J O U R N A L

NEW ZEALAND COLLEGE OF MIDWIVES, SEPTEMBER 1989

FIRST ISSUE – "A NEW BEGINNING"

Regional Boundaries of the New Zealand College of Midwives

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C O N T E N T S

The **New Zealand College of Midwives Journal** is the official publication of the New Zealand College of Midwives. Single copies are $4.00.

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Editorial Committee
Regional members being established.

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Contributions
Contributions such as letters, reviews, forthcoming events and other items of interest are needed, and are welcome from anyone who feels they have something to offer. Art work will also be gratefully accepted. We can return originals.

Articles herein express the opinions of the author.
Articles may be reprinted with the written permission of the Board of Management.

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EDITORIAL

Welcome to the NZCOM Journal

Advertising of Breast Milk Substitutes

The Board of Management and the Co-Editors decided unanimously that it is unethical to advertise breast milk substitutes.

In 1981 WHO and UNICEF published an International Code of Marketing of Breast Milk Substitutes.

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WELCOME TO THE FIRST ISSUE OF THE New Zealand College of Midwives Official Journal.

The aim of this journal is to enable midwives,

- to share their reflections in the whole field of midwifery including practice education and research, imparting knowledge and personal experiences.
- to communicate information and insights by engaging in fruitful dialogue and debate with the providers and consumers of midwifery services.

The first issue highlights the political aspects of the formation of the New Zealand College of Midwives.

Congratulations go to Joan Donley for her inspiration, to the Board of Management and the regional chairpersons for all their hard work and effort to get the College of Midwives established.

Judy Hedwig, Helen Manoharan

Co-Editors, NZCOM Journal

We acknowledge the $1,500 grant given by the Ministry of Women's Affairs.

COMING EVENTS

Anne Oakley Tour

17th - 26th September — Auckland
30th September — Dunedin
3rd-5th October — Auckland

Anne Oakley, the world renowned English sociologist and supporter of midwives, will be visiting New Zealand this year as the ASB Visiting Professor.

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Guest Editorial

THE YEAR 1989 HAS BEEN A REMARKABLE year for mdiwives and midwifery in New Zealand.

Future midwives will view this year as a significant step forward in our history. Ultimately, the decisions made and directions taken will have far reaching effects on the New Zealand family. The reaffirmation of midwifery as a profession in its own right will, I believe, lead to a stronger and more effective midwifery service which in turn will strengthen women's perception of birth as a normal life event.

This year we have seen the re-introduction of separate midwifery education. These courses have started in Auckland, Wellington and Dunedin and reports so far, from midwives and students, have been very positive.

The New Zealand College of Midwives was launched officially on April 2nd, 1989, after many years of soul searching discussion. The New Zealand Nurses Association wished us well and we continue to have a close liaison. Our early fears of severing the "umbilical cord" were not realised - we have come of age!

We continue to receive overwhelming support from the women of New Zealand

- i.e. many groups are actively campaigning for a return of the midwife as defined by the WHO.

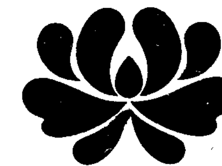
Thanks to the marathon efforts of Judy and Helen (editorial marvels), midwife colleagues and New Zealand women, we can now celebrate our achievements with the publication of our own journal.

It gives me great pleasure to welcome you all to these pages and I am confident that this "public voice" will enable us to continue on our way forward.

Karen Guilliland

President

Congratulations!!



More Magazine

Congratulations on your enterprise in launching the Midwives Journal. We know from our experience at publishing a monthly glossy for women that issues relating to childbirth and mother care are dear to the hearts of every woman moving through the childbearing years. On a personal level, I have a daughter whose aim is to become a midwife, so you can be assured that your first issue will be read with much interest by at least two people in our household!

Lindsey Dawson
Editor

Broadsheet

Congratulations are in order on the birth of your first journal. *Broadsheet* looks forward to the critiques and information that midwives in Aotearoa have offered for so long, being put into writing.

Midwives have always been a source of power and energy for women, despite the fact that they have been undervalued and devalued by the medical profession. We hope that your journal will also provide that source of strength and continue to grow and flourish.

Happy birthday.

The Broadsheet Collective

W.H.O.

The World Health Organisation gives high priority to the health of women, their reproductive health and safe motherhood. It stands committed to play its role in action for the agreed four elements of safe motherhood: social equity for women (including the promotion of health, nutrition, and education for girls); family planning for all couples; primary health care to provide maternity care for all; and provision of essential obstetric care at first referral level. The World Health Organisation is pleased to be one of the partners in the Safe Motherhood Initiative launched at the International Conference on Safe Motherhood , held in Nairobi in 1987, and to contribute to this global movement through the WHO programme of maternal health and safe motherhood.

All involved in this Conference - governments, nongovernmental organisations and the international health and development community - can take pride in the distance we have come in a relatively short time with respect to advocacy on safe motherhood, which now has to lead into concrete action. Midwives from around the world have responded to the impetus of safe motherhood by adopting an action statement which was forged at the International Confederation of Midwives/WHO/UNICEF collaborative pre-congress workshop held in the Netherlands in August 1987.

Midwives have started to ask themselves several relevant questions. These include, among others: are midwives equipped to analyse the special needs of women, or are they mainly concerned with traditional pre-, intra- and postnatal care, leaving decision making and problem-solving to others? Are midwives prepared to undertake research projects and lobby for better conditions of care for women, including counselling and family planning during childbearing years?

In comparison with women in other countries, women in New Zealand enjoy a greater degree of safety during pregnancy than many women in other parts of the world. However as in many countries, women are now asking for more personalised care and access to services, as well as responses to their needs as individuals.

The beginning of this journal suggests that new thinking is taking place: that midwives are committing themselves to action and are recognising that problems exist which they are insufficiently trained to solve.

The World Health Organisation hopes that this journal will give the opportunity to New Zealand midwives and others concerned with health care for women in the reproductive process to define issues and search for new solutions.

We congratulate the midwives of New Zealand on their initiative in midwifery leadership and wish them success in the achievement of their aims in the quest for Health for All by the Year 2000.

Dr A. Petros-Barvazian
Director,
Division of Family Health

Advisory Committee on Women's Health

The committee is aware that this is a time of change for maternity services in New Zealand and hopes your organisation will make an important contribution to the development of services which meet the needs of all New Zealand women.

Diana Edwards

The Royal College of Midwives Trust

I was delighted to hear the decision that a new journal for midwives is to be produced in New Zealand for the New Zealand College of Midwives. It is the College's experience in the UK that midwives are hungry for information and up-dating material and I am therefore sure that you will find success when you begin publishing your new journal. We at the Royal College of Midwives in the UK wish you every success in this venture and congratulate you for having made the decision to go ahead.

With our very best wishes.

Ruth Ashton
General Secretary

The Federation of New Zealand Parents Centres Inc.

Congratulations to the New Zealand College of Midwives on the initiation and setting up of a professional body for midwives and consumers. The Federation of New Zealand Parents Centres sees this as a step forward for those who work with birthing women and their families.

We are pleased that our representative, Sharron Cole, Rotorua, will be joining your College.

Well done from the Executive and myself.

Karen Eagles
National President

Ministry of Women's Affairs

I am pleased to have the opportunity to congratulate the New Zealand College of Midwives on the publication of the first issue of their journal.

Because they play such a major role in assisting and supporting women through childbirth, midwives make an important contribution to the wellbeing of women. New Zealand midwives are recognised for their commitment to responding to women's needs during childbirth and providing a consumer based approach.

At this time of change in the health services in New Zealand, it is encouraging to see midwives asserting themselves as a profession through the establishment of the New Zealand College of Midwives. The publication of this journal will be welcomed not only for the communication and debate it will encourage within the profession, but for the forum it will provide for the expression of consumer needs.

Margaret Shields
Minister of Women's Affairs

Australian College of Midwives Inc.

