JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, APRIL 1994

TENTH ISSUE

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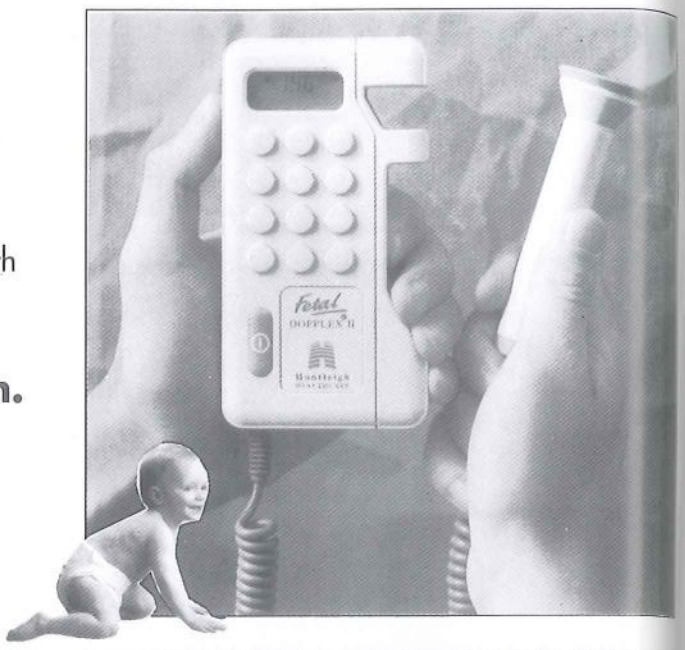

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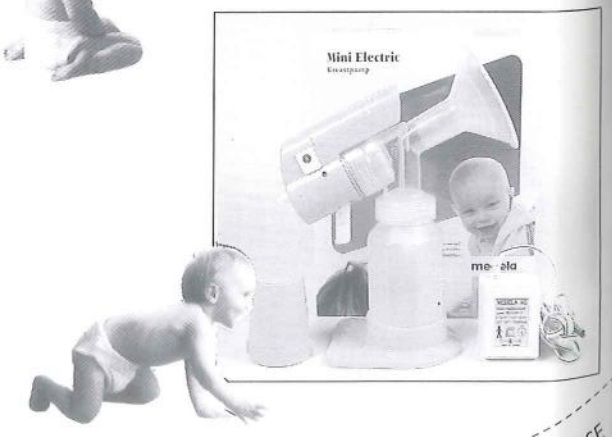

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* Promote women's health issues as they relate to childbearing women and their families.
* Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
* Provoke discussion of midwifery issues.

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EDITORIAL

Welcome to the 10th issue of the Journal which marks the first five years of production.

It is thanks to you we've produced such a high quality journal, receiving various articles from far and wide and as different as they can be!! We appreciate them all. If *you* haven't submitted anything to us yet, *please* consider it – we are always very keen to hear about your experiences and welcome accompanying photographs. Each article adds something to our understanding of childbirth and midwifery today.

In this issue, Marina Isa shares her knowledge with us about Muslim women and offers some guidelines for midwives working with muslim women. Very interesting reading. Mary Minto looks set to become the College's first poet – we are ready for the next poem Mary! As always Joan Donley's political comment gives us plenty of 'food for thought' and should lead you to a few colourful debates with your colleagues. Thank you Joan for your thought-provoking articles. Thank you all for your contributions.

I hope you enjoy this issue. Remember to keep those articles and letters coming. This is your journal and your contributions make it!

Please note:
Dr Murray Enkin will be visiting N.Z. during May. He is an obstetrician, currently the Emeritus Professor of Obstetrics and Gynaecology, McMaster University, Canada, and Head of the Pregnancy and Childbirth Module, The Cochrane Centre, Oxford, U.K. He is best known for his co-authorship of *Effective Care in Pregnancy and Childbirth*, amongst his many other publications.

Murray Enkin will be in:

Auckland	18 May, 1994
Palmerston North	21 May
Wellington	24 May
Christchurch	26 May
Dunedin	28 May

Check out the venue and times with your local COM branch.

Helen Manoharan

LETTERS TO THE EDITOR

Plunket Society (Inc.)

Dear Editor,

Re: Jo Coco's article – Midwives Raise the Options for Childbirth. October 1993 Journal.

With reference to the above article, the clause that states 'Midwives are the only professional group that actively involves its consumers in its organisation' is misrepresented.

Since their inception, Plunket nurses have actively sought information from consumers and volunteers, who have been a valuable part of the Plunket service. They are involved in decision making and provide many resources to run the service. Clients are being asked continually what they want from the service. Isn't it this community evaluation and consultation which is so important in today's health market?

As Plunket nurses we appreciate the opportunity to be associate members of the College of Midwives. Midwives have brought a new dimension to birthing in New Zealand, one in which a client can have continuity of care by a midwife she meets early in pregnancy, and keeps through the birthing process and the early postnatal period.

We also feel it is important that when it is time to discharge the client to a Plunket nurse a full report is given so we can continue the high quality care. For us it is important to be involved early in the postnatal period, so a relationship can develop which will aid better parenting practices in the long term. As 'well child' health providers in the community, we value the professional relationship we can have with midwives and can assure you our main aim is to assist parents to maintain and, where necessary, improve their health and that of their children, with special reference to mothers both before and after childbirth, and children up to school age.

Yours faithfully,
Margaret Clark,
Manawatu Area Manager

National Women's (Auckland) Inaugural Evelyn Bond Fellowship

Dear Editor,

Applications for this Fellowship are invited from suitably qualified midwives who wish to enrol at the University of Auckland for the Master of Health Sciences (MHSc) degree. The Fellowship is funded by a bequest to National Women's Hospital from the estate of Evelyn Bond, a midwife who was Matron of Pukekohe Obstetric Hospital for many years. The term of the Fellowship is for one year, extendable to two years.

Applicants must hold a Bachelor's degree and have no less than two years' employment in nursing or midwifery. The provisions of the degree require a course of study of not less than 12 months, a pass in three papers and a pass in respect of a thesis. Study and research will be undertaken in the Research Centre in Reproductive Medicine at National Women's Hospital.

The Fellowship will provide a salary of $20,000 plus an allowance of $5,000 for working expenses and university fees. The opportunity for employment as a midwife for eight hours/week at National Women's Hospital may be available.

Further information can be obtained from:

Professor Sir Graham Liggins
Director
Research Centre for Reproductive Medicine
Department of Obstetrics and Gynaecology
National Women's Hospital
Private Bag 92189
Auckland
Telephone: (09) 6309 856

Applications, including a detailed curriculum vitae, should be made by 30 June 1994 to:

Sheryl Smail
General Manager
National Women's Hospital
Private Bag 92189
Auckland

Correction

Dear Editor,

Regarding the 'pullout leaflet' SANDS – Staff Guidelines in the October 1993 Journal. I would like to point out that there was a misprint in No. 14. It should read:

> .... It would usually be too soon anyway, and would lead to term around the anniversary of the baby's death. Following an early pregnancy loss, it is best to wait until a normal menstrual cycle is re-established and the parents – particularly the mother – feel physically and emotionally ready.

Yours sincerely,
Chris Stanbridge

Understanding the Muslim Woman

Marina Isa
Midwife

There is an increasing number of Muslims now residing in New Zealand – at least 5,000. As midwives we are going to come into contact with more and more Muslim women giving birth and therefore we need to understand their needs during pregnancy and birthing. It is also important to understand the many misconceptions that Muslim women are often subjected to. Some stereotypes are: that most Muslims are immigrants of low socioeconomic status; and that the women are suppressed and powerless victims of their marriages and societies.

Much of our misunderstanding arises from media coverage of extremist behaviour of some Muslims, mostly from the Middle East area. A distinction also needs to be made between religion and custom. In order to clarify these differences it is necessary to examine the basis of the Islamic religion.

Islam

The Islamic religion is based on the will of God as revealed to humanity by prophets sent since the beginning of time. Muhammad, the founder of Islam, lived in the seventh century AD. He received the word of God at Mt Hira, through the archangel Gabriel. This revelation is now written in the Quran which is to Muslims as the Torah is to Jews and the Bible to Christians. Muhammad is seen by Muslims to be the final prophet in a line which began with Abraham and included Jesus.

Islam is the second largest religion in the world after Christianity, but it is the largest practised religion. It is a very broad religion and is divided into two main sects, Shiite and Sunni.

Sunni is further divided into several other sects. Differences are mostly entrenched in custom or are a reflection of life's manifestations. All follow the teachings of the Quran. The Quran contains 114 Suras or sections which are the literal word of God as revealed through the archangel Gabriel.

There are five pillars of Islam which are the duties of all Muslims.

1. Profession of faith, or 'Shahadah'... "I witness that there is no God but Allah and that Muhammad is the prophet of Allah".
2. Prayer, five set times a day.
3. Alms giving.
4. Fasting in the month of Ramadan.
5. Pilgrimage to Mecca at least once in a lifetime if possible.

Islam is the belief and worship of only one God. Worship of people or objects is forbidden. Mosques are decorated only with writings, these are usually elaborately decorated with flowers, plants or geometric patterns.

A Way of Life

Islam is a total way of life – law and religion are intertwined and it is considered the framework of a healthy society.

Islam begins at birth with the reciting of the 'Shahadah' into the baby's right ear. Muslim children learn their religious duties from watching their parents. As they grow older they are taught to memorise parts of the Quran and are encouraged to participate in the fast of Ramadan, at first for a day at a time until the age of about 13 years when they should be able to carry out their duties as adults. Learning to recite the Quran is an important part of a Muslim child's education. In Muslim countries this is part of the regular school curriculum. In non-Muslim countries special classes are held at the mosque.

Respect for elders at all times is encouraged. A saying of the prophet Muhammad, 'Be careful of your duty to Allah and be fair and just to your children'.

Prayers

There are five set times a day for prayers which must be said in a clean place. It involves washing the body, using a prayer mat and facing Mecca. Adult males should attend the mosque at midday Fridays. Women do not have to attend. There are separate areas for men and women in the mosque. The Quran is always read in Arabic.

Fasting

Fasting during the month of Ramadan involves not partaking of any food or fluid from sunrise to sunset. Ramadan is the ninth month of the Islamic calendar and is decreed by the sighting of the new moon. This is a month of prayer, of remembering

the sufferings of the poor and hungry, of being kind and helpful to friends and neighbours and taking care not to quarrel. All adults must keep the fast. However, very old people, the sick and women who are pregnant or breastfeeding are excused. Travellers and menstruating women are also excused but must make up the days at a later time.

The festival of Id ul-Fitr comes at the end of the month of Ramadan. Elaborate meals are prepared, visits are made to relatives and friends, and children are given new clothes and gifts.

Food Requirements

Muslims may eat only meat that has been killed in a particular way. It involves the saying of a prayer, the cutting of the jugular vein and the bleeding of the carcass. This is called Halal meat, or 'lawful' meat. Muslims are forbidden to eat pork or any food which is prepared with pork products, or other foods such as biscuits or ice cream which contain animal fats that are not Halal. Alcohol is also forbidden.

Burial

Because Muslims believe in the resurrection of the body, they are always buried and never cremated. They are buried as they are born, unadorned and wrapped in a simple white cotton shroud. They are never embalmed. Before burial the body is specially washed, usually by the family, and a funeral prayer is said.

