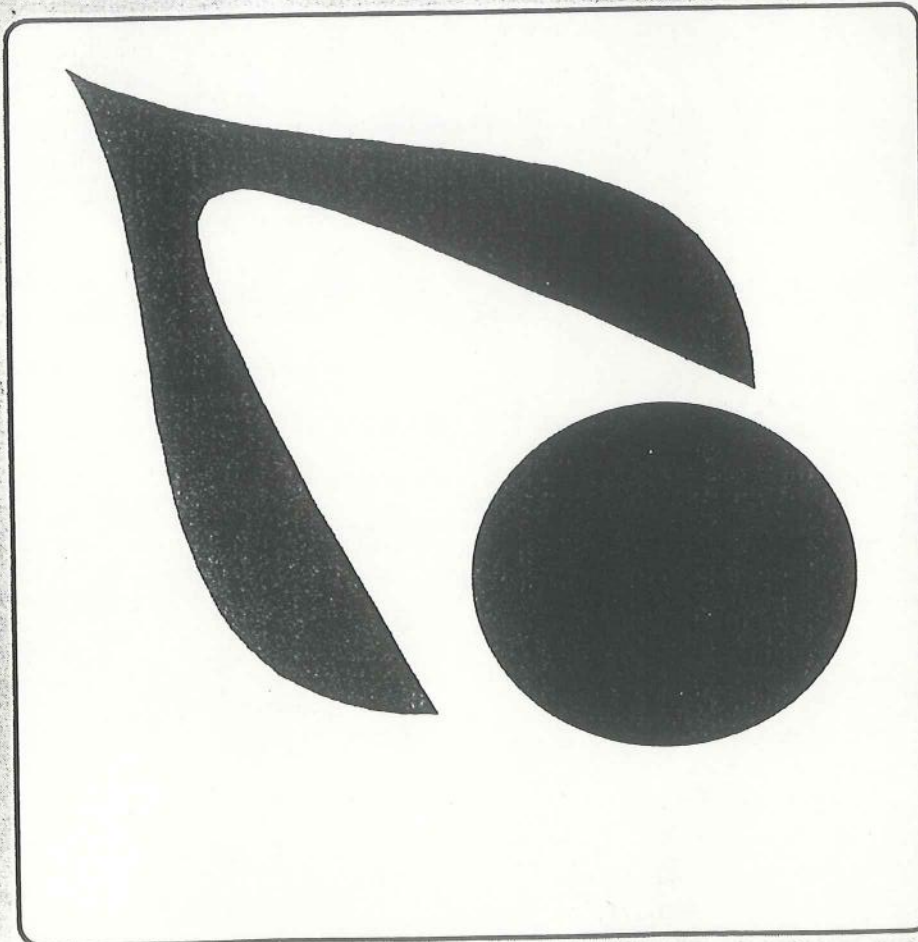




JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, APRIL 1995



TWELFTH ISSUE



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ISSN 0114-7870
No.12. April 1995

The New Zealand College of Midwives Journal is the official publication of the New Zealand College of Midwives.

Single copies are \$5-00

Editor:
Helen Manoharan
PO Box 249
Palmerston North

Printed by:
Hannah & Young
Palmerston North

Research Editor:
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Special Thanks:
Lois McTaggart

National Advisor:
Karen Guilliland

Page Layout by:
Double EM Design

Philosophy of the Journal:

- * 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.

Advertising Sales:

Contact:- 'Advertising',
NZCOM Journal,
PO Box 249, Palmerston North.
☎ 06 358 1917

Submissions:

Articles and letters should be addressed to:-
The Editor,
NZCOM Journal,
PO Box 249, Palmerston North.

If possible submit on 3.5" disk in either MacIntosh or IBM compatible format. The disk will be returned to the sender.

SUBSCRIPTIONS AND ENQUIRIES:

Contact:-
Subscriptions,
NZCOM,
PO Box 21-106, Christchurch.

Copy Deadlines:

Last Monday in February - for the April Issue.
Last Monday in August - for the October Issue.

Classified Advertisements:

Rates are as follows:-

- \$25 for a block of 25 words or fewer.
- \$20 each additional block of 25 words or fewer (GST included).

Payment please with order (cheque, bank cheque etc.).

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EDITORIAL

I hope by now your year has taken 'some order' and you are achieving your goals. We now have the Easter break to look forward to.

I want to start by thanking Sally Pairman for her words of kindness in the last Editorial – thank you Sally. The 'proverbial boot' is totally on the other foot though. We are indeed fortunate to have so many talented midwives who are

willing to share a part of their world with us. We are not all literate geniuses – articles can be/are worked on together until the author and the editorial crew are happy with them.

We publish about 95 per cent of all material received. Of the rest, usually it is more suitable for the newsletter, so it is redirected there.

We like to waste nothing!! We have not/do not print anything that has been in print before. In *all* Journal Issues to date, we have been approached for permission to reprint articles. So, if you have something you want to share – no matter how big or small – please send it in. Photographs are always welcome too.

This Issue brings the addition of a new

section – research. We hope to bring you a 'step-by-step' approach to tackling research under the careful guidance of Alison Stewart, a Senior Midwifery Lecturer at Otago Polytechnic – thank you Alison. No doubt you will convert all of us!!!!

The first 'home-grown' research is a retrospective exploratory study of the physiological care of the third stage of labour. We are eager to print your research, so send us a copy. If you want guidance, let us know.

Happy Easter reading.

Helen Manoharan
Editor

LETTERS TO THE EDITOR

Dear Editor

Re: Breast Infections due to Woolworm

I thought it might be useful to give an update on this issue first raised with the New Zealand Wool Board in September 1994.

A reply from Mr Pat Morrison, Chairman of the Board, indicated that although he was aware of shearers getting infections in the nailbeds, the clefts between the fingers and in the axilla, he was not aware of woolworm being a problem for female wool-handlers.

Steps have now been taken to raise the issue in wool-handling training courses and with the Shearing Contractors' Association. Mr Morrison also supplied me with information about a N.Z. made bra which gives protection from the woolworm. The address is Baa Bras, P.O. Box 812, Taupo.

I have written to the Maori Women's Welfare League, Tipa Ora Charitable Trust and the New Zealand Medical Journal to draw attention to the issue.

Hopefully, by raising the issue and making people aware of preventative measures, the incidence of breast infections in non-lactating women will be reduced.

There is another issue I would like to mention, and that is antenatal preparation for breastfeeding. A young woman who presented with a breast abscess was 36 weeks pregnant when I first saw her. She had originally been booked into a base hospital but then decided to birth in a rural hospital. Presumably she had been seen by medical and midwifery personnel during the first part of her pregnancy, yet no one had talked to her about breastfeeding, let alone looked at her breasts. I know that antenatal preparation for breastfeeding is no longer fashionable in some quarters, but I shall continue to discuss, look and examine when necessary and give women advice on how to prepare for breastfeeding. There is

nothing worse than birthing a woman and finding she has nipples that disappear when touched. So much easier for the baby to feed when there is something to get hold of.

Yours faithfully
Gelske Gardiner
Midwife, Kaiapoi

Dear Editor

After reading *The Midwifery Partnership – A Model for Practice*, I felt compelled to write.

Since I gave birth to my second son, 16 years ago, I have believed in the concept of continuity of care.

When I registered as a midwife last year (1993), I still believed continuity of care was the best care I could offer to women and their families. However, since working as a midwife in a high-risk area, I have learned that many women do not have the option of a 'normal life event' without medical AND midwifery help.

I have learned that I can indeed allow the necessary time and commitment required to develop a partnership with a woman.

I have been encouraged, excited, and even humbled when women have told me how important our partnership has been to them.

I felt disappointed when I read that because I choose to give 'fragmented care' I am not practising midwifery.

For me, midwifery comes from the heart; it is part of who I am, and is dependent neither upon where I work, nor upon whether I fit into someone else's theory.

Yours sincerely
Barbara Clotworthy
Midwife, Auckland

Dear Editor

Re: The Midwifery Partnership *NSCOM* Journal October 1994

Guilliland and Pairman's concept of midwifery practice is narrow, restrictive and very limited. The partnership model as presented:

- * Takes no account of the large number of New Zealand women who choose hospital care,
- * Allows the midwife no life other than midwifery practice,
- * Denigrates the work of the midwife employed in a hospital setting,
- * Is elitist,
- * Is politically motivated,
- * Promotes professional isolation.

There are many midwives working in hospital settings who provide excellent women-centred care. The tradition of midwifery is to be with childbearing women, wherever they may be. It is not an environmentally exclusive practice.

The whole tenor of this paper suggests that if a woman does not see childbirth as a normal life event, then she is a second-class midwife. For the College of Midwives to support a paper that suggests midwives in hospital settings are not practising midwifery, is at best irresponsible and at worst downright dangerous. It encourages divisiveness within the midwifery profession and encourages subservience to medicine. It is also a very short step for management to take such a statement and use it; if midwives in hospital settings are not practising midwifery why do we need to employ midwives?

Continued on Page 5

continuity of care. Our unquestioning commitment to these principles has ensured we now provide women with a total midwifery service that reflects these principles and also provides us, as midwives, with a life other than midwifery.

For years vain attempts have been made to mould midwifery into nursing frameworks – it didn't fit.

Thanks to Sally and Karen for making a new mould.

Yours sincerely

Rose Gray, Julie Richards, Juliet Thorpe
Christchurch Home Birth Midwives

Response

Midwifery Partnership

Dear Editor

When reading these letters it is apparent that we have not explained our interpretation of the Midwifery Partnership clearly enough. It may help to explain that the full paper is to be published this year and we would encourage the writers to read the full text.

Midwifery is constantly and consistently described as a partnership by our code of ethics, standards of practice, education and registration requirements. We must therefore understand what we mean by *partnership*. In the absence of a documented analysis of what partnership means in actual practice, we endeavoured to describe an interpretation from the perspective of our own practice and the observed practice of other midwives. We also relied on the observations and records of the hundreds of submissions written by consumers and midwives to Parliamentary Select Committees, the Maternity Benefits Tribunal and various health authorities consumer surveys. What we offered to the midwifery community was a model of midwifery as a partnership and as a beginning in the exploration of midwifery as praxis.

All three writers have chosen to interpret the midwifery partnership on their personal circumstances with the midwife as the focus. The model, however, is a description of the professional status of midwifery not necessarily the individual midwife. In order to be a profession we must offer a service that is unique otherwise we cannot describe midwifery as a profession.

Continuous total care throughout the normal experience of pregnancy, birth and the postpartum is only provided by midwives. All other maternity caregivers require the presence of a midwife at some stage of the childbirth continuum regardless of the women's health status. Women outside the normal experience may still have continuing midwifery care but the midwife must now involve another profession.

Continuity of care is therefore required in order to fulfil the demands of professional status.

This is not to say that midwives cannot and do not provide excellent care in the absence of continuity. They can and they do, however we agree with Barbara Churcher that the concept of continuity is ideal. The converse must also be true, that fragmented care is not ideal. It is therefore by our analysis essential that the profession works towards enabling *all* women to know their own midwife throughout their childbirth experience.

We would strongly disagree with Edna Rose's view, that continuity of care and independent practice is the realm of the self-employed. Quite the contrary, all midwives, under the 1990 statute, have been given the opportunity to practise independently and hundreds already do so. In our areas alone there are nine maternity units, including the base hospital in Dunedin, where employed midwives can provide continuity of care on their own responsibility. These midwives are also able to choose a part-time or full-time caseload, arrange their families and work commitments according to both their own and their clients' needs. Furthermore, the majority of base hospitals are working hard to re-organise their maternity services towards continuity. Auckland's National Women's have a very successful midwifery continuity scheme for 'high risk women'. The health status of the women, contrary to Edna Rose's view, is no reason to deny her continuity of care. It does, however, take a mind shift on the part of midwives and hospital management to re-organise their services around the women in order for this to happen.

