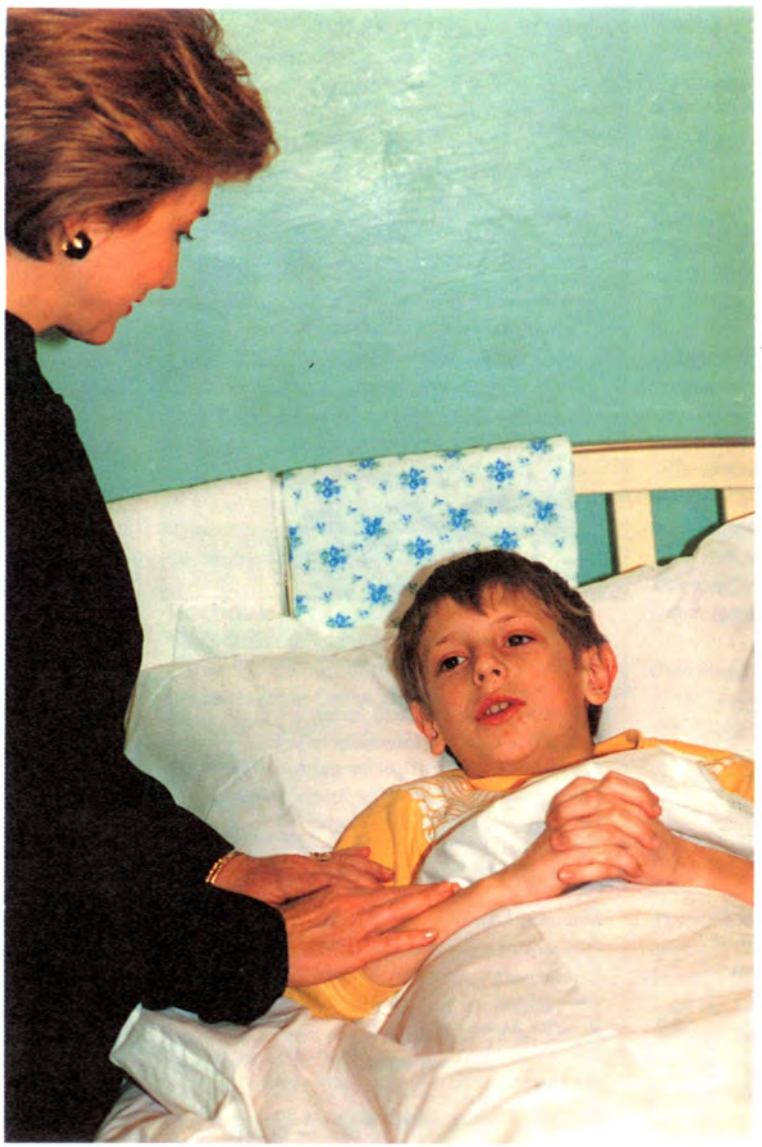
NEWSLETTER OF THE AMERICAN INTERNATIONAL HEALTH ALLIANCE ▪ VOLUME 2, No. 3



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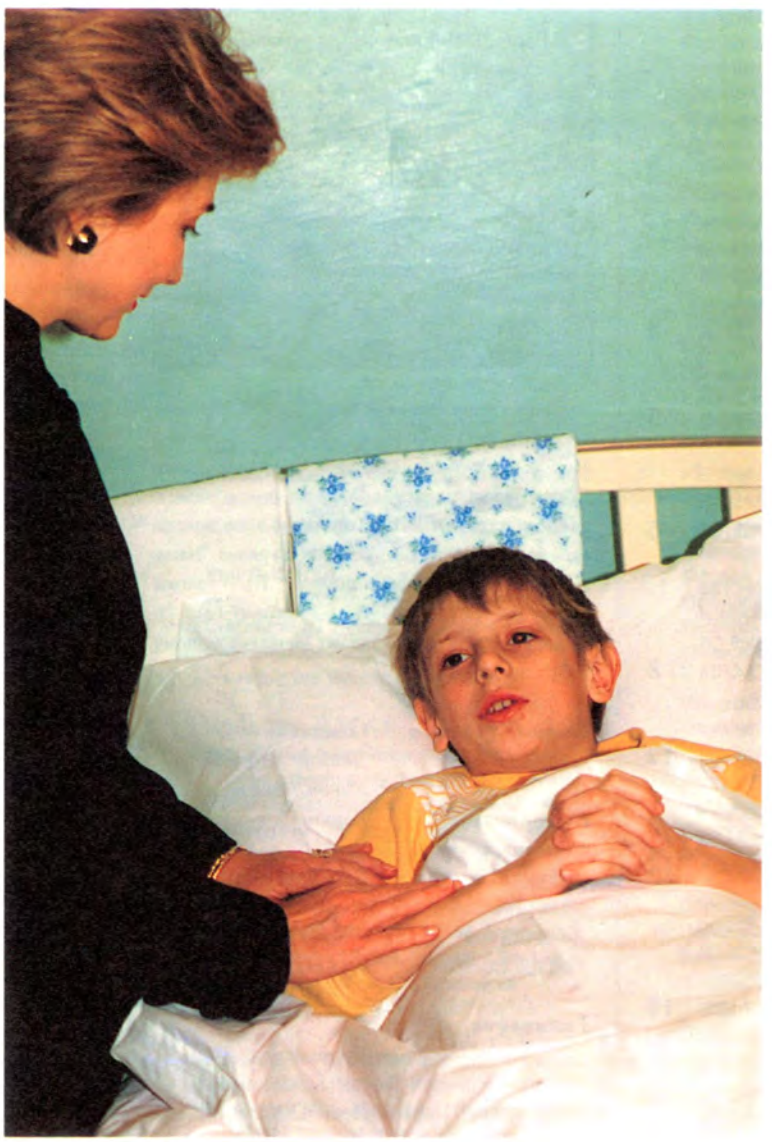
НашеЗдоровье
CommonHealth

БЮЛЛЕТЕНЬ АМЕРИКАНСКОГО МЕЖДУНАРОДНОГО СОЮЗА ЗДРАВООХРАНЕНИЯ

Том 2, № 3
ФЕВРАЛЬ -
МАРТ 1994



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NEWSLETTER OF THE AMERICAN INTERNATIONAL HEALTH ALLIANCE ▪ VOLUME 2, No. 6

AIHA ANNUAL PARTNERSHIP CONFERENCE ISSUE

St. Petersburg, Russia

file Russia

FILE COPY

HEALTH CARE ALLIANCE SEEKS US HEALTH CARE INSTITUTIONS FOR PARTNERSHIP PROGRAM IN CENTRAL AND EASTERN EUROPE

The American International Health Alliance (AIHA), in collaboration with the US Agency for International Development (USAID), has expanded their hospital partnership program to include the Central and Eastern European (CEE) countries of Albania, Croatia, and Estonia. AIHA is presently working with USAID representatives to identify specific sites and areas of primary focus for partnership activities in each of these three countries. AIHA has begun to solicit expressions of interest from qualified US hospitals willing to devote substantial in-kind resources, primarily in the form of human resources committed on a volunteer basis, to a three-year partnership with one of the selected CEE health care institutions.

Jim Smith, AIHA's Executive Director, anticipates that the new CEE partnerships will meet technical assistance needs similar to those addressed in the NIS: "AIHA partnerships have enabled American providers to work with their counterparts in the NIS to address significant mortality and morbidity issues, improve health care organization, and introduce market-oriented solutions to hospital and health system delivery and finance problems. We expect these new partnerships to have similar goals and enjoy equal success."

While the CEE partnerships will share certain goals, namely, improving medical and technological knowledge, enhancing institutional management and financing skills, and training health policy-makers to effect rational adaptations of health financing and delivery reforms, AIHA and USAID expect the focus of activities to vary with each country:

Albania: The extreme isolation of the past half-century has left Albania as the least-developed country in Europe. The Albania Ministry of Health has recently drafted ambitious

plans to reorganize health care, focusing on improvements in the management and financing of the system. Health services are provided through one large teaching hospital located in the capital city of Tirana, and 33 district hospitals and rural clinics. The hospital partnership is likely to focus on improving trauma and emergency medical services and women's health care. The ideal US partner hospital will have substantial experience in these areas as well as the ability to support institutional and systemwide improvements in health administration and management. Additionally, the US partner should have experience in organizing the delivery of health services for a largely rural population.

Croatia: The health care system in Croatia faces significant challenges.

- The conflict now in Bosnia-Herzegovina and earlier in Croatia has placed inordinate stress on the health care system as it must provide services for 600,000 refugees and displaced people.
- Croatia is facing health system delivery and finance problems as a result of the conflict, economic restructuring and reconstruction of many parts of the country.
- There is a lack of trained personnel and health systems capable of dealing with the varied trauma and psychological issues faced by people as a result of the war. A supportive social service and health care system is necessary to cope with long-term implications of victims of physical and mental trauma. These systems must also be adapted to reflect the new economic and political changes in Croatia.

In addition to being able to assist the Croatian partner in improving systemwide productivity, institutional management and financing, the ideal US partner for Croatia should have additional expertise in organizing services for the victims of trauma. At the recent signing of the Bosnia-Herzegovina - Croatian Peace Agreement in Washington, DC, President Tudjman of Croatia offered that "Determined support is critical to restore a decent standard of living...we look to the United States and the international community to assist us in these burdens so that the harsh conditions under which our citizens continue to suffer can be alleviated."

Estonia: The Estonian health care system offers moderate health care services compared to Western standards and is experiencing difficulties and deficiencies in many health service areas. Health care continues to be coordinated by the Ministry of Health, but an emphasis has been placed on decentralizing the rigid system inherited from the Soviet Union and upgrading it to meet Western standards. As local authorities do not yet have the experience or resources to replace central government support, it is anticipated that technical assistance provided through the partnership will contribute significantly to efforts to increase privatization and reorganize the health system in order to make it more self-reliant. The partnership with Estonia is expected to also contribute to the reform of nursing and general medical education and address clinical and organizational issues related to improving emergency medical and trauma services, an area where significant improvements in morbidity and mortality can be achieved.

Julia Terry, USAID Project Officer for the Central and Eastern European Medical Partnership Program, asserts that "We are delighted to be working with AIHA on new partnerships in Albania, Estonia and the former Yugoslavia. Not only are we convinced of the enormous benefits and possibilities of this type of assistance; we also know that AIHA will give us a greater capability to understand, measure, communicate and share the impact of the work being done through all of the partnership programs."