Congratulations and good luck with the new professional organisation and Journal.

Martin Goreing
Editor,
Australian College of Midwives Journal

Professionalism

Joan Donley

The importance of consumer control over childbirth.

LAST YEAR, 1988, WAS A MOMENTOUS ONE for New Zealand midwives. After decades of dragging the chain, we finally broke free and formed our own 'professional' organisation - the New Zealand College of Midwives - in order to speak for ourselves and improve the status of midwives.

Just what does professionalism really mean? Further, what should it mean to midwives on the threshold of the 21st century?

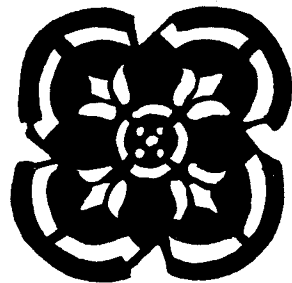
It is generally accepted that a profession has a specialised body of knowledge, standardised training and has developed its own standards and code of ethics. These things we have achieved. Further attributes of a profession are it is self-defined and self regulated and legally recognised. These are yet to be achieved - hence the College.

While we have defined ourselves according to the W.H.O. definition of a midwife, e.g. as an independent practitioner, legally we are defined as 'obstetric nurses' i.e. as handmaidens to the doctor and are required to work under medical supervision. Casually, we are referred to as 'midwives' and are even licensed as such, e.g. R.M., but this is a relic of the days when we had some autonomy, i.e. prior to the Nurses Act, 1971.

Regaining our autonomy is one of the first projects our new College is working on. If we are to work efficiently it is crucial to be aware of who are our allies and who is our opposition. Also, to avoid arrogance it is necessary to understand the negative aspects of professionalism.

Professions developed in the 19th century, aided by the growth of science and in response to capitalist market forces which were being freed from feudal structures. At that time there were many empirical, alternative practitioners and midwives competing for a place. In order to gain a dominant position in the medical market place, doctors first had to establish 'authority'. This was done by establishing a body of esoteric knowledge, by standardising training and licensing the practitioners. Then as a group which had objectively validated its competence, it proceeded to define the nature of reality and needs of those consulting them in terms of medical interests.

Authority not only justified the psychological dependence of the 'patient' - a surrender of private judgement - it also masked it's nonrational basis of power. Both these aspects enabled the medical profession to establish themselves as 'experts'. As such, they were able to infiltrate the bureaucratic structures the state was setting up during a period of growing concern over public health. As experts, the medical profession was able to have its definitions of 'health' and 'health care' officially recognised. This was followed up by state patronage, which placed them in a very powerful position.



In the files of maternity care, the medical profession defined normal/abnormal labour as a conceptual basis in order to blur the boundaries and accomodate 'residual normalcy'[1] By deliberately defining 'power' as 'safety', it is justified medical control of childbirth, convincing the political decision-makers that the only safe place to have a baby was in hospital with the doctor in charge. And the Department of Health still faithfully parrots the official line whenever the issue of autonomy for midwives is raised, that is that 'the Nurse's Act 1977 is designed to ensure that mothers receive a safe service. It provides for medical supervision and nursing services at a defined level of competency'.[2]

The proliferation of technology led to the centralisation of maternity services - for the convenience of doctors - and the current high level of medicalisation of childbirth. In the process, the subordination of midwives was completed by incorporating them into nursing. This has resulted in the loss of the special attributes which made midwives a real alternative to medicalised childbirth.

Despite the negative aspects of professionalism, this is the only form of organisation open to us to enable us to achieve our ends. However, the issue of power must be confronted. Power for whom?

If we pursue power for narrow social and economic interests, in the long term we will lose everything. All we will have achieved in the short term is to have replaced the present high cost obstetric service with a more cost effective midwifery service. It will still be a maternity service removed from the woman's control and active participation, where dynamic personal relationships are replaced by passivity, impersonal relationships and standardised procedures. If we are reasonably compliant to medical edicts, we may be allowed a modicum of professional status. But, we would NOT be midwives - 'with women'. In due course, we would be replaced by lay midwives.

However, if we insist on being midwives, accountable to women, then we can expect strong opposition from the medical profession. In fact, this is already evident. The N.Z. Medical Association, backed they say, by M.P.s have hired a firm of Wellington lawyers to analyse the structure of the Otago/Southland separate midwifery course because it is based on the W.H.O. definition of a midwife.

The legal opinion is that 'the midwifery course is clearly directed to a "stand-alone" responsibility for the patients and there is no "normal" doctor/nurse structure in existence... (which) would presumably be to replace the existing relationship with one where the midwife was in a direct relationship with the mother... '[3] Since the doctor has legal, professional and contractual responsibility whether the patient is public or private, says this opinion, this arrangement leaves the doctor without adequate protection. Obviously the patient is seen to belong to the doctor, deprived of any decision-making powers, while the adoption of the W.H.O. definition of a midwife and the separate midwifery courses threaten the doctors' clinical freedom which appears to be seen as a divine right and as such is jealously guarded.

Tony Baird recently told the Wellington O & G Society that the three greatest threats to modern obstetrics are

1. consumerism
2. feminism and
3. midwives

He is of course correct.

If we trace the historic development of

these 'threats' we see that it was the reaction of the knowledgeable middle class women against the medicalisation/centralisation of childbirth that led the rebellion. These women were able to opt out of the system because they had the support of a handful of domiciliary midwives (DMs). Although the DMs were seen by their colleagues as mavericks and the women seen by the medical profession as the 'lunatic fringe', the trickle soon became a flood. From being a 'vociferous minority' this group gained considerable lobbying power. In the matter of only a few years, the Domiciliary Midwives Society Inc - formed by eight DMs - was recognised by the Department of Health as the bargaining body for DMs, completely independent of the medical hierarchy. The achievement of this power base could never have been attained by the DMs alone. It only happened because of the consumer support. Now the DMs have set up their own Standards Review (regional) committees comprised of equal numbers of consumers to health professionals.

Similarly, there are less than 3000 midwives practising in New Zealand. Chances of gaining midwifery autonomy against the well organised medical lobby backed by M.P.s are slim unless we have the active support of consumers - not only because of their voting power, but because they control the clinical material which is the real power of the market place!

Women will only support midwives if midwives are accountable to them and share power with them - which is why they have been included as members of our College!

No doubt, some midwives will see consumer choice and participation in our 'professional' organisation as a threat to their status and so-called power (which is really only reflected from the medical profession). Surely, we no longer have to fear an outdated and discredited professional code that is seen to be violated if a professional yields to consumer demands. In earlier days when doctors were struggling to establish their power base, such practitioners were called 'quacks'. Quacks were defined as those who pleased their patients in preference to their colleagues, e.g. they let their patients define their reality and the state of their health. Like the doctor in New Plymouth who refused to support a woman wanting a home birth 'out of respect to his colleagues', which is another way of saying he lacked the courage to stand up to peer pressure. Hopefully, midwives won't be such cowards!

In including consumers as active members of the College, New Zealand midwives are leaders in a modern trend.

The Director General of Health has set rules for ethics committees which require these to have half lay members, appointed after consultation with the community.

In her Report, Judge Cartwright stated that 'the doctor is no longer autonomous... the focus of attention must shift from the doctor to the patient'. This principle also applies to midwifery autonomy.

The W.H.O. says that every woman has a right to a central role in all aspects of her care, including participation in the planning, carrying out and evaluation of the care.[4]

If our College seeks to become a narrow self-interested professional group, it will fail, wither on the vine, as such professional organisations are resistant to market forces and psychologically unable to share power. Judge Cartwright noted these attitudes among the medical profession, saying that its 'prevailing atmosphere of defensiveness and even arrogance... and its resistance to the patient's right to be freely involved in decisions concerning her management' did not bode well for the future care of patients.

Our College must be progressive and dynamic and welcome consumers as actively participating members. Together we can establish an autonomous midwifery service in the best interests of mothers, babies and midwives!