It is the wishes of women and the work and commitment of hospital and self-employed midwives which has made these bureaucratic institutions change their service direction. Our paper has never suggested the process towards


continuity must be overnight. It must be an evolution of understanding and insight into new ways of practising. Those same midwives who are currently not providing continuity but nevertheless are changing or enhancing women's birth experiences with the contact they do have with women, can now expand that service to its fullest potential.

Barbara Clothworthy is right when she records the midwife's role as making a difference and that an individual midwife is able to form relationships which women value regardless of where she works. This, however, is not to be confused with the *profession's* unique ability to be able to provide continuity for all women wherever they choose to give birth. Neither is it to be regarded as dictating what that relationship is other than if it is really a partnership its power balances must be negotiated to each partner's satisfaction.

Midwifery has undergone a transformation of a magnitude seldom achieved by a profession. Such changes will always be accompanied by uncertainty and very often 'hurt' as people slowly accept and redefine the old and the new.

Karen Guilliland
Sally Pairman





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The losers will be;

- the women who choose hospital care,
- the women who require secondary services (when the need for the skills and knowledge of a midwife is paramount),
- the midwives who work in hospitals (for many complex reasons),
- the midwives as women and mothers for whom job opportunities are already limited.

This paper serves to reaffirm the opinions expressed in the Wellington NZCOM Conference, that the College is focused on the interests of the independent practitioner. There is no recognition or acknowledgement of the work and commitment of the many midwives that are employed in hospitals.

Edna Rose
Midwife, Palmerston North

Dear Editor

Re: Continuity of Care

At the 1992 NZCOM Conference, Bronwen Pelvin declared that women who work with women through their labour and birth, and without further involvement in their lives, may not be called midwives. She said, '... let us not mistake providing excellent care with *being* a midwife'. Now it seems to me that this attacked some women at the level of the way they identify themselves. We do not say 'We do midwifery' - we say 'We are midwives'. To deny the right of a woman who perceives herself in this way is narrow and alienating. At a time when we as a group need to promote solidarity for our survival as a profession, such division through definition is destructive. It promotes reaction and denial; it is closed.

Now this division has been intensified by the publication in the October '94 NZCOM Journal of a partnership model designed by Karen Guilliland and Sally Pairman. This is a wonderful model in most respects, except that once again there is an insistence on the inclusion of 'continuity of care' as an essential element of partnership. Sally and Karen themselves say in their article, 'Each person in the partnership brings a different dimension and the negotiated outcomes will therefore be different between the different midwifery partnerships'. The remainder of their article denies this enlightened statement, enlightened because it speaks of choice.

It is important to remember that in some situations, e.g. in a hospital environment, the midwives who work with women have no option but to form a relationship very quickly with the women in their care. This relationship may well include the concepts of individual negotiation, equality, shared responsibility and empowerment, while only continuity of care is missing, and yet

a partnership has been formed. To form such a relationship quickly and under conditions of stress is a special skill that should be celebrated, not denied.

Our Code of Ethics states that 'midwives accept the right of each woman to control her pregnancy and birthing experience'. We need to remember that not all women subscribe to the belief that the birthing process must include all the elements which we may see as ideal. Neither do all midwives. When Karen and Sally speak of political activity leading to a greater understanding of the relationship between women and midwives, they must be aware that they are speaking of *some* women and *some* midwives. If the NZCOM is to be truly representative of midwives, then some definitions must be broadened.

I was present at a discussion the other night which was typical of many I have witnessed on this topic. Midwives are hurting midwives. In order that this may stop it is important we recognise that at least three issues are contained within the current discussion of the 'continuity of care' concept.

These are:

1. *Identity*: there is *not* only one kind of midwife.
2. *Ideals*: of which 'continuity of care' may be.
3. *Scope of practice*: chosen by the individual midwife according to her needs and special abilities, and which may change over time.

It is a time to regroup, to remember that power comes from the joined voices of the many and that division within our professional group could be very damaging. Do not allow the concept of continuity, one of our loveliest ideals, to become an instrument of division. Remember that midwifery is woman-centred, and midwives are women too. We must take care of our own.

Yours sincerely
Barbara Churcher
Midwife, Dunedin

CORRECTION

In the October 1994 Journal, regarding the article, 'Is Breastfeeding a Feminist Issue?', a few errors were noted.

Amongst these author Chrissy Fallow had her name spelled incorrectly. Please accept our apology for the errors, Chrissy. We will get your next article just perfect.

Dear Editor

We are writing on behalf of the first graduates of the Otago Polytechnic Direct Entry Midwifery degree course.

It is difficult to reach all the midwives with whom we have had contact during our course, but we hope that this letter will be read by many of you.

We want to express our gratitude for all the time and all the knowledge that has been so freely given to us. The spirit in which it has been given has made us aware of your concern for our success, and ultimately, of course, for the care that we give to women. We hope that the quality of the work we do in the future, will cause you to feel your generous support has been worth-while.

A very big thank you to all of you.

We look forward to working with you in the future.

Yours sincerely

Debbie Frieling and Barbara Churcher for
the 'Class of 92!'
Dunedin

Congratulations

Dear Editor

I would like to take the opportunity to congratulate you on the informative journal that the NZCOM has produced. I receive occasional copies from friends and have pleasure in sharing these with my Australian colleagues. New Zealand midwives certainly have done themselves proud, in the advances they have made as a professional body, here's hoping Australian midwives will follow.

Yours faithfully

Donna Millicent-Christison
Brisbane, Australia

Congratulations

Dear Editor

Congratulations to Karen Guilliland and Sally Pairman for at last providing us with a framework which truly reflects midwifery practice, 'The Midwifery Framework', published in the October 1994 issue.

Since the 1990 law change our practice has evolved to embrace the principles we all strongly believe in, i.e. partnership with women and

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Third Stage of Labour

Outcomes of Physiological Third Stage of Labour Care in the Homebirth Setting (November 1991)

Kirsty Prichard, Anita O'Boyle and Jenny Hodggen

Midwives

This article by Kirsty Prichard *et al.* reports on a research paper submitted to Wellington Polytechnic as part of the Diploma in Midwifery.

Abstract

A retrospective exploratory study of physiological care of the third stage of labour. The aim of this study was to develop a research method which would examine the outcomes of the undisturbed physiological processes at work in the birth of the placenta. Blood loss and other outcomes were examined as indicators of the safety of physiological management and relationships between the variables were explored for trends which may warrant further study. Homebirth was chosen as the setting, where practitioners are both confident and competent with this method.

Forty-eight New Zealand Domiciliary midwives (213 births in total) were surveyed using a postal questionnaire. The results showed a mean estimated blood loss of 239 ml, primary postpartum haemorrhage (blood loss >500 ml) rate of 3.3 per cent and no manual removals of the placenta were required.

Introduction

Is birth a normal occurrence in which the wisdom of nature is evident, or a risky event requiring routine intervention to minimise the risks? To address this question, midwifery researchers must rise to the challenge of obtaining accurate and unbiased data, without compromising the complex and delicately balanced processes, they are endeavouring to study.

Reliable research, into natural birthing methods, is an essential resource for women making informed choices in their care. One of the choices women face is the method of management of the third stage of labour.

Literature Review

The issue of the routine active management of the third stage was raised by Sally Inch in her book *Birthrights* and in subsequent articles.^{1,2,3,4}

There has been a great deal of research on various aspects of third stage management, but it is the 'Bristol Trial',⁵ and more recently the 'Dublin Trial',⁶ which have focused on comparison of active and physiological management.

There are design problems in each of these studies which limit their usefulness. The Bristol Trial included labours involving epidurals, Syntocinon augmentation or induction and instrumental delivery. In consultation with the Bristol team, the Dublin Trial went some way to addressing these problems, eliminating births that were not normal, but the physiologically managed group continued to include a large number of women who had elements of active management in their care. For example, 58 per cent had the cord clamped at delivery and 66 per cent had controlled cord traction applied. As the basis of physiological management is physiological separation of the placenta, this constitutes a serious limitation.

Walsh⁷ states that cord clamping could interfere with separation of the placenta and both Botha⁸ and Walsh⁷ noted that early cord clamping in the absence of an ecchymotic blood loss.


A comparison of methods by randomised controlled trial required greater resources than those available to the Wellington students. However, the need as identified in the Bristol Trial for a study 'in a setting in which physiological management is the norm' and call by the Dublin Trial for a comparison of 'totally physiological management' and 'one where oxytocics are not given but more 'active' type of management is used, guided the design of this study.

Method

A retrospective postal survey design was used. A questionnaire was developed and piloted with five midwives familiar with physiological care.

The initial intention was to aim for a census (whole population) of New Zealand domiciliary midwives, using the Domiciliary Midwives Society contact list. However, difficulty in locating all practitioners made a census impossible, therefore the sample is one of convenience. Sixty-six midwives were sent a questionnaire and an accompanying information sheet. Respondents were asked to provide information on the last five births in which physiological management of the third stage was used.

Ethical considerations included using a retrospective data collection design (thereby ensuring there was no possibility of compromising the woman's choice of care) and anonymity for women with no identifying details on the questionnaire.



Why Worry about Research?

Alison Stewart

Senior Lecturer
Department of Nursing and Midwifery
Otago Polytechnic, Dunedin

In the *New Zealand College of Midwives (NZCOM) Handbook for Practice*, standard seven states; 'The Midwife is accountable to the woman, to herself, to the Midwifery profession and to the wider community for her practice'. One of the criteria for this standard is that the midwife 'ensures her practice is based on relevant and recent research', supporting the idea of a 'research-based profession'. The term 'research-based profession' makes it all sound so easy, we literally base our practice on that which has been proven or observed. However, we are all aware of numerous issues, such as postnatal vitamin K or syntometrine in the third stage of labour, where research has produced conflicting results making it hard to decide on what to base our practice. Struggling through complicated articles and jargon such as 'randomised double blind trials' can leave a feeling of 'research is done by researchers for researchers and what use is this to me?' However, to offer women information for informed choice and to practise with current knowledge means using research to draw conclusions for practice from articles with contradictory findings using critiquing skills (see next issue) and which the *MIDIRS Midwifery Digest* illustrates in the reviewers' comments about articles and abstracts.

As midwives we can have a range of relationships with research:

- We can be an OSTRICH and ignore it.
- We can be a CONSUMER and read an article (often the beginning and end only; accepting the findings without thinking if they apply to our practice).
- We can be a QUESTIONING CONSUMER and read articles (looking at the strengths, weaknesses and implications for practice).
- We can be a PARTICIPANT in research (being part of someone else's study either ourselves or inviting clients to join).
- We can be a DOER of research (undertaking small or large-scale studies designed to provide knowledge which we want for our own practice).

To be part of a research-based profession we need to be within the latter three groups, and hopefully to enjoy research. It can be a very powerful and interesting tool, and in the next few issues we will briefly explore aspects such as critiquing, ethics in research, choosing designs and writing proposals.

I would like to take this opportunity to invite you to participate in research in this journal.

- * This could be to submit any research which you have done as either:
 - (a) a structured abstract of approximately 500 words under the headings of introduction, design, sample, study setting, methods, ethics, results, conclusions;
 - (b) a full research article, maximum of 12 double-spaced typed pages.
- * Use the Research Notice board which will start in the next issue to invite other readers to contact you about a topic, share ideas, swap articles, etc.

Please send any copy to:

Alison Stewart, 710 Brighton Rd, Ocean View, Dunedin.

References

- MIDIRS Midwifery Digest and Database Service* (based at 9 Elmdale Rd, Clifton, Bristol BS8 1SL, England).
NZ subscriptions, Linda McKay, PO Box 7093, Wellesley St, Auckland.
New Zealand College of Midwives. 1993. *Midwives Handbook for Practice*. Christchurch, NZ: NZCOM.