ISLAM AS IT RELATES TO WOMEN

The Status of Women in Islam

Contrary to popular belief, Muslim women have equal rights and responsibilities compared with men. Men and women, however, have different duties. Women have the same religious obligations as men but are excused attendance at the mosque on Fridays in order to be with the family. They should not attend during menstruation or postpartum bleeding.

Men will be chiefly involved with work and public affairs and women will be involved in care of the home and family and also 'the business of women'. This is a very respected role as great importance is placed on home and family. Women may, however, work outside the home. Popular occupations for women are nursing, teaching, medicine, and craft industries such as carpet weaving. They can have separate bank accounts and are not required to share their incomes. Men are obliged to provide financial support for the wife and family. The inheritance protects women. A woman receives only half the portion that a male relative does, however the male relative is bound to support a female relative if she is without a husband. The female does not have to support a male relative and may spend her money as she wishes.

Women are entitled to equal education. Muslim women can partake in serious discussion, they can also stand for parliament and express views on legislative matters.

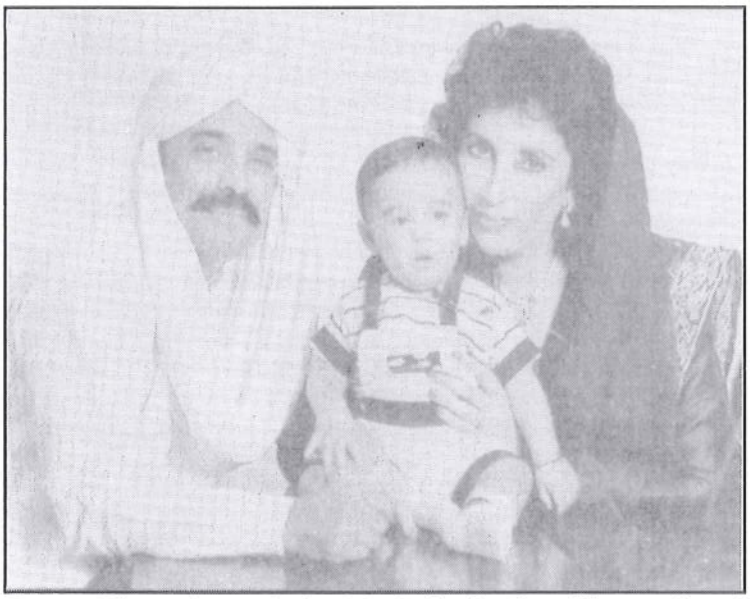
Modesty

Modesty and privacy are important for a Muslim woman's dignity and are also part of her faith. The 'hijab' (outer garments used to cover the head and body) will often identify a Muslim woman in public where it is worn to discourage inappropriate attraction between male and female. Within the home and amongst female friends and family the women dress as they please. The wearing of the hijab varies according to environment and situation, and the degree of cover varies among individuals. Some societies have strict codes to follow while some are more lenient.

Marriage

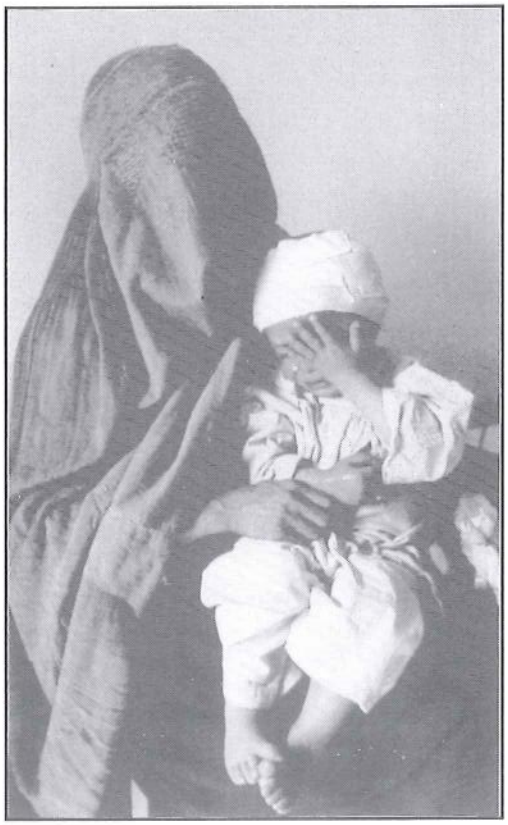
Arranged marriages are not Islamic, rather they are a custom. However, in a society where the sexes are not encouraged to mix freely it is a very convenient arrangement. Attitudes

Muslim Women of Contrast



Benazir Bhutto photographed with her husband and son. She was educated at Oxford and is now Prime Minister of her country.

Both women have traditional arranged marriages.



A woman, heavily veiled, from war-torn Afghanisatan, comforts her son injured by a stray bullet.

of the couples to these marriages mean that they are usually successful and life lasting. The couple must consent to the marriage and no one can force a couple to marry if they do not agree. Women may propose to men. Under Islamic law polygamy is allowed, a man may marry four wives. The law, however, requires that they all be treated equally and, as few men can afford to do this, polygamous marriages are the exception rather than the rule. Sometimes a second wife is taken if the first cannot bear children or is very ill and needs someone to look after her and the family. Some men will marry a widowed woman with children in order to support them.

Divorce

Divorce is permitted in Islam. Both men and women may apply for divorce. Before this point is reached, however, they are encouraged to reconcile their differences. If divorce occurs, the wife receives some money from her ex-husband and takes all their household goods and furniture. Her maintenance then becomes the responsibility of her male relatives.

Contraception

Contraception is allowed. During the time of Muhammad the withdrawal method was used with the wife's consent. Children are considered to be a gift of God, so many Muslim women will not use contraception by choice as they do not wish to interfere with God's plan.

Abortion is forbidden. An exception can be made if the life of the mother is in danger due to the pregnancy.

Circumcision

It is a popular belief that all Muslim women undergo clitoridectomy. This is again a custom rather than a religious practice. This ritual is carried out in some cultures to varying degrees, from a small 'nick' in the clitoris to total removal, sometimes including both labia. The latter often results in problems with urinating and childbirth. If a Muslim woman has had a clitoridectomy performed it will have been due to factors other than her religion. Many Muslim women do not have this done and there is no requirement for it in the Quran.

All male Muslims are circumcised, usually at the age of seven years. Once again there is nothing in the Quran that requires this. It actually stems from the Judaic tradition that all believers in one God are circumcised. This differentiated them from those who prayed to people or idols. Circumcision is considered important for its cleanliness aspect. The saying, 'Cleanliness is next to Godliness', is Islamic in origin.

Childbirth

Childbirth must occur only within marriage. Motherhood is a powerful and respected role. Muhammad said: 'The mother is more important than the father of the child.' To the man who carried his sick mother to Mecca the prophet Muhammad said: 'You are only repaying her for the kicking she received from you in the womb.' He also said: 'Paradise lies at the feet of the mother.'

The preference for a male child is not Islamic but rather a custom. It is most likely to be the result of social conditioning in a patriarchal society. Muhammad stated that: 'Female children are more likely to bring their family blessings.'

Needs in Childbirth

Pregnancy and childbirth are normal events in a Muslim woman's life. The local midwife is an integral part of this process and is greatly respected by families and communities. In countries where Western culture is predominant there are difficulties for the Muslim woman, especially in communication if the woman is non-English speaking. A woman can be presumed, often wrongly, to be under-educated. Written communication often does not express feelings or concerns. Use of family members as interpreters is not satisfactory either, as the accuracy of information is not assured and also confidentiality may be breached. Interpreters who are not health workers can cause similar difficulties.

For many reasons migrant women may not be able to rely on family for help. They often feel isolated as birthing is a very family-orientated occasion. At this time support people are usually the woman's mother and female family members. Husbands may be present at the birth with the woman's consent. The attendance of male doctors or nurses is a great compromise and will only be accepted in cases of extreme need.

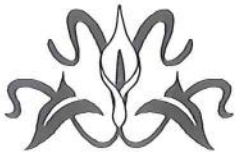
Immediately after birth, the first sound the baby hears is the 'Shahadah' whispered into its right ear. A mixture of crushed dates and honey is touched on the baby's tongue. Ideally this would be performed by a devout Muslim, or the father if present, but anyone can do it. It is considered to be a very good and wholesome start to life.

Suffering and Pain

Suffering and pain are expected during childbirth and a woman is expected to bear the pain. The pain of childbirth cleanses the mother of all sin and she herself is like a newborn after giving birth. Suffering is explained in the Quran as follows:

That it is God's way and cannot be questioned
Suffering cleanses one of sin
Suffering tests a persons faith
Pain and suffering therefore makes one more aware of God.

Pain relief is not seen as an easy option. However, it is accepted if it is required as a consequence of intervention in order to save the life of the mother or baby. Pain is an important part of becoming a mother.



Breastfeeding

Great value is attached to mother's milk. The Quran states that a woman should breastfeed for two years. The veil is used very conveniently to hide the breast during suckling.

Conclusion

Emotions, expectations and family dynamics may be hard for us to comprehend. There are facets of mothering passed from generation to generation which can be deeply rooted in superstitions and beliefs. Behaviour can be misleading when dealing across cultures and can lead to misdiagnosis due to what is conceived to be inappropriate behaviour. Many Muslim women are not in a position to question the way they are cared for and they may feel very vulnerable due to communication difficulties and racist attitudes in society.

We have to be very careful not to project any negative attitudes, as these will obstruct communication, understanding and inevitably management, even resulting in unsatisfactory outcomes. Education will reduce this risk and can highlight specific areas of need.

Whilst it is not expected that we have an in-depth understanding of all cultures and religions, we should always be open-minded, tolerant and accepting of the differences.

Acknowledgements

The Muslim World Richard Tames MacDonald and Company.

Midirs Midwifery Digest 1991, 1:3.

Homebirth Australia Newsletter No. 26, Spring 1990, pp. 7-10.

Maternity Services – Black and Ethnic Groups.

■

Guidelines

For Midwives with Muslim Clients

Marina Isa
Midwife

For many Muslim women who are migrants, the first time they come into contact with health professionals is when they give birth.

Antenatal Care

Muslim women need, and respond well to, antenatal education. However, classes which include male partners or educators are not suitable for them. They will usually respond by just staying away.

Communication is very important and should be established as early as possible. The woman must feel able to express her needs in a comfortable and friendly atmosphere and to know that she will not be judged.

Education during the pregnancy can overcome many fears for the woman and enable her to make choices for herself.

Economics may have to be considered when choosing her birth option, especially if she is a non-resident. For many reasons the migrant woman may not be able to rely on family for help and may have difficulty getting help to care for older children. Homebirth is an excellent option for these women if they have no risk factors, or, if a hospital is chosen, early discharge can be considered. Explanation of the hospital environment is appropriate and a knowledge of the venue and its dynamics will enable her to deal with events as they arise. A visit to the venue is also valuable.

Choice of appropriate birth attendants should be made at this time too. The strong preference for females only as attendants must be respected. Arrangements should be made prior to the birth for appropriate caregivers to be available in case they are required. These would include the midwife, a female obstetrician, a female anaesthetist, and possibly a paediatrician or a GP (female).

The woman should make decisions about who her support people will be for the birth and an appropriate interpreter can be arranged if needed.