The hospital partnership program is unique in that AIHA/USAID is not the principal funding source for partnership activities, but rather supplements the voluntary and in-kind commitments of the hospital partners and their respective communities. These public-private partnerships have already resulted in a tremendous commitment from non-government sources, with over two dollars of voluntary support and donations for every US government grant dollar expended. AIHA funds will largely support travel and other essential costs which are not easily subject to in-kind contributions but are essential to establishing and realizing the full potential of a partnership program.

According to Donn Rubin, Program Director, CEE, in addition to meeting the specific country characteristics described above, US partners must also satisfy the following criteria:

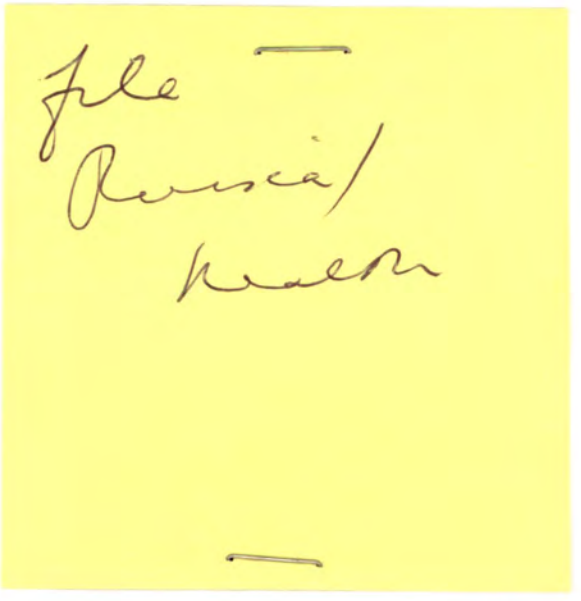
- Be institution-based -- *i.e.*, a hospital or group of hospitals (if a group of hospitals, a lead institution must be designated);
- Be supported by the institution's senior medical leadership and Board, actively involve the hospital's Chief Executive Officer and clearly identify an overall partnership coordinator;
- Actively involve the local community served by the US partner, including any significant emigre community that may be present;
- Adhere to AIHA's rigorous objective-setting and results-oriented approach and participate in semi-annual program evaluations to assess partnership progress and achievements; and
- Share information openly and participate fully in AIHA's efforts to exchange information with other US-CEE and US-NIS partnerships through the AIHA Partnership Clearinghouse.

Any hospital or other health care institution wishing to be considered for participation in the CEE partnership program should send a short statement (10-page maximum) detailing its interest and ability to enter into a collaborative agreement with a CEE partner hospital. (As AIHA will not be dispensing grants *per se*, a formal grant application is not necessary.) The statement should describe the institution's commitment to the program, the human and material resources it can devote to a partnership, and the specific clinical areas in which the institution excels and can emphasize in addressing the needs of the CEE partner. AIHA will select those institutions which best match the needs of the CEE partners, fulfill the criteria for participation in the partnership program, and offer the greatest potential for sustaining a partnership beyond the availability of AIHA funding.

Statements should be directed to:

Mr. Donn Rubin
Program Director for Central and Eastern Europe
American International Health Alliance
1212 New York Avenue, NW, Suite 750
Washington, DC 20005.

For additional information contact Mr. Rubin or Ms. Christina Patterson, Program Analyst, at (202) 789-1136; Fax (202) 789-1277.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PENN NURSING

THE FUTURE STARTS HERE

UNIVERSITY OF PENNSYLVANIA
School of Nursing

DO YOU KNOW?

- Penn Nursing is the #1 ranked graduate nursing program in the country according to a recent study by *U.S. News and World Report.*

- Penn Nursing's master's program, which graduates nurse practitioners, midwives, clinical specialists, and nurse administrators, is one of the largest in the world.

- Penn Nursing has led the nation's nursing schools in federally funded research—research that has a direct impact on patient care.

- Penn Nursing has the premiere nursing faculty in the country, with the largest number of fellows in the American Academy of Nursing of any nursing school in the nation.

- Penn Nursing is the only Ivy League school to offer baccalaureate, master's, and doctoral degrees in nursing.

Penn Nursing has led the way in defining and articulating nursing's role during a time of rapid change for the profession. As health care reform takes shape, nurses will play an even greater role in implementing a revised system of care. We intend to build on our proven strengths in education, practice, and research to make Penn Nursing the model school of nursing for the coming century. Penn Nurses will continue to provide the finest care—learning from their patients, as well as from nursing research, and advocating the role of nursing in the health care delivery system.

Our success depends on the support of our alumni, faculty, and friends. Currently, we are working to complete the School's most ambitious fund-raising campaign. Our goal is to ensure the continued excellence of Penn Nursing through growth in annual giving and investments in student financial aid, faculty enhancement, and bold initiatives in nursing practice and scholarship.

We must move forward together; the future starts here.

PENN NURSING

University of Pennsylvania
School of Nursing
420 Guardian Drive
Philadelphia, PA
19104-6096

215-898-4841
FAX:
215-573-2114

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Button

Listen to Women


LISTEN
TO
WOMEN

UNIVERSITY of PENNSYLVANIA

School of Nursing
Nursing Education Building
Philadelphia, PA 19104-6096

215-898-8281

May 5, 1995

Dear Mrs.Clinton,

We are delighted that you are visiting Kiev and the hospital that has been a part of the exchange with the University of Pennsylvania. The partnership with Kiev has been an excellant opportunity for nurse-midwives to exchange information,resources and our strong beliefs concerning women and infants' health (and the visions we have for change).

Enclosed is information about nurse-midwives that will help you understand our significant role in maternal child health in our country and internationally. We believe that all women deserve the right to have a voice in choosing their health care. The "LISTEN TO WOMEN" button, put forth by the American College of Nurse-Midwives, symbolizes our effort to empower the silent women of the world, to have voices. The poem given to you in India, "Silence" by Anasuya Segupta, reinforces our belief that women must be heard.

We commend you on your continuing vision and efforts to reform our health care system, especially for mothers and children!

Sincerely,

Vivian Lowenstein, CNM,CRNP,MSN
and the faculty of the
Nurse-Midwifery Graduate Program
School of Nursing
University of Pennsylvania

The curriculum is designed in self-contained units of instruction (modules) that promote self-directed learning, provide flexibility in approaching individual clinical management situations, and allow the student to build upon prior knowledge and clinical expertise.

Penn's nurse-midwifery program has a special commitment to increase the number of nurse-midwives in the State of Pennsylvania, especially in rural, underserved areas. To meet this goal a Distance Learning Program has been initiated using interactive audio/visual computer technology.

Course of Study

Required Core Courses (4 course units)

- 528 Female and Fetal Pharmacology
- 626 Family Systems Theory I
- 637 Introduction to Research-Methods and Design
- 695 Physiology of Pregnancy and Fetus

Nurse-Midwifery Required Courses (12 course units)

- 685* Health Assessment of the Adult Female
- 686* Nurse-Midwifery Management: Well-Woman Health Care
- 687* Nurse-Midwifery Management: Antepartum
- 688 Professional and Societal Responsibilities of the Nurse-Midwife
- 689* Nurse-Midwifery Management: Intrapartum
- 690* Nurse-Midwifery Management: Early Postpartum
- 691* Nurse-Midwifery Management: Childbearing Cycle
- 692* Nursing Management of High-Risk Pregnancy and Neonates
- 693 Current Issues in Nurse-Midwifery
- 696 Public Policy and Maternal/Child Health I
- 708 Public Policy and Maternal/Child Health II
- Nursing Elective

*Clinical Courses

Financial Assistance

The School of Nursing has a limited number of scholarships available to graduate students. Information concerning financial assistance, scholarships, and loans may be obtained through the School of Nursing's Financial Aid Office, Room 4001, Nursing Education Building or call (215) 898-8191.

In addition the nurse-midwifery program has tuition assistance for eligible applicants through a grant from the Department of Health and Human Services, Bureau of Maternal/Child Health.

For further information write to:

Joyce Beebe Thompson, DrPH, CNM, FAAN
Director, Nurse-Midwifery Program
University of Pennsylvania
School of Nursing
Nursing Education Building
Philadelphia, PA 19104-6096

(215) 898-4335

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Joyce Beebe Thompson
Director, Nurse-Midwifery Program
University of Pennsylvania
School of Nursing
420 Guardian Drive
Philadelphia, PA 19104-6096

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School of Nursing

Nurse-Midwifery Program

PENN
UNIVERSITY of PENNSYLVANIA

The University of Pennsylvania School of Nursing is ranked #1 among the nation's graduate schools of nursing in a major survey conducted by U.S. News and World Report. *In determining its rankings, the criteria considered were the school's reputation for scholarship, curriculum, and the quality of faculty and graduate students.*

Since its inception, Penn's Nursing School has been on the cutting edge of developing education and research programs that prepare nurses for the constantly expanding and complex services they provide. As our nation confronts its health care crisis and examines how we can best provide improved and accessible health care in a cost effective manner, the need for baccalaureate, master's, and doctorally prepared nurses is expected to be three times the current supply.

Our graduates go on to assume leadership positions throughout the profession in diverse academic and clinical settings, in administrative posts, in successful entrepreneurial ventures, and in flourishing practices. Opportunities abound for our graduates because the Penn degree speaks excellence to the world at large.

For the nursing profession, the time is right, the time is now, Penn is the place!

Norma K. Lang

Margaret Bond Simon Dean of Nursing

What is a nurse-midwife? A certified nurse-midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery who has been certified by the ACNM Certification Council (ACC). Nurse-midwives care for essentially healthy women before, during, and after childbirth, and provide gynecological care and family planning. Working within a system that provides for physician consultation and referral for complications, nurse-midwives practice according to the standards established by the American College of Nurse-Midwives.

The nurse-midwifery program at Penn enrolled its first students in the fall of 1980. The program is designed to prepare all students at three levels of competence: first, to become excellent clinicians; second, to become proficient in knowledge about political systems; and third, to develop and/or enhance leadership skills so as to be able to function effectively in multiple systems that interact to deliver health care to women and their families. Graduates of the four-semester program earn a master of science in nursing (MSN) and are eligible to sit the exam for certification given by the ACC.

The graduate faculty in the nurse-midwifery program believes that education is an ongoing process which continues after graduation. Faculty members believe in and support self-directed learning, critical thinking, analytical self-evaluation, and efforts of the students to succeed. The program bears out the faculty's belief that learning is reinforced by the immediate and repeated application of knowledge and skills in clinical situations. Available clinical sites for students in the program include home births, birth centers, community and tertiary care hospitals, and health centers in Pennsylvania and surrounding states.