The statistical method, exploratory data analysis, developed in the late 1980s, was chosen to suit the approach adopted. It acknowledges the enormous diversity of variables interacting in the study of human kind. Data is collected in situations where the variables are free to interact in their normal manner. The emphasis is on flexible probing of the data for patterns and relationships for which appropriate explanations can be sought. Scatter plots (e.g. Graph 3) are frequently used to give visual images of distributions. Computer analysis can be employed to further define the relationships. Confidence intervals (95 per cent) are also used, being an expression of confidence that the true mean has been captured. 'A confidence interval is usually much more informative than a test of hypothesis' (Noether, p.70).⁹ Analysis of Variance of Confidence Intervals determines whether a relationship of significance exists.

Statistical inference (used in randomised controlled trials) relies for its accuracy on data adhering to a normal distribution (Bell shaped curve). Exploratory data analysis allows for the frequent failure of real data to do this.

Definitions

The study separated care into two groups.

1. Total Physiological Care;
 - the cord is not clamped or cut until after birth of placenta and membranes, no ecobolic is given, the fundus is not massaged, no traction is applied to the cord and the placenta is expelled by maternal effort.
2. Modified Physiological Care;
 - differs from total physiological care in that other action may be taken. However, it is essential that no ecobolic is given, and if cord traction is applied, it is after signs of separation of the placenta.

This distinction was made to capture a sample in which it was assured no interference in the process had occurred. No time frame was applied to retained placenta which was simply defined as a placenta requiring manual removal.

Findings

Response Rate

Eighty-three per cent (53) of midwives replied to our questionnaire. Of these, 75 per cent (48) of the replies were able to be used, yielding information on a total of 213 births. Where gaps were left in questionnaire n < 213.

Demographic Data

The mean age of the women was 30 yrs, with a range of 19-46 yrs. Of the 213 women 39 (18.3 per cent) were primiparous, 62 (29 per cent) were parity one, 68 (31.9 per cent) parity two, 27 (12.6 per cent) parity three, 14 (6.5 per cent) parity four, and 3 (1.4 per cent) parity five.

Main Outcomes

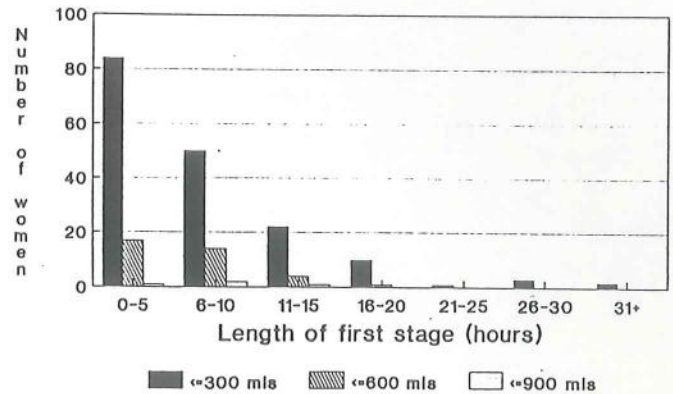
The mean estimated blood loss was 239mls, with a range of 20-900 mls. The primary postpartum haemorrhage (PPH) rate was 3.3 per cent (blood loss >500 mls). This compares with Dublin Trial which recorded an 8 per cent PPH rate for physiological management. Using the alternative definition (> or = 500 ml) this study recorded a 7.5 per cent PPH rate, in comparison the Bristol Study found a PPH rate of 17.9 per cent in the physiological group. None of the women required manual removal of the placenta. The rate of retained placenta would have been 2.8 per cent, using the same definition as the Dublin Trial (>60mins). The length of the third stage had a wide range of 1-274 minutes. The rate of puerperal infection in this study was 2.8 per

cent and secondary PPH 0.9 per cent. The haemoglobin level at 36wks (n = 137) was an average of 114mg/dl, with a range of 91-136mg/dl.

Relationships Between Blood Loss and Other Variables

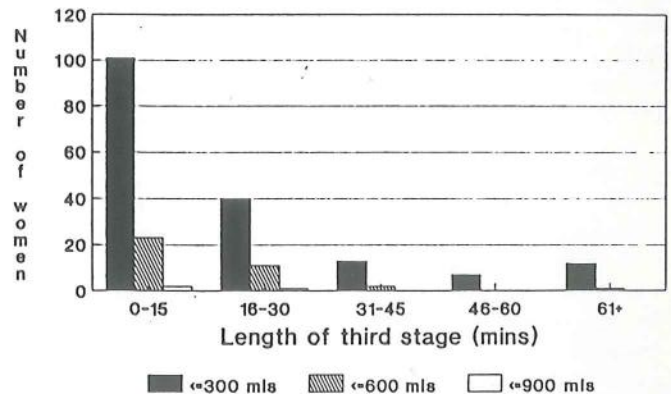
There was no evidence of increased blood loss with increased maternal age or high parity. Length of first (Graph 1) and second stages of labour likewise bore no relationship to blood loss. This is of particular interest as prolonged labour has been cited as cause of PPH (Bennett)¹⁰ (Llewellyn-Jones).¹¹

Graph 1: Length of First Stage vs Blood Loss



Women who experienced a long third stage did not have an increased blood loss (Graph 2). Of the 16 women who had a third stage longer than one hour, none sustained a PPH and their mean blood loss was 205ml (Compared with total mean 239ml). There was no evidence of greater blood loss with lower haemoglobin levels (Graph 3).

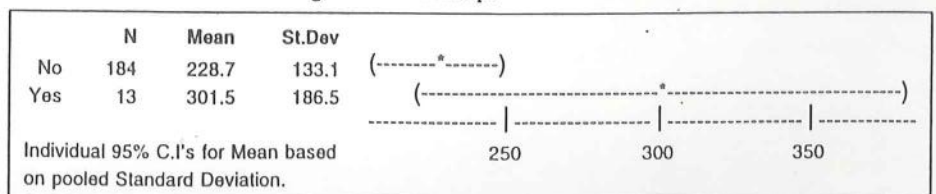
Graph 2: Length of Third Stage vs Blood Loss



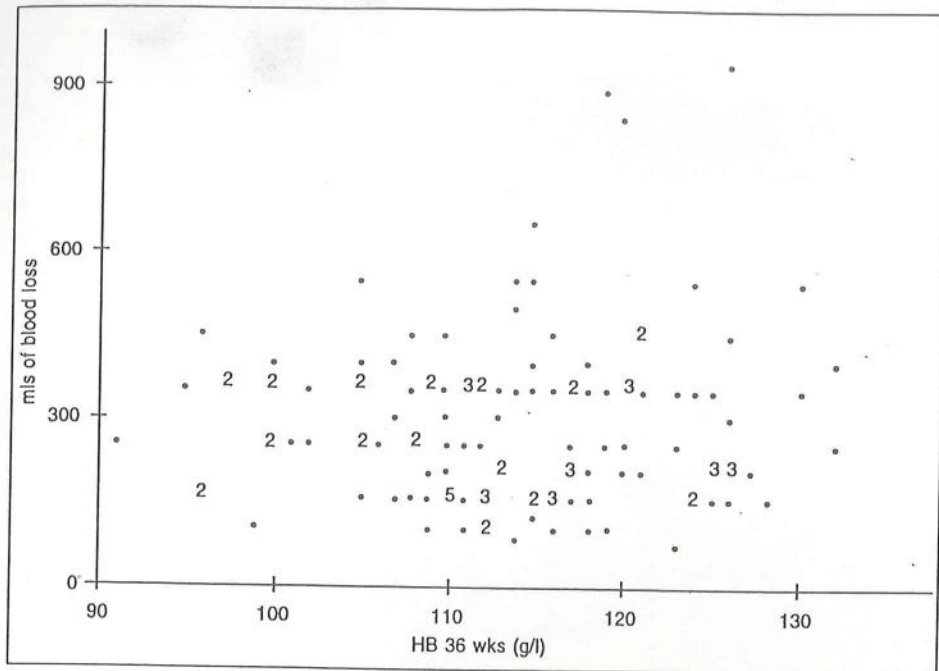
Of interest is the fact that none of those with Hb <100mg/dl at 36 weeks gestation, sustained a PPH and that all, except one, of the women with a PPH had a Hb >115mg/dl with a blood loss of >600ml, i.e. the scatter plot illustrates a tendency to greater blood loss with a higher Hb. The mean blood loss for those women with a previous history of PPH was

Diagram 1: Analysis of Variance (Blood Loss/Previous PPH)

A significant relationship between previous PPH and blood loss would require the brackets in the diagram not to overlap.



Graph 3: HB at 36wk vs Blood Loss



301ml. Analysis of variance, comparing those with or without a previous history of PPH revealed that the means were within 95 per cent confidence intervals, but nevertheless a notable difference (Diagram 1).

Fifteen per cent of those with a previous history of PPH had another PPH with this delivery. The number of women in this study requiring an ecobolic was 11.3 per cent. No significant difference was found between the mean blood loss for modified and total physiological care (see definitions), indicating that midwives modified care in ways which did not affect outcomes.

Limitations

The most serious limitation is the well recognised difficulty in accurately estimating blood loss (Brandt)¹² which has been used as the main tool of measurement in this study. In addition there is sample bias, which is unavoidable in postal surveys (Woolley).¹³ Therefore whilst this study provides an insight into the third stage outcomes of the 213 women whose data was examined, the results need to be interpreted with caution and can not be assumed to be representative of all physiological births. The value of this study lies primarily in the development of the method.

Recommendations

1. The relationships observed in this study between blood loss and both haemoglobin levels (at 36 weeks gestation) and the length of the stages of labour warrant further study to determine what risk is associated with these factors.
2. This study supports the question posed by (Begley, 14)³ of 'whether the definition of

PPH should be reviewed'. A blood loss of greater than 500ml is of questionable clinical significance in 'expectant women who are superbly prepared for blood loss by the haemodilution of pregnancy' (Begley)³. Such a revised definition should include therefore, an assessment of the woman's physiological response to the blood loss. Future studies would need to develop instruments which measure the woman's physiological response to blood loss at delivery. These instruments in conjunction with more accurate measurement of blood loss, such as pre- and post-delivery haemoglobin differentials (Begley)³, would give a more accurate information on the outcomes of the third stage.

3. The rate of retained placenta also warrants further study and the definition of retained placenta may need to be revised in relation to physiological care.
4. The possible relationship between previous PPH and a subsequent PPH should be investigated also as it may be an identifiable risk factor.
5. Women base their choices on a wider variety of issues than tolerable differences in outcomes, between methods of care (e.g. personal beliefs, and cultural practices). In the absence of a reliable randomised controlled trial, which could offer a true comparison of outcomes, continued analysis of statistics generated from midwives' practice may be useful to demonstrate safety. A large population study using Exploratory Data Analysis would be helpful to further analyse the trends observed in this study.

Conclusion

Creditable research is urgently needed to counter the attack on natural childbirth both nationally and internationally. Aotearoa is leading the world in many aspects of midwifery. Let us hope that this innovative spirit will extend into the realm of research, utilising our unique and privileged conditions to the full.

Acknowledgements

We wish to thank all who contributed to this study, the midwives, our tutors Annette Huntington, Beryl Davies and Sue Bogard, the Nursing Education and Research Foundation and special thanks to Mike Camden the statistics tutor.

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New Zealand's First Doctorate in Midwifery!

Partnership, Power and Politics: Feminist Perceptions of Midwifery Practice

Valerie Fleming PhD

Interview by Andrea Gilkison

Valerie Fleming has 18 years' midwifery experience in a variety of settings, and in different countries. Prior to becoming, in 1990, one of New Zealand's first independent midwives, Valerie practised as a rural community midwife, serving Maori women.

In 1991 Valerie took up an academic position at Massey University where she commenced research for a PhD.