Footnotes:

1. Arney, William, *Power and the Profession of Obstetrics* University of Chicago Press, 1982.
2. Hon David Caygill, Minister of Health, in letter to Lynda Williams, 12 August 1988.
3. Macalister Mazengarb, Barristers & Solicitors, Wellington, 10 March 1989.
4. *Appropriate Technology for Birth*, 1985.

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Scott, S., Richards, M.—Nursing Low-Birthweight babies on lambswool. *Lancet* 1979; 1:1028—Lambswool is safer for babies. *Lancet* 1981; 1:556

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To My Dear Sisters in New Zealand

Caroline Flint

S.R.N., S.C.M., A.D.M.

Midwifery Consultant to Riverside Health Authority and Independent Midwife, Caroline is wife and mother to three adult children. Author of 'Sensitive Midwifery' and co-author of 'Community Midwifery'.

UNTIL THE DAY I DIE ONE OF THE GREAT highlights of my life will always be the wonderful week I spent with the midwives of New Zealand in August 1988 - a time when I was acutely conscious of history being made and brave decisions being taken. The time when the midwives of New Zealand decided to form their own College of Midwives and break from the Nurses Association. A frightening decision, one surrounded by doubts and a wish to be able to see into the future to check out that it was the right decision and not one taken in a moment of madness and impulse. The siren call "stay with us we are so much bigger and therefore so much more influential" sounds SO reasonable but did size ever win anything? I doubt it.

Women at this time probably more than at any other in the whole history of womenkind need midwives more than ever before. Why am I suggesting this? I am suggesting this because women in 1989 are at lower obstetric risk than they have ever been and yet they are being subjected to greater and greater levels of intervention.

Professor J. MacVicar, Professor of Obstetrics at Leicester (UK) pointed out in an article in *Maternal and Child Health* that "there is an increasing number of mothers who come into an obstetric low risk category for themselves and their babies." He went on to surmise that "this may account for some of the decrease which has taken place in perinatal mortality". [1]

The reason that women are in such a favourable state for giving birth is that women today are better educated, better nourished and better off than any generation of women have ever been and most importantly of all, the babies they have are babies which they intend to have. Women in 1989 do not have 13 or 18 pregnancies just because that is the lot of women - most women have no more than 2 or 3 pregnancies during their fertile years and they have those children because they want them. The babies who have always been at most risk are the babies who come to the woman who has more than enough children already or the babies who come to women who are still children themselves at 13, 14 or 15.

Nowadays 80% of deliveries occur to women aged between 20 and 35 years - the safest years for women to have babies and yet the caesarean section rate is going up and up, in the UK from 4.3% in 1970 to 11.3% in 1987, and the whole concept of birth as a normal or even POSSIBLE event seems to be fading. Every woman you meet has either "needed" an episiotomy because the baby was "in distress" or "needed" forceps because the mother was exhausted or "needed" a fetal scalp electrode because the baby was "in distress", or has had a doctor who "saved my life" or who "saved the baby's life". The con-

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cept of birth as being something which women are designed to do and whose bodies are wondrously and beautifully made to do is being lost. As birth is taken out of homes and into hospitals which become more and more cluttered with the panoply of equipment which beeps, flashes, or computes midwives tend to become "nurses" tending these poor invalids who are "at risk" and whose babies are in peril.

Only by staying separate, only by standing strong can midwives hope to protect women from the seductive onslaught of pathological childbirth, "we're only doing it for the baby's sake, my dear".

Eventually the madness of this situation will percolate into the mass consciousness - at a time when economics are important and ways of providing cost effective health care are being sought, the realisation that midwifery care is not only effective but also cheaper will win us through. Our care is cheaper and more cost-effective, not just because of the great discrepancy in the salaries of both professions. Women who are able to get to know the midwives who will be delivering them need less antenatal admissions (cost saving), they feel more "in control" of the situation during labour, they need less analgesia (another cost saving), they look back on labour more favourably and they feel more prepared for motherhood.[2]

Women looked after by the "Know Your Midwife" team waited less time at the antenatal clinic which probably indicates cost savings for the community at large because employers were deprived of their employees for less time than those of working women in the Control Group. Midwives use the technological aids available for birth, but they use them more rationally and appear to be able to look at every woman as an individual with individual needs and not treat ALL WOMEN with specific equipment because IT'S ROUTINE. If anything is done as a "routine" in childbirth it needs to be looked at and challenged - it may be entirely appropriate for many women but in something so unique as birth it cannot be right for all women regardless.

In 1987 a booklet produced by the National Epidemiology Unit "Where to be Born - the debate and the evidence"[3] collated all research on the place of birth during this century. They concluded that "there is no evidence to support the claim that the safest policy is for all women to give birth in hospital" and "there is some evidence, although not conclusive, that morbidity is higher among mothers and babies cared for in an institutional setting." Their conclusions and growing evidence from GPs[4,5] and statisticians like Marjorie Tew[6] who for years has pointed out that the perinatal mortality rates would have fallen more quickly if women had been encouraged to give birth at home are part of a rising chorus which claims that childbirth belongs to women and that the type of highly controlled and medicalised birth that many women are subjected to is inappropriate and not always in the best interests of women or their babies.

The women of New Zealand need strong, identifiable midwives - don't fret because there are so few of you - if just one person can change and influence the world, there's more than enough of you - dear midwives.

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Attempting to Involve Consumers in Midwifery Policy Development

Joy Bickley

A paper presented at the National Midwifery Conference, Auckland, August 1988.

This paper is aimed at describing an exercise that the NZ Nurses' Association Ad Hoc Committee on Maternal and Infant Policy went through to try and collect consumer views about midwives and the services provided by them. Those views were expected to help shape the resulting policy document.

As a starting point, I want to reflect for a moment on the term 'consumer'. To me, the word presupposes a passivity, an object to which something is done: the end result of the process of production. If fits easily into the capitalist model of production and reproduction, and in so doing accounts for the commodification of those people who use the health services during the process of childbirth i.e. those who pay for a service. At this point, it is not necessary or useful to develop that model to illustrate how the commodification of birth is designed to increase the profits of the health care providers (i.e. obstetricians). Others have done that. What is relevant is the consideration of the term consumer and its development, paradoxically, into 'health activism'. That's what the development of the consumer movement suggests, historically. Regardless of context, 'consumer' connotes some form of relationship with the health care system. The economic connotations need to be acknowledged. The word consumer can refer to individuals groups or institutions. Certainly, the consumer movement has gained momentum in the last thirty years and undoubtedly has its origins in dissatisfaction with health care practices. Health activism and self-help groups imply a critique of professionalism, and especially in relation to childbirth the women's movement has made a profound impact.

An example of a consumer movement in the New Zealand context is the Direct Entry Taskforce, co-ordinated by Judith Strid. To me, this represents the core of the consumer movement: the part that will be accused of being radical, overzealous or unrealistic. But it is the core that gives the consumer movement its focus, drive, intensity and constancy of purpose.

It is because of the tenacity of people in the core of the consumer movement that the movement survives against attempts by providers (or professionals) to fob them off with tokenism and dissmissive attitudes towards their degree of knowledge or commitment. Such attempts exist. Three examples are:

1. The refusal of the Health Department and other decision-makers to allow consumer representation in the group preparing for the new midwifery curriculum.
2. The comment by a member of the Medical Research Council at a meeting I attended recently. He dismissed the idea of consumer representation on the Council (which has a major responsibility for funding research projects) because consumers

"don't have an understanding of the issues".

3. The proposal by Gibbs et al for a new health care structure, which, while it claims to promote 'responsiveness to the consumer', actually creates more barriers against real consumer participation in planning and decision-making than exist currently.