The practice of nurse-midwifery as taught at Penn is based on the health promotion model and the concept of interdependent team practice—the promotion and effective utilization of the unique aspects of each health professional's and client's knowledge and skills joined together to ensure safe, satisfying health care for every client. Nurse-midwifery practice encompasses the provision of family-centered, comprehensive care to essentially healthy women and newborns with respect for human dignity and worth, variety in cultural forms, and the client's right to self-determination in health care.

We further believe that by providing optimal holistic care for women, nurse-midwives promote the empowerment of all women in controlling their lives and their health. Nurse-midwives need to participate with other professionals in health planning for all women and to create and institute systems for the delivery of safe, cost-effective health care to all socioeconomic groups.

Program Requirements

Sixteen course units are required to complete the program, including one elective and four core courses that are shared with other nursing students. The nurse-midwifery full-time program begins in September and covers four consecutive semesters over 16 months. Graduation is in mid-December.

To allow greater flexibility in completing the program, a limited number of students are accepted on a part-time basis. An individual course of study is worked out with a faculty advisor for core courses and prerequisites to the nurse-midwifery sequence. At an agreed-upon time, the student will begin the nurse-midwifery courses in September and complete them in the four-semester sequence. A BSN/MSN matriculation option is also available.

Admissions Requirements

1. A bachelor of science degree in nursing with a satisfactory GPA.
2. Recent (within 5 years) satisfactory completion of Graduate Record Exam.
3. Current RN license in one of the 50 states.
4. Completion of courses in elementary statistics and physical assessment. A recent course in biology or reproductive physiology is strongly encouraged.
5. Completed application with references.
6. A personal interview.

I am interested in the Nurse-Midwifery Program at the University of Pennsylvania School of Nursing. Please send additional information.

Name _____

Address _____

City _____ *State* _____ *Zip* _____

Telephone _____

A 60-Year Heritage

Nurse-midwives can trace their heritage to the Frontier Nursing Service that provided help to women in rural areas. That was more than half a century ago. Today there are more than 4,000 certified nurse-midwives who provide a wide range of health care services to women and newborns in all 50 states. Most of the CNMs are members of the American College of Nurse-Midwives, the professional association that accredits education programs, sets practice standards, and provides a clinical journal, consumer information, liaison with state and federal healthcare agencies and members of Congress, and a variety of services to strengthen the profession and its public service role.

An Outstanding Record

Medical journal articles, government studies, and healthcare organizations continue to recognize and endorse the services provided by CNMs. Here are just a few of the testimonials to the benefits of nurse-midwifery and contributions by CNMs.

"The use of midwives is a natural solution to the problem of improving access to skilled perinatal services while lowering costs...mothers and babies have distinctly better than average outcomes when births are attended by midwives, either in or out of hospitals." –American Journal of Public Health

"The extra element of prenatal support that nurse-midwives offer appears to pay off. Women report a greater sense of trust in their ability to birth, which in turn eases their labor. Among poor, high-risk populations, studies have shown that care by midwives increases access to and utilization of prenatal care, reducing the incidence of low birth-weight, prematurity, and neonatal death." –The New Physician

The Institute of Medicine report "Prenatal Care: Reaching Mothers, Reaching Infants," calls for a new system that relies *"on a wide array of providers, including both physicians and certified nurse-midwives..."*

For More Information...

The American College of Nurse-Midwives
818 Connecticut Avenue, NW, Suite 900
Washington, DC 20006
202-728-9860

4/94 400K

Today's Certified Nurse-Midwife

For Your Personal Care

Certified Nurse-Midwives and You!

Today's Certified Nurse-Midwife (CNM), a professional healthcare provider, is a Registered Nurse (RN) who has graduated from 1 of more than 30 advanced education programs accredited by the American College of Nurse-Midwives (ACNM). In addition, CNMs must pass a national certification examination and meet strict requirements set by state health agencies.

Most CNMs work in hospitals or birthing centers. Some assist women in homebirths. They attend women during labor and delivery and are trained and experienced in prenatal, postpartum, and normal newborn care, and in routine gynecological care. Thus, as they carry on a centuries-old tradition of assisting women in the safe delivery of babies, they can draw not only on their professional skills but the use of advances and techniques in modern medicine.

CNMs continue the family-oriented, safe, personalized, and thorough health care that assures healthy women of having the healthiest babies possible. And, although many work as primary care providers, they consult with physicians when there are problems that may put a pregnant woman at risk.

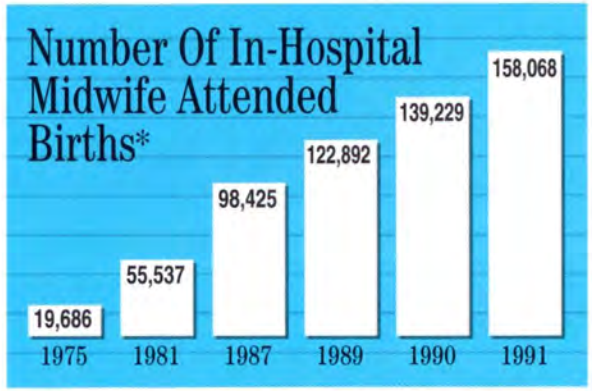
Midwife Means "With Woman"

Safe, personalized healthcare by nurse-midwives means a special skill and understanding of the unique physical, social, and spiritual needs of women. Nurse-midwifery focuses on wellness and consumer choice. Women are encouraged to make informed decisions about their healthcare. And, nurse-midwives believe the family should have a voice in selecting the site of healthy birthing. CNMs welcome your questions and take time to listen to you and talk with you. They can provide you with well-woman gynecological care, including breast examinations, Pap smears, and family planning.

Women and Newborns: Great Expectations

- The hallmarks of nurse-midwifery care are continuity and teaching women to be self-relient, to trust their own bodies in delivering healthy babies naturally.
- During pregnancy the nurse-midwife monitors the health of you and your baby regularly and is prepared to teach and to answer questions about proper diets, personal hygiene, exercise, sleep, travel, and how to maintain a healthy lifestyle.

- During labor, the CNM evaluates your progress and is there to offer emotional and physical support. You can expect your nurse-midwife to make your delivery natural and uncomplicated and to involve your family to the extent possible. At any time a problem arises, the nurse-midwife can call on a physician to assist in protecting you and your baby.
- Followup care begins immediately at birth as the nurse-midwife examines the newborn, provides advice on breastfeeding, infant care, and rejoices with you and your family in another healthy beginning.
- Prescriptions for medications and/or vitamins can be written by nurse-midwives in most states, should you require these good health care aids.
- You will be advised about reproductive health, preconception, and personal care. Later, CNMs can provide regular gynecological care, such as annual pelvic and breast examinations and Pap smears.



SOURCE: Monthly Vital Statistics Report, National Center for Health Statistics (NCHS), Vol. 42, No. 3(s), Sept. 9, 1993, Hyattsville, MD. DHHS Pub No. (PHS) 93-1120, and previous reports.

*With revision of the U.S. birth certificate in 1989, more detailed classification of delivery sites and identification of the persons attending the births is possible. Certified Nurse-Midwives (CNMs) attended 132,286 births (122,892 in hospitals) in 1989; 148,728 births (139,229 in hospitals) in 1990, and 167,704 births (158,068 in hospitals) in 1991. In previous years, the NCHS reports did not differentiate between a CNM and a lay midwife; however, since only CNMs are permitted to attend births in hospitals, where most babies are born, it can be assumed CNMs attended most of the in-hospital births prior to 1989. In 1991 CNMs attended 92% of all midwife attended births.

Where to Find A Certified Nurse-Midwife

While most of the 4000 or more nurse-midwives work in hospitals, many are in private practice with physicians or operate their own birthing centers, free-standing facilities where every healthcare service from prenatal care to birthing to gynecological care is offered.

Many CNMs are employed by Health Maintenance Organizations (HMOs) or other types of managed health care plans, while others work in public health clinics, both independent clinics and those associated with a hospital that have a record of serving indigent and underserved populations. Some, as noted, attend women in their homes, if certain safety criteria are met.

If you wish to locate a CNM in your community, one resource is the ACNM Directory of Nurse-Midwifery Practices. For more information on The Directory, call the ACNM national office, 202-728-9860.

Reimbursement: Nurse-midwifery services are covered by most private insurance carriers, Medicare, Medicaid, and managed care programs. Services are also covered under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Federal Employees Health Benefit Plans (FEHBP).

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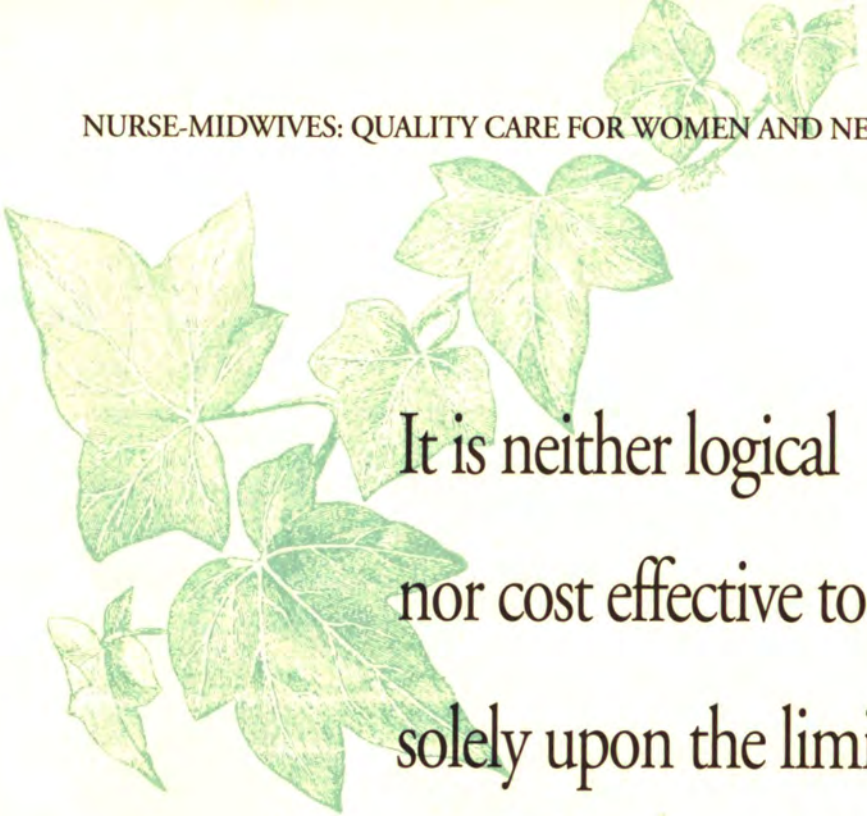
16 Pages
American College of
Nurse-Midwives
Monograph Booklet



It is neither logical nor cost effective to rely solely upon the limited supply and specialized skills of physicians to address the preventive healthcare needs of all American women...