As well, Valerie has been instrumental in establishing a Masters of Midwifery programme in New Zealand.

I talked to Valerie about her research, her findings and their relevance to midwives and the women she cared for.

How did your research come about, Valerie?

I felt that some midwives were turning out like doctors, that some were abusing what the fight was all about when we gained the right to practise independently. I wanted to look at an established midwifery practice and see what the relationship was between the midwives and women.

How did you go about setting up your research?

I approached an independent midwifery practice, of which there were very few in 1991 when I started this research. I visited them and saw how it was set up, and then asked the midwives if they would be interested in being involved in some research. They were great; even if they'd been up all night at a birth, they would come to see me.

I also interviewed each of the women in the study six times during their pregnancy, and after the birth. These tapes were analysed and validated by the women.

What were your findings?

Twenty-four themes emerged from the tapes, which could be broadly grouped into power, partnership, working together, leaving/dissolving the partnership.

Power and partnership were major issues for the midwives who went to great lengths to divest themselves of power, and they really worried about how to work in partnership with the women. They agonised over the issue of protecting themselves and their partnership with the women.

It's one of my strong beliefs, that this is one of the backbones of midwifery. While the biggest thing that a midwife should

be doing is affirming the women the whole way along. I've seen so many people in the situation where because they are trained, think they know more than the woman ...

I don't go in there telling women what they should be doing at all ... I don't even show anyone how to bath their baby or to breastfeed unless there are problems. And I think to do things in a way that is very affirming and to let people make their own choices. I mean, it's just so important to me.

Sarah (Midwife)

Women were less likely to be actively participating in major decision-making. For example, the midwife would usually bring up the topic of Vitamin K or ecbolics. The midwife would instigate the birth plan. Women in the study saw the midwife as the 'professional', although they didn't focus on the partnership. They knew what they wanted from the midwife.

Both midwives and women enjoyed the antenatal visits – they weren't rushed and were in their own home. It didn't matter if it wasn't the primary midwife available for the birth, which surprised me. The women didn't want a stranger, but as long as it was a midwife they had met, and it was the same midwife throughout the labour, they were very happy. Midwives in hospital are now doing this more. If they've got a woman in transition, they'll stay on past their shift rather than hand her over to another midwife.

What about dissolving the relationship, how did this come through in your research?

This was difficult for the woman, especially for women without partners. It came through that the relationship was very intense and that termination was difficult for the midwife as well, particularly if they got on very well or very badly. I suppose resolving this problem is a part of developing professionalism.

What is the importance of this research to the midwifery profession?

Some midwives have become complacent since 1990 and need to challenge assumptions about independent practice. Midwives need to re-evaluate their practice and realise that they can't be all things to all people.



The intensity of the relationship is evident. Memories of the birth are lifelong for women, and they can remember amazing detail. Women's intuition also came through. The midwives were very aware of this, and it came through from both the women and the midwives that the relationship was different from that of their relationship with a doctor.

We (G.P. and the woman) are not at the level of intimacy that I think women find very easy to be at and men find it very difficult to be at. ... If I cry, the midwife will put her arm around me ... my G.P. would pat me on the shoulder.

Alison

What do you mean by the assumptions about practice?

That one to one continuity from conception to six weeks is necessary. It's lovely for the woman, but where it didn't happen it didn't matter. It's important in terms of burnout for the midwife. The approach in the beginning is important, that if the woman understands the way the practice works and they know there is a midwife they know to ring that's all that matters. A 'Know your own midwife' arrangement where the woman meets two or three and gets one for the birth, rather than midwives working as sole practitioners, is very acceptable to the woman.

This is New Zealand's first major piece of research in a midwifery topic, and as such, is a great contribution to the midwifery profession. In order to establish and declare midwifery as a profession in its own right and to create our own body of language, this kind of research is extremely important. Valerie's thesis is 'readable'. Written in terms that we can all understand, I found it to be applicable to my practice. She has written articles about her thesis which she hopes to publish. This process takes time. If you can't wait, her thesis is available through Massey University library or through Valerie Fleming at Massey University.

The Magical Moment of Birth: Two Perspectives

Mary Hammonds

Midwife

A baby is about to be born.

The mother is working hard to birth her baby. It is just before dawn. Birds are starting to sing – a sound she will always associate with the baby's birth. The room is dimly lit. If people talk, they do so quietly, encouraging the mother. There are no intrusive or irrelevant conversations among the people present.

The baby is born. Her arms, free of the confined space of the birth canal, open wide. Fingers spread as if to embrace the world. She is placed gently between the mother's legs. The midwife can see at a glance that the baby is a healthy girl but says nothing.

The little girl lies quietly, arms now flexed, hands curled up, and opens her eyes in the dim light to look for the first time at the outside world. She makes no sound. No one panics. Her cord is pulsating strongly. She is taking in the new sensations in the silence that surrounds her. She takes a few small gasps then breathes quietly. Less than a minute has passed and still no one has spoken. Her father, overwhelmed by emotion, can't take his eyes off his beautiful daughter.

Now the mother, after taking some time to recover from the great effort of the birth, is looking for her baby. She reaches down and touches her gently, speaking softly to her. Hers is the first voice the baby hears. She picks up her baby and cradles her. She discovers she has a girl. No one has told her this.

'Welcome, little girl,' she says.

The midwife keeps a quiet eye on mother and baby, not intruding unless really necessary. The mother starts to move as if uncomfortable and complains of backache. She is having a contraction. She is helped into a more upright position, and with a small gush of blood the placenta comes out.

When the cord has been cut the midwife ensures the mother is comfortable before leaving the family alone for a while. She is available but does not intrude without good reason.

She suggests the mother hold the baby close to her skin, close to her breasts so the baby can smell and nuzzle into her. The mother enjoys the feel of her baby's naked body against her skin and the sweet smell of her new-born child. There is no hurry to dress or weigh the baby. She is warm and secure next to her mother.

After a while the baby mouths at the breast and takes the nipple. The midwife is still in the background but ready to give advice if necessary.

The baby is weighed within the next hour, and dressed by her father. The mother watches, feeling a strong bond already with her new-born.

★ ★ ★ ★ ★

A baby is about to be born.

The mother is working hard. To one side people are chatting among themselves, and this distracts and irritates the mother. She gives birth to a girl who is plonked wet and slippery on her abdomen. She is overwhelmed and finds it hard to hold on to her baby.

'Well done. Aren't you clever?'

'Look what you've got. She's beautiful. Look at her.'

The mother gathers she has had a girl and says hello to her.

'She's a bit rattley. I'll just suck her out. Oh, you didn't like that, did you? What a noise. She's got a good pair of lungs, hasn't she? I'll just dry her so she doesn't get cold. Oh, you don't like that either?'

'It's all right,' says the mother, comforting her baby and trying to get into a better position to hold her.

The placenta comes out and the father cuts the cord. The mother is cleaned up and made comfortable.

'I'll weigh and dress the baby now, if you like, and give her Vitamin K, then that'll all be done,' says the midwife, who is kind, well-meaning and very efficient.

She hands the baby back to the mother, a cleverly wrapped bundle with only her face showing.

'I'll help you get her on the breast if you like, then I'll get you a cup of tea and leave you alone for a while.'



★ ★ ★ ★ ★

Obviously these two scenarios can vary a lot, depending on how the birth goes, where it takes place and who is present. Initially our practice as midwives is shaped by our training, our conditioning, our beliefs, philosophies and life experiences. It is also affected by where we practice and the policies and protocols we are obliged to follow. Sometimes our practice is restricted by the need to fit in and survive in our workplace.

If we are open and not rigid in our thinking, we see there are different ways of doing things. We evolve and grow, and our practice changes. We may look back and cringe at some of the things we have done or been part of, but we can also accept that we did the best we knew how at the time and move on. We can learn from the women we care for, from our colleagues, from books and gatherings and conferences to do with birth.

We can be privileged participants in a process in which the mother has the power, or, by our need to be busy and doing and in control, hold the power ourselves.

The choice is ours.

I am concerned about your College's submission on the Public Health Commission's (PHC's) draft Immunisation Standards which has appeared in the October issue of your journal as an article by Joan Donley. I would appreciate a copy of the New Zealand College of Midwives' policy on immunisation. I would hope that the views of Joan Donley do not represent the College position because of the flaws in her article.

Informed Consent and Advice on Side Effects

Joan Donley states that '[p]arents should be given a written list of possible side effects and contraindications'. The booklet *Immunisation Choices*, which is available free of charge from doctors, nurses, public health units, and hopefully midwives, provides this information and is readily accessible.

The *Immunisation Choices* booklet is normally given to the mother of every child at the time of birth. Midwives should therefore know about the availability of this booklet and other relevant health education material from the approved provider at the local public health unit.

Measles, Mumps and Rubella

Joan Donley questions the rubella vaccine's effectiveness by quoting a secondary source of old research on a type of rubella vaccine that is not now used in New Zealand. The research is supposed to appear in the May 1978 issue of the *Australian Nurses Journal*. The contents page of that issue has no reference to rubella vaccine.

Rubella vaccines have been shown to be highly effective in maintaining protective antibody levels.^{1,2,3} It must, however, be noted that reinfection has been rarely reported to occur even with protective levels of antibodies, both vaccine derived and derived from natural infection.⁴ Even if immunity from natural infection is superior, rubella immunisation programmes have dramatically reduced the rate of congenital rubella syndrome, especially with the addition of a dose in the second year of life.⁵ Joan Donley attempts to dispute this by quoting a British official from 1976 in an unreferenced statement.

The occurrence of a severe form of atypical measles following immunisation was a problem with killed measles vaccine. The reference used by Joan Donley relates the case histories of two of four siblings who developed atypical measles some years following the use of killed measles vaccine. Their illness was not particularly severe compared with wild measles and both made full recoveries.

Only live attenuated measles vaccines have been used in New Zealand which have not been shown to cause a severe atypical measles illness. On the contrary, previously immunised children tend to have milder disease. There was no evidence of more severe disease in previously immunised children in the 1991 measles epidemic. In fact, all four children who died in this epidemic were unimmunised. The fact that many cases of measles occur in immunised children is not surprising. If 80 per cent of children are immunised with a vaccine that is 80 per cent effective, one would expect about half the cases to be immunised. This relatively low efficacy of measles vaccine was estimated from the data relating to Wellington cases in the 1991 epidemic.⁶ The lower efficacy may be related to thermal damage to vaccines and giving the vaccine relatively earlier. Other studies suggest that measles vaccine is about 95 per cent effective.^{7,8} Furthermore, contrary to Joan Donley's assertion it is clearly stated in *Immunisation Choices* that aseptic meningitis and seizures can occur after MMR vaccine. The Institute of Medicine, in their comprehensive review of the adverse effects of vaccine,⁹ considered that there was inadequate evidence to accept or reject a causal relationship between measles vaccine and residual seizure disorders or transverse myelitis. It would be unreasonable to include these reactions as adverse effects.

Conclusion

It is a matter of grave concern that the midwives' professional organisation is happy to selectively use the medical literature to exaggerate the risks of immunisation, downplay its benefits, and apparently to oppose immunisation which has the endorsement of all major scientific bodies as being the one of the most cost-effective means of preventing disease.

Midwives play a critical role in preparing mothers for their newborn children. Their advice on the issue of immunisation is important. There will always remain some uncertainty about adverse reactions to vaccines, especially if the reaction occurs very rarely. This uncertainty is balanced against the known risks of the disease and the known benefits of immunisation in preventing these diseases.

The PHC believes, on the basis of the available evidence, that immunisation is of considerable importance for protecting the health of New Zealand children. I would welcome the opportunity to meet with you to discuss your College's policy on immunisation. We would also appreciate an opportunity to answer the concerns raised by Joan Donley in a future edition of your journal.