Modesty

Her modesty must be respected. Unnecessary exposure will result in loss of dignity and can have long-term effects. She may wish to keep her veil on. This can become very important to her if she feels it is the last piece of modesty she has to hold on to.

Cleanliness

Cleanliness is a very important part of her faith. This is demonstrated by the washing before praying. She will be used to washing her vulval area after passing urine, defaecating or following intercourse.

Cleansing after vaginal examinations will be appreciated. If unable to get up to wash herself, a pan can be placed under her and a jug of warm water used to pour over the vulval area. Postpartum she will be able to attend to herself as she is used to doing during menstruation. Soaking in a bath or spa is not appropriate, nor is water birthing. However, showering in labour is useful for pain relief.

Fasting

Some very strict Muslims may wish to fast during pregnancy but it should be pointed out that this is not a requirement, nor is it wise, especially if the woman has an associated condition such as gestational diabetes. Breastfeeding women are excused fasting, as are the sick.

Contraception

Contraception is allowed in Islam. However, children are considered a gift from God so some women will choose not to use contraception as they will not want to interfere with God's plans. Muslims are very fond of children and enjoy having large families. The home and family are important aspects of their religion. Mothers who choose to have large families should be supported. It is their choice, they are not irresponsible nor are they abused by their husbands as we may think. Oral contraceptives are acceptable. If condoms or the withdrawal method are to be used the husband must have the wife's consent.

Circumcision

Circumcision can be discussed prior to the birth. Nowadays many baby boys are circumcised at birth. There are doctors who are sympathetic to the needs of Muslims and will perform the surgery for them. At the time of writing, the cost at birth for circumcision is approximately $60.00. The operation is quite minor with quick healing. If performed between the ages of five to seven years, hospitalisation is required. The wound is painful and difficult for the child to deal with and healing takes longer. Costs vary but with the different hospitals' anaesthetist and surgeons' fees, it can be as much as $500 to $1,000.

Birthing Needs

The respect for the woman's modesty and preference for female attendants and support people will apply.

Attention to cleanliness, perineal toilet during labour and showering postpartum.

Pain relief is not seen as an easy option as most women will wish to bear the pain of labour as it is an expected part of the birthing process. An exception is made if it is required as a consequence of intervention. Her options should complications arise should be discussed in the antenatal period.

Immediately after the birth of the baby the 'Shahadah' is recited into the baby's right ear. This should be the first sound the baby hears, so it will be necessary to organise, before the actual birth, that no one speaks until after the recital. Following this, a mixture of crushed dates and honey is touched on the baby's tongue. This is a 'Sunna' or practice approved by the Prophet Muhammad. Ideally these rituals will be performed by a devout Muslim which would signify a good and wholesome start to life. A medal may be pinned to the child's clothing, which will remind Muslims to pray to God to look after the child.

These rituals take only a few seconds and are of great significance to the Muslim family.

The placenta should be offered for burial. As no body parts are ever burned it should be explained that the hospital method of disposal is incineration as the woman may not realise this.

It is essential that the baby be bathed as soon as possible after delivery in order to cleanse away the fluids of the birthing process. The head is washed first, followed by the body, the head will not be immersed in the water in which the body has been washed.

Breastfeeding is expected as great value is attached to mothers milk and the Quran states that a mother will breastfeed for two years. This has some contraceptive advantage too, if the mother chooses not to use any other form.

Diet is very important for the postpartum woman. The Muslim woman will refuse to eat hospital food as it is not Halal. Even a vegetarian diet is not suitable as she will not be sure that it has not been prepared in containers that have previously held pork. The best solution is for the family to bring her meals in to her. Arrangements will need to be made with staff on the postnatal ward to allow the family to bring meals in at meal times.

Death of a Baby

In death, washing of the body is very important. As before, the head is washed first followed by the body. If it is a stillbirth the midwife may wash the body, it should not be photographed or dressed. A cotton napkin can be used to wrap the body in place of a shroud. If it is a neonatal death, the washing will be done by the family, a male member for a male child, a female member for a female child. Once again, no photographs and the use of a napkin to wrap the body. The body is treated with great respect, the family may wish to say prayers. The baby can be placed in a plain cot, a frilly Moses basket is not suitable. The family may wish to hold the baby as part of the grieving process.

As a rule, a postmortem would not be an option, remembering the belief in the resurrection of the body and the respect with which it is treated.

Burial usually takes place as quickly as possible following death. The family may make the funeral arrangements and take the body themselves. In Auckland the NZ Muslim Association arranges for burials and someone from the association may uplift the body.

These guidelines are as stated, 'guidelines'.

As in any society, some Muslims adhere to their religious principles more than others. Customs also become entrenched in people's lives, therefore not all women's needs will be the same. It is up to us to offer and explain their choices in a non-judgmental atmosphere in order that the woman will feel comfortable and able to freely express her needs and make her choices.

■

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	126110	Combur-4-Test	50					✔	✔		✔		✔
	126101	N-Combur-Test	50			✔	✔	✔	✔				
	1203452 1203479	Combur-10-Test	50 100	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	398420 398411	Combur-9-Test	50 100		✔	✔	✔	✔	✔	✔	✔	✔	✔
	163163 185558	Combur-8-Test	50 100			✔	✔	✔	✔	✔	✔	✔	✔
	185515	Combur-7-Test	100				✔	✔	✔	✔	✔	✔	✔
	784656	Combur-6-Test + Leuco	50		✔		✔	✔	✔	✔	✔		✔
	1008552	Nephur-7-Test	100		✔	✔	✔	✔	✔	✔			✔
	784672	Combur-5-Test + Leuco	50		✔	✔		✔	✔		✔		✔
	185213	L-Combur-5-Test	50				✔	✔	✔	✔			✔
Screening	398454	Nephur-Test + Leuco	50		✔	✔	✔	✔	✔				✔
	704784	Ecur-4-Test	50		✔			✔	✔				✔
	163180	Ecur-Test	50					✔	✔				✔
	126098	Combur-Test	50				✔	✔	✔				
	200743	BM-Test-GP	100					✔	✔				
Diabetes mellitus urine	647705	Keto-Diabur 5000	50						✔	✔			
	647659	Diabur-Test 5000	50						✔				
	126187	Ketur-Test	50							✔			
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Poet's Nook

When I can't take any more of the
poverty, childbearing, and
the heavy work load

a woman will come
and she will teach me
how to live love again,
and to trust women.

This woman was Maori,
she was obese,
she was multiparous,
she was locked in conflict
with the doctors,
and also with me.

Yet
she refused to submit
to any of our pressures.
But she did appreciate
that I was her defeated advocate.

So this burdened and unwell woman
took me,
a child-free woman, and drew me to herself.
She stroked my shoulder.
She felt at my hair.
She slipped her hand to my waist. She held me.....

When time moved again
she said to me,
"Both you and I
have been through this many times before;
let's just organise ourselves,
and get on with it."

We did, and she gave birth naturally.

Mary Minto
Midwife

POLITICAL COMMENT

Informed Consent

Joan Donley O.B.E.

Photo: Jane Scotts

The Cartwright Inquiry into clinical research brought doctors in New Zealand face-to-face with the concept of informed consent and patients' rights. This struck at the root of their long tradition of clinical freedom. As Judge Cartwright said:

> *The doctor is no longer autonomous. As a concept, clinical freedom has been proved worthless at National Women's Hospital when patients' safety or the rigorous testing of a new treatment protocol were at stake.*[1]

The NZ Health Council Working Party came up with protocols which were ridiculed by many doctors. Rather than acknowledge their determination to maintain the clinical freedom on which their doctor-patient relationship is based, they argued that patients in hospital are too dependent on doctors to make their own decisions; the time required to meet ethical requirements would make doctors lives very difficult and add to the time they took to do their jobs causing waiting lists to grow.[2]

The NZ Medical Association (NZMA) claimed the protocols were unworkable, proscriptive and time-consuming.[3] (Cartwright considered that the the doctors' argument about time constraints and the patients' level of understanding to be more the fault of the doctors' inability to communicate.[4])

In fact, medical opposition operated as a block at all levels, including the media, to try and undermine the credibility of the 1988 Cartwright Report. This rearguard action enabled the bureaucracies to slow the pace of implementation and provided a breathing space for medical interests to regroup and finally co-opt much of the process of change.[5]

In the obstetric field doctors had already had some experience in co-option tactics. From the early 1970s they had been trying to cope with women supported by a minority of midwives who were evading the medical model of childbirth. The Maternity Services Committee provided an explanation for the need for co-option tactics in 'Obstetrics and the Winds of Change' (1979):

> *Nowhere do the winds blow more strongly than across the field of obstetrics.... Many of us feel threatened by the changing attitudes of our patients. To try and justify our old practices, and to be questioned about our traditional roles and rituals makes us feel uncomfortable.*

Delivery room walls were painted in pastels, curtains and pictures were hung, monitoring technology was camouflaged or hidden, and doctors and nurses were advised to make attitudinal changes, to listen to women. This natural childbirth conflict between women and obstetricians was not an isolated NZ phenomenom: it existed throughout the Western world. Obstetricians shared co-option tactics and strategies internationally.

Arney describes the process.[6] Assuming the role of 'fetal advocate' obstetricians involved women wanting 'natural childbirth' as 'joint adventurers'.[7] As part of the 'team' – with the obstetrician as team leader – women would be able to give birth within a flexible system of obstetrical alternatives, but within the strict limits of safety as defined by the obstetrician and supported by their growing monitoring technology.

By reconceptualising pregnancy as a process, monitoring provided more and more points of intervention with the possibility of more and more treatments. Hedged with criteria and guidelines to extend surveillance[8] and medicalisation, this enables doctors to replace their authoritarian control with more social monitoring and surveillance, based on the 'confessional mode of interaction'. Here, the woman exposes her innermost fears and anxieties. This keeps her constantly visible and able to be monitored and subjected to the new technologies of normalisation.

However, monitoring also limits the doctors' options as they could be culpable if the pregnancy is not kept on its so-called scientifically medicalised course. Therefore, any deviation becomes the responsibility of the woman – IF she feels brave enough to disregard the doctor's dire warnings about the danger to her baby, AFTER she has been given 'balanced information'.

According to Arney, 'informed consent' takes on a new meaning. The woman must now actively participate in decisions about her care based on an exchange of information. An obstetrician sees it as:

> *A new form of autonomy ... which will provide a new space within which the physician can still exercise a degree of professional prerogative and control, but which also will provide the physician a degree of protection from unwanted inquiry about the ramifications of his actions at peripheral locations throughout the layers of systems articulated with the physiological processes that used to be the sole concern.*[9]

The only women able to escape the chains being forged were those having homebirths.

By 1990 the medical profession was reluctantly accepting the Cartwright concept of informed consent – in principle, if not in practice. In the 'shift from beneficence to autonomy', Auckland Medical School established a course in communication. Students were being taught to be sympathetic and to empathise; to use the reflective listening technique and non-verbal communication such as observation of body language, ambivalence, etc.[10]

One wonders if this is similar to the neurolinuistic technique referred to as the illusion of choice, which gives the health professional control, but does it in such a way that the patient believes s/he is in control.[11]

Then, in October 1990, NZ midwives had the option to become independent practitioners with the same professional and economic status as GPs in maternity care – the final threat to GPs' control of childbirth! What better weapon than informed consent based on the medical model/ monitoring to undermine the midwife and place her back under medical control? Like asking a woman who had a postpartum haemorrhage, 'Did your midwife inform you of the dangers of the physiological third stage?'