So what about the Midwifery Policy Committee and consumer input? When the committee agreed that consultation of consumers was desirable it was acknowledged that it could only be done in a restricted way i.e. through organised groups of women who had their own networks. This would mean that those women who did not have affiliation to an organised group would not get an opportunity to have their say. It could possibly be assumed that the results would reflect a class and ethnic bias, as well as a focus on urban rather than rural women. In spite of these limitations it was believed to be worthwhile to write to 140 women's groups and ask for their views on midwifery. It was my responsibility to contact these groups which I did with varying degrees of success. The first point of contact was an address list of groups affiliated to the National Council of Women. This was available in our office so they were the first groups contacted. They ranged from the Association of Home Science Alumnae to the Catholic Women's League of New Zealand, the New Zealand Federation of Country Women's Institutes to the Maori Women's Welfare League, from the NZ Playcentre Federation to the Society for Research on Women in New Zealand.

The next round of contacts was made through an address list provided by the Ministry of Women's Affairs, on the basis of which such organisations as La Leche League and the National Collective of Independent Women's Refuges, Pacifica and New Zealand Women's Studies Association were contacted. I also found an address list from *Broadsheet* very helpful and as a result of looking through what I wrote to Women's Health Collectives, Maori Women's Centres, New Mother Support Groups and individual Home Birth Associations, Disabled Women's Groups and the Caesarian Birth Network, plus Save the Midwives and Judi Strid. This process happened over three or four months as time and addresses were made available. One hundred individual groups responded.

You may be asking yourself "Why wasn't there a consumer representative on the committee?" In explaining that I should tell you how ad hoc committees are usually set up. A list of names is offered to National Executive and they have the final decision. The re-writing of the policy was agreed to, in response to the National Committee of Midwives' request. There were 3 nominees from the Midwives' Section, National Executive nominated one of their members and the Professional Services Committee nominated a retired midwife and midwifery tutor. I can't recall whether consumer representation was discussed at this stage or not. However, it is not normal practice to have consumers represented on Nurses' Association committees. The committee did look at proper representation of a Maori perspective and acknowledged that the committee should have had a member who represented Maori views. In an attempt to overcome that shortfall the following actions were taken:

1. The National Council of Maori nurses was sent a copy of the first draft for their comments, particularly regarding the Maori perspective on health and childbirth.
2. The historical section of the midwifery policy statement was to contain material on race and culture issues.
3. Christina Lyndon, at that time a member of the Staff at Te Ohu Whakatupu, Ministry of Women's Affairs was consulted about how we could demonstrate cultural sensitivity. She suggested that the committee could ask for comment from Maori midwives. Three Maori women were recommended by Irahapeti Ramsden, Department of Education.

One of those respondents was Mereana Pitman, a Maori women's health activist and nurse from Wairoa. Mereana sent the Committee an extensive submission. While she congratulated the Committee on an " extensive overview of changes needed" she also said:

1. The committee should have invited a group of Maori women to gather together to articulate how they perceived the issue.
2. The National Council of Maori Nurses should have been involved in above, and have access to the report.
3. The policy statement should be made available in Maori, Samoan, Tongan, Niuean and Tokelau languages.

She went on to say

"There are tribally different perspectives on the issue of birthing. Birthing is part of a wider concept of whenua (land). Because of the effects of colonisation on our people and especially Maori women there has been very little consultation by the pakeha professions with our women as to their traditions and our needs. Under the second article of the Treaty of Waitangi we are entitled to be consulted, the link of the survival of our race is linked to the survival of our lands. Therefore as the tangata whenua we should be consulted. The institutionalisation of the health system over the past 150 years has had a devastating effect on our people with our race almost being wiped out. Even in this day and age the demands made on our women in the name of professionals and economics regarding birthing can be likened to cultural and environmental genocide."

Mereana pointed out that she did not see herself as a spokesperson for the Maori people but spoke from her personal and professional experience.

Her submission supported Maori midwifery tutors, Maori wananga (schools of nursing), and Maori resources made available for direct entry courses. Research should be done in consultation with Maori communities. Anti-racism workshops are necessary as is discussion on the Treaty of Waitangi: more Pacific Island and Maori nurses.

Draft two of the Midwifery Policy Statement sought to incorporate some of those concerns, and comments from midwives' sections and branches confirmed their importance. NZNA is currently working towards establishing an equal, collegial and professional relationship with the National Council of Maori Nurses.

The questionnaire designed by the committee was forwarded to the consumer groups as I have explained. Five open questions were asked: easy to ask but difficult to collate in any objective and scientific way.

1. What do you feel about the service provided by midwives?
2. What service would you like midwives to provide in the future?
3. In what ways are you currently involved in decision-making about midwifery services?
4. In what ways could you be involved in decision-making about midwifery services?
5. Is there any further comment you wish to make?

The committee didn't want to restrict, through a formally structured questionnaire, what respondents said. It was a device that worked. Groups put an impressive amount of work into their submissions and expressed their appreciation at being invited. The best thing that could happen is that they are taken notice of. There was such a depth of commitment and interest and expertise in those groups that wrote to the committee. One response said "We can only submit our ideas and we get hacked off by the lack of response." Each group that wrote to the committee was sent a letter of thanks and a copy of the summary of responses. A copy of the Policy Statement will be sent to national bodies of organisations when it has been ratified by NZNA members.

Question 1

"What do you feel?" rather than "What you think" because feelings were considered important. However, most respondents told us what they thought.

61% were very positive and included comments about the midwife's personal characteristics as well as professional skills. Responses tended to focus on the birth itself but some did recognise the role of the midwife in antenatal and post-natal days. 11% of responses acknowledged the constraints that prevent midwives from providing the service they would like to provide e.g. staffing levels. What came through clearly was a recognition that midwives are under-valued professionals who deserve more status and autonomy. Criticism of the service provided in the hospital setting tended to centre around midwives' relationships with doctors, the intrusion of the hospital routine, the high degree of intervention, and the amount of control the doctor had.

Domiciliary midwifery services were clearly differentiated from hospital services, and continuity of care was cited as the central feature of the difference. Consumer comments on domiciliary midwifery were universally positive. In contrast, hospital experience highlighted the perceived variation in standards of midwifery care. This tends to result in women in labour worrying about which midwife will be caring for them. Individual responses referred to bossy midwives, judgemental or antiquarian attitudes. One woman mentioned being cared for by 10 midwives through her hospital stay, an experience that demonstrated the need for consistent policies in the health environment. Absence of cultural sensitivity was cited by another submission.

Specific issues noted were:

1. Misallocation of funding
2. Shortage of midwives
3. Absence of maternity services in small country areas
4. Lack of support for domiciliary services
5. Fragmentation of care
6. The need for midwives to be the centre for a women-orientated service.

Question 2

"What service would you like midwives to provide in the future?"

Almost without exception people were optimistic about the future, future practice being characterised by:

- continuity of care
- choice for the women
- a national domiciliary service
- removal of limitations on midwifery practice
- practice characterised by cultural sensitivity
- innovative styles of practice e.g. group midwifery practices
- back up services for home birth
- more extensive ante-natal programmes
- maintenance of small rural units
- more availability of good quality literature
- more expertise in breast-feeding support
- better liaison with support agencies
- more consistent hospital policies

Midwifery education was more likely to be commented on by consumer groups whose focus was childbirth e.g. Home Birth Associations. Their comments highlighted such issues as:

- more funding
- greater remuneration for midwives
- direct entry programmes as a more attractive alternative
- the need for a campaign to educate the public about the value of midwives
- the need for compulsory in-service courses and refresher courses

Question 3

"In what ways are you currently involved in decision-making?"

The vast majority of groups believed they had no involvement.

Question 4

"In what ways could you be involved in decision-making about midwifery services?"

The majority of responses answered in the affirmative, but others could not identify ways in which they could be involved in decision-making. A number of consumer groups called for closer links between midwives and consumer groups e.g.:

- offers to speak at midwives' seminars
- invitations to midwives to speak at consumer seminars
- regular discussions with staff of maternity units
- supporting midwives in making changes

Involvement in decision-making at individual, through Area Health Board to national levels was seen as imperative, though some consumer groups were pessimistic about their ability to influence decision-makers.