Immunisation

Dr Gillian Durham

Chief Executive
Public Health Commission

Response

Joan Donley

Independent Midwife

30 November 1994

In response to the letter from Dr Gillian Durham, Chief Executive, PHC (7 Nov.), I feel that it is important that she has an understanding of the role of the midwife.

According to Marsden Wagner, WHO Officer for Maternal and Child Health for the European Region (32 countries), the midwifery model is the social model which sees life as a solution. He compares this with the medical reductionist approach which sees life as a problem, full of risks and in almost constant danger. Further, as a major institution of social control, physicians as morally neutral and objective experts, are capable of making absolute judgements about people's lives and the form health services should take.¹

Conversely, the holistic midwifery model includes the social, psychological and spiritual components of technologies.¹ It also takes into consideration the Cartwright Report (1988) which said the focus must pass from the doctor to the patient. Cartwright established the legal basis for consensus decision-making and informed consent in New Zealand.

Opposition to immunisation does not just come from the Immunisation Awareness Society. Pro-lifers and the Catholic Church are currently opposing rubella immunisation because the vaccine is derived from the lung cells of aborted embryos.³

Dr Roger Booth, an Immunologist at Auckland Medical School, has recently expressed concern about the assumption that 'because (vaccination) works for some things it's going to work pretty well for lots of things'. He worries about changing immune structures which is a difficult theory to test. Since immunisation isn't straightforward, particularly when there's no guarantee a vaccine is 100 per cent effective, Dr Booth rules out the theory that unvaccinated children are a threat to others by providing a reservoir of any virus.³

The Christchurch based IPA, Pegasus, obviously recognises there is a considerable number of conscientious objectors to immunisation. It applied to the Justice Department for birth notification data (which was refused under the Privacy Act) in order to find out how many parents conscientiously object to having children immunised so no effort is put into chasing them up.⁴

Vaccine manufacturers also have the ability to undermine vaccination programmes. Recently, U.S. vaccine manufacturers were critical of a plan to offer free vaccines to children under 18

years who are Native American, on Medicaid or who have no health insurance. A discounted price for so many was seen to cut too deeply into profits - from 55 per cent down to 20 per cent sold at private sector prices. Merk threatened to get out of vaccines if it became unprofitable. Lederle-Praxis claimed to need the revenues to develop new vaccines.

Regarding the 'secondary source of old research on a type of rubella vaccine not now used in N.Z.', the page number quite clearly referred to Chaitow 1987. However, Durham was, so to speak, in the right church but the wrong pew, as the research did appear in the *Australian Nurses Journal* mentioned - pp. 1-4. Allen's original 'old research' report is in *Australian Journal Medical Technology*, 9: 26-27.

Regarding the vaccine, according to Morgan-Capner,⁶ British Consultant Virologist (p. 38) 'one strain of live attenuated vaccine is available in New Zealand: the Cendehill strain (Cendervax)'. Cendervax was the vaccine used in Allen's research. Morgan-Caper notes that Cendervax elicits an antibody response in over 95 per cent of susceptible individuals - as opposed to the Wistar RA 27/3 strain which elicits an antibody response in about 98 per cent of susceptible individuals (and according to Scheibner⁷ appears more effective in preventing reinfection, but has been implicated in acute arthritis in 13 per cent to 15 per cent of adult women).⁸

Obviously, Cendervax was the vaccine in use in N.Z. in 1988. No doubt, the change has been the use of human embryo cells replacing monkeys', which could not provide uncontaminated cells.⁹

Regarding maintenance of protective antibody levels, the findings of Hermann *et al.* (1982) refute this. In a study on the Hawaiian Islands of 5,153 children who had had rubella vaccinations using three different vaccines within four years, the level of antibodies halved compared with their level of antibodies just after the injections. There was a further slight fall between four and seven years. At seven years (1977) there was a sharp rise in antibodies corresponding with a documented outbreak of rubella on Oahu.¹⁰

Regarding reduction in rates of congenital rubella, following the U.S. strategy of preferentially but not exclusively vaccinating all girls at age one, there was an outbreak of rubella in California in 1979 among young adults. California reported 13 confirmed or probable cases and four possible cases of congenital rubella syndrome (CRS), as well as six cases of congenital rubella.¹¹

The researcher concluded that, 'Since natural rubella infection is almost always benign and confers better immunity than the vaccine but without additional risks, rubella vaccination is not justified in young children'.¹¹

Scheibner makes reference to Cherry (1980) (Lederle consultant) who noted that the number of rubella infections in women in childbearing

age had remained the same (in U.S.) and suggested that two of the reasons for the reduction in congenital rubella was the U.S. fall in fertility rate and/or the more frequent use therapeutic abortion.¹²

Morgall-Capner (1988) confirms the latter. He states that the frequency with which rubella complicates pregnancy during non-epidemic years is about one per 2,000 pregnancies; and that approximately 200 to 300 terminations are performed every year (U.K.) for suspected or proven maternal rubella during these non-epidemic years.⁶

Although, in 1985, Dr John Clements of the Department of Health claimed that N.Z. 'has probably the most effective rubella prevention programmes in the world'¹³ dire warnings were issued during the 1988 rubella epidemic advising all non-immune women and Form One girls to get immunised if a national tragedy of deformed and disabled babies was not to ensue.

Regarding 'atypical measles', Durham infers this was only a problem following the use of killed measles vaccine. This is the 'reason' provided by the U.S. Morbidity Mortality Weekly Reports for the persistence of atypical measles, i.e. 'ineffective formalin-inactivated ('killed') measles vaccine, which was administered to 600,000 to 900,000 individuals from 1963 to 1967'.¹⁴

According to Scheibner (p. 257), 'children vaccinated by either live or killed measles vaccine may develop atypical measles'.

However, Cherry (1973) studied 103 (U.S.) children with measles vaccine failure, 12 of whom had illness resembling atypical measles syndrome; 70 had clinically typical measles and 15 had mild modified measles.¹⁵

According to Scheibner (p. 83) so-called 'mild measles' with underdeveloped rash, can have long-term dangers such as chronic diseases, including cancer.

A previous (1972) study by Cherry described a 1970/71 epidemic in St Louis during which 130 children were hospitalised and six died. The attack rate was much higher in vaccinated than in unvaccinated children. A number of vaccinated children developed atypical measles.¹⁶

One of the problems of atypical measles is its occurrence in children one-year-old or less who should have been protected by their mothers' placental immunity. Lennon and Black (1986)¹⁷ found that 'haemagglutinin-inhibiting and neutralising antibody titers are lower in women young enough to have been immunised by vaccination than in older women'.

The N.Z. 1991 measles epidemic showed vaccination failure rates of up to 50 per cent. According to medical epidemiologist Paul Stehr-Green, 10 per cent of the under-reported 4,400 children nationwide were under one year of age, 40 per cent were aged one to 10. Three babies died - two of whom were too young to have been immunised! It was the opinion of Stehr-Green that the immunity passed on from mothers



is waning. The Departmental response was that some children were immunised too young and/or some storage and handling procedures were inadequate¹⁸ – the same excuses used in 'old research' by Plotkin (1973).¹⁹

Regarding neurologic effects – Landrigan and Witte (1973) described some 80 cases of neurologic disorders within 30 days of measles virus vaccination, plus cases of sclerosing panencephalitis after measles virus vaccination; Roden (1974) reported 19/10,000 cases of convulsions after measles vaccination. Maybe these research reports are too 'old' therefore irrelevant.²⁰

A group of Swiss doctors critical of the U.S. policy of mass vaccination against MMR issued a statement:

We have lost the common sense and the wisdom that used to prevail in the approach to childhood diseases. Too often, instead of reinforcing the organisms defences, fever and symptoms are relentlessly suppressed. This is not always without consequences ...²¹

And, the Ministry of Health and Welfare in Japan decided in 1993 to discontinue the use of MMR 22 because of the published reports of vaccinated children and their unvaccinated contacts contracting mumps from the MMR vaccine. Previously when the Japanese policy moved all vaccination to age of two years, cot death disappeared and its infant mortality became the lowest in the world (Scheibner, p. 263). This was mentioned by Isaac Golden on IYA²³ who said that when immunisation was raised from three months to two years in Japan:

SIDS dropped from 11 to zero;
Infant mortality dropped from 26 to 3;
Reactions dropped from 132 to 29.

References

Available from the Journal upon request.

College Response

Karen Guilliland

National Co-ordinator

12 December 1994

Dear Gillian Durham

Your letter was discussed at the recent National Committee meeting and several issues were raised. The National Committee has representatives from 10 regions (where all base hospitals are included), Parents Centre, Maori Midwives Collective, Home Birth Association and Maternity Action Alliance.

1. Immunisation Choices Booklet

Whilst most regions are now aware of this booklet this had only been so relatively recently. Neither individual midwives nor the College had been notified by the PHC of its publication. The College would have been happy to promote distribution of the booklet had it known it was available. We have now initiated moves to advertise its availability. Your understanding that the booklet is 'normally given to the mother of every child at the time of birth' was not supported by the midwives present at the meeting. It is more usual that the booklet is 'displayed' in antenatal clinics or at GP rooms but are not actively handed out. Some are given out with the Plunket books and some Plunket rooms distribute them. It is by no means uniform or automatic.

2. The Role of Midwives in Immunisation

Immunisation is generally not taken up within the timeframe in which most midwives operate. Most midwives refer families back to the primary medical system for immunisation. However, some mothers request midwives to provide this service at the six-week postnatal check. This is usually because:

- (a) The family does not have a GP and the visit is an opportunity to at least start the process.
- (b) Geographic isolation which means a separate trip to the doctor or practice nurse.

3. The Role of the Midwife

Midwifery, unlike medicine, does not see its role as 'advisor' but rather as having the responsibility for providing full information, options and choices to women and families which encourages understanding, self-reliance and responsibility for their own health care decisions. Informed choice and consent within a social and wellness model is promoted and it especially applies to any issue where there are different points of view. Immunisation, regardless of our personal beliefs, continues to attract two viewpoints within the community and health professions (medicine included).

Midwifery's philosophy of regarding the individuals as the decision-makers within the normal healthy birth process means the profession in general is unlikely to make a stance or policy statement which comes down on the side of one viewpoint over another. There are plenty of organisations and professions which take on this role. It believes the research should be able to state its own case and in the absence of clear unequivocal research the decision must be the parents as to whether the

benefits outweigh the risks. It is the experience of midwives that the vast majority of clients decide on immunisation when exposed to all the literature.

The National Committee was concerned to read your comments where you make statements based on assumption, e.g. the College is opposed to immunisation. It would appear following several communications from yourself over the last year or so that the Public Health Commission's perception of midwives, midwifery and midwifery education is less than knowledgeable and the College would appreciate a forum for rectifying this situation.

We would also welcome the opportunity to meet with you in order to address some of these concerns and the issues they raise.

* Editor's Note:

For those who are interested in following the debate, the upcoming international symposium on vaccination has Gillian Durham and Viera Scheibner as speakers.



MIDCENTRAL HEALTH

Palmerston North

Midwifery Co-ordinator

Do you have the skills to co-ordinate and lead a team of midwives to provide the best care within a Women's Health Unit?

We are looking for someone who has a commitment to and a vision for women's health within New Zealand. If you have recent clinical experience in all areas of midwifery care; have excellent motivational leadership and time management skills; and a commitment to staff education and development, then we welcome your applications.

Staff Midwife

This is a full-time night duty position working within a busy antenatal and post natal area. Some Delivery Suite work may also be required.

You must be a NZ registered Midwife with post basic experience. Job sharing will be considered.

We welcome all enquiries for these vacancies. Further information can be obtained from:

Megan Slater, Employee Relations Consultant,
Palmerston North Hospital, Private Bag 11-036,
Palmerston North, Phone 0-6-350 8850; Fax
0-6-350 8982.

Applications for both positions close at 5.00pm,
19 April 1995.