Do midwives ask women who have avulsed cord, postpartum haemorrhage or retained products – 'Did your doctor inform you of the dangers of routine oxytocics with the delivery of the anterior shoulder?'

Continued on Page 20

Contracting for Health Services

Marion Lovell
Midwife

Comprehensive Maternity Service Provision Using a Fund Holding Approach

Introduction: Opportunity or Threat?

In July 1991 the National Government announced its intention to effect reforms in the health services. Improved community health status, universal access to identified core health services and increased cost effectiveness and accountability were the stated aims of the health reforms. A number of changes to the then current system were to be instrumental in the achievement of these aims. The purchaser or funder/provider split represented the most major change. The intent of this split was to allow the purchaser to select the best services available to meet the needs of its consumers. The purchasers, four (Northern, Midland, Central and Southern) Regional Health Authorities (RHAs) would be funded by government according to their population size and characteristics. Providers such as the Crown Health Enterprises (previously Area Health Boards) and independent health professionals (including midwives) would contract in a competitive market for the provision of subsidised services.

The integration of primary and secondary care funding and, consequently, improved integration of care were the perceived benefits. (Health Reforms Directorate, Internal Publication, Nov 1992.)

In April 1992 the newly formed Health Reforms Directorate, set up to establish the RHAs and develop policy advice, proposed to fund a number of initiatives in personal health contracting. Objectives for proposals included addressing public policy questions (e.g. competition, integration and service specification) and generating information to assist purchasers and providers in the development of contracting options.

Although not widely publicised and with a tight timeframe over 80 responses were received. Ten projects were selected nationally for funding, representing a range of providers and services.

Domino Midwives Wellington were successful in having their proposal for fund holding for maternity services accepted.

Background to Initiative

In August 1990 the passing of the Nurses' Amendment Act restored the right of midwives to practise in New Zealand independently of medical supervision.

The law change was the culmination of a long struggle by women who opposed the medicalisation of childbirth. The formation of the New Zealand College of Midwives in 1989, effectively uniting midwives and giving them a political voice, enabled midwives and women to join together in partnership and added impetus for a change in the law (Donley, 1991).

While the law change enabled a greater choice for women and increased remuneration for midwives, problems were becoming apparent a year later. Midwives campaigned for a law change on the grounds that birth is a normal life event for most women and that midwifery care with this focus would reduce intervention and prove cost effective. It would also provide women with the choice of care from either a medical practitioner or midwife.

The appearance of the words 'or both' in the final version of the 1990 Nurses' Amendment Act *(Part 2, Amendment to Social Security Act section 106.[1])* was a surprise to midwives who had not contemplated or argued for this.

In a discussion paper presented at the NZCOM meeting in August 1991, the authors identified unintended consequences of the law change.

'The provision in the law for either doctor or midwife or both has resulted in:

1. *An incentive for the provision of continued dual funding and escalating costs of childbirth.*
2. *Doctors continuing in their role as 'gatekeepers' and controlling access to alternative midwifery services. (Doctors can now direct 'patients' to midwives in their own practices.)*
3. *Fragmentation which the law was designed to reduce, continues to exist. By failing to provide a complete service, midwives are able to concentrate on the more lucrative aspects (labour and birth) of midwifery. The responsibility for the care remains with the doctor, thus retaining the obstetric approach to childbirth.'*

(Lovell and Virtue in Donley, 1991)

As noted, the combination of women and midwives was a powerful force and instrumental in the fight for change.

Oakley and Houd (1990) note that exclusion or restriction of autonomous midwifery restricts women's choices and fuels the dissatisfaction with existing 'official' systems of childbirth care.

Arney (1983) in a discussion of the American childbirth system identifies that a change in the discursive practices of the obstetric profession occurred when women's interests in childbirth conflicted with the interests of the obstetrician. From 1940 the natural childbirth movement, unconvinced of the value of hospital birth, presented a significant threat to obstetric autonomy. A compromise involved a reformulation of obstetric practices to take women's interests into account.

The discovery of the fetus, an entity to be monitored, was opportune for the medical profession. Childbirth was redefined in terms of ecological or systems theory and a new age of monitoring or surveillance began. The hospital became the 'surveillance' centre and different practitioners regrouped into 'teams'.

Whether coincidental or a clever strategic move by the medical lobby, the provision in law for a woman to choose both practitioners has supported and reinforced the dominant discourse of obstetrics. While midwives can function independently of the medical profession, doctors cannot provide a maternity service without midwives. Thus, the dominant theme of the opposition to the 1990 Nurses' Amendment Bill was that 'safe' maternity care required a 'team' approach, that is, with the doctor as team leader.

The twin juggernauts of the obstetric and economic discourses created a formidable force in the health reform environment. Weedon (1987), however, notes that 'the dominant discourses governing the organisation and practices of social institutions are under constant challenge'. Compatibility between subject position in a particular discourse and individual interest ensures the maintenance of power relations. Incompatibility creates resistance, provides subject positions other than the preferred, and creates the possibility of reverse discourse. The reverse discourse, in challenging power and meaning, facilitates new discourse development. Increasing the power of a marginal discourse is dependent on the wider context of power and social interests in which the challenge to the dominant discourse is made.

Midwifery autonomy exists as a tolerated marginal discourse because it has not challenged the obstetric hegemony greatly. The language remains essentially intact. The words 'team' and 'safety' remain and the idea of continuity of care has been appropriated and become part of the medical language. Preferred subject positions continue to be occupied by those midwives who make no attempt to practise independently of medical supervision.

Lumby (1993) has criticised the corporate culture approach to the health reforms for promoting corporate (masculine) business values at the expense of women's values. However, the competition/cost effective ethos favours a maternity service with low (less expensive) intervention rates and minimal dual payments!

The purpose of the project then, was to use the opportunity offered by change in the organisation of health care services to trial a model of maternity care delivery which supported the original aims of the law change. Whilst not necessarily endorsing the free market approach to health care provision, accepting the inevitability of the change and organising ourselves accordingly seemed to offer the best prospect for survival.

THE MIDWIVES' PROPOSAL

Comprehensive Maternity Service Provision using a Fund Holding Approach

The aim of the project was to provide a comprehensive maternity service for those women who are expected to have a normal birth (approximately 80% according to WHO statistics). The service would be cost effective, accessible, and have a high user-satisfaction level.

The argument for cost effectiveness and efficiency was based on the idea of replacing the fee for service payment available through the maternity services benefit with a bulk funding approach. Contracting was the proposed method for achieving this. The midwife group would contract to provide a total maternity care package, providing continuity of care, for a negotiated fee per maternity episode. The objective was to work within a set budget. Any surplus would be used to extend the service.

All care would be provided by the midwives, referral when necessary would be to those specialist obstetricians with whom the midwives had a good working relationship. The initial proposal was to include the fee for consultations and in a small number of cases shared care with a GP.

Quality objectives were identified as maintaining normal birth rates and intervention rates in keeping with the WHO statistics and demonstrating high user-satisfaction rates.

The midwifery practice has had a comprehensive data collection system and a regular method of surveying service users in a satisfaction questionnaire since its inception in March 1990.

The Domino midwives practice includes increasing numbers of homebirths. Other births are in hospital and the Domino approach involves spending much of the labour at home, and the woman is home again within two to six hours. This provides an efficient link between the primary and secondary service.

A budget of $18,500 was proposed to cover accounting and legal fees, clerical and data entry costs and setting up a computer system including the computer and software.

The final sum awarded for the pilot project was $16,000. The Maternity Services Benefit would continue to fund actual care provision albeit in another form.

The Process

Initially the primary care projects were managed by the Health Reforms Directorate (HRD) with administrative assistance from the Health Department.

Later (December 1992) the Health Reforms Directorate dissolved and responsibility for the project transferred to the Department of Health.

Problems associated with this change were a change in personnel involved in the project, discontinuity of information between the first purchaser group and the second, and inadequate resources within the Department. There was also an uncertainty on the part of the Department over what resources it should make available as the pilot funding had come from the HRD. As noted in the evaluation, the purchasers recognised that the midwives funding was inadequate for what they were expected to do: 'The Dominos got the smallest seeding grant [out of all the budget holding Initiative projects] and have by no means done the smallest amount of work for it' (Middleton, 1993). The extra resourcing required was provided by the midwives.

The first task to be achieved was the drafting and negotiation of the initiatives contract for the payment of seeding money by the HRD. This was a relatively straightforward procedure and provided us with initial experience in contracting. A condition of government funding was that the funds be paid only to a group with legal entity status. The Domino midwives, although loosely connected as a group, practised as sole traders financially. Exploring the options for groups becoming legal entities was time consuming and expensive.

In association with our lawyer we managed to work through the issues involved in changing from an informal group to a legal entity. The structure agreed on was a company. Objectives of the practice and a philosophy of practice, while previously implicit, became explicit in the company documents. Each of the midwives had equal shares in the company and all were directors. Directors' responsibilities were identified and agreements on fees reached.

The establishment of a computer database was seen as fundamental to providing the information required by the contracts. However, this proved a complex procedure. The area hospital was in the process of setting up a perinatal information management system (PIMS). Consultation between the computer group and the midwives led to an agreement to develop a midwifery information management system compatible with the PIMS. Over the course of the year since the project began PIMS was successfully trialed at Wellington Women's Hospital and is now being marketed throughout the country. Carey, one of the practice midwives, has continued to be involved in the development of both PIMS and MIMS (midwifery information management system) and a shareware prototype for MIMS is now in circulation around the country.

The practice was computerised with the purchase of a computer and appropriate software for database and administration needs.

A financial accounting system to manage bulk funding was established and proved to be one of the easier parts of the process, in part due to appointing a client as accountant.

Attempts to streamline the administrative system were facilitated by a business management consultant who was also a client. Previously the business was managed by one of the midwives. Reporting requirements have generated a greater amount of administration work.

Currently, having moved the financial responsibility to the accountant, the administration is manageable, although still done by Carey. Although not part of the original proposal, the purchasers (HRD and DOH) requested that as part of the global fee contract, attempts be made to interest a GP with whom we sometimes worked in subcontracting for some shared care cases. As this was in line with original initiative objectives of integration and developing options, it was agreed on and proved to be straightforward. The subcontracted GP is paid from the global sum for cases referred for shared care.

Contract Negotiation

It was envisaged that work on the global fee contracts would begin in August 1992 but the time the negotiations would take was unknown. It was, however, expected that by October a contract would be in place. In May 1993 the final contract was signed! This was at the same time as other pilot projects were signed. The amount of work involved was underestimated by all involved. For the midwives the work was additional to the already time-consuming tasks of attracting business, administering the practice, providing a maternity service and the omni-present politics of childbirth. Having stated in the proposal what we thought the global fee should be, we expected the purchaser group to come up with an offer as a point of negotiation. The Department finally sought to contract a health economist to deliver what was described as a 'robust funding formula' for the initiative (Middleton, 1993).

Significant progress was made as the contracted economist sought to understand exactly what was involved in delivering a maternity service.