A BIRTHDAY FOR MIDWIVES

SEVENTY FIVE YEARS OF INTERNATIONAL COLLABORATION

The International Confederation

of

Midwives

1919-1994

A BIRTHDAY FOR MIDWIVES

SEVENTY FIVE YEARS

OF

INTERNATIONAL COLLABORATION

The International Confederation of Midwives
1919-1994

EARLY BEGINNINGS

The International Confederation of Midwives (ICM) was born in unpromising circumstances in Europe, immediately after the First World War as the International Midwives Union (IMU). Midwifery had neither the prestige of the established professions, such as law or medicine, nor the attraction of the new ones, such as radiography. There had been previous attempts to get Europe's midwives together, and some of them, such as the Berlin Congress in 1900, had been amazingly successful, drawing over 1000 participants from nine countries. Nonetheless, until 1919, no lasting structure had emerged and no permanent bond had been created among the many midwifery organisations in Europe.

What the profession **did** have on its side in the aftermath of the war was growing public concern about the continued high maternal and infant mortality rates which put maternal and child welfare high on the political agenda. In many respects, midwifery was a besieged profession during these inter-war years. The birth-rate was dropping everywhere, doctors willing to care for childbearing women were becoming both numerous and fashionable, and a number of other new-style health care professionals, such as health visitors and visiting nurses, were beginning to encroach on the community, the midwives' traditional practice base.

DEVELOPING A NETWORK

The International Midwives' Union (IMU), brainchild of a Belgian midwife, Marie Perneel, Matron of the Bruges Maternity Hospital and Franz Daels, Professor of Obstetrics at the University of Ghent, set out from the beginning to improve the services available to childbearing women through campaigning for a stronger, better educated and properly

regulated midwifery profession. Public perception of the midwife was frequently coloured by the handywomen, or lay-midwives who still practised extensively in Europe, particularly among the poor or in rural areas. While many nations such as the Nordic countries and Germany had comprehensive state regulation of the practice of midwifery for many years, others offered little or nothing to the women who wished to establish themselves on a better professional and educational basis.

The post-war call to unite in a European grouping of midwifery organisations met with a swift and growing response. Starting with what was virtually a "fringe" meeting of a handful of midwives from Belgium, Holland and England, attached to a multidisciplinary gathering for nurses and social workers in Antwerp, meetings of the IMU grew to over a thousand participants from 32 different countries within a very few years. By the end of the 1930s full membership of the Confederation was held by Austria, Belgium, Bulgaria, Czechoslovakia, Danzig, Denmark, England, Estonia, Finland, France, Germany, Italy, Latvia, Lithuania, Luxembourg, Sweden, Switzerland and Yugoslavia.

Table 1. shows the venues of the International Congresses, with the names of the Presidents, who were always drawn from the host association. The early congresses show all the signs of a corporate body seeking its own distinct pattern of operation, its own clear identity. As with other women's organisations, the IMU realised from the beginning that the strength of an international body lay less with individual than with corporate membership. If it were to be able to achieve its goals of improved services for women and improved status and conditions for midwives across national and cultural boundaries, it needed to speak with the authority which alone could be conveyed through the national organisations of midwives. At Prague, in 1925, and in Vienna , in 1928, the member

associations were clearly united behind the call for a minimum of three years education for the profession, as well as a clearly-defined scope of practice (although they were less united on the detail of this!), together with state guaranteed pensions and sickness rights. Despite this, the infant Confederation took a number of years to clarify the most effective use of the biennial meetings, for there were complaints during the twenties that host organisations were focusing more on matters of limited local interest than on issues commanding international concern.

ESTABLISHING A PROFESSION

By the thirties there was a new, more assured note in the Confederation's proceedings. The record of the 1934 Congress stated that

> *"The International Federation of Midwives (sic) has for its object the protection of the mother and child. With this object in view the efforts and activities of the Federation shall at the same time be directed towards the scientific, moral, social and economic improvement of the profession of midwife."*[1]

Each Congress had a clear theme and there was vigorous debate around issues of midwifery education (London, 1934), the place of birth (Berlin, 1936) and the midwife's role as social worker, (Paris,1938). The country-by-country reports in response to previously-circulated questionnaires provide a fascinating, if limited overview of the development of midwifery services throughout Europe over the inter-war decades. Sadly, the record is mainly restricted to the published proceedings of the Congresses, since the IMU's archives were lost in Ghent during the years of the second world war. Although Marie Perneel died

very shortly after the foundation of the IMU, her work was relayed from midwife to midwife through the presidents of the European associations. The administrative complexities caused by the constantly-changing presidency and the lack of a fixed secretariat were an ongoing problem for the organisation, only partly resolved by the constant presence of Professor Daels, who, despite repeated efforts to resign and hand his work over to a midwife, remained effectively the Secretary General right up to the outbreak of the second war.

BEGINNING AGAIN

At the last Congress on the eve of the war, in Paris, the International Midwives' Union stepped beyond its usual, professional preoccupations to issue an impassioned plea for peace.[2] This was the last that was to be heard of the Confederation for more than ten years, while the world was once more embroiled in conflict. In 1954, after several years of tentative discussion and meetings in Rome and Paris, as well as in London, the decision was finally taken to relaunch the organisation as the International Confederation of Midwives, with a permanent secretariat based in London and a new Constitution. Madame Mossé, the pre-war president whose organisation had hosted the Paris Congress, had long cherished the dream of an ICM reborn in France, and had even made provision in her will for premises for the secretariat. However, her death in 1949 left that project without its strongest champion and the Royal College of Midwives in London set about the task of organising the first full-scale congress since before the war.

More than 50 countries sent representatives to the 1954 Congress, the first to see expansion of ICM membership well beyond the bounds of Europe. For the first time the

organisation was able to develop significant activity in between the "peak event" of the triennial Congress, thanks to the appointment of an Executive Secretary, and for the first time the organisation was entirely in midwives' own hands. Little time was lost in getting the reorganised ICM on to the international political scene. By the end of the 1960s the Confederation held its Congress outside Europe for the first time, and in the southern hemisphere, in Chile (1969), and three years later Congress went to the United States (1972), where midwifery had been all but obliterated during the course of the century.[3]

THE UN SYSTEM

In the early 1960s the Confederation was formally recognised as a Non-Governmental Organisation accredited by the United Nations. This meant, and still means, that ICM has the right to send midwife delegates as official observers to all relevant UN agency meetings, wherever they take place in the world, and that ICM is acknowledged by the UN system as the forum for consultation when the midwives' view on the health careof the mother and child is needed. Close collaborative links were rapidly established with agencies such as World Health Organization (WHO), the United Nations Childrens Fund (UNICEF), the International Labour Office (ILO) and professional bodies such as the International Federation of Obstetricians and Gynaecologists (FIGO). An early consequence of this activity was the first draft of what was later to become universally known and quoted as the International Definition of the Midwife, a statement which was to be used over and over again as a international "yardstick" to establish the parameters of a midwife's education and practice and to help governments draft appropriate legislation for the profession.[4]

INTER-PROFESSIONAL COLLABORATION

From the early 1960s an ICM/FIGO Joint Study Group worked intensively for over more than a decade to produce two editions of Maternity Care in the World, a sort of global census of services for women and their babies in some 210 countries. These were the years where governments worldwide were struggling to establish health care systems capable of offering a minimum service to everyone. During the early years of post-war economic recovery there was a growing concern about the rapid increase of the world's population and the equitable distribution of finite resources both in goods and in services. Developments in technology and pharmacology had made fertility control, at least in theory, realisable, and in many parts of the world the old social attitudes towards it were changing quite rapidly.

As a result of these changes, and as an outcome of its earlier collaboration with FIGO, the International Confederation of Midwives began a massive programme on behalf of the United States Agency for International Development (USAID), conducting educational projects with midwives in family planning and the training of Traditional Birth Attendants (TBAs). Between 1972 and 1979 the Confederation held twenty Inter-Regional Working Parties involving more than eighty countries. Participants included obstetricians, members of family planning associations, government officials and international agency representatives, as well as midwives. Generous funding from USAID had allowed ICM not only to take on the necessary staff to administer such a vast project, but to become sufficiently established to move, for the first time , to its own premises. The Confederation's name became very well known through the complex outreach achieved through the USAID project, although it is worth noting that membership numbers did not increase greatly during this time.

REORGANISATION

Once the USAID funding ceased at the end of the 1970s, ICM was thrown back on its own financial and professional resources. These were found to be very slender, and a period of anxious debate took place among the membership about whether and how the Confederation could be re-established on a sustainable footing. In 1981 a new Constitution was voted by Council and during the eighties ICM once more played a significant, if at times less visible part in international affairs associated with childbearing women and their babies and with the education and regulation of the profession of midwifery. A process of regionalisation, introduced through the new constitution, resulted in non-European members of ICM taking a more visibly active part in determining the Confederation's future direction. The first Congress in Australia in 1984 took the ICM further afield than ever for its triennial meeting and gave new vigour to many of the debates which have persisted throughout the Confederation's history - the role and status of the midwife and the place of birth. Established once more on a small but reasonably solid basis, the organisation which now numbered midwives from all over the world and from a wide range of cultures seemed to have freed itself to look in greater depth at the problems facing childbearing women in the late twentieth century.

WORKING FOR SAFER MOTHERHOOD

The new energies found their focus with the launch in 1987 of the Safe Motherhood Global Initiative.[5] Following the World Health Organization conference in Kenya which highlighted the persistent scandal of the half million maternal deaths which still occurred annually, ICM took up the challenge at the Hague Congress to lower maternal mortality, with the first of a series

of collaborative Pre-Congress Workshops conducted in partnership with the World Health Organization and UNICEF. From the vigour with which the safe motherhood issue was adopted by midwifery associations throughout the world it became obvious that it had struck an important chord. The initiative provided a focus for women and midwives from all sorts of backgrounds to work together in many different ways to improve conditions of childbirth. Over the next six years ICM undertook a systematic exploration of the main areas where midwifery could make an impact on the safe motherhood problem. While the Hague Workshop focused directly on the causative clinical factors of maternal death, the sequel, held in Kobe, Japan, in 1990, directed attention to designing an community-based educational framework for midwives, and the most recent workshop, held in Vancouver, British Columbia, in May 1993, worked on developing indicators for measuring the quality of care delivered. Follow-up activities were undertaken in many parts of the world, including francophone and anglophone West Africa, and the Asia-Pacific region, to ensure that the lessons learned in the workshops gradually bore fruit.