Patient Files: Whose are They?

Anne Whyte, Muriel Wormald and Chris McCall

Independent Midwives
Pukekohe

For the past 12 months we have adopted a team approach in our independent midwifery practice. Women in our care now look after their own notes.

When we began independent practice, each midwife made alternate visits to each woman in our care. Having no clinic, all our antenatal visits occurred at the women's homes.

We soon accumulated large volumes of notes which were being transported over long distances, and being carried in and out of cars and homes. Because each of us needed access to the information, we tried various methods to 'pass notes around' meetings, posting, photocopying and finally, for convenience, we began to leave each woman's notes in her care.

At first we were not sure if this was a sensible idea, and to relieve our own anxiety we impressed upon the women the importance of keeping these notes safe, bringing them to each antenatal visit, and hospital (if a hospital birth was planned). For a homebirth, it seemed sensible that the notes should stay at the woman's home where they would be available when needed.

Because of the legal requirement for midwives to keep records, each woman is advised on booking that when our term of care is completed the notes must be returned to us. When referred to Plunket/Public Health care, each woman is asked if she wants a copy of her notes.

This was a valuable exercise for us which works very well, enhancing the idea midwives and women are equal partners working together choosing and securing care which achieves the best possible outcomes.

Knowledge and information can be issues of power which may be utilised in a variety of ways and purposes. For example, some large industrial conglomerates, and some nations, spend vast amounts of money and energy obtaining and retaining information and knowledge. Elaborate precautions are taken to prevent others sharing the knowledge.

Knowledge and information used as an issue of power may be used to frighten and extort.

Medical knowledge and, ergo, health knowledge, have previously been awesome things to the lay person. Knowledge and information as concepts still have overtones of power.

Secret squiggles and hieroglyphics are etched onto papers kept in arcane files to be read by the health professionals involved in a person's care (read by other health professionals who might not have any interest in the state of one's health). Often more time was spent reading and writing in the notes than interacting with the patient concerned.

Recently there has been a shift away from the notion that health information and knowledge are for professional use only. Now shared with the 'patient' at the discretion of the professional, it meant notes remained with women. We were no longer encumbered with huge midwifery files, and other health, medical and personal data.

It also meant that:

- if hospitalised in an emergency;
- if visiting another G.P. in lieu of their own;
- if seeing their own G.P. for any reason;
- if another opinion was sought;

the woman's antenatal records are immediately available to those involved in any care and/or treatment. Each woman has all her midwifery and associated health data available to take with her at these times, with an up-to-date record of past and present progress and status immediately available giving the woman control over whom she shares information with.

If women have their own notes, it makes for ease when referring, obviating the need for lengthy referral letters and further copies of notes.

We also found that women hear and see midwifery terms and soon become proficient in 'midwife speak' (with apologies to George Orwell).

The women take responsibility for the notes: they are able to ensure that any relevant changes are immediately noted (e.g. change of address), and some women, have begun to make comments of their own in them. Moreover, they can be assured personal information contained in each set of notes is accurate and up-to-date.

Keeping the notes seems to encourage persons involved with particular woman's care to treat her more as a 'responsible adult' than as 'a patient'. It reduces the likelihood of women becoming upset by, or of misunderstanding, the information provided by the midwives and other health professionals.

At each visit the antenatal care is discussed and documented with each woman being able to ask for clarification of any verbal and written comments. Documentation is strictly objective. There is less confusion because facts are clearly documented and women may refer to their notes as they wish which helps foster the educational side of antenatal visits.

These women have become proud possessors of their midwifery notes. There was no need for our stern injunction to look after them. In fact, one woman in our care who lived in deprived circumstances, admitted to a base hospital for suspected complications in her third trimester, gruffly told the specialist, 'give those notes back they're mine, not yours!'

Comments have been made that women may lose the notes or forget to bring them to hospital. In independent practice notes carried by the patient are less likely to get lost than bulk notes carried by ourselves or filed by a large institution.

So far, we have had over 50 women hold their own notes. None have lost them (perhaps because they contain such important information about themselves). Only two women forgot to bring them to hospital. One woman, although in strong labour, insisted her husband telephone and wake his brother in the middle of the night to ask him to pick up the notes and bring them to hospital!

So far everyone has been pleased to have their notes, remarking:

'Oh good, now I'll be able to keep an eye on everything.'

'Are you sure it's alright for me to have these?'

'Can I read them?'

'I won't lose these!'

We use H678 obstetric notes and attach two pages of our own information to the front and back of these.


The front sheet records names and telephone numbers, and the woman's name and list of appointment times. This effectively covers personal information on the first page of the H678.

We provide each woman with a plastic envelope in which to keep the notes and results of the tests. We encourage women to become accustomed to carrying notes in handbags and take them everywhere.

We are becoming partners in midwifery care with women. It has become clear that while we have varying degrees of expertise in midwifery practice, it is women who are the experts, who know their own bodies, emotions and beliefs.

By sharing ownership of the midwifery notes all involved are making a clear statement of commitment to the philosophy of partnership in midwifery care, and participating in its concrete expression. It seems rational to allow women to hold and take responsibility for information which, after all, is about them.

A Report of a Pre-conceptual Education Programme in Wairarapa Colleges

Ire Ireland, Anne Temple
and Marita Merry

Midwives

For some years staff at the Masterton Maternity Unit have expressed concern about the number of teenage pregnancies in the Wairarapa. In 1993, 9.4 per cent of all births occurred in women under 19 years of age.

Often the first contact we have with a teenage client is on admission for antenatal care with Intra Uterine Growth Retardation (IUGR) or premature labour.

These young women are invariably withdrawn and anxious, often smoke heavily and have a history of marijuana and alcohol consumption.

Many are young Maori women. They have little idea of self-care, or choices in pregnancy, and find themselves powerless – often facing a difficult road ahead, living with parents, in unstable relationships, or alone, often beginning a cycle of deprivation and loneliness.

A 1993 Coopers and Lybrand Report expressing a belief that research suggests poor birth outcomes often result from events before conception, suggested education programmes in secondary schools could be a way of preparing women and their partners to make informed lifestyle choices. The report purported that young Maori teenagers found peer group education more appropriate to their needs.

This belief echoed in a United Kingdom Government Report on Maternity Services, 1993, in which it cited Pre-Conceptual Education (PCE) as a way of reducing the number of teenage pregnancies and poor birthing outcomes.

In this report, Christina Potrykus, Minister of Health, states: 'PCE was most likely to be effective linked with health promotional programmes in secondary schools'.

We began to explore creating a pre-conceptual education programme for local colleges. We accepted teenage values emphasising group identification and belonging, e.g. to gain acceptance in the group it may be necessary to smoke or have sexual relations (Silva, 1993), would be difficult to change. However, through a PCE programme there was an opportunity to offer information which could change attitudes, and foster concepts of personal choice and responsibility.

Combined with other sources of information, e.g. parents or other health promotion programmes in the colleges, we anticipated making some impact on teenage behaviour over time.

★ ★ ★ ★ ★

The Process

Three midwives were directly involved in the project. The first task involved investigating current health promotion programmes in the colleges. We discovered:

- * a module on sex education and contraception in the 4th form
- * a small parenting class run as a 6th form option
- * the Heart Foundation Programme smoke free and healthy living modules.

We could effectively interface with these existing programmes.

The concept of a PCE programme was presented to our local CHE management who gave positive support to proceed with the project.

Board of Trustees

After contacting the Board of Trustees of two local co-educational colleges we were invited to discuss the project, meeting with overwhelming support.

The Teachers

The teachers requested a teaching plan: a two-session programme for 5th formers at Wairarapa College and one session for 6th formers at Makoura College. We were invited to teach 166 students in 15 classes.

The Workshop

Knowing that a successful teaching plan must involve the students actively in the learning process we held a workshop with interested teachers. We learned teenagers were avid information seekers. However, teaching methods had to vary, involving not only affective cognitive knowledge seekers, but also kinaesthetic learners who need models and active involvement in classroom activity.

Staff Workshop

In the beginning some members of the maternity unit had concerns about the programme.

- * They questioned the need to give this information to teenagers.
- * They felt our brief was to teach pregnant women.
- * They were concerned at the time involvement and staffing issue.
- * Initially there was poor communication about the aim and content of the project.

We discussed these issues and most staff members gave their support.

The Teaching Plan

The philosophical basis for our teaching plan: birthing is a normal, happy, family lifestyle event.

The teaching plan outline discusses: pre-conceptual issues, how to stay healthy in pregnancy, how a baby is born and the responsibility of parenting, students counselling and support if they thought they could be pregnant. (A note was sent home to all parents about the course.)

Pre-conceptual issues related to the health of the mother and the protection of the developing fetus. Advice supported by information suggesting that women should:

- * be immunised against the possibility of Rubella infection,
- * should not have unprotected X-ray pictures in the second half of their menstrual cycle if sexually active,
- * seek advice from their doctor if they have some underlying medical condition which could affect the pregnancy, e.g. diabetes,
- * to be off drugs, smoking and alcohol and to be living a healthy lifestyle all before conception as the first weeks of fetal development are critical.

We stressed it was important for a couple to have a long-term, stable, supportive relationship as parenting requires a lot of commitment, and asked the students to ask themselves if they personally would feel ready to take on the responsibility of nurturing an individual before

contemplating pregnancy. We also provided information on where to go to get confidential counselling and help if they thought they might be pregnant.

In pregnancy we stressed:

- * the need for women to take responsibility for their own health,
- * to seek a caregiver early – we provided objective information about the advantages and disadvantages of receiving care from different providers,
- * that there was a need to take folic acid early in the pregnancy to ensure proper neural stem development in the fetus,
- * full understanding that because the pregnant woman is, in fact, her developing baby's environment she must have a healthy lifestyle, a well-balanced diet, take appropriate exercise and be smoke, drug and alcohol free,
- * the value of attendance at antenatal classes to prepare for birth and parenting including the importance of breastfeeding.

Finally, we thought it was an opportunity for career seeking students to talk to us about the work of midwives. One of the authors was a recent graduate and so provided a great role model.

To illustrate our teaching we used a variety of posters, a doll and pelvis, and a video on birthing. As a suitable video we selected *A Sister for Hugo* which placed birth in a family context. It was in a New Zealand setting and has a discrete ambience. Two teaching midwives attended most classes to give variety to teaching methods. The teaching plan included goals and expected learning outcomes and incorporated evaluation from both students and college teachers.

Discussion

Initially we found the classroom situation daunting, but because we had prepared the programme carefully we quickly gained confidence and began to field questions which lead to classroom interaction. It was encouraging that many of the Maori students were active participants.

Here is how the students evaluated our programme:

★ ★ ★ ★ ★

We felt this was a fair assessment.

How much did the student already know about the topic?

Very Little	-	44 out of 166	26 %
Moderate	-	103 out of 166	62 %
A Lot	-	19 out of 166	12 %

Was this an overall adolescent perception of the subject? Did you feel it was important to receive this information?

Yes	156 out of 166	94 %
No	6 out of 166	4 %
Undecided	4 out of 166	2 %

Students were asked to comment on why they felt it was important to receive this information? Many answers centred around the 'need to know what actually happens', or 'it's 'good information for later in life'.

Other repetitive comments were:

- 'So girls are prepared with at least some information and guys could have some understanding what is going on and know they are responsible too'.
- 'Needed because some parents don't tell their kids about birth'.
- 'Needed because teenage pregnancy is becoming more common – it is good to be able to know what I or my friend may go through as a result of getting pregnant'.
- 'When pregnant – where to turn to'.

The questionnaire asked students about the content of the programme. Most students enjoyed the presentation and found the explanation clear. They found the ladies 'friendly and honest'. The video caused much comment, e.g. 'having a baby is not like it is on TV!'. Other teaching aids, the posters, diagrams, doll and pelvis were popular.