Once the report, *Proposed contractual arrangements for the Domino midwives initiative* (Sutton, 1993), was prepared, the purchasers entered into contract negotiations. At this stage a third purchase manager appeared and some difficulties were encountered when suggestions were made that the midwifery service was 'high cost' and the population it served 'low risk'. While unable to produce evidence to support these claims, the purchasers proposed the level of service be revisited.

This was a period of some disillusionment as the aim of the project for us was to fund a comprehensive maternity service that would prove cost effective both in funding only one provider and in better outcomes (lower use of hospital stay and expensive technology). In the evaluation the purchaser group state: '... Ours (objective) was more input-focused theirs was more outcome-focused' (Middleton, 1993). This attitude seemed antithetical to the intent of the reforms. The debate was not continued, however, and work on the contract progressed.

The Budget

Our aim in proposing a global fee approach to funding was to trial a type of funding that would give incentives for continuity of care, cost effectiveness and good outcomes. Fundamental to this was the idea of a single provider managing the budget for each woman. The budget proposed by the purchasers was based on the idea of fiscal neutrality, competitive neutrality and fiscal constraint. Interpreted this meant that funding should be no higher than claims made against the maternity benefits system, at the same level as other providers of primary maternity care, and not allow quasi open-ended claiming. Other considerations were not to encourage inappropriate cost shifting and ensure monitoring was feasible and related to the formula structure (Sutton, 1993).

We felt the economist made a concerted attempt to understand what our practice involved in terms of time and services. Interviews were conducted with the midwives and the proposed funding figure was based on both our past years' claiming patterns and our claims that the current schedule payments were not reflective of work and hours spent in other parts of the maternity episode apart from labour and birth. Although the subsequent formula proposed a multi-global fee structure, this was finally accepted as an appropriate transition approach which moved away from open-ended funding but avoided cost-shifting risks.

The final agreement was for a funding formula that provided a fee for the constituent parts of the maternity episode. These were identified as first, second and third trimesters, labour and birth, postnatal services to six weeks and six week examinations. The agreed sum for each part was an aggregate of maternity fee and travel.

Other Influences

The period of the negotiation was much longer than anticipated for all of the initiative projects. In the case of those involving maternity care a number of outside influences impinged on the process.

The concurrent negotiations of the Maternity Benefits Tribunal were a major impediment to progress. The tribunal was subject to delays in reporting dates and it became apparent that the purchasers were unwilling to proceed in the uncertain climate. Other problems were the bad publicity the reforms were receiving and the negative publicity over independent midwifery care, part of a campaign to reintroduce the 'safety of the team' concept (*Frontline*, November 1992).

In the Wellington area the lucrative maternity benefit payments were luring many midwives from the hospitals into GP and obstetricians' practices. 'Midwife only' care remained a largely unknown option.

As the date for signing the contract became closer to the 1 July 1993 (changeover to RHA structure), negotiations with the RHA began and the signing of the initiative contract became a formality. In the event the RHA was keen to roll over the contract.

Evaluation

An evaluation of the process of negotiating a global fee was undertaken by the Department. This included interviews with both parties (Middleton, 1993).

Conclusion

Currently the Wellington Midwifery Service, Domino, have a one year contract until July 1994 with the Central Regional Health Authority to provide maternity services using a global fee. The combined RHAs are reviewing maternity service provision and funding and one of the options is the global fee alternative.

From the midwives' perspective this system provides freedom to provide care that meets the woman's needs and is not restricted by a fee structure. Reallocation of funding with increased recognition for aspects other than labour and regular monthly payments enables finances to be more effectively managed. It is also an incentive to provide total care and not only the lucrative aspects as per the maternity benefits schedule. One fee is paid for each maternity episode and in cases where two providers are involved both are paid from the one fee.

> '... We make history as well as being subject to it.'
>
> (Oakley and Houd, 1990)

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After Birth

A Perspective of Postnatal Care and Early Discharge

Mary Wood

Independent Midwife

Within the sphere of midwifery practice, postnatal care seems to almost hold an aura of the 'poor relation', when compared with ante or intrapartum care. Yet, when women are asked what the most significant aspect of the whole experience of childbearing has been, the most frequently mentioned time is the postpartum period, with the second most common being the actual birth (Prince and Adams, 1987 p. 104).

Within hospitals, these three aspects of midwifery care in general, continue to be fragmented, with continuity of midwifery care being the exception rather than the rule, despite the generally accepted knowledge this is what women and their families want. It is my intention in this article to reflect on my experiences of postnatal care and of the challenges that couples sometimes face, especially with their first child. I will discuss why I have found early discharge to be beneficial for women and their families, and consider the barriers to planned early discharge.

It can be extremely difficult to get a couple expecting their first child to focus in any great detail on the time after the birth – to remember the whole purpose is to have a child, not to have 'a birth'. Although good antenatal preparation can pave the way, nothing can completely prepare a couple for changes that are about to take place in their lives, the transition from being a couple to being a family.

Working as an Independent Midwife Practitioner over the last two years has given me the opportunity to provide continuity of midwifery care for women and their families throughout the childbirth process, from conception (occasionally prior to conception), until two weeks post-delivery. Working in this way has developed a strong commitment to planned early discharge for women who either choose to, or need to, give birth within the hospital environment. My commitment to the promotion of early discharge developed through my observations of women and their babies in various birthing settings.

Hospitals have various policies which define early discharge as discharge within a specified number of hours, usually four to six hours, after delivery. My definition of early discharge is discharge within 24 hours, or on day one.

It is often appropriate for the woman and her baby to stay the night in hospital because of the timing of the birth, and sometimes for other reasons. At North Shore Hospital where I predominantly practice, about 13.5% of women are discharged on the first day.

The early days when the new baby begins to become integrated into the family structure can involve enormous stress, both for parents and older siblings. In the book *The Psychology of Childbirth*, Prince and Adams (1987, p. 116) state 'the postnatal period is a time of rapid change making considerable demand on a woman's ability to adapt to her new role, new family and new self'.

When it is the first born, the couple is in the process of working through the role changes involved in becoming parents. They may have been the most well informed, motivated antenatal couple in the world, but the reality of life with a newborn can be somewhat of a shock nevertheless. The reality of constant broken sleep, the sometimes overwhelming sense of responsibility for this new, little person in their lives, the role confusion sometimes experienced with career and lifestyle changes, and the coming to terms with a slightly altered perspective of life in general, can be harrowing. Added to this may be the physical discomforts and slightly altered body image the new mother may be experiencing.

Recently, one young woman said to me tearfully, regarding her body, 'It's either leaking, sagging, sore or all of the above!' Also it can be a struggle to master those sometimes daunting tasks involved in physically caring for a newborn.

The adjustments when there are older siblings involved can be quite different, but just as potentially difficult. When the mother and new baby stay in hospital for a few days, feelings of jealousy by an older child may be unavoidable, with accompanying feelings of abandonment, displacement and separation anxiety. Tears, tantrums and inappropriate behaviour may surface as a manifestation of these insecurities. 'Less sibling rivalry is one of the possible benefits of early discharge' (Bennett *et al.*, 1993, p. 288).

When a woman gives birth within a hospital environment, the couple, baby, and sometimes other family members, are usually together in the delivery unit for at least a couple of hours after the birth. But once the woman and baby are transferred to the postnatal ward, the father goes home, and during those important first few days the father's role thus becomes that of 'visitor'.

Even when the hospital has open visiting for fathers, he is still a visitor. This often sets the pattern where the physical care for the child becomes almost exclusively the domain of the woman.

When couples go through the birth together, stay together for those few hours in the delivery unit, and then go home together, it has been my experience that the father tends to become more involved and takes more responsibility for the day-to-day tasks involved in the baby's care. Learning those tasks becomes a joint effort, rather than part of the woman's role. This is not to say that the father becomes the 'assistant mother' or that he is able to 'help with mothering', but rather, he takes more responsibility with 'fathering', for example: he will change the baby's nappy because it needs changing, not to 'help the mother' (Leach, 1986, p. 19).

Kitzinger (1991, p. 183) refers to those precious days after the birth, as the 'babymoon'. She points out that this time should never be merely a sequel to delivery, nor an interval for postpartum recovery. This important time is when the parent/child relationship begins to form – this special relationship so vital to the development of the mature adult personality (Prince and Adams, 1987, p. 22).

As midwives, we are in a position to influence the beginnings of this special parent/child bond. My experience has led me to question the appropriateness of the hospital environment for healthy mothers and babies during this time. It must be acknowledged that for some women and babies a hospital stay after birth is both necessary and appropriate, but there are aspects of the hospital environment which can interfere with family relationships involving a new family member.

Part of becoming a 'patient' in hospital involves taking on a 'sick role' to some extent. Part of taking on the sick role is to transfer responsibility. Prince and Adams (1987) state that: 'When she (the mother) is at home she knows that it is she who is responsible for the baby's welfare. Inevitably in hospital, that responsibility is divided, which is not necessarily to the benefit of normal mothers with healthy babies' (p. 107).

What I often observe is the integration of the baby into the lives of not only the mother and father, but the family as a whole. This really doesn't appear to begin until the mother and baby are home, whether that be on day one or day six. Inch (1989) refers to this in her book *Birthrights*. Inch says: 'The time in hospital may be regarded retrospectively as a sort of limbo state' (p. 190) and in many respects hospitals are not good places to learn about mothering in the psychological sense. This is certainly true of fathering. Kitzinger (1991) also refers to this,

stating 'in hospital, bonding is delayed or hindered, or sometimes never gets going until after they (mother and child) are home' (pg. 186).

Within the midwifery practice that I am associated with, we have found we have far less difficulty with parents' self-confidence and the establishment of breastfeeding after early discharge, particularly with first-time parents. Paradoxically, establishment of breastfeeding and lack of confidence are probably the most commonly cited reasons women give for choosing to stay in hospital for a few days.

Leach (1986, p. 36) says the skill of the midwife should be a comforting background to a woman's first mothering, not a replacement for it. At home, it is the midwife who is the 'visitor', depending on the needs of the individual woman and baby – usually two or three times a day for the first two days, then daily, then every two to three days. 'There is considerable evidence that mothers who are left on their own with their babies and encouraged to feed on demand find it easier to establish breastfeeding than where the care of the baby is divided in the first few days between midwife and mother.' (Prince and Adams, 1987, p. 131).

The seemingly insurmountable problem of conflicting and confusing advice can effectively be eliminated when the woman is seeing only one or two midwives, and those midwives are part of a team who are in close communication with each other. Continuity of care that begins early in the pregnancy makes it possible to form a strong, trusting relationship with the woman and her family. Working within a small midwifery team means we can guarantee the woman 24 hour, on-call after birth midwifery care with a midwife she will be familiar with.

Ongoing contact with the family throughout the antenatal period means ample opportunity for assessing the knowledge base, pre-existing ideas, and expectations of the couple. Discussion and education about the birth process, early parenting, and breastfeeding can then continue. Continuity of midwifery care that includes 24 hour, on-call service is, in my experience, important for successful early discharge.

I believe that one of the main reasons that women seem to find their feet so well after planned early discharge, is simply because they are in their own environment – home ground. Being in an alien environment, in the company of strangers is not, in my experience, the best environment for the healthy new mother and baby.