MEMBER ASSOCIATIONS

One of the hardest tasks which ICM has persistently been faced with has been helping to establish national, professional midwifery associations on a firm footing. In most countries the associations have only emerged after the profession has been legally regulated, although, like a number of the newer organisations in the Canadian Provinces, they are occasionally formed to act as campaigning groups to lobby for the legal recognition of the profession. In some countries the position of women in society still makes it difficult for midwives to organise themselves into a formal professional body. From its very earliest days ICM has seen the need to strengthen

midwifery by nurturing developing associations, and in more recent years a special fund has been reserved to make it possible for the newer, smaller groups to come into membership of the international midwifery organisation.

TODAY - 1994

With what looks like a world-wide surge in interest in midwifery - governments as far apart as Indonesia and the United States of America are engaged in projects to expand and strengthen the profession - the International Confederation of Midwives continues to play a vital part in providing a focus for the collection and dissemination of information and expertise. It succeeds in the task using very modest resources. A considerable international network of midwives extends, through their member associations, Headquarter's capacity to respond to the many calls for advice, collaboration and consultancy which come to it from all over the world.

The small, business-like headquarters in London houses the first full-time Secretary-General and her staff. Three times a year the Director (Australia), Deputy Director (United States) and Treasurer (United Kingdom) meet there as the Board of Management, responsible for seeing that the policies established at the preceding triennial Council Meeting are being implemented. An independent expert Finance Sub-Committee offers advice on money management and progress on the triennial Action-Plan is reviewed in the light of reports from the Region. In mid triennium the Executive Committee meets to prepare advice for Council on the professional policy and philosophy which guides ICM's action. It was the Madrid Executive, in 1991, which prepared the finalised draft of the first International Code of Ethics which Council voted unanimously in May 1993, giving all midwives a formal, public declaration of their commonly-held professional beliefs and values.

A further, important tool for ICM's action is the body of formally-voted Position Papers which set out succinctly the Confederation's beliefs with regard to subjects as varied as the place of birth and midwifery research, harmful birth practices and AIDS. At times, these papers are used to campaign on contemporary issues from the point of view of the midwife, much as the pre-war resolution on the midwives' commitment to peace did. Recent examples of such statements from the Vancouver Council in May 1993 include a statement on women, children and midwives in situations of war and civil unrest and on the rights of indigenous women and their families.

Midwives have very rarely been wealthy, or even particularly influential. Their very existence as a distinct profession has been under threat many times. Despite all this, they have succeeded in establishing, maintaining and developing their own network of inter-related professional associations worldwide, capable of speaking on important issues with a single voice and of working together for improvements in the reproductive health care of women and of their families, as well as for education and practice improvements for midwives themselves. Their capacity to do this, despite repeated setbacks and frequently severely limited resources, has won them the right to a voice in the international arena wherever maternal and child health are discussed. Midwives are tenacious, practical women. Threequarters of a century ago they decided that they needed to break out beyond small, local boundaries to share with each other and to strengthen each other as the profession moved into yet another, even more challenging phase of its existence. Seventy-five years further on the challenges remain, although the social context has changed dramatically. The world still needs its midwives working on behalf of women and their families and the International Confederation of Midwives continues to help them face the challenges together.

Table 1.

PRESIDENTS

Mlle Marie PERNEEL	BRUGES	1919
Mme De GRAEF van den ELST	ANTWERP	1922/3
Mme LISCOVA	PRAGUE	1925
Mme Berthe HUBEL	VIENNA	1928
Mlle BLOCK	GHENT	1932
Miss Edith M. PYE	LONDON	1934
Frau CONTI	BERLIN	1936
Mlle MOSSE	PARIS	1938
Signora SCHIMMENTI	ROME	1950
Madame JAY	PARIS	1953
Miss Nora B. DEANE	LONDON	1954
Miss Ellen ERUP	STOCKHOLM	1957
Miss Ellen ERUP	ROME	1960
Srta. Maria Garcia MARTIN	MADRID	1963
Frau Anne SPRINGBORN	BERLIN	1966
Sra. Olga JULIO	SANTIAGO	1969
Miss Lucille WOODVILLE	WASHINGTON	1972
Frau Georgette GROSSENBACHER	LAUSANNE	1975
Mrs. Rachel RECHES	JERUSALEM	1978
Mrs. Winifred A. ANDREWS	BRIGHTON	1981
Miss Margaret PETERS	SYDNEY	1984
Mrs. Filippa LUGTENBURG	THE HAGUE	1987
Mrs. Sumiko MAEHARA	KOBE	1990
Ms Carol HIRD	VANCOUVER	1993
Mrs.Sonja Irene SJϕLI	OSLO	1996

References:

1. Communications of the International Union of Midwives, 8, 1936, p.61.

2. Communications of the International Federation of Midwives Unions, 10, 1939, p.75.

3. Litoff, J.B., The American Midwife Debate. A sourcebook on its modern origins. London, Greenwood Press, 1986.

4. WHO Expert Committee, The Midwife in Maternity Care, WHO Technical Report Series No.331., World Health Organization, Geneva, 1966. The International Definition of a Midwife, newly revised by ICM/WHO/FIGO, 1990/92, International Confederation of Midwives, London.

5. Preventing the Tragedy of Maternal Deaths, a Report on the International Safe Motherhood Conference, Nairobi Kenya, February 1987, Co-sponsored by the World Bank, World Health Organization and the United Nations Fund for Population Activities.

STANDARDS FOR THE PRACTICE OF NURSE-MIDWIFERY

American College of
Nurse-Midwives

STANDARDS FOR THE PRACTICE OF NURSE-MIDWIFERY

Nurse-midwifery practice is based upon academic preparation in the sciences and upon clinical skills necessary for the management and care of essentially normal women and newborns. The care, as defined by the American College of Nurse-Midwives (ACNM), includes the antepartum, intrapartum, and postpartum/newborn periods and family planning/gynecology. The nurse-midwife is committed to maintaining a high standard of professional care, to participating in the education of nurse-midwives, and to promoting the concepts of nurse-midwifery practice in the community.

STANDARD I

NURSE-MIDWIFERY CARE IS PROVIDED BY QUALIFIED PRACTITIONERS

The practitioner:

1. Is certified by the American College of Nurse-Midwives.
2. Shows evidence of continuing competency as required by the American College of Nurse-Midwives.
3. Is in compliance with the legal requirements of the jurisdiction where the nurse-midwifery practice occurs.

STANDARD II

NURSE-MIDWIFERY CARE SUPPORTS INDIVIDUAL RIGHTS AND SELF-DETERMINATION WITHIN BOUNDARIES OF SAFETY

The certified nurse-midwife:

1. Supports the **Philosophy of the American College of Nurse-Midwives.**
2. Provides clients with a description of the scope of nurse-midwifery services and information regarding the client's rights and responsibilities.
3. Provides clients with information on other providers and services when requested or when care required is not within the scope of practice of the individual nurse-midwife.
4. Promotes involvement of support persons in the practice setting.

STANDARD III

NURSE-MIDWIFERY CARE IS COMPRISED OF KNOWLEDGE, SKILLS, AND JUDGMENTS THAT FOSTER THE DELIVERY OF SAFE AND SATISFYING CARE

The certified nurse-midwife:

1. Collects and assesses client care data, develops and implements a plan of management, and evaluates the outcome of care.
2. Demonstrates the clinical skills and judgments described in **Core Competencies in Nurse-Midwifery.**
3. Practices in accord with the **Standards for the Practice of Nurse-Midwifery** of the American College of Nurse-Midwives.
4. Practices in accord with the policies of the nurse-midwifery service/practice that meet the requirements of the particular institution or practice setting.
5. Expands clinical practice in accordance with **ACNM Guidelines for the Incorporation of New Procedures into Nurse-Midwifery Practice.**

STANDARD IV

NURSE-MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN POLICIES

The certified nurse-midwife:

1. Establishes policies for each practice area, which include but are not limited to:

   Antepartum

   a) criteria for admission to the nurse-midwife service
   b) parameters and methods for assessing the progress of pregnancy
   c) parameters and methods for assessing fetal well-being
   d) indicators of risk in pregnancy and appropriate intervention
   e) medications used during pregnancy

   Intrapartum

   a) parameters and methods for assessing progress of labor and birth
   b) parameters and methods for assessing maternal and fetal status

c) medications/solutions used during labor and birth
d) management of the birth
e) methods to facilitate the newborn's adaptation to extrauterine life
f) significant deviations from normal and appropriate interventions
g) parameters and methods for assessing the immediate well-being of the newborn

Postpartum/Newborn

a) parameters and methods for assessing the postpartum status of the mother
b) parameters and methods for assessing the well-being of the newborn
c) medications used in the puerperium
d) significant deviations from normal and appropriate interventions

Family Planning/Gynecology

a) parameters and methods for assessing general physical and emotional status of the client
b) medications and devices used
c) significant deviations from normal and appropriate interventions

2. Defines nurse-midwifery management, collaborative nurse-midwife/physician management, and physician management for the nurse-midwifery service/practice.

STANDARD V

NURSE-MIDWIFERY CARE IS PROVIDED IN A SAFE ENVIRONMENT

The certified nurse-midwife:

1. Assesses the practice setting for reasonable freedom from environmental hazards.
2. Promotes adequate staffing in the clinical setting where the nurse-midwife practices.
3. Knows the location and use of emergency equipment.
4. Uses infection control procedures.
5. Demonstrates accessibility to an emergency transport system appropriate for the practice setting.

STANDARD VI

NURSE-MIDWIFERY CARE OCCURS INTERDEPENDENTLY WITHIN THE HEALTH CARE SYSTEM OF THE COMMUNITY USING APPROPRIATE RESOURCES FOR REFERRALS TO MEET PSYCHOSOCIAL, ECONOMIC, AND CULTURAL OR FAMILY NEEDS

The certified nurse-midwife:

1. Demonstrates an agreement with a physician for a safe mechanism of obtaining medical consultation, collaboration, and referral.
2. Uses community services.
3. Demonstrates knowledge of psychosocial, economic, cultural, and family factors that may affect care.

STANDARD VII

NURSE-MIDWIFERY CARE IS DOCUMENTED IN LEGIBLE, COMPLETE HEALTH RECORDS

The certified nurse-midwife:

1. Uses records that facilitate communication of information to consultants and institutions.
2. Facilitates clients' access to their records.
3. Provides written documentation of risk assessment, course of management, and outcome of care.
4. Provides for prompt entry on the health record of laboratory tests, treatments, and consultations.
5. Provides a mechanism for sending a copy of the health record on referral or transfer to other levels of care.
6. Treats records as confidential documents.