Twelve students had concerns about the presentation 'the video had poor sound' (the machine in that classroom was faulty): 'classroom control was not good'.

Finally we asked students at what level is the information most appropriate?

- 8 % of students thought 4th form
- 53 % of students thought 5th form
- 28 % of students thought 6th form
- 11 % of students were undecided.

It seems the programme is well targeted for 5th and 6th formers.

Teacher Evaluation of the Programme

Eight teachers at Wairapa College were asked to comment on the project. All were supportive and thought it was relevant information for 5th and 6th form students. We asked if the teachers could comment on student reaction and acceptance?

Replies suggest that:

- * we had not left enough time for questions,
- * because of the explicit nature of the video more time was needed for debriefing,
- * some girls had extra unanswered questions,
- * students' interest had been maintained.

We asked about the midwives presentation with respect to quality.

There was general comment about the programme being well prepared and:

- 'Lovely relaxed ladies – they understood and accepted adolescent embarrassment'.
- 'Birthing video and visual aids, models and charts very helpful'.
- 'Has a good rapport with students'.
- 'Well prepared – may have been better with one midwife'.
- 'Need to learn class control techniques'.
- 'Some use of sexist language'.

Other comments suggested teaching techniques which could be used in future sessions to improve effectiveness:

- * the use of group work and feed back as a debriefing method,
- * the use of a postbox with anonymous questions for midwives to answer,
- * several teachers were concerned about the use of words like *parent* – suggesting *caregiver* more appropriate (we had some difficulty with this one!),
- * there was more need to emphasis the smoke, drug and alcohol free messages.

Conclusion

An absence of parental criticism, and 100 per cent student attendance at classes, demonstrated the programme's success.

The students indicated that they thought the information relevant and the format of the teaching programme acceptable. It appeared some students were thinking about taking more responsibility for their lifestyles.

Teachers keen to continue the programme next year indicated that the teaching unit was definitely appropriate for 5th and 6th form students. We will incorporate many of their suggestions, such as a more structured debriefing period after the video and the need to emphasis the smoking, drug and alcohol free messages. In addition, future programmes will include Maori midwives to meet Maori student needs.

This programme has the potential to influence teenage attitude and behaviour patterns. Actual measurement of its effectiveness will only be determined over time. Indicators include reductions in teenage pregnancies, smoking in pregnancies, numbers of antenatal admissions, reduced admissions for 'small for dates' and premature babies, an increase of breastfeeding in our community, and an increase in women and their partners attending antenatal education classes.

Already, other Wairarapa colleges have indicated interest in our programme. Availability of funding presents the only stumbling block to the expansion of the pre-conceptual education unit.

In conclusion, we thank our staff colleagues who supported us during the three-week-long teaching programme.

We would like to thank our staff colleagues at the unit who took interest and supported us over the three-week teaching programme.

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Growth

No longer a student,
now a Midwife I am.
This only through support from the Midwives I admire
and my never ending desire.
At times I wonder what else I could have been
but no regrets I have for what I have seen.
So much I have changed,
So much I have grown.
Looking back realising how little I'd known.
But forever I will continue to learn more
from women than from the pages I turn.
For this profession I play a part
in the delivery of a ... tiny beating heart.

Helen M. Wood
Midwife
Burwood Birthing Unit



Midwifery as a Culture

Angela Kearney

Midwife

New Zealand midwives are pioneers in the field of mother and child health.

At long last we are able to be independent of doctors and offer to the mothers and children of Aotearoa quality care, nurturing and support.

In traditional societies a midwife holds a prestigious position. She is the primary health care provider for the majority of women in the developing world.

Recognising this, some governments have encouraged training and supervision of these traditional midwives and allowed them to understand and practise safe techniques of childbirth.

But we still have a long way to go, in terms of providing antenatal, delivery and postnatal care to all women. For, as women, we are entitled to safe birth practices.

My New Zealand midwifery background has allowed me to be part of many different customs and cultures. Although I studied midwifery back in the days of hospital-based programmes with mostly male obstetricians and only a few midwives who really were able to stand up and defend the professionalism of midwifery practice, it gave me a strong background for leaping forward (and sometimes backward) to places as far afield as Papua New Guinea, Sudan, Mozambique, Iraq and latterly Angola.

I would like to share some of my experiences with you in the hope that we New Zealand midwives will gain new understanding of cultural, religious, language and race differences.

My memories of Papua New Guinea as a newly trained midwife now fill me with some fear and trepidation. I knew little about physical responses to pain.

In New Zealand we had nitrous oxide, pethidine, and epidurals. The labour ward in Lae where I worked had hugs, shouting, the occasional gentle slap on the back or even face, but more importantly a labour ward that was always filled with many labouring women on mats on the floor, and they encouraged each other in their quests for childbirth.

I recall on my second day there, not knowing how I could calm down a frightened primip who was screaming with each contraction. It was left to the lady on the mat beside her who was having her ninth child. She rolled over tapped the primip on the shoulder and said, 'Listen here girl; it may go in like a banana but it sure does come out like a pineapple'.

End of story and end of screams by this young mother. She was comforted.

I think one of my long-lasting memories of my time in the Pacific is the reaction women have to pain. Sometimes it is OK to scream, flail around the bed or mat and curse everything and everybody in and out of sight. Analgesia in our traditional form as mentioned above is not always appropriate. We should consider allowing these women to have their own support mechanisms usually their mothers and mothers-in-law, aunties, and village women leaders.

Sudan left me with many conflicting emotions. I worked with refugees. Eritreans fleeing Ethiopia lived in awful conditions of poverty in Sudan. Every woman refugee I met in antenatal clinics was circumcised. An operation of total destruction and mutilation, it has been banned in Sudan since 1953 but is practised every day. Now private clinics in London are performing them. Who knows, one day we in New Zealand might provide assistance to African or Arab women who wish to have a daughter circumcised. An obstetrical nightmare, what about the human factor of suffering, lack of self-worth and esteem?

In Mozambique I spent five happy years of working with health workers and traditional birth attendants, where 30 per cent of pregnant women in Mozambique give birth in a hospital or health centre.

I was based in Zambezia Province where less than 14 per cent of births are attended by a trained midwife. Eighty-five per cent of Mozambique's population lives in rural communities. The Mozambique Government responded to a challenge to provide training courses for traditional birth attendants (TBAs) and prioritise maternal and child health care, by enhancing TBA understanding of childbirth processes and puerperium cares. Attention to cleanliness and hygiene practices represent the main focus of these health care initiatives.

Training of TBAs is co-ordinated by the Ministry of Health as a means of extending the health care system beyond the hospitals and health centres to rural communities.

The government-trained midwives participated in training courses on how best to assist TBAs in their communities. Now these midwives encourage knowledge, attitudes and practices of the TBAs which are useful, and explaining the reasons to change habits that could be prejudicial to the mother or baby. It is necessary to give clear and concise explanations and if the case is to change a dangerous habit, then the new behaviour needs to be practised frequently.

My memories of Iraqi Kurdistan are peppered by Kalisnikovs, freezing outside temperatures, armed guards 24 hours a day, and women struggling to gather firewood, cook for their families, and scavenge a living.

Historically the Iraqi government had a centralised system of bureaucracy. All orders come from Baghdad. Money was hardly a problem. Building huge technology filled hospitals was easy. Medical doctors, trained in

large numbers, went to Britain to undertake postgraduate studies. Almost all women delivered their babies in hospitals, without their families present, and in a sterile, hard environment.

After the 1991 Kurdish uprising money stopped flowing. Hospitals no longer have maintenance, fuel to run generators, light bulbs in incubators, solutions for simple tests like haemoglobins. The Kurdish people are trying to maintain lifestyles they historically knew. Doctors who head a newly-established Kurdish Ministry of Health are unable to adapt to community and rural health needs and rural-focused services. Rural maternal and child morbidity and mortality continues to rise rapidly. Setting up an immunisation campaign against preventable childhood diseases should be given priority. Instead, many times we hear chiefs ask for heart drugs, renal transplant facilities and brain surgery equipment.

Now I work in Angola. Given that Angola has the highest infant mortality rate in the world (two out of ten children die before age one, and three out of ten are dead before their fifth birthday), our Save the Children interventions

must involve mother and child health care. It is a central plank of our health strategy.

Working in war is difficult. All the goodwill in the world to deliver humanitarian aid does not go far when up against war mongering men who only want to win by arms. Mothers and children suffer first. The quiet death ... the slow one - malnutrition. A childhood disease like measles is 500 times more likely to kill an African child than a New Zealand child. Polio maims and cripples, diarrhoea kills and pregnant women die of anaemia, malaria and obstetrical complications.

Training of traditional birth attendants is the ideal, but at the moment the dream. Roads are mined, troops are moving, bombs are falling, rain is falling and I am currently unable to be with the team in Huambo where we are based because it is too unsafe.

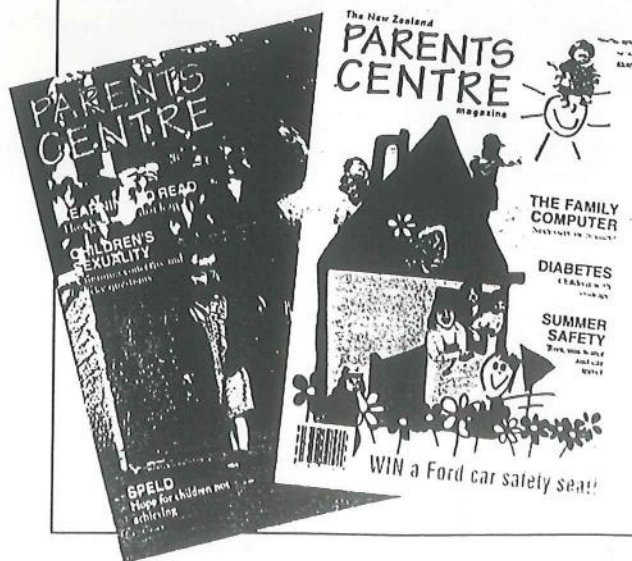
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A Midwife – the Definitions

Glenda Murray

Midwife

She must have a good memory, be industrious and patient, moral so as to inspire confidence; be endowed with a healthy mind and have a strong constitution; and finally she must have long delicate fingers with nails cut short.

Soranus

What paragon of virtue does Soranus describe in this paragraph?

MIDWIFERY

What is meant by this word?

What do people understand a midwife to be?

What do they write that midwives should do?

How do midwives perceive themselves?

The Definition of Midwifery

As a student I felt it very important to be able to quote the definition of a midwife. It gave me a sense of stability, a base from which to work. This was where education was taking me. That definition was learned word for word from our main midwifery text, *Mayes Midwifery, A Textbook for Midwives* (1988). The chapter, entitled, 'The Midwife', goes like this:

In English the word midwife means 'with woman'. In French the midwife is called sage femme, meaning wise woman and in Latin the word cum-mater is used for midwife. The midwife has a unique role which is complementary to but different from the role of other health care professionals involved in the care of mothers and babies.

Immediately I sensed an historical conflict. The definition of a midwife adopted by the International Confederation of Midwives in 1972, and by the International Federation of Gynaecologists and Obstetricians in 1973, is as follows:

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical aid. She has an important task in health counselling and education, not only for the patients, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

The key issues in this definition seem to be the education required, supervision and care of women and babies throughout the childbearing experience, to practise *on her own responsibility*, counselling and education, and the ability to practise in any setting. However, I believe this definition is mainly task-orientated. It does not reflect an holistic women-centred approach.

The *New Zealand College of Midwives Handbook for Practice* (1993), carries a statement of the philosophy of midwifery:

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

Midwifery is:
dynamic in its approach;
based upon an integration of knowledge
that is derived from the arts and
sciences;
tempered by experience and research;
collaborative with other health profes-
sionals.