During a very busy time recently at North Shore Hospital, I cared for a woman who chose to go home from the delivery unit with her new baby son because the postnatal ward was so busy. I visited her in the afternoon two hours after she had arrived home. There she was, in her dressing gown, ensconced on the couch with her feet up, babe asleep in a Moses basket next to her. Father was sitting on the floor playing with the older daughter, who was just two, and grandmother,who had come to help care for the older child and the household tasks, was sitting on the couch knitting. The open fireplace was in use and I could smell the roast for the evening meal cooking in the kitchen. The atmosphere was intimate and peaceful, and I had a tremendous sense of being the 'visitor' in that woman's nest. She was in control of her environment and I couldn't help but compare how different she would have found the environment in a busy postnatal ward.

One of the main barriers to planned early discharge is the perception of being tossed out of hospital with no support, back-up or recourse five minutes after the baby's first-drawn breath! I have found, as with the introduction of many new ideas, the concept of early discharge is best introduced gently, while stressing the point the choice is the couple's and no pressure will be applied either way. A study reported in the Midirs Digest (1991, 1:1 p. 65) on voluntary and involuntary early discharge showed significantly less satisfaction when the choice was removed. I have found that as my relationship with the family grows, their trust in my commitment to them also grows, and the idea of planned early discharge becomes more acceptable and more appealing.

Another reason people often reject the idea of early discharge is because in New Zealand people in the main have been socialised to believe that not only is hospital the only safe place to give birth, but it is also the safest place to be during those early days after the birth. Both of these are widely-held assumptions with absolutely no evidence to support them.

An example of this appears in the international bestseller *What to Expect When You Are Expecting*. This book states that although it is 'safe' for a woman who has had an uncomplicated delivery to go home early, the baby on the other hand requires hospitalisation for 'a minimum of two, but an average of three days', for observation in case of jaundice. The book goes on to stress how unwise it is to 'play doctor' and to discharge yourself from hospital against medical advice (Eisenberg *et al.*, p. 353/4). Heaven forbid a woman might know what's best for her baby! The book *A Guide to Effective Care in Pregnancy and Childbirth*, which is research based, points out there have been no demonstratable adverse consequences of early postnatal discharge from hospital in teams of maternal and child health (Enkin *et al.*, 1991, p. 310).

Lack of social support can be another barrier to early discharge. For the woman who has two or three other children at home, in the absence of any state-provided home help or child care during this time, and if adequate family support is not available, the postnatal ward can be a welcome haven.

The perception the postnatal ward is a place where one can 'rest for a few days' after the birth is another strongly held misconception. This is an expectation often reinforced by older women who had their babies during the era of the two-week hospital stay when nursing staff primarily cared for the baby, and the woman was nursed in bed for the first week.

At the beginning of this article I commented on the 'poor relation aura' of postnatal care within midwifery. It became very evident in my search for literature written by midwives on postnatal care, it doesn't focus merely on fundus, breasts, wound healing and baby's weight.

I made reference to the focus couples often have on the pregnancy and birth and their difficulty in focusing on the parenting aspect, with all its challenges and transitions. Could it be that we as midwives also tend to focus on the birth and disregard the vital importance of postnatal care? The essence of postnatal care say Flint and Cronk (1990, p. 80) is to produce a woman who is confident in her ability to nurture and care for her child.

Conclusion

My experience of the planned early discharge option and benefits I have discovered which are so often the result have been outlined, along with considerations of some of the barriers to early discharge (both perceived and actual).

Postnatal care in hospital will always be necessary for some women and their babies, both for physical and social reasons. Whatever the setting, our role as midwives in all aspects of care should be to guide and encourage, to provide positive feedback, and to enhance at every opportunity the couple's confidence and belief in their own abilities.

Where better than their own environment, their home, to accomplish this.

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Recommendation

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Jean Sutton (Midwife)
Independent Consultant for Normal Birth

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Relationships Within Midwifery

Jenny Woodley
Midwife

On 5 August, 1987, several hundred midwives and consumers attended a conference in Auckland where the keynote speaker, Caroline Flint, an English midwife, asked us to participate in a short, guided visualisation of ourselves as women. Caroline asked us to close our eyes and feel how unique we are as individuals, how strong we are as women, and the miracle of the conception, growth and birth of a child through ourselves as women. We were then asked to open our eyes and be together as midwives and women.

Since 1987 the politics of control over childbirth have undergone dramatic change. The 1990 Nurses' Amendment Act has liberated midwives from the control of doctors and with this liberation has come uncertainty, stress and conflict. We seem to have closed our eyes and separated into our own isolated areas of work. This division causes severe problems for our profession and the women we are here to serve. The purpose of my writing is to discuss the effect that the recent legislation has had on midwives' relationships with one another and ultimately with the women. I will look at where we are historically within this culture of rapid change and suggest ways of altering our behaviour to enable us to truly work to support and sustain one another.

Once we received equal pay for equal work our incomes grew and with that a rapid movement to centre stage. While we are the centre of public attention there is plenty of opportunity for a carefully planned attack on us from the groups of professionals whose previously unchallenged monopoly of control has been upset. This was expected and for those of us who had worked outside the system for some time, entirely predictable. Of greater concern than the external threat, however, is the internal strife, dissension and disharmony amongst midwives working in different areas. We need to look carefully at what we are doing to one another, understand the mechanism of change and the fear this creates, then resolve to move from here to a new relationship with one another. We are one anothers' immune system. All parts of the whole need to be healthy.

Recently midwives who put their names forward for nomination to committee and chairperson of the Auckland branch of the New Zealand College of Midwives included, without exception, in their statements of belief a need to see midwives working together in harmony and co-operation. There is obviously a strong need in the midwifery profession for this to occur. I sense a readiness, a willingness for change in our ways of relating to one another. If we try as a profession to separate into parts, to live as closed systems, we are bound to stay stuck in conflict without resolution. If we enlarge our awareness, admit new information and take advantage of our wonderful capacity as people to integrate and reconcile we can reorder into a new way of working together for the benefit of ourselves as a profession and the women with whom we are so intimately connected.

I have learned through time that whatever I am feeling is usually what many other women are feeling. I have a need to be working with a group of women I trust and care about. I need to feel valued and to love my work, to know that I am not being attacked and criticised when I am not present. I believe most of us have a need to feel harmony together. It is very difficult and exhausting to be in conflict. Our combined strengths and talents should make for creative and innovative ways of working instead of the defensive isolation some of us are experiencing.

How can we support each other as midwives? We are not the acts of parliament, the pay structure of the CHEs (Crown Health Enterprises), the hospitals or any of the structures that enable us to work as midwives.

What we are and do is defined for us in the *New Zealand College of Midwives Handbook for Practice* (1991). These principles underline our practice wherever we choose to work. At different stages of our lives we will choose different ways of working. How much more flexible and exciting are the possibilities now for fulfilling work while being able to meet the needs of women? When minority groups such as midwives are released from oppression and free to become autonomous there appears a tendency for the oppressed to become oppressor for that is the behaviour they are most familiar with. Paulo Frierre, an Educationlist writing in *The Pedagogy of the Oppressed* (1985) has this to say:

> (I have replaced his use of the word man with the word midwife)
> *Liberation is thus a childbirth and a painful one. The midwife who emerges is a new midwife. Viable only as the oppressor – oppressed contradiction is superseded by the humanisation of all midwives. Or, to put it another way, the solution to this contradiction is born in the labour which brings this new midwife into the world. No longer oppressor or oppressed but midwife in the process of achieving freedom.*

This quote probably needs rereading a couple of times to understand what Frierre is saying.

We need to understand that our behaviour is not isolated from our culture and that when liberation occurs reactions will vary as people struggle to cope with the dramatic change. Another significant concept that has helped me understand my own personal growth and the role of stress in enabling people to reorder into new ways of behaving is Prigogine's *Theory of Disapative Structures* (Ferguson, 1980, p. 176). Prigogine won the right to be flexible, creative, empowering and supportive.

Again quoting from the *NZCOM Handbook for Practice*, responsibilities to colleagues and the profession.

'Midwives support and sustain each other in their professional roles and actively nurture their own and other's sense of self worth.'

The values that have been labelled feminine – compassion, co-operation, patience – are very badly needed in giving birth to and nurturing a new era in midwifery today.

I am at present working to organise a workshop on behalf of the Auckland branch of the College of Midwives. This workshop is for between 10 and 20 members of the College, midwives from all areas of practice and consumer representatives. We have contracted a highly recommended facilitator with no previous knowledge of our dilemmas, hired a venue away from our places of work and plan to meet for a day. Our intention is to work together as a group to identify the issues that are of greatest concern, and to work through our facilitator until we find a resolution for the group. This process will be difficult but our intended outcome is for a greater sense of unity and understanding of one another and a feeling of alignment as a profession. Unless we move towards a new way of being we risk having our conflicts resolved by authorities outside ourselves. My strong desire is to work at this issue no matter how long it takes and whatever the frustrations until we begin to sense a feeling of unity and trust within our profession.

In this article I have portrayed where the midwifery profession is at this point in time, described the role of chaos and stress in the reordering of any system, and outlined a process we intend to undertake to create a beginning in new and improved relationships between midwives. I feel confident that our willingness to recognise this need and work together will result in a new understanding and help create more harmony in our relationships with one another.

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■

Joan Donley – Political Comment Continued from Page 12

At the recent Maternity Benefits Negotiations, 27 January, discussions centred around how the maternity services were to be structured and funded in future, the NZMA claimed that the GP is the principal practitioner for maternity care in accordance with women's choice, and that the woman's own GP is the one who should provide the woman with 'balanced information' about maternity care choices and risks.[12] This secures the GP's position as 'principal contractor' and 'subcontractors must follow the principal contractor's instructors'. They justify this on the basis that midwifery is only a component of maternity care.[13]

As current members of the Flat Earth Society, the NZMA claims that the Amendment was never intended to allow midwives to take the same scope and level of responsibility as was previously reserved for doctors.[14]

In fact, the present fragmentation of care and differing philosophies (midwifery vs medical model) 'can be directly attributed' to this legislation.[15]

Informed consent is a two-edged sword. While the NZMA tries to prevent this concept in order to maintain the medical model of childbirth and its former monopoly control, it has the power to provide women with the means of reclaiming their voice and real choice.

The question is: Where will midwives stand at this critical moment in history? Will they have the courage to embrace the midwifery model and give advice that reflects the values of this model? (It is surprising the number of women under midwifery care who have serial ultrasonic scans, polycose tests, epidurals, routine oxytocics.)

Or will they become paralysed agents for the medical model – because they fear birth or obstetrical criticism, or because it is in their economic interests to gather the crumbs from the obstetric table?

References available on request from the author.

Establishing a Private Lactation Consultation Practice

Kath Ryan

Lactation Consultant

Is This What You Want to Do?

Anyone considering establishing a private lactation consultancy needs to have a realistic idea of what to expect in order to avoid entering practice with 'stars in their eyes' that leads to eventual disillusionment and disappointment. So the first part of this article is devoted to painting my version of a realistic picture.

The questions to ask yourself fall neatly into six categories: experience, costs, time, counselling skills, job satisfaction and income. The ideal experience consists of some mix of tertiary education and practical or clinical experience. With these you can be sure of being able to understand the medical terminology that is likely to confront you, both during preparation for the examination and later when reading to keep up-to-date.