STANDARD VIII

NURSE-MIDWIFERY CARE IS EVALUATED ACCORDING TO AN ESTABLISHED PROGRAM FOR QUALITY ASSESSMENT THAT INCLUDES A PLAN TO IDENTIFY AND RESOLVE PROBLEMS

The certified nurse-midwife:

1. Participates in a program of quality assurance for the evaluation of nurse-midwifery practice within the setting in which it occurs and within legal requirements.
2. Collects client care data systematically and is involved in analysis of that data for the evaluation of the process and outcome of care.

3. Seeks consultation to review problems identified by the quality assurance program.
4. Acts to resolve problems that are identified.
5. Participates in peer review.

GUIDELINES FOR THE INCORPORATION OF NEW PROCEDURES INTO NURSE-MIDWIFERY PRACTICE

Nurse-Midwifery practice will continue to evolve, depending on the needs of the client, the needs of the site, the expectations of the institution, and the nurse-midwife's desire to improve care to women and their families. Procedures incorporated into the practice of nurse-midwifery should be in concert with the **Philosophy of the American College of Nurse-Midwives** and the **Standards for the Practice of Nurse-Midwifery** of the American College of Nurse-Midwives (ACNM) and should not conflict with any current clinical practice statements of the ACNM.

While the ACNM does not approve or disapprove the incorporation of new clinical procedures into nurse-midwifery practice, the following guidelines were developed by the Clinical Practice Committee and approved by the Board of Directors to assist the nurse-midwife in expanding clinical practice:

1. Identify need for the procedure, taking into consideration:
   a) consumer demand
   b) safety considerations
   c) institutional request
   d) lack of other appropriate personnel
   e) interest of nurse-midwives
2. Cite relevant statutes/documents that would constrain or support procedure, including:
   a) statutes and regulations
   b) institutional bylaws
   c) legal opinions
3. Evaluate procedure as a nurse-midwifery function, including:
   a) relevant literature
   b) use by other nurse-midwives
   c) risks/benefits
   d) management of complications

4. Develop process for educating nurse-midwives to perform this procedure, using:
   a) bibliography
   b) formal study method
   c) supervised practice
   d) protocols
   e) evaluation of learning
5. Evaluate use of procedure, documenting:
   a) outcome statistics
   b) satisfaction with procedure
      — consumer
      — institution
      — nurse-midwifery practice
   c) maintenance of competency
6. Any new procedure incorporated into nurse-midwifery practice will be done according to these "Guidelines" as outlined in the "**Standards for the Practice of Nurse-Midwifery**," and reported on the form provided by the American College of Nurse-Midwives. The completed form shall be mailed to the ACNM for reporting purposes. Supporting documents as outlined in these "Guidelines" should be placed with the written policies of the nurse-midwifery practice/service (Standard IV)

Standards for the Practice of Nurse-Midwifery, 1987; supercedes Functions, Standards, and Qualifications, 1983.

Guidelines for the Incorporation of New Procedures into Nurse-Midwifery Practice, 1987; supercedes Guidelines for Evaluation of Nurse-Midwifery Procedural Functions, 1979 (Amended 10/90; 11/92)

AMERICAN COLLEGE OF NURSE-MIDWIVES
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CORE COMPETENCIES

FOR BASIC

NURSE-MIDWIFERY PRACTICE

AMERICAN COLLEGE OF NURSE-MIDWIVES

Core Competencies for Basic Nurse-Midwifery Practice

Nurse-midwifery education is based upon theoretical preparation in the sciences and clinical preparation for the judgment and skills necessary for management of the care of women and newborns. The care as defined by the American College of Nurse-Midwives (ACNM) includes antepartum, intrapartum, postpartum, neonatal, family planning and well woman gynecology, and occurs within a health care system that provides for collaboration (co-management) and referral. Nurse-midwifery practice is based on these Core Competencies, the Standards for the Practice of Nurse-Midwifery and the ACNM Code of Ethics. Nurse-midwives assume responsibility and accountability for practice by applying their knowledge and skills in a process for clinical decision-making: the management process.

Core competencies delineate the fundamental knowledge, skills, and behaviors expected of a new graduate. Because nurse-midwifery practice continues to be a dynamic and changing discipline, these core competencies are presented as guidelines only for educators, students, physicians and other professionals, consumers, and employers of nurse-midwives. The guidelines will continue to evolve with the practice of nurse-midwifery. The concepts and skills identified below and the aspects of the nurse-midwifery management process outlined in the following sections apply to all components of nurse-midwifery care. This document must therefore be used in its entirety.

Because creativity and individuality in nurse-midwifery education are essential to the vitality of the profession, educational programs are encouraged to be innovative. Each program will develop its own characteristics and may extend into other areas of health care. Each graduate is responsible for practicing in accordance with state laws and institutional protocols. Core competencies remain, however, as the basic requisites for the graduate of any educational program.

Certain concepts and skills from the social sciences and public health permeate all aspects of nurse-midwifery practice. The following have been identified:

1. Promotion of family centered care.
2. Facilitation of healthy family and interpersonal relationships.
3. Constructive use of communication and of guidance and counseling skills.
4. Communication and collaboration with other members of the health team.
5. Provision of health education.
6. Promotion of continuity of care.
7. Use of appropriate community resources.
8. Promotion of health and prevention of disease throughout the life cycle.
9. Recognition of pregnancy as a normal physiologic and developmental process.
10. Advocacy for informed choice and decision making.
11. Consideration of bioethical issues related to women's health.
12. Knowledge of and respect for cultural variations.

NURSE-MIDWIFERY MANAGEMENT

The process for nurse-midwifery management of care has three aspects: primary management, collaborative management (co-management), and referral of management. Implicit in this process is timely action and the documentation of all its aspects.

I. PRIMARY MANAGEMENT

A. Systematically obtains or updates a complete and relevant data base for assessment of the client's health status.

B. Accurately identifies problems and diagnoses based upon correct interpretation of the data base.

C. Delineates health care goals and formulates and communicates a complete needs/problems list in collaboration with the woman.

D. Identifies need for consultation with or referral to appropriate members of the health care team.

E. Provides information and support to enable women to make appropriate decisions and to assume appropriate responsibility for their own health.

F. Develops a comprehensive plan of care with the woman based on supportive rationale.

G. Assumes direct responsibility for implementing the plan of care.

H. Initiates management of deviation from normal, including emergencies and specific complications.

I. Evaluates, with the woman, the achievement of health care goals and modifies the plan of care accordingly.

II. COLLABORATION (CO-MANAGEMENT)

A. Identifies problems and related complications requiring consultation and collaboration (co-management) .

B. Obtains consultation. Plans and implements collaborative management (co-management) with other providers.

C. Continues management of midwifery aspects of care.

D. Serves as consultant or co-manager for other providers.

III. REFERRAL

A. Identifies the need for comprehensive management and care outside the scope of practice.

B. Selects appropriate sources of care in collaboration with the woman.

C. Transfers the care of the client as appropriate.

COMPONENTS OF NURSE-MIDWIFERY CARE

Implicit in a nurse-midwifery knowledge base is the ability to perform skills pertinent to each of the outlined areas of practice.

I. PRECONCEPTION CARE

A. Assumes responsibility for management of care of the woman who is preparing for pregnancy.

B. Uses a foundation for nurse-midwifery practice that includes but is not limited to the knowledge of:

1. Female and male reproductive anatomy and physiology related to conception.

2. Health history, family history and relevant genetic history.

3. Health and laboratory screening to evaluate the potential for a healthy pregnancy.

4. Assessment of emotional, psychosocial, sexual status and readiness for pregnancy of the woman and her support system.

5. Nutritional assessment and counseling.

6. Influence of environmental and occupational factors, health habits and behavior on pregnancy planning.

II. ANTEPARTUM CARE

A. Assumes responsibility for management of care of the pregnant woman.

B. Uses a foundation for nurse-midwifery practice that includes but is not limited to the knowledge of:

1. Female anatomy and physiology.

2. Anatomy and physiology of conception, pregnancy, and lactation.

3. Clinical application of genetics, embryology, and fetal development.

4. Diagnosis of pregnancy.

5. Assessment of the emotional status of the woman and of her support system.

6. Common screening/diagnostic tests used during pregnancy.

7. Indicators of normal pregnancy.

8. Causes of maternal morbidity and mortality.

9. Indicators of risk and complications in pregnancy and appropriate interventions.

10. Parameters and methods for assessing the progress of pregnancy.

11. Parameters and methods for assessing fetal well-being.

12. Nutritional assessment and counseling of the pregnant woman.

13. The influence of environmental and occupational factors, health habits and maternal behaviors on the family.

14. The etiology and management of common discomforts of pregnancy.

15. Pharmacokinetics of medications commonly used during pregnancy.

16. Prescription of medications and treatments.

17. Psychosocial, emotional, sexual changes during pregnancy.

18. Planning and implementation of individual and/or group education.

19. Counseling on the physical and emotional changes of pregnancy; preparation for birth, lactation, parenthood and change in the family constellation.

III. INTRAPARTUM CARE

A. Assumes responsibility for management of care of the woman and fetus during the intrapartum period.

B. Uses a foundation for nurse-midwifery practice that includes but is not limited to the knowledge of:

1. Anatomy and physiology of normal and abnormal labor processes through the four stages.

2. Anatomy of the fetal skull and its critical landmarks.

3. Parameters and methods for assessing progress of labor through the four stages.

4. Parameters and methods for assessing maternal and fetal status.

5. Common screening/diagnostic tests used during labor.

6. Emotional changes during labor and delivery.

7. Physical and emotional support measures used during labor and birth.

8. Pharmacokinetics of medications commonly used during labor and birth, including effects on mother and fetus.

9. Prescription or administration of appropriate medications/solutions during labor and birth.

10. Techniques for administration of local and pudendal anesthesia.

11. Techniques for spontaneous vaginal delivery.

12. Indicators of deviations from normal and appropriate interventions.

13. Diagnosis and assessment of labor and its progress through the four stages.

14. Techniques for management of abnormal birth events.

15. Anatomy, physiology, and indicators of normal adaptation of newborn to extrauterine life.

16. Techniques for placental expulsion.

17. Techniques for performance and repair of episiotomy and repair of lacerations.

IV. POSTPARTUM CARE

A. Assumes responsibility for management of care of the woman during the postpartum period.

B. Uses a foundation for nurse-midwifery practice that includes but is not limited to the knowledge of:

1. Anatomy and physiology of the puerperium, including the involutional process.
2. Anatomy and physiology of lactation and methods for its facilitation or suppression.
3. Parameters and methods for assessing the puerperium.
4. Emotional, psychosocial, and sexual changes of the puerperium.
5. Etiology and methods for managing discomforts of the puerperium.
6. Common screening/diagnostic tests used during the puerperium.
7. Indicators of deviations from normal and appropriate interventions.
8. Pharmacokinetics of medications commonly used during the puerperium.
9. Prescription or administration of appropriate medications, treatments and solutions.
10. Appropriate anticipatory guidance regarding self-care, infant care, family planning, and family relationships.