Any further comment?

While only half of the groups returned responses to this question, those that did, reiterated views demonstrated in responses to the earlier questions. Power was a central issue and shaped the other features identified:

- utilisation of resources:
  (a) in funding of services
  (b) in funding of midwifery education
- education of the public
- the essence of midwifery practice

The above views are from women's groups that have resources and some form of organisation. It is much harder to collect women's view of midwifery who are not organised into groups. Midwives can learn what women think and feel about them, and the services they provide, by their individual practices, and the relationships they have with the women they are with throughout the childbirth experience.

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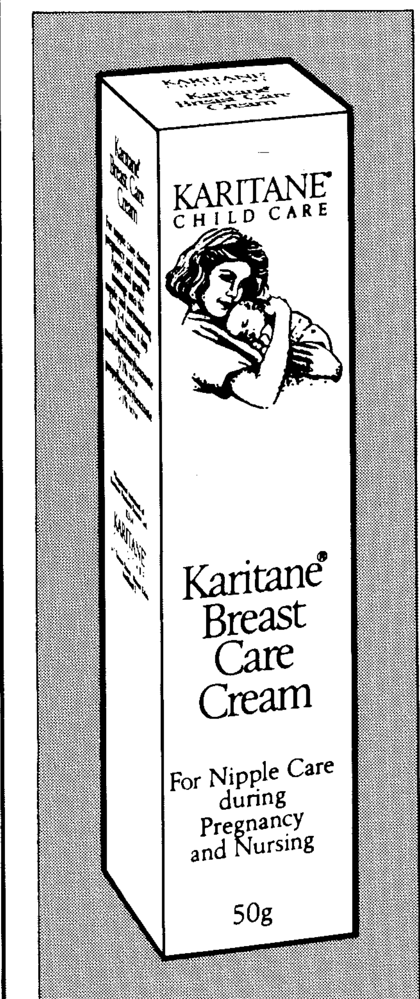

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Maintaining the Links

Karen Guilliland

A history of the formation of the NZCOM.

Midwives in New Zealand have come to acknowledge the pivotal role the consumer plays in the protection of their profession. In the following discussion, I hope to outline for you how New Zealand midwives have come to this realisation and how women as consumers of the service have made it possible.

Medical domination over maternity health services has been part of New Zealand's history.

As in other western societies, hospitalisation, sedation and infection redefined birth outcomes and shaped today's "management" of the pregnant woman. This lead to maternity services, provided "clinical material", and kept medical monopoly on childbirth. The move from small cottage hospitals into large city hospitals was therefore a response to the health professional's needs - not to women's needs.

Women became segregated into antenatal, intranatal and postnatal components; therefore reducing the midwives ability to provide total continuity of care.

The significance of these events for the profession of midwifery was often lost on midwives whose main allegiance was to nursing.

Midwifery was totally in the hands of the nursing profession - decisions were made by nurses and nurse midwives on that which was considered best for nursing. There was no recognition of midwifery being a profession, separate, but complimentary to nursing.

Midwifery's only representation came from the Midwives and Obstetric Nurses Special Interest Section of the New Zealand Nurses Association (NZNA) set up in 1969. Initially the role of the section was to provide a forum for updating midwives knowledge; meetings were held once every two months or so and generally business was of an apolitical nature.

Several events changed this low key approach.

1. Women started questioning the medical approach to birth as the only way to have a baby.

Joan Donley, a highly respected midwife and researcher who has inspired many midwives and is a founder member of the College of Midwives, says "I would give first place to the women who rebelled against the medicalisation of childbirth, thumbed their noses at the monopoly of regionalisation, and opted for home births, supported by the few midwives working outside this system. In 1978, the Home Birth Association was formed. This was a strong political lobby. It was aided by an extensive overseas network which provided information on development and struggle elsewhere.

This has been responsible for the improvements in the hospital based maternity care. Along with the feminist movement, it has raised women's awareness of their rights and encouraged them to be assertive."

2. More and more small maternity hospitals closed as a result of regionalisation and the downturn in the New Zealand economy. The high risk protocol forced the GPs to refer women to their obstetrician colleagues. Consequently, birthing decreased at small maternity hospitals, rendering them non-viable.

Women's choices over where they could have their babies were reduced. Local communities rallied to protect their maternity hospitals.

3. Legislation changes in 1971 to the Nurses Act, took away midwives independent practice and made it illegal to attend births without a supervising doctor.

4. Midwifery education was moved out of the maternity hospital schools in 1979 into the Polytechnics and became an option within the Advanced Diploma of Nursing. Midwives were beginning to recognise that the NZNA, Departments of Health and Education's objectives for nursing could well be at the expense of midwifery.

5. Further legislation in 1983 allowed nurses without midwifery qualifications to carry out maternity care under the supervision of a doctor. Restrictions were also made to the Direct Entry midwife's scope of practice and the Domiciliary or Home Birth Midwife's legal requirements were intensified.

The Obstetric Regulations were altered in 1986 to allow Hospital Boards to run maternity institutions without having midwives on duty at all times and re-enforcing the view that the medical practitioner was the professional best suited to dealing with childbirth.

It was these legislation changes, however, which finally mobilised New Zealand midwives into action. It united and politicised midwives as nothing else had.

Midwives started to seriously consider the need to establish their own voice as distinct from the Nurses Association. While midwives throughout the country were re-educating and defining the role of the midwife, New Zealand women were doing the background work of lobbying their Members of Parliament and writing letters to government departments demanding the return of the traditional midwife role. Another group was formed to support midwifery called "Save the Midwife". Its members were made up of consumers and midwives. Out of this initial group arose the Direct Entry Midwifery Task Force - their specific objective is to get a direct entry midwifery course established.

In August 1988 at the second National Midwives Conference, Joan Donley presented her paper "Midwives or Moas" and called for the formation of our own College of Midwives. Midwives had spent five years, at least, talking about this possibility and her call was responded to with enthusiasm. A working party was nominated from the AGM to start the process.

Consumer representatives from the Home Birth Association, Maternity Action Alliance and Save the Midwives were immediately nominated to the working party. This background was to set the scene for the structure and function of the New Zealand College of Midwives.

Significantly, the opening of this conference fell on the day that the Cartwright Report on the Cervical Cancer Enquiry was published.

Judge Cartwright's recommendations included the importance of consumer contribution and participation in policy and decision making in the health services.

The New Zealand College of Midwives has taken these recommendations to heart with their commitment to consumer participation at the decision making level of their professional body.

Radical, legal and social changes are needed in New Zealand if we are to return the midwife under the ICM definition. We will not achieve these changes without women's support as the WHO report on Strategies for Health for All points out, "together we are a powerhouse of change".

On April 2nd, 1989, the Constitution of the NZCOM was formally accepted at the inaugural AGM. Our constitution allows for consumer participation both regionally and nationally.

The majority of regions have consumers on their committees of management and there are three consumer representatives on the national committee.

Obviously the structure of the College has evolved as a response to a uniquely New Zealand situation. With the support of New Zealand's strong women's consumer movement, midwives both personally and through the College membership, can play a leadership role in changing the system to give women back the control over their birth experiences.

The College consciously recognises that the only real power base we have rests with the women we attend.

Structure of the NZ College of Midwives

Individual Member

Full	-	Midwife
	-	Student Midwife
Associate	-	Consumer
	-	Non-Midwife
Affiliate	-	Interested Organisations

Region of The New Zealand College of Midwives

- 10 Regions throughout New Zealand
- Decision makers for Region
- Representatives of related organisations
- Elect regional committee/collective and office bearers
- Formulate regional constitution or rules

Regional Committee of NZCOM

- Select and finance representatives to National Committee
- Collect subscriptions and manage regional finances
- Facilitate ongoing education in region with seminar workshops
- Raise funds required for region
- Communicate regularly with Board of Management
- Disseminate information to members

National Committee of the NZCOM

- 10 Regional Representatives, 3 Consumer Representatives, Board of Management (voting as per Constitution)
- Meet at least four times a year
- Policy and decision makers
- Facilitates ongoing communications both nationally and internationally

Board of Management of NZCOM

- 6 Regionally elected members from the region holding office, at least 4 of whom shall be midwives.
- Disseminate information to the regions.
- Responsible for day to day Housekeeping and Secretarial needs to aid management of College.
- Manage National Committee finances.