Financial considerations are a major part of the picture. Expenses will be required for continuing education both in the form of travel, accommodation and fees for exam and conferences or workshops, and also for subscriptions to organisations, journals and resources. Then, of course, there will be the initial costs of going into business which I shall cover later.

It is important to accurately assess the time you have to spend on such a venture taking into consideration home and family commitments. The age of dependent children will determine just how flexible you can be with your time. Remember that the client is paying for a service and must have your undivided attention. If you would need to put children into child care or arrange baby sitting don't forget to include the costs. The very nature of the work demands maximum flexibility since mothers generally contact you at a time of crisis and need instant attention. For this reason not many lactation consultants have very young children. Furthermore, time will need to be spent away from the family for continuing education. It is also necessary to set aside time for reading and study. Initially to a great extent and later to a considerable extent, time will need to be spent in promoting your services. The number of consultations you perform will be directly proportional to the time you spend on such promotion. This means making appointments with people and introducing yourself and your practice.

Are you confident in your counselling skills? The situations you will find yourself in are often highly charged emotionally and your client will expect you to wave a magic wand and correct the situation. Also, by the time a mother contacts you she has probably seen a number of other health professionals, so not only are you inheriting other people's 'difficult cases', but your client has probably been filled with conflicting advice.

Job satisfaction doesn't come automatically. You will be working alone and will have to create your own satisfaction. Acceptance within the health care team occurs slowly and is built up on your reputation for achieving results. A great deal of energy will go into this area.

Last but not least, I hope that you are not planning on getting rich! Very few lactation consultants are making a living from their practice. Many are engaged in other employment to supplement their LC earnings and a few rely on their spouse's income to keep body and soul together.

Now, if all that hasn't put you off, then maybe private lactation consulting is for you. When you have made the big 'Yes' decision your head will begin to buzz with all the things that need your attention. I will try to put them into some sort of logical sequence for you.

Logistics

Fortunately, we don't have the tangled legal nightmare that exists in the United States and most of the legal matters will fall into place when considering other details.

Obviously, the basis of your practice will be the consultations you perform with the mothers who are prepared to pay for your help so the first decision will be where to hold these consultations. Are you going to visit mothers in their own homes; have them come to your home; or establish a clinic at some other location?

What are you going to charge for your services? Here you need to consider all your costs including transportation to your client's home, overheads such as printing, telephone, electricity, rental, etc. I cannot urge you strongly enough to remember that you are establishing a professional service, obtaining the qualification which has probably taken years and cost a great deal of money. Your continuing education will also be expensive. Your credibility will hinge on your fees. If you undervalue yourself so will everyone else. If you over price your services no one will take you seriously. Remember you are not a social service, you are in business and there is no room for the voluntary mentality. This does not mean that you should become money grubbing as there will be some services that you may still perform voluntarily. Make sure that you have a clear understanding of where you stand at the outset. This becomes even more important if you have previously been working in a voluntary capacity.

You will find that a great deal of your time is spent on the telephone which, if you are not careful, will be 'dead time'. Phone calls generally come from two sources – clients and colleagues. Unfortunately, colleagues who should know better (particularly those who are already in paid employment) are the worst offenders. You will need to decide upon a policy for dealing with such calls. Since the telephone will be your main means of contact you may consider a business listing in the directory but remember that your rental is then charged at a higher rate. To avoid missing important calls or frustrating potential clients I suggest installing an answerphone.

The next area to think about comes under the heading of stationery, and before you can make any progress with this you will need to decide what to call yourself. Do you want to use a logo? If so, this will need to be prepared to a satisfactory level for printing – camera-ready copy is the technical jargon. The wording on brochures and business cards requires careful thought because you are going to have to live with it for a long time. Letterhead and envelopes are part of the professional image of your practice and are important in the way other people perceive what you are doing. Various forms for keeping client records and handouts such as patient care plans can be produced more cheaply by photocopier but still need to be of a high standard.

Records are a legal requirement and are your security in the case of a dispute. They also help to jog your memory when dealing with several clients at any one time. Make them neat, factual and objective. Don't forget that under the Freedom of Information Act a client may ask to see her file!

The accounting side is a tough one as there are several ways of organising your business. You would be well advised to seek expert help with this. You will be responsible for GST and tax returns and a myriad of other paperwork which seems to materialise from the letterbox. Insurance in New Zealand is not such a thorny problem as it is in the United States – the Accident Compensation Act has seen to that. Again, if you are unsure, seek advice and don't be surprised if you come up with a different answer from everyone else. There are several opinions – just make sure that you are comfortable with what you decide to do.

It is wise to decide at the outset what auxiliary services you are going to provide and how these will be charged. If you decide to stock equipment for sale such as breast pumps and devices to aid the breastfeeding mother or books and pamphlets, work out in advance what levels of stock you wish to carry as it is very easy to have a lot of money tied up in stock which is not selling quickly. Another alternative is a hire service for electric breast pumps. If you are considering becoming an agent for someone else, do your sums carefully as you may find yourself earning very little for a great deal of time spent.

Some lactation consultants set up their own workshops or teaching courses for other lactation consultants, health professionals or expectant parents. If you enjoy teaching, these sessions can be very rewarding. Remember to include your preparation time when working out costs.

Non-clinical Responsibilities

With the logistical side taken care of, you will turn your attention to what I have termed non-clinical responsibilities. As I said before, constant public relations work and promotional activity will be necessary. How are you going to let people know that you exist? How are you going to attract clients and referrals? The catch word must be 'DIPLOMACY'. While I am on this topic, a word of warning. Beware of being over-zealous. It is very easy to get tied up in the breastfeeding world where we tend to egg each other along and forget that the rest of society is miles behind in its thinking. It is very easy to come across as being 'way out' with statements which you take for granted. Try to remember the lowest common denominator when talking to people from other backgrounds. Along with promoting your business (which incidentally is synonymous with promoting yourself, whether you like it or not) you will also be promoting breastfeeding *per se*. This is work that you do without being aware of it at the community level even in 'off duty' hours. An optional extra in terms of breastfeeding promotion involves work at a national or governmental level. For example, writing letters, communicating with departmental officials and sitting on working parties, etc.

Another optional arm to a lactation consultant's work includes research. Even in private practice there is work to be done at this level. I am currently combining research work with running a private practice and find that the two fit quite comfortably together. For those so inclined research can be immensely rewarding. Don't forget the professional approach here too as the credibility of all lactation consultants is at stake in the quality of the work you produce.

No sooner have you begun to announce that you are ready for business than you will find yourself asked to speak to various groups. Grasp these opportunities eagerly as they are your chance to promote the profession of lactation consultancy, your own business and the cause of breastfeeding. Initially a lot of your talks will be of a voluntary nature simply describing what you are doing and the services you offer but eventually you will receive invitations of the paying kind. Some people will want your time for nothing or quibble over the cost. Don't worry about them and be firm – they are not the sort of customers you want anyway! If you are worth your salt people will soon get used to paying for your input. The changes to the health care system are very fortuitously timed for the birth of lactation consultancy in New Zealand as people will soon become familiar with 'user pays'.

Some time will need to be devoted to your professional organisation, that is the New Zealand Lactation Consultants' Association, or the International Lactation Consultants' Association, or both. You may be an office bearer, a speaker at workshops or a writer for the newsletter or other organisations' journals. Maintaining good relationships with other groups must be a top priority. Community support groups such as La Leche League, Parents' Centre and the Home Birth Association will benefit from your recognition and you from theirs. Contact with these groups helps you keep your feet on the ground and in touch with what the mothers are thinking and saying. The same applies for the likes of the networks (e.g. BEN Breastfeeding Education Network, BEST – Breastfeeding Education Support Team, DBN – Dunedin Breastfeeding Network) which are springing up in most centres. Other professional bodies such as the College of Midwives, Nurses' Association and Plunket Society can be contacted at a local branch level. You will also need to establish contact with the local maternity hospital, neonatal intensive care ward, independent midwives and teaching staff at the polytechnic if appropriate.

Now all this is beginning to sound somewhat evangelical so you can see why the first few years require so much energy. Remember your sense of humour and accept that you won't change the world over night.

Looking After Yourself

It would be very easy to spend your whole time meeting other people's needs and forget about your own. So, although I am covering this section last, I would rank it as the most important because you cannot help others if you yourself are a mess. On the professional front your continuing education is what will keep you up-to-date and in business so don't skimp on the reading, tapes, videos and attendance at workshops, seminars and conferences. Meeting with colleagues, both formally and informally, is when you will get your enrichment.

I mentioned before that most consultations will be under stressful circumstances so you will need to make some provision for your own stress release. For those who can afford it professional debriefing would be a godsend. Not only would it keep you on your toes but it would prevent you from burning out and, believe me, burn-out is the greatest danger facing someone in private practice on their own. For those who cannot afford such a luxury a similar system can be established with a colleague who is able to provide peer support, at the same time as being critical when necessary without endangering your relationship.

Last but not least, take time out regularly. Get away from the telephone with family and friends. Take time to relax, enjoy life and get things back into perspective.

In summary then, my take home message must be:

Be realistic and you won't be disappointed. ■

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One of the basic needs we all have is to grieve properly over deaths in our lives – be it for parent, spouse, friend or child.

To grieve properly is to come into touch with our feelings of loss, anger, hurt, aloneness, sadness – and to ventilate those feelings through crying, words and actions.

It is our belief that by being involved in the funeral of a loved one, you not only help work out your grief in a healthy manner, but you also, more importantly, show your love and caring towards the person who has died. Partial or total involvement is a positive outlet for you and your family, and is surely the deepest expression of love.

DID YOU KNOW THAT?

* Often, with caring support a dying person can live at home with you until their death. A trusting, familiar and loving environment is usually best for both the dying person and their family.

* If the death has occurred at home and no autopsy is required, the body can stay at home with you so you have time to say "goodbye" and quietly arrange your funeral plans. If the person has died at home or in hospital and an autopsy is required, then, once the autopsy is completed, the body can come home to you.

* You can simply lay out with love and care the one who has died. Under normal circumstances a body does not have to be embalmed.

* You can build your own coffin.

* You can buy your burial plot from the local council.

* In many instances you can dig and fill in the grave-site. Arrange this with the sexton at the cemetery, but it is important to note that grave digging is a skilled job.

* You can use your own vehicle for the transport of the deceased.

* You can decide on your own funeral notices for the paper.

* In many cemeteries you can make your own memorial headstone or cross.

* Cremation is a preferred option for many. It is usually cheaper.

THE LAW

The requirements of law in relation to funerals are really very simple.

If you wish to organise your own funeral, then someone needs to be appointed by the next-of-kin to 'take charge'.

That person must fulfil the following requirements:

* A medical certificate of cause of death, or a coroner's burial order must be obtained before the body can be buried or cremated.

* The body must be enclosed in a coffin or other suitable container.

* The body can be buried only in an area permitted by law (usually a cemetery), or cremated only in an approved crematorium.

* Within three days of burial the following forms must be lodged with a Registrar of Births and Deaths:

  - A death registration form

  - A completed burial certificate

  - Either a medical certificate as to cause of death from a doctor, or a coroner's burial order, depending on the circumstances.

Forms are all available from local Registers of Births, Deaths, and Marriages.

Compiled by Chris Stanbridge for Christchurch SANDS.