V. NEONATAL CARE

A. Assumes responsibility for management of care of the neonate.

B. Uses a foundation for nurse-midwifery practice that includes but is not limited to the knowledge of:

1. Anatomy and physiology of adaptation to extrauterine life and stabilization of the neonate.
2. Parameters and methods for assessing neonatal status, including emotional and psychosocial needs.
3. Parameters and methods for assessing gestational age of the neonate.
4. Nutritional needs of the neonate.
5. Indicators of deviations from normal and appropriate intervention.
6. Screening/diagnostic tests performed on the neonate.
7. Pharmacokinetics of medications commonly used for the neonate.
8. Prescription of medications and treatments.
9. Methods to facilitate adaptation to extrauterine life including resuscitation and emergency care of the newborn.
10. Factors influencing neonatal behavior and parental interaction.

VI. FAMILY PLANNING/GYNECOLOGICAL CARE

A Assumes responsibility for management of care of women seeking family planning and/or gynecologic services.

B. Uses a foundation for nurse-midwifery practice that includes but is not limited to the knowledge of:

1. Anatomy and physiology of the reproductive systems through the life cycle.
2. Anatomy and physiology of the female breast.
3. Anatomy, physiology, and psychosocial components of human sexuality.
4. Provision of counseling regarding general health promotion.
5. Common screening and diagnostic tests.
6. Factors relating to barrier, steroidal, mechanical, chemical, physiologic, and

surgical conception control methods, including:

a. Rationale for use.

b. Contraindications to use.

c. Effectiveness rates.

d. Mechanisms of action.

e. Advantages/disadvantages.

f. Risks/side effects/ complications.

g. Comparative cost.

h. Instructions/counseling.

i. Psychological and sexual considerations.

j. Provision of appropriate method.

k. Discontinuation or change of method.

7. Indicators of developmental changes of women throughout the life cycle and health promotion measures specific to these changes.

8. Indicators of problems of sexuality, methods for counseling, and indications for consultation or referral.

9. Factors involved in decision making regarding unplanned or undesired pregnancies and resources for counseling and referral.

10. Indicators of deviations from normal, risk factors, and appropriate preventive measures and interventions for selected pathology.

VII. PROFESSIONAL ASPECTS

Assumes the role and professional responsibilities of nurse-midwifery practice. As a leader or change agent, the nurse-midwife demonstrates:

1. Knowledge of the historical development of nurse-midwifery in the U.S., structure and function of the American College of Nurse-Midwives, and the legal base for nurse-midwifery practice.

2. Knowledge of contemporary issues and trends in maternal-child health care nationally and internationally.

3. Knowledge of standards for quality maternal and child health services.

4. Knowledge of current and pending health legislation.

5. Knowledge of the role and responsibilities of the nurse-midwife in supporting legislative contributions to high-quality maternal and child health services.

6. Knowledge of the various nurse-midwifery practice options and the resources available for their development and evaluation.

7. The ability to carry out the philosophy of the American College of Nurse-Midwives.

8. Respect for the dignity and rights of health care providers and clients.

9. Responsibility and accountability for:

   a. Personal management decisions made in caring for clients.

   b. Periodic self-evaluation and participation in peer review to maintain currency in practice.

   c. Delivery of services to families in collaboration with other health care providers.

10. The ability to evaluate, apply and collaborate in research.

11. Awareness of the professional responsibility to participate in nurse-midwifery education.

Source: EDUCATION COMMITTEE
Approved by ACNM Board of Directors, February 3, 1992
(Supersedes ACNM Core Competencies in Nurse-Midwifery, May 1985)

PARTNERSHIPS FOR PROGRESS

ICM's story is one of the emergence of a modern, public, health care profession from an ancient, private craft. It is inevitably closely linked to the educational, social and economic status of the women it serves. As conditions for women improved in some parts of the world, so midwifery grew stronger as a formally organised profession. From village handywoman to senior midwife adviser in a Ministry of Health seems a huge step, but it is one which encompasses the experience of midwives during the seventy five years of ICM's existence.

Within four years of the end of the Second World War moves were made to re-establish an international midwifery organisation. By 1954 the reborn International Confederation of Midwives had established its new headquarters in London. ICM grew quickly well beyond Europe, as midwives everywhere sensed the value of sharing information and working together to develop strategies for improving conditions for childbearing women and their families. Throughout its lifetime ICM has been a small-scale structure despite its worldwide outreach, now covering nearly seventy midwifery organisations in almost sixty countries.

Cooperation and partnership, with women and with professional and international bodies such as the World Health Organization (WHO) and the United Nations Childrens Fund (UNICEF), have allowed ICM to influence policy and bring about change. It is appropriate that 1994 should be both the International Year of the Midwife and the International Year of the Family, and the International Confederation of Midwives is celebrating its birthday under the theme of *"Seventy five Years of Global Partnership - Empowering Women - Empowering Midwives"*.

The Safe Motherhood Initiative and the Baby Friendly Hospital Initiative have been recent major collaborative ventures with WHO and UNICEF, aimed at making both birth and babyhood safer and happier for millions. Midwives everywhere have taken up the challenge and move towards the future with confidence. Partnership with the women they serve is their great strength and it is time to find new ways of expressing a global vision of women, their health and the health of their families. *Member Associations are encouraged to send their "Vision Statements" to ICM Headquarters by October 1st 1994.* The resulting document will be published to mark the closure of the International Year of the Midwife and to point the way forward for the future.

Do please send any documents you may have concerning the history of your midwifery association and its relations with the ICM as soon as you can to ICM Headquarters, London.

Milestones in International Midwifery 1994

ICM

EMPOWERING WOMEN ... MIDWIVES

GLOBAL PARTNERSHIP

International Confederation of Midwives

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MILESTONES

IN

INTERNATIONAL

MIDWIFERY

MILESTONES

IN

INTERNATIONAL MIDWIFERY

Midwifery managed very well for thousands of years without the structures and complexity of formal organisation. It was a vital service for women at a critical moment of their lives, in the intimacy of their own homes. Although some countries such as Finland, Germany and France developed quite sophisticated schemes for the education of midwives and regulation of their practice during the centuries after the Reformation, others were content to leave childbirth to the care of traditional practitioners whose skills were transmitted from generation to generation through some form of apprenticeship.

By the end of the nineteenth century things looked very different. Nations were becoming concerned about the poor health and high death rates of women and babies and midwives were beginning to realise that if they were to survive within the newly developing health care systems they would have to improve their standards of education and their working conditions. Some old-established schools of midwifery existed in various places in Europe, but in other parts of the world, particularly in North America, midwives found their practice limited to their own immigrant group, such as Swedish, Latvian, or Polish. Elsewhere they were largely being pushed aside by the huge increase in the number of male doctors.

ORGANISING INTERNATIONALLY

In 1900 over a thousand midwives from nine European countries met together in Berlin for a congress, but no permanent organisation was formed. Immediately after the First World War, however, with rapid institutionalisation of childbirth, falling birth rates, and an ever-growing number of doctors, the threats facing the ancient practice of midwifery were so overwhelming that the need to work together across national and cultural boundaries became urgent. In 1919 the International Midwives Union (IMU), later to become the International Confederation of Midwives (ICM), was founded and grew steadily through the interwar years, with meetings every couple of years in great European cities such as Prague, Vienna, Ghent, London and Paris. Debates focused on issues such as the place of birth, the expansion of the midwife's traditional role, particularly with the use of pain relief, and ways of improving standards of education and working conditions.

Sadly, ICM's archives for this period were lost as war swept over Europe once more, but the journal which was published as a record of the Congress proceedings survived in London and provides a fairly detailed picture of the major pre-occupations of midwives during these years. The ICM has commissioned a full history, but this will take a number of years to produce. The story of the ICM is the story of its member associations - to give a full and accurate account of the organisation of midwifery cooperation internationally as much detail as possible is needed about the history of each of the member associations.

INTERNATIONAL CODE OF ETHICS FOR MIDWIVES

1993

With Explanatory Notes and Glossary

INTERNATIONAL CODE OF ETHICS FOR MIDWIVES

1993
With Explanatory Notes and Glossary

"[A code of ethics] is not a dry dusty piece of paper; it is a living, breathing embodiment of the spirit of midwifery and we are the ones that make it not only live, but sing and dance with the joy of life itself."

Bronwen Pelvin
New Zealand Midwife
Journal of NZCM, 1992

Published by the
International Confederation of Midwives
1993

Further copies of this book are available from:

International Confederation of Midwives
10 Barley Mow Passage
London W4 4PH
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ACKNOWLEDGEMENTS

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Members of the International Confederation of Midwives Executive Committee 1990/93 and Delegates from member associations attending International Confederation of Midwives Council meeting May 1993

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INTRODUCTION

In an effort to increase understanding and, hence, use of the International Code of Ethics for Midwives (1993), the ICM Board of Management commissioned the publication of this booklet. The booklet contains the Code, the glossary of terms used in the Code, the ethical analysis of the Code, a brief history of the development of the Code, and suggestions on how the midwife can use this Code in practice, education or research.

International Code of Ethics Midwives (1993)

PREAMBLE

The aim of the International Confederation of Midwives (ICM) is to improve the standard of care provided to women, babies and families throughout the world through the development, education, and appropriate utilization of the professional midwife. In keeping with its aim of women's health and focus on the midwife, the ICM sets forth the following code to guide the education, practice and research of the midwife. This code acknowledges women as persons, seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect, trust, and the dignity of all members of society.

THE CODE

1. Midwifery Relationships

   a. Midwives respect a woman's informed right of choice and promote the woman's acceptance of responsibility for the outcomes of her choices.
   b. Midwives work with women, supporting their right to participate actively in decisions about their care, and empowering women to speak for themselves on issues affecting the health of women and their families in their culture/society.
   c. Midwives, together with women, work with policy and funding agencies to define women's needs for health services and to ensure that resources are fairly allocated considering priorities and availability.

d. Midwives support and sustain each other in their professional roles, and actively nurture their own and others' sense of self-worth.
e. Midwives work with other health professionals, consulting and referring as necessary when the woman's need for care exceeds the competencies of the midwife.
f. Midwives recognize the human interdependence within their field of practice and actively seek to resolve inherent conflicts.