Photos from the AGM

Christchurch, April 1st-2nd, 1989

Photographs by Glenda Stimpson

NZ College of Midwives - National Committee

Regional Representatives

Northland
Lynley McFarland
16 Russell Road
Whangarei
Phone: 480 046

Auckland
P.O. Box 24-403, Royal Oak
Glenda Stimpson
3/28 Findlay Street
Ellerslie
Auckland 5
Phone: 525 3437

Waikato/Bay of Plenty
Maureen Leong
55 Tawa Street
Hamilton
Phone: 436 219

Eastern Central Districts
Julie Kinloch
76 Charles Street
Westshore
Napier
Phone: 357 170

Wanganui/Taranaki
Kathy Glass
184e Seaview Road
New Plymouth
Phone: 35 083

Wellington
P O Box 9600, Courtney Place
Carey Virtue
110c Grafton Road
Roseneath
Wellington
Phone: 847 261

Nelson
Marjorie Toker
28 Stansell Avenue
Nelson
Phone: 86 415

Canterbury/West Coast
P.O. Box 21-106, Christchurch
Norma Campbell
23 Merrin Street
Christchurch 4
Phone 585 425

Otago
P O Box 6243, Dunedin North
Suzanne Johnson
27 Constitution Street
Dunedin
Phone: 777 325

Southland
Margaret McDonald
8 Home Street
Winton
Phone: 368 739

Consumer Representatives

Parents Centre
Sharon Cole
22 Barnard Road
Rotorua

La Leche League
Marcia Annandale
16 Shannon Place
Belfast
Christchurch
Phone (23) 7124

Maternity Action Alliance
Celia Grigg Sowman
102 Summerfield Street
Christchurch 2
Phone 326 637

Board of Management

P O Box 21 106, Christchurch

Karen Guilliland *(President)*
136 Springfield Road
Christchurch 1
Phone: 559 579

Kathy Anderson *(Finance Co-Ordinator)*
34 Rutland Street
Christchurch
Phone: 554 700

Jacqui Anderson
20 Brabourne Street
Christchurch
Phone: 329 088

Julie Hasson
4a Stoke Street
Sumner
Christchurch 8
Phone: (26) 5743

Del Lewis
26a Conway Street
Christchurch
Phone: 325 546

Lynda Bailey
150 Innes Road
Christchurch
Phone: 557 713

National Constitution of the NZ College of Midwives

1. NAME

The name of the society shall be *New Zealand College of Midwives (Incorporated).*

2. INTERPRETATION

Unless the context otherwise requires:

"College" shall mean The New Zealand College of Midwives.

"Conference" shall mean the Biennial Conference of the College.

"Midwife" is any person whose name is entered on the New Zealand Register of Midwives.

"National Office" shall mean the registered office of the College situated at such a place as the National Committee may from time to time determine.

"National Committee" shall be the regional representatives, the Board of Management and three consumer representatives.

"The Board of Management" shall comprise six regionally elected members in the region holding office, at least four of whom shall be midwives.

"AGM" shall mean the National Annual General Meeting of the College.

"SGM" shall mean a Special General Meeting called by the National Committee of the College.

In this constitution any term implying the feminine gender shall be deemed to include the masculine.

3. OBJECTIVES

3.1 To promote and enhance the profession of midwifery in New Zealand.

3.2 To uphold the International Confederation of Midwives definition of the midwife's role and scope of practice.

3.3 To set and promote the New Zealand "Standards of Midwifery Practice, Service and Education".

3.4 To adopt and promote the New Zealand Nurses Association "Midwifery Policy Statement".

3.5 To speak nationally and regionally in the interests of midwives.

3.6 To promote the health status of women and their families.

3.7 To nominate midwife advisors to the Minister of Health and Education and Women's Affairs.

3.8 To provide and promote midwifery education and research.

3.9 To produce newsletters, publish books and material concerning midwifery.

3.10 To promote biculturalism in midwifery to incorporate the principles of partnership, protection and participation as implied by the Treaty of Waitangi.

3.11 To liaise with other organisations within New Zealand and internationally to promote the objectives of the College.

3.12 To affiliate with the International Confederation of Midwives.

4. PHILOSOPHY

In the implementation of these objectives, the College relies on the following philosophy:

Midwifery is a profession concerned with the promotion of women's health. It is centred upon sexuality and reproduction and an understanding of women as healthy individuals progressing through the life cycle.

Midwifery is: Dynamic in its approach based upon an integration of knowledge that is derived from the arts and sciences, tempered by experience and research; collaborative with other health professionals. Midwifery care takes place in the context of mutual support. Clients play a role in shaping midwifery.

5. POWERS

The College shall be empowered to:

5.1 Make any decisions at its meetings which could further the objectives of the College.

5.2 Employ such persons as may be deemed necessary by the National Committee.

5.3 Take in gift any property whether or not subject to any special trust for one or more of the objectives of the society.

5.4 Erect, buy or rent property or do all lawful things as may be deemed incidental or conducive to the attainment of the above objectives. Any borrowings may be unsecured or secured against any or all of the assets of the College.

Authority for the borrowing is given by a resolution passed at a Special or Annual General Meeting, with 14 days notice being given to members of such a resolution.

6. NON PROFIT STATUS

6.1 The College shall not engage in any activities involving private pecuniary profit for its members.

7. MEMBERSHIP

7.1 People who support the objectives and philosophy of the College shall become members upon paying any membership fee fixed under these rules.

7.2 There is individual membership to regions.

7.3 *Honorary Members*

7.3.1 Those members who by virtue of their contribution to midwifery can be granted honorary membership by the National Committee.

7.3.2 Honorary membership shall be proposed by a region of the College and shall be subject to such criteria as the National Committee shall determine.

7.3.3 An honorary member shall pay no subscription, but have all the rights and responsibilities of a full member.

7.4 *Full Members*

7.4.1 Any person who is a registered midwife may apply for associate membership of the College.

7.5 *Associate Members*

7.5.1 Any person not being a registered midwife may apply for associate membership of the College.

7.5.2 Associate members shall have no voting rights over matters concerning the midwifery profession.

7.6 *Affiliate Members*

7.6.1 Any organisation may apply for affiliate membership but will not have voting rights.

7.6.2 Affiliate members elected on to the National Committee shall have voting rights except on issues concerning the midwifery profession.

7.7 *Rights and Responsibility of Members*

Subject to other provisions in this constitution, all members shall:

7.7.1 Have the right to nominate and elect to positions of responsibility, to propose motions and vote at any meeting of the College.

7.7.2 Be eligible to accept nominations for positions of responsibility.

7.7.3 Shall receive on joining a copy of the constitution of the College.

7.8 *Termination of Membership*

7.8.1 The member gives notice in writing to the region.

7.8.2 The member has paid no subscription for one year.

7.8.3 The National Committee decides their actions are prejudicial to the objects and philosophy of the College.

7.9 *Membership Fees*

7.9.1 May be determined from time to time at the College's AGM or any SGM by a concensus decision or failing a concensus by a simple majority.

8. NATIONAL COMMITTEE

The National Committee shall be made up of one full member from each region, three consumer representatives and the Board of Management. At least two consumer representatives shall be from the same region as the current Board of Management.

8.1 *Functions of the National Committee*

8.1.1 Provide direction to the Board of Management.

8.1.2 Do such things as will enable the College to achieve its objectives.

8.1.3 Facilitate communication between regions.

8.1.4 Call for nominations for consumer membership of the National Committee from affiliated organisations, three months prior to the AGM.