BOOK REVIEWS

Book Title: New Zealand Baby and Toddler
Authors: Helen Tomson with Sylvia Wood
New Edition Published: 1993

New Zealand Baby and Toddler is attractively laid out with many colourful photos and points emphasised in boxes in the margins. It is well indexed and cross-referenced.

There are 20 chapters which include feeding, sleeping and settling, toilet training, medical matters and special families.

Some of the chapters are rather short (e.g. two to four pages) and others I feel are misnamed. For example, the chapter on 'First Solids' is applicable mainly to toddlers rather than babies commencing their first intake of solid food.

Helen Tomson, the main author, is a Plunket Nurse and the information given in the book is generally traditional 'Plunket' advice. The authors are in favour of routines which, aside from numerous mentions throughout the book, merit a whole chapter to themselves. There is also a whole chapter of recipes.

Also emphasised are the importance of avoiding overfeeding or overtiring the baby, and the desirability of sleep training from an early age, if not from birth. This primarily involves leaving the baby to cry. Babies seem expected to spend most of their time asleep.

Midwives are not mentioned in the section on 'preparing for your baby', only doctors. We do get two sentences in the postnatal support section, but otherwise we don't appear to exist!

Much of the information on breastfeeding is disappointingly outdated. Examples are as follows:

* Advises antenatal expressing of colostrum and antenatal nipple preparation – *which, in my view, is unnecessary for most women and if taken to excess may be harmful.*
* Advises restricted feeding times. Starting with two to three minutes each side and building up to 10 minutes *which has long been shown to be ineffective in preventing sore nipples and interferes with establishing a good milk supply.* Never feed closer than two-hourly as the baby needs time to digest the feed. *This is at odds with demand feeding and does not allow for the establishing phase of lactation or subsequent growth spurts.*
* States women over 30 years of age having a first baby may be poor lactators.
* Advises the mother to drink plenty of fluid including milk. *Research has shown that an excessive fluid intake actually reduces the milk supply and we now advise drinking to thirst only. Milk does not need to be drunk to make milk.*
* Advises using cabbage leaves for blocked ducts *which is potentially hazardous and has no research evidence to support it.*
* Advises massaging vitamin A cream into sore nipples for one minute before and five minutes after feeds. *Hind milk has been shown to be the best preparation to apply to sore nipples and I doubt that massage would be very comfortable for the mother.*
* Advises limiting sucking time for sore nipples. *This has been shown to be ineffective and leads to a number of other problems.*

The photos on positioning are generally good but the line drawings are poor, showing baby turned side on to the mother (rather than chest to chest) and the mouth 'prissy-lipped'. There is a picture of a baby latched on to the breast with its tongue above the nipple but no corresponding correct latch!

The whole approach to breastfeeding is somewhat negative right from the opening sentence – 'While some mothers have little difficulty in establishing feeding the majority have problems'. In comparison bottle feeding appears a breeze. The only problem unique to bottle feeding is the baby may become constipated.

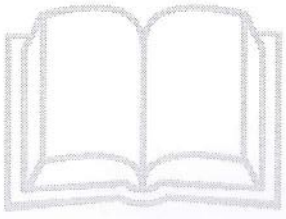
Over all, the section on feeding offers advice which is often confusing and frequently wrong. Problems are skimmed over without offering enough information to solve them. Midwives are not mentioned as a resource.

There are good chapters on safety, development, travelling, postnatal depression, medical matters and a good list of available support groups, but I was disappointed with much of the rest of the book. Examples that stand out are:

* Giving straight cows' milk from six months old. *Recent advice is to avoid cows' milk until a year.*
* With twins it is suggested you can breastfeed one, while expressing and bottle feed the other alternate feeds. *This is a lot of work and would soon lead to weaning.*
* 'Holding out' on the potty for toilet training.
* Side lying for cot death prevention *but no mention of laying on the back as being the safest position.*
* Advises not sleeping with your baby as important to prevent cot death *but doesn't say this is a factor only if the mother smokes.*
* Advice on contraception mentions the minipill only.

Generally I found *New Zealand Baby and Toddler* disappointing.

Reviewed by Gail Warwick



Book Title: Postpartum Depression and Anxiety – A Self Help Guide for Mothers
Authors: Pacific Postpartum Support Society
Date Published: 1987

Beginning with a simple 'What's happening to me?' this readable book presents postpartum depression in a down-to-earth, hands on, manner – from a woman's perspective rather than being filled with professional jargon. I believe this is a 'must read' for interested women and for midwives in all scope of practice as it brings postpartum depression into the open. It outlines how sufferers may feel, common reasons why women blame themselves for being depressed, and ways for helpers to assist in the emotional support role, accepting decisions and listening in a non-judgmental way.

The book breaks down the process of recovery and recognises the need for 'patience, perseverance and courage' in the healing process. Self-help skills are discussed, there is also an informative chapter entitled 'Getting Help from Professional Helpers', including a list of questions for women to consider when looking for a 'professional helper', be it a doctor, psychiatrist or therapist. These questions include:

(a) do they routinely prescribe drug therapy?
(b) do they speak in terms you can understand?
(c) do you feel the professional respect what you say?

Making an informed choice on medication is clearly analysed, including an explanation of advantages and problems associated with taking medication.

Because of its ease of reading, down-to-earth terminology, and confirmation that postpartum depression is a women's illness, greatly alleviated by the support, encouragement and understanding of other women, this book is excellent resource material.

Midwives owe it to women in their care to have a sound knowledge of postpartum depression, its effects and treatment. This handbook goes a long way to providing much-needed knowledge.

Reviewed by Brigid Mieras
Midwife

COMING EVENTS

NZCOM Conference 1994
'The Culture of Midwifery: Celebrating Women & Family'
13, 14 and 15 August, 1994
Te Papaiouru, Ohinemutu, Rotorua.
Call for Abstracts: Forward abstracts for papers to:
Nita Van Boven,
cl- Post Office, Lake Okareka, Rotorua.

Women's Studies Association Conference 1994
Friday 26 to Sunday 28 August, 1994
Victoria University of Wellington.
Contact:
WSA (Wellinton) PO Box 5043, Wellington.

The First World Congress on Labour and Delivery
Jerusalem, Israel. 3-7 July, 1994.
Write to the Midwifery Resource Centre for more information or write directly to:
The Secretariat, Da'at Conventions,
25 Jabotinsky Street, PO Box 71047,
Jerusalem 91710, Israel.

Nursing Education & Research Foundation
The 1994 National Nurses Forum to be held in Dunedin a Knox College on 1, 2, 3 July, 1994
Celebrating the Year of the Family
Contact:
Ann Chapman, Nursing Advisor Officer, (Professional), NZ Nurses' Organisation,
PO Box 2128, Wellington.

Murray Enkin Tour of New Zealand
Palmerston North Workshop: 21–22 May, 1994
Including many other exciting speakers.
Contact:
Secretary, Midwives Workshop,
Faculty of Nursing & Health,
Manawatu Polytechnic, Grey Street,
Palmerston North.

Midwifery Today – Pacific Rim Conference – Weaving a Global Future
2-5 February, 1995.
Honolulu, Hawaii, USA.
Topics will include cultural approaches to various emergencies, natural remedies and more.
Guest Speakers – **Karen Guilliland** and more.
Write:
Midwifery Today, PO Box 2672, Eugene, Oregon, 97402. USA.

Midwifery Today Fourth Annual West Coast Conference
15-18 June, 1995
Eugene, Oregon, USA.
Marshall & Phyllis Klaus, Ina May Gaskin, Elizabeth Davis, **Joan Donley** and more. Topics include – Counselling, Keeping Midwifery Alive, Cross-Cultural Approaches to Pregnancy and more.
Write:
Midwifery Today, PO Box 2672, Eugene, Oregon, 97402. USA.

Midwifery Today – Second Annual East Coast Conference
12-15 October, 1995. New York City, New York, USA.
Speakers include **Karen Guilliland**, Penny Simkin, Sister Angela Murdaugh, Mary Cooper and others. Topics include Nutrition, Basic Suturing, Epidural and more.
Write:
Midwifery Today, PO Box 2672, Eugene, Oregon, 97402. USA.

The 24th Triennial Congress of The International Confederation of Midwives
26-31 May, 1996
Oslo, Norway
Hosted by Norwegian Association of Midwives in co-operation with The International Confederation of Midwives

The 2nd Announcement for the conference, which will contain the call for papers, will be distributed in November 1994.

Questions about the scientific programme of the workshop should be directed to the Norwegian Association of Midwives, and those concerning local arrangements and participation to Team Congress, at the following addresses:

Norwegian Association of Midwives
Tollbugt. 35
N-0157 Oslo, Norway

Team Congress
PO Box 6
N-6860 Sandane, Norway

New Zealand College of Midwives (Inc)

Membership Application Form

B.O.M.
P.O. Box 21-106
Christchurch

Regional Information

Name _____

Address _____

Telephone Home _____ Work _____ Extn _____

Place of Work _____

Subscription Enables:

* A Professional Midwifery Organisation
* Establishment of an office and a National Midwifery Centre
* Employment of a Co-ordinator for the College
* Professional Indemnity Insurance

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Associate Member (with Indemnity Insurance)	**$155.00**
Associate and Affiliated Member (Other groups e.g. Parent Centre, La Leche League, etc, and other interested individuals)	**$30.00**

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)

☐ Automatic Payment (contact Treasurer)

National Information

New	
Renewal	
Change	

Name _____

Address _____

Telephone Home _____ Work _____ Extn _____

Place of Work _____ Date of birth Are You: [Delete One]

NZNA Member: YES/NO

NZNU Member: YES/NO

Claiming on Maternity Benefit Schedule: YES/NO

Membership Number Allocated _____

Type of Membership

Full — Waged ☐ / Unwaged ☐

Associate with Indemnity ☐

Associate Affiliate ☐

Place of Work _____

Please return completed form (together with money if applicable) to the local Regional Treasurer for your area.

Northland
BETTY TRENN
c/- Antenatal Clinic
Whangarei Base Hospital

Auckland
The Treasurer AK NZCOMI
P.O. Box 24-403
Royal Oak, Auckland

Waikato/Bay of Plenty
HEATHER MACFARLANE
3 Frederick Drive
Hamilton

Eastern/Central Districts
MARY MATHER
27 Shamrock Street
Palmerston North

Wanganui/Taranaki
SHERYL ROSS
Flat 1 Hawera Hospital
Hawera

Wellington
BERYL DAVIS
123 Marine Parade
Seatoun, Wellington

Nelson
GILLIAN FARROW
P.O. Box 672
Nelson

Canterbury/West Coast
ANTHEA FRANKS
24 Riverlaw Terrace
Christchurch

Otago
JANICE KONTOULES
6 Doon Street
Dunedin

Southland
MARION FERGUSON
59 Glenalmond Crescent
Invercargill

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Calendula, the original Marigold, has been widely acknowledged as a healing plant: herbalists call it a vulnerary. Research shows the Calendula plant to possess marked anti-inflammatory and antiseptic properties. The mild and soothing qualities of Calendula, make it WELEDA's perfect choice as the basis of the WELEDA Baby Care Range.

A practical booklet entitled "WELEDA Remedies for Mother & Child" is available for Health Professionals.
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Dept MJ, WELEDA (NZ) Ltd,
PO Box 8132, Havelock North.

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