II. Practice of Midwifery

a. Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures.
b. Midwives encourage realistic expectations of childbirth by women within their own society, with the minimum expectation that no women should be harmed by conception or childbearing.
c. Midwives use their professional knowledge to ensure safe birthing practices in all environments and cultures.
d. Midwives respond to the psychological, physical, emotional and spiritual needs of women seeking health care, whatever their circumstances.
e. Midwives act as effective role models in health promotion for women throughout their life cycle, for families and for other health professionals.
f. Midwives actively seek personal, intellectual and professional growth throughout their midwifery career, integrating this growth into their practice.

III. The Professional Responsibilities of Midwives

a. Midwives hold in confidence client information in order to protect the right to privacy, and use judgement in sharing this information.
b. Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.
c. Midwives may refuse to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.
d. Midwives participate in the development and implementation of health policies that promote the health of all women and childbearing families.

IV. Advancement of Midwifery Knowledge and Practice

a. Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.
b. Midwives develop and share midwifery knowledge through a variety of processes, such as peer review and research.
c. Midwives participate in the formal education of midwifery students and midwives.

6 May 1993

Glossary of Terms used in ICM Code of Ethics

It is the goal of the ICM that this Code of Ethics be used and tested for its relevance to the practice of midwifery and for midwives. One element of understanding relates to the use of language across cultures and societies. Therefore, the following terms are defined as used in the ICM Code of Ethics.

equity in access to health care (preamble): this implies fairness in the allocation of limited resources according to need; for example, vulnerable populations/groups could receive more attention to their health needs and access to services than those who can purchase such services anywhere.

informed right of choice (I.A.): "informed" implies that complete information is given to and understood by the woman regarding the risks, benefits and probable outcomes of each choice available to her.

human interdependence (I.F.): since midwives work in relationship with women and others and may not always agree about what is right or should be done in a given situation, it is important that midwives seek to understand the reasons for the disagreements with clients or colleagues. Midwives do not stop with understanding, however. They also work to resolve those conflicts that need to be resolved in order for ethical care to continue.

individual conscience (III.B.): defined as thoughtful reflection on, analysis, and ownership of deeply held moral positions; in this context, the midwife can refuse to provide care only if someone else is available to provide the needed care.

professional (Preamble): this term is used to recognize the concept that to be ethical is to be professional, to be unethical is to be unprofessional.

professional knowledge (IIC.): this implies midwifery knowledge gained from both formal and informal educational opportunities that lead to competence in practice.

professional responsibilities (III.): this refers to the broad ethical duties/obligations of the midwife that are not practice, education or research specific.

related outcomes (III.C.): midwives are responsible for the results of their own decisions and actions; they cannot be held responsible for outcomes over which they have no control (e.g., genetics). There may be situations in which the midwife is ordered by someone in power to practice in an unethical manner. We appreciate the difficulty of this situation, but the action remains unethical if the midwife chooses to follow such an order. The midwife must be aware of the risks in choosing not to follow such an order, however.

rights of women as persons (IV.A.): human rights related to any research involvement include privacy, respect, truthtelling, doing good and not harming, autonomy and informed consent.

throughout the life cycle (II.E.): midwifery care is more than care related to childbearing; midwives care for women of all ages, many of whom never conceive or bear children; use of this phrase is an attempt to cover both the reproductive and gynaecological health care for women.

women as persons (preamble) : women will be treated with respect for human dignity (not as objects). Principles of truthtelling, privacy, autonomy and informed consent, doing good and not harming will direct any interaction between women and midwives.

ETHICAL ANALYSIS OF THE CODE OF ETHICS

INTRODUCTION

Ethics codes are often a mix of universal ethical principles and strongly held values specific to the "professional group." Below is a brief analysis of the major ethical principles and concepts that form the basis for each of the statements of the ICM International Code of Ethics for Midwives.

I. Midwifery Relationships

a. Autonomy and accountability of women
b. Autonomy and "human qualities" of women
c. Justice/fairness in the allocation of resources
d. Respect for human dignity
e. Competence, interdependence of health professionals, safety
f. Respect for one another

II. Practice of Midwifery

a. Respect for others, do good, do not harm
b. Client accountability for decisions, do not harm, safety
c. Safety

d. Respect for human dignity, treat women as whole persons
e. Health promotion: attain/maintain autonomy, good/no harm, allocation of resources
f. Competence in practice

III. Professional Responsibilities of Midwives

a. Confidentiality
b. Midwife accountability
c. Midwife conscience clause: autonomy and respect of human qualities of the midwife
d. Health policy development: justice, do good

IV. Advancement of Midwifery Knowledge and Practice

a. Protect rights of women as persons
b. Midwife accountability, safety, competence
c. Professional responsibility: enhance competence of all professionals to do good, do not harm

The Process of Development of the ICM Code

The charge to develop a code of ethics that defined the moral context of midwifery in meeting the needs of women came from the ICM Board of Management. A brief history of the process of development of the ICM code of ethics may help the reader to understand more fully how specific principles and concepts were included and why others were not. The Code was drafted in a series of workshops, beginning in May 1986 in Vancouver, and continuing in 1987 in the Hague and in 1991 in Spain.

The final draft, the consensus document of the Executive Committee in Madrid, was presented to the ICM Council in Vancouver, British Columbia, and adopted on 6 May 1993.

Code development began with a review of systems of ethics, an understanding of how individuals develop morally, and a brief review of the history of code development in medicine and nursing. This was followed by an analysis of the values inherent in the ICM Constitution's statements on the aim and objectives of the Confederation, the ICM/WHO/FIGO definition of a midwife, and accepted ICM position statements as of 1992.

In order to provide a world-wide (global) focus to the ICM code, the group aimed at statements that were often broader in their meaning than individual association codes so that cultural/societal or ethnic variations could be respected. Seven midwifery association codes of ethics received at ICM headquarters during 1991 were analysed, revealing the following ethical concerns:

> Safety, competence, accountability, confidentiality, appropriate consultation and referral, respect for human dignity, client involvement in decisions, participation in knowledge development in midwifery and the design of maternal-child health policies, respectful interaction with other team members, health promotion, justice/fairness, non-discrimination, and the education of future midwives.

At all times,the concern for understandability, culturally sensitive wording, and the global nature of the ICM code were kept in mind. Two other important features were agreed: first, that whenever possible, the ICM code would promote a global (universal) level of morality; that is, the statements would be made reflecting universal ethical principles, with reasonable consideration for personal and/or legal authority. In keeping with this first agreement, the second was consciously to exclude reference to the law or legal entities within the code. While ethics and law are related, the law varies from country to country. Normally, ethics or ethical systems respect the law, but at times ethics may go beyond the law.

As noted during the introduction to this booklet, the Code of Ethics for Midwives is intended to be a "living" document, and the ICM welcomes comments and suggestions for enhancing the understanding and usefulness of this document over the years.

SOME QUESTIONS ABOUT A CODE OF ETHICS

1) What is a Code of Ethics?

   A code of ethics is a public declaration of the beliefs and values of a profession and the members of that profession. This code makes public the goals, values and morals of those who call themselves "midwives"- a statement to the public about what the profession of midwifery defines as moral behaviour for its practitioners.

Why have a code?

A code of ethics acts as a specific, identifying feature for a particular professional group, both for the professionals themselves and for the general public. In addition, the need for an explicit code has become more urgent in recent years, as an accelerated pace of social and technological change has produced a sharp increase in the number and complexity of professional situations that demand an ethical response. Finally, the increased speed and frequency of global communications have made the development of a formal statement of shared beliefs and values vital as an agreed point of departure or common language for the profession worldwide.

3) What can a code do?

A code of ethics offers guidance (ideals) for professional conduct - the moral "shoulds" and "oughts" of life. These "morals" direct the behavior of midwives in their relationships with individuals, institutions, and the world. The code offers a framework which may enhance midwives' capacity for effective moral decision-making and reflection. It may also provide external, agreed criteria by which the appropriateness of a given course of action may be challenged or justified.

4) What can't a code do?

A code of ethics cannot assure ethical practice or "good" decisions in midwifery care; it cannot "tell" one how to make ethical decisions or what to do in every situation; it cannot prevent its misuse; and the code cannot offer specific issues for discussion or resolution. Finally, a code cannot remove from midwives the responsibility and pain of living

and acting, at times, in situations of ambiguity or "not knowing", of having no in-built guarantees about what, in a given case, constitutes "right action".

5) What is required for use of a code of ethics?

The main requirements for using a code of ethics as a professional include the commitment to critical thinking (time and moral reasoning); the ability (capacity and willingness) to make decisions; a commitment to being a good moral agent - wanting to do the right thing for the right reasons in caring for others while accepting responsibility for one's own actions and decisions; and an understanding - of ethics, of oneself and one's values, and other's values as well.

Suggestions on how to use the Code of Ethics

The value of a statement of one's professional code of ethics lies in its usefulness in all spheres of professional practice. For the midwife, these spheres of practice may include direct caregiving, teaching others, administration and research. The following are suggestions of how the International Code of Ethics for Midwives may be used:

In daily practice, the Code can be an important tool or reference point (yardstick) when facing decisions on what one "should" do in caring for women and childbearing families. While the statements of the Code may not give absolute direction to your decision making, they can (or the ethical principles they are based upon can) offer a framework for action; eg. selecting an option that promotes good or prevents harm to women.

Practitioners could use criteria within the code when negotiating with others in an effort to obtain the best outcomes for women and their families. The code can be shared with the public by the posting of printed copies.

In education, the midwife teacher has an obligation to help students understand what it means to be a moral agent, to practice ethically, and to identify, understand and accept the dominant values of the profession of midwifery. Teaching methods include a value analysis of each statement of the Code, using the Code in the ethical analysis of critical incidents from midwifery practice, and comparing the basic tenets of the Code for Midwives with those of codes from other professional groups. Critical incident analysis can be a powerful teaching instrument at any level, illuminating practice decisions with the code's principles as well as with personally identified values.

In administration, midwives can use the Code to establish a working environment for ethical practice. Administrators can use the tenets of the Code to define expectations of how midwives wil l relate to clients, as a framework for ethics rounds and for establishing an ethical environment in which employees can function.

In **research**, the Code explicitly defines the ethical approach of the midwives in Statement III.A and Statement IV. in its entirety. Researchers, whether midwives or others, should adhere to these basic principles.

ICM 12/93