8.1.5 Organise voting between affiliated groups for consumer positions of the National Committee.

8.1.6 Call for regional nominations for national Board of Management every two years, 15 months prior to intended change.

8.1.7 Approve regional constitutions.

8.2 National Committee members are elected for a period of two years, with a two year right of renewal

9. BOARD OF MANAGEMENT

The Board of Management is made up of six members from the region elected to hold national office, at least four of whom shall be midwives.

9.1 *Functions of the Board of Management*

9.1.1 Keep a register of members.

9.1.2 Keep records and handle the College's finances.

9.1.3 Give an annual statement of income, expenditure and a balance sheet to the Registrar of the Incorporated Societies.

9.1.4 Inform members of meetings.

9.1.5 Notify the Registrar of any changes of the address of the Society.

9.1.6 Give notice to the Registrar of any changes in the rules of the Society.

9.1.7 Have control of the common seal as stated in the rules.

9.1.8 Carry out the policies and directions of the National Committee.

9.1.9 Provide a newsletter to all members.

9.1.10 Co-opt members as necessary.

9.1.11 May employ a person to carry out secretarial duties.

9.1.12 Nominate from amongst its own membership a spokesperson and co-ordinator of finances.

9.2 The region elected to hold national office and its Board of Management are elected for two years with a two year right of renewal.

10. REGIONS

10.1 There will be ten regions throughout New Zealand.

10.2 Each region shall forward an annual report to the National Committee prior to the AGM.

10.3 Each region may have its own constitution which must be in harmony with the constitution of the College.

11. MEETINGS

11.1 The AGM of the College shall be held each year, and not more than 15 months after the previous AGM.

11.2 Any regional member may request the National Committee to hold a SGM, specifying the issues to be discussed.

11.3 National Committee meetings will be throughout the year as required, in the region in which the Board of Management is situated.

11.4 Board of Management meetings will be throughout the year as required.

11.5 *Notice of Meetings*

11.5.1 A minimum of 14 days notice of all AGM and SGM shall be given in writing to each member.

11.5.2 The notice shall specify time, date and location of the meeting and specify the reason for calling the meeting.

12. QUORUM

12.1 The quorum for any meeting of the National Committee shall be fifty percent of its members. Teleconference may be used to hold these meetings.

12.2 The quorum for any meeting of the Board of Management is four.

12.3 The quorum for an AGM or SGM shall be all National Committee regional representatives or their designated proxy.

13. DECISION MAKING

13.1 Decisions at the National Committee meetings shall be made by consensus. Voting shall take place when consensus is not possible on the basis of one vote per region, one vote per consumer (not on issues concerning the midwifery profession) and one vote per Board of Management.

13.2 Decisions at AGMs and SGMs is by consensus. Voting shall take place when consensus is not possible and shall be by postal ballot to all members.

14. CONTROL OF NATIONAL FUNDS

14.1 The National Committee makes decisions regarding use and investment of national funds.

14.2 The College through its finance co-ordinator shall keep records of its accounts.

14.3 All funds received by or on behalf of the College shall be paid into the College's bank account.

14.4 The College's bank account shall be operated by the finance co-ordinator and one other signatory from the Board of Management. These signatories are authorised to sign all cheques and withdrawal slips drawn on the College's account.

14.5 *Capitation*

14.5.1 Finance will be obtained on a per capita basis as determined by the AGM or SGM. This amount to be sent from the regions at a date set by the National Committee.

14.6 Members from the College shall be excluded from personal liability in respect of financial commitment of the College which shall be guaranteed solely by the College's assets.

14.7 The National Committee of the College shall not be responsible for debts incurred by any region.

15. SEAL

15.1 The Common Seal of the College shall be kept in the custody of the Board of Management's finance co-ordinator.

15.2 The Common Seal shall be affixed to such documents as the National Committee decides.

16. CONFERENCE

The College will hold a conference every two years.

17. ALTERATION OF RULES

17.1 The rules of the College may be altered, added to or rescinded on by a resolution at an AGM or SGM of the College.

17.2 Any proposed change shall be included in the notification calling the meeting.

17.3 The region proposing the change shall submit a copy in writing to the Board of Management not less than 21 days prior to the General Meeting.

18. WINDING UP

18.1 On the winding up or dissolution of the College, the surplus of assets of the College after of all liabilities and expenses shall be distributed in such a manner as the College or National Committee shall decide, provided that no portion of such assets or surplus funds shall be distributed to any individual member of the College.

BY LAWS OF THE NEW ZEALAND COLLEGE OF MIDWIVES
APRIL 1989

To be read in conjunction with the National Constitution of the New Zealand College of Midwives April 1989

1. That the College close its financial books on the 30th April annually and that an audited set of accounts be available for presentation at the Annual General Meeting.
2. That subscriptions shall be collected regionally and that a capitation fee of exactly half the subscription shall be paid to the National Committee.
3. A year's membership to the College shall be from the 01st May to the 30th April.
4. That capitation fees be paid annually at the Annual General Meeting by each region based on numbers of members for the previous year.
5. That each region forward a list of new members to the Board of Management monthly.
6. That the rates and types of membership are:

- Full Membership *(Registered Midwives - Full or Part Time)*	$52.00
- Full Membership *(Student Midwives, Unwaged Midwives)*	$26.00
- Associate Membership *(Other interested individuals)*	$52.00
- Associate Membership *(Unwaged interested individuals)*	$26.00
- Affiliated Membership *(Interested Groups e.g. Parent Centre, La Leche League)*	$26.00

BOOK REVIEWS

Community Midwifery: A Practical Guide

by Caroline Flint and Mary Cronk

Published by Heinemann Medical Books 1989

Following the widely read and enjoyed 'Sensitive Midwifery' Caroline Flint has penned another book especially for midwives. This time she is joined by Mary Cronk as co-author in 'Community Midwifery: A Practical Guide'.

Although the focus is for the community or domiciliary midwife, the hospital based midwife should not discard this book as inappropriate. With many women choosing a home style birth in hospital, this book is brimming with ideas for making birth (whether at home or in hospital) a powerful and positive experience. 'Community Midwifery' contains everything a thoughtful midwife would want to know. All aspects of pregnancy, birth and immediate post natal care are discussed with the home of the child bearer the central focus.

The book is easily read using simple terminology.

There is good use of helpful illustrations plus samples of practical charts and records. One chapter is on the midwife and the law and although referring to United Kingdom legislation, this important section should not be passed over. Equally worthwhile is the chapter - rather euphemistically called 'Special Challenges' which deals with sensible and supportive ways of overcoming emergency situations.

This book will be welcomed by all midwives involved in any community based practice. It may even give those midwives who intend to work from a home base, the incentive to actually get started.

Diana McIvor (nee Taylor)

R.G.O.N., R.M.
Nurse Tutor, Hawkes Bay

Shared Parenthood - A Handbook for Fathers

by Johanna Roeber

Published by Century Paperbacks 1987.
Also by the same author 1982 'Exercises for Childbirth'

Johanna Roeber is a family therapist, an Antenatal teacher and a mother of 3 and living in England, and is well known in midwifery circles.

Johanna Roeber's goal in writing this book 'was to give mothers and fathers the opportunity to develop as fully rounded human being with less conflict between the masculine and feminine elements of their nature'. This handbook is very comprehensive and I feel goes a long way toward meeting Mrs Roeber's goal, as it explores many ways in which men can become involved in parenthood.

'The trend today is for fathers to play an increasing part in the day to day care of their children, but many prospective fathers lack a role model for this new and challenging role'.

The contents of the book are set out in the chronological order of events which take place throughout a pregnancy, from preparation, health, labour and delivery, to the postnatal period.

Problems of preterm birth and solo parenting are well covered. I especially liked the flow charts for quick easy reference during labour and delivery of the mother and baby. These flow charts would be of use to childbirth educators.

I feel I can recommend this book with every confidence and thoroughly enjoyed reading it although I wouldn't say it was light bedtime reading material.

The message of the book is truly international and thus multi-cultural. The publishers have incorporated a tender Maori poem at the beginning of the book, but I was disappointed to note that they have not exchanged the British reference addresses at the end of the book for those useful to our New Zealand readers.

Happy reading.

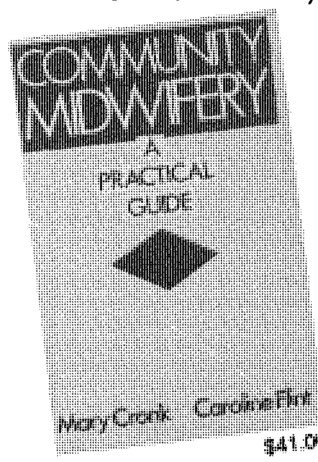
C.M. Tee (nee Taylor)

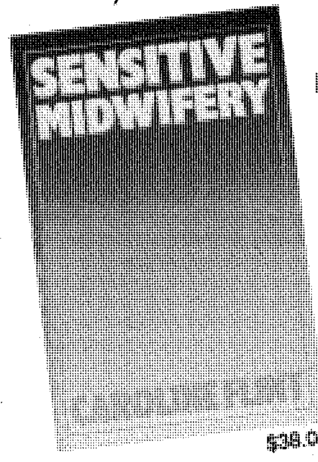
R.G.O.N., R.M.
Midwife, Antenatal Clinic Kenepuru.

MIDWIFERY BOOKS

MEDICAL BOOKS (NZ) LTD ARE PLEASED TO SUPPORT THE FIRST ISSUE OF
THE NEW ZEALAND COLLEGE OF MIDWIVES JOURNAL
AND TO CELEBRATE
NATIONAL MIDWIVES DAY

As a follow up to Caroline Flint's enormously succesful first book, *Sensitive Midwifery*, we are pleased to announce the release in New Zealand of *Community Midwifery.*





Published by Heinemann Medical, this well respected English midwife joins Mary Cronk to produce further valuable insights for both medical and helping professionals on the process of childbirth.

PLEASE SEND ME:
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Sensitive Midwifery - $38.00

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Nihil Sine Labor

Dorothy E. C. Taylor

R.N.R.M

CONGRATULATIONS AND BEST WISHES TO the Midwives of New Zealand for having the courage and initiative to form their own professional body.

I have been asked to share with you a few memories of my Midwifery Training during World War II in England and I deem it an honour and privilege to contribute in some small way to this first edition of the Journal - along with my two daughters.

I was trained in General Nursing in a North of England hospital but chose a London Training School of Midwifery for my six months Part 1 course.

The Hospital functioned in two places - part had been evacuated to a large Stately Home about 40 miles from London whilst the usual Hospital carried on with limited wards and staff. The Hospital was lucky not to be hit by bombs as many surrounding buildings had been demolished in the heavy air raids.

Our country house was about 200 years old - quite large and ornate especially the Ball Room. Most rooms had been adapted for hospital use and even the stables had been altered for our sleeping quarters. The large attractive garden had been neglected owing to labour shortage. Sometimes from the huge fountain we carried buckets of water to wash the nappies when the inside tap was dry - we had to be inventive and improvise in lots of ways but this was all part of everyday life in those days. The babies bottles and teats were boiled in a large pot on a paraffin stove, and couldn't this be temperamental at times belching forth flames and dense smoke.

It was hard work.

Not only did we care for mothers and babies but had to do part cleaning of the wards, wash dishes and prepare suppers.

About 40 nurses were in Training most of whom were General trained from various hospitals all over England, but some nurses were widows having lost their husbands in the war and were only taking the 2 year Midwifery course and were not interested in General Training.

We had lectures from an eminent London doctor together with two Sister Tutors and no one liked having to get up for lectures when on night duty. Night duty lasted for a month with 2 nights off before resuming day duty when we had half a day a week and a day off every 2 weeks.

Twenty deliveries were expected for each nurse on our course, and one case history to be written up. One night I delivered seven babies and this included twins - it was hectic.

In London it was a different scene and I enjoyed the experience of working in the capital City during the war. The patients were so friendly and kind with a sense of humour unsurpassed. I remember one incident when a mother was changing her baby on the table, suddenly it was on the floor (with no apparent harm) and I heard her remark - "That should get up his wind".

Despite food rationing mothers were not generally malnourished the Government provided extra food coupons for expectant mothers. When we heard the air raid siren we picked up the babies one under each arm and rushed to the safety of the cellars.

After I finished the Course I worked for some time in the Abnormal ward of the Maternity wing of a large hospital. I disliked this work seeing grossly deformed babies, the worst cases were not resuscitated.

Instead of taking Part 2 midwifery I joined the Q.A.s serving in India, Burma and Singapore and it was whilst working in the Military Hospital in Singapore that I met my husband.

I have retained an interest in Midwifery over the years - methods, drugs and technology have changed, but in my opinion there will always be a need for midwives in Hospital and in the home.

Mothers will continue to produce babies no matter what.

"Nihil Sine Labor".

(Nothing without labour.)

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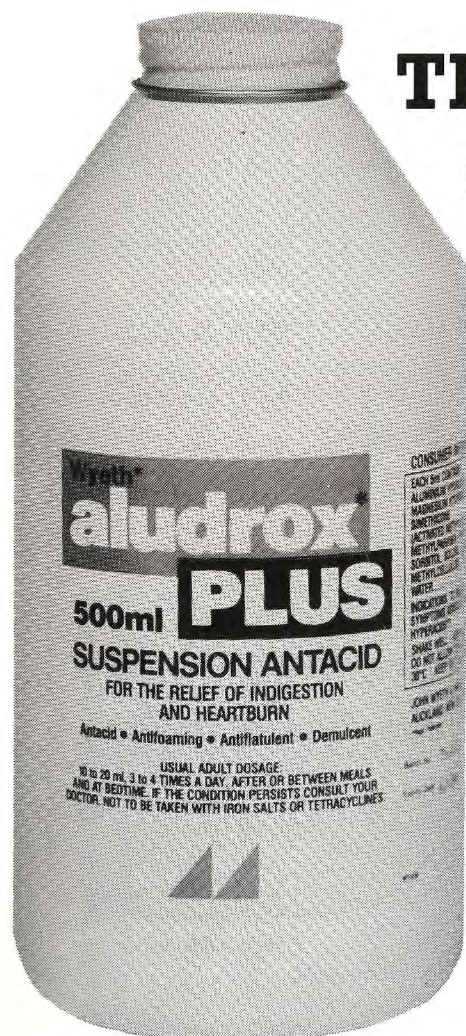

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New Zealand College of Midwives
Membership Form

Regional Information

Name ______________________________

Address ______________________________

Telephone ______________ Home ______________ Work

Place of Work ______________________________

Type of Membership

Full Member (Registered Midwife Full or Part Time)	$52.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	$26.00
Associate Member (Other interested individual)	$52.00
Associate Member (Unwaged interested individual)	$26.00
Affiliated Member (Other Groups e.g. Parent Centre, La Leche League, etc)	$26.00

Method of Payment
Please tick your choice of payment method.
☐ Subscription payable to College Treasurer (Please enclose cheque or money order)
☐ Deduction from Salary (Please arrange with your pay office)

National Information

Name ______________________________

Address ______________________________

Telephone ______________ Home ______________ Work

Date of Birth ______________

Type of Membership

Full — Waged ☐ / Unwaged ☐
Associate — Waged ☐ / Unwaged ☐
Affiliate ☐

Place of Work ______________________________

Please return completed form (together with money if applicable) to
Local Regional Treasurer
New Zealand College of Midwives
Address:

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WELEDA recognizes our bodies as living organisms and treats them accordingly with preparations from the living kingdoms of nature. This principle is basic to all WELEDA products, whether for internal or external use.

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