Midwifery is:
holistic by nature, understanding and
combining the social, emotional,
cultural, spiritual, psychological and
physical ramifications of women's
reproductive health experience;
actively promoting and protecting
women's wellness;
promoting health awareness in women's
significant others;
enhancing the health status of the baby
when the pregnancy is ongoing;
midwifery care is delivered in a manner
that is flexible,
creative, empowering and supportive;
midwifery care takes place in partnership
with women;
continuity of midwifery care enhances
and protects the normal process of
childbirth.

The above philosophy highlights the more important aspects of who a midwife is or should be. The emphasis on wellness rather than illness is especially important to me. Another important point is the wording 'women's reproductive health experience'. I have difficulty dividing midwifery care into areas of 'pregnancy, labour and the postpartum period', as stated in the Mayes' midwifery definition. There is no general term to include the whole childbearing experience, so I applaud the N.Z. College of Midwives for their wording in their stated philosophy. During the introduction to the *Midwives Handbook for Practice* it states this information is not only for midwives but also for women and the general public, giving the public some idea of what to expect from a midwife.

More Definitions of Midwifery

A brochure published in the U.K. by the Association of Radical Midwives (1990) states: 'Midwives are the only people whose training is concerned solely with maternity care. The only other people legally allowed to deliver babies are doctors (who need not have been specially trained).' We should be proud of this uniqueness! Pelvin (1992) believes, 'Midwifery is the relationship which exists between the woman having the baby and the woman attending her'. Walzer Leavitt (1984) states: 'Midwifery is the most traditional of women's healing occupations. For millennia, women have attended other women as they laboured to bring new life into the world.'

Morten, Kohl, O'Mahoney (1991) state: 'Midwifery, meaning "with woman", is accepted as a profession that serves rather than controls the woman and her birthing energy. Emotional

and spiritual support of childbearing women and their families have always been professed as the hallmarks of midwifery care.'

'The traditional midwives were elderly women, well-known in their communities and experienced mothers in their own right. Their status derived from a lengthy apprenticeship with an established midwife, usually a kinswoman, from whom the practice was inherited' (Dingwell and McKintosh, 1978).

Bennett, Etherington, Hewson (1993) in a book aimed at giving women in New Zealand and Australia information, and therefore informed choices, state:

Midwives are almost always women. Most were initially trained as nurses, and then studied midwifery as a specialist qualification. In hospitals, midwives provide most of the care during labour for all women. They are usually the birth attendant at home births in Australia. Anyone who has been with a woman in labour who has a good relationship with her midwife may have seen how, with each contraction, she sought the midwife's eyes, and be aware of the bond between the two women which gave the mother the strength to go on. When you have witnessed that kind of sharing and empathy, you can be in no doubt that there is an art to midwifery. No amount of hi-tech equipment can make up for its absence.

The Difference between Nursing and Midwifery

Midwives are considered to be specialised nurses. This issue is addressed briefly in a N.Z. magazine article, 'The Politics of Childbirth, Midwives versus Doctors' (1993). Karen Guilliland states:

The forty women doing the three-year polytechnic courses are being trained as midwives from the outset, a different concept to the traditional practice, in which someone wanting to become a midwife first had to become a registered nurse, work as a nurse for two years, then do a 12-month post-registration midwifery diploma. That was hopeless because you had been a nurse for five years. You were totally institutionalised. A nurse is there to nurture and care for the sick. A midwife is there to be an adviser, a facilitator. It's a different concept. If you wanted independent midwives, you had to change the education system. Graduates from the new courses will have quite a different view of the world to those who have done the nursing course. They are being trained to be independent.

The *Standards for the Practice of Midwifery*, Australian College of Midwives Inc. (1987), states: 'Midwifery care differs from nursing

because it involves the care of two lives simultaneously in the maternal fetal phase during pregnancy, labour, birth and its importance to the neonatal maternity dependency bond.' Quite a different argument than Karen Guilliland presents! Sweet (1988) considered it necessary to highlight the unique but complementary role that midwives have.

The Politics of Midwifery

Lee and Morgan (1990) feel that 'One effect of the struggle for this freedom' (of choices throughout reproduction and childbearing) 'has been to create out of maternity a battlefield not only for patriarchal but also for professional supremacy; 'motherhood is a political battleground, a contested area for control - of women's bodies, of the fortunes of families, of the obligations of community support, of the constraints on choice'. This statement poses a challenge to midwives to care for women in a dignified competent manner without making them feel part of a 'political battleground'.

Midwives, in their fight for survival of their profession, need to beware of involving women in a fight for power and control.

Oakley (1986) states:

It has become improper in the modern world to have a baby without consulting medical experts. Even women who want to go against the tide and have babies at home seek doctors or midwives to attend them. Throughout most of history and in most cultures, childbirth has not had, does not have, this medical aspect: those who manage childbirth are experienced women in the community. But in many places today, having a first baby brings a woman into a direct encounter with medicine, probably the first or the most thorough she has had in her life. Certain practices are regarded by medical experts as correct, and it is the role of midwives, doctors and health visitors to spread the word among mothers.

This brings us back to consider who has control?

Greer (1984) remarks:

In non-technocratic societies, except for remarkable accidents, birth is always attended. The commonest arrangement is that the mother sits or crouches, her back rounded, supported by another person, with another to 'catch the baby', an expression common in folk dialects around the world. Birth in traditional societies is always attended by a strictly specified group of people - midwife, female relatives, other women who have borne children and the like - birth in hospital is semi-public, carried out among strangers and passers-by who may or may not be health professionals with a duty to attend.

The concept of the midwife as an attendant seems to be important here.

The *Midwives Handbook for Practice* emphasises in its philosophy the normality of pregnancy, and its relation to health.

In Greer's experience:

From conception, pregnancy is regarded as an abnormal state, which women are entitled to find extremely distressing. Such an attitude is itself the product of the fact that Western women are pregnant so seldom, but even so, pregnancy is not simply viewed as a natural, if rather peculiar condition, but as an illness, requiring submission to the wisdom of health professionals and constant monitoring, as if the fetus were a saboteur hidden in its mothers soma. If women are in partnership with midwives as suggested by the New Zealand College of Midwives, we are able to learn from each other. Midwives need to avoid taking the stance of 'knowing best', or 'spreading the word' as suggested above.

The Vulnerability of Midwives

Garrigues (1902) states:

Midwives do harm – not only through their lack of obstetric knowledge, their neglect of antiseptic precautions, and their tendency to conceal undesirable features, but most of them are the most inveterate quacks. The institution of midwives is a remnant of barbaric times, a blot on our civilisation which ought to be wiped out as soon as possible.

Why did Garrigues (a doctor) feel so strongly about eradicating midwives? Were they genuinely a danger to women and babies (born or unborn), or was it that midwives were a danger to him personally? Were they in competition with him for his livelihood, or was it just that Doctor Garrigues considered women had no place making decisions in a health field? Illustrative of this reasoning was John Maubray's comment:

MEN ... being better versed in anatomy better acquainted with physical helps, and commonly endued with greater presence of mind, have been always found readier or discreeter, to devise something more new, and to give quicker relief in cases of difficult or pretermatural BIRTHS, than common MIDWIVES generally understand.

Walzer Leavitt (1984)

Garrigues considered he and his colleagues would do a better job than the 'quack' midwives. Lewis (1980) in her book about this era states otherwise: 'Janet Campbell's early reports on maternal mortality emphasised the particularly fine record of the Queen Victoria Jubilee Institute

of Midwives. The maternal mortality rate was half the national rate', and later, 'In 1847, Semmelweiss had observed that the death rate of mothers in hospital wards attended by medical students was three times that in wards attended by midwives'. Even earlier in history, 'The entire process of reproduction, from gestation through parturition, was still imperfectly understood as late as the middle of the eighteenth century. Considered nature's assistant, rather than a primary agent, the acceptable midwife was the respectable older woman who carried herself correctly, encouraged and supported the mother, watched and waited, and interfered as little as possible in the actual mechanics of the birth' (Walzer Leavitt, 1984).

In the increasingly hospitalised births of today, it is even more essential for midwives to regain this skill of non-interference which I feel is in danger of being lost. In America we find, 'As midwifery regains popularity it may become more common to find women with women in the birthing process, but it is no longer possible for midwives and their clients to be truly alone in the lying-in chamber. In the modern world medicine and law are partners – perhaps unwelcome companions at birth' (DeVries, 1985).

Tony Baird, an obstetrician, states in an interview by McLoughlin (1993), 'In my experience, some midwives believe a beautiful birth experience is the main event, not a healthy baby'. Very subtle terms indeed, implicating that doctors deliver safer care than midwives.

Perceptions of Midwifery

Sledzik (1991) explores community perspectives on midwifery practice and states:

The midwife as the person professionally prepared to assist women in childbirth and as the key provider of continuous care during labour and childbirth, has played an important role in society. Although midwifery has been practised throughout recorded history, the role and status of midwives varies considerably within different societies and over different times and the office of midwife still remains an enigma to many people.

This is highlighted by Donegan in Walzer Leavitt (1984):

In the United States today the term midwife suggests disparate images. It is not surprising that confusion exists, given the fact that for many years standard medical histories either neglected to mention her at all, or dismissed her as a relic discarded not a moment too soon in the name of medical progress. Consequently, some people continue to think of the midwife as an ignorant, slovenly crone whose ministrations women were forced to accept in the remote past as an essential feature of the trauma of birthing.

Sledzik went on to explore how mothers, obstetricians, nurses and midwives perceived midwives. Some of the main themes to emerge included the following:

Midwives are caring people. ... mothers also included such concepts as respectful, non-intrusive, reassuring, and trusting. All interviewees considered the midwives' opportunity to establish a unique, sensitive, and valued relationship with the family during labour as most important. This relationship of midwives with mothers was perceived to be unique...

A characteristic highly valued by mothers and by midwives is sensitivity ... mothers, obstetricians and also several nurses perceived midwives to be part of the obstetric birthing team. ...

All four groups and families used the term intuitive in relation to a midwife's role and midwife's skills. Midwives were perceived to be knowledgeable people.

In an earlier paper Sledzik (1989) states:

Sensitivity, the ability to listen with an open mind and intuition were aspects of midwives' characteristics which mothers perceived to be most valuable. Honesty, trust, understanding, gentleness, and firmness when appropriate, as well as the ability of midwives to adapt to mothers and their families needs and idiosyncrasies were considered essential characteristics of midwives. How these mothers perceived midwives cared for them appeared to be related to how they and midwives themselves viewed acceptance of responsibility and accountability to:

1. mothers;
2. doctors;
3. their institutions, including their profession and colleagues; and
4. the confidence and pride midwives displayed in their work.

Later a mother's account of the characteristics of midwives according to her perception is recorded verbatim:

First of all a midwife should be able to:

1. develop a rapport with a woman in labour;
2. competently discuss issues which are of importance to you and your husband, because there is no time to do so in labour;
3. establish a trusting and respectful relationship, one in which the midwife can hear what the woman wants, and one in which the woman can hear what the midwife wants as well;
4. listen, that is most important; even if people can not express themselves well;
5. honestly explain to you any worries she may have;

6. know when to intervene and when to sensitively withdraw, and yet be there;
7. be caring to all people not just the ones they, that is the midwives can identify with, or with mothers who can help themselves.

How a group of people perceives themselves impacts on how that group behaves. How important is it then that midwives have a clear idea of their profession?

It is stated that midwives are autonomous, but in practice many midwives are reluctant to accept their independence.

Guilliland despairs in McLoughlin's article, 'There has to be a change in attitude among midwives too - they have to see themselves as independent'.

The Divisions of Midwifery

There is a division between midwives. Taylor and Griffiths (1992) highlight this division under the heading, 'Choosing Your Caregivers':

Midwives: Midwives have been the traditional caregivers of childbearing women for thousands of years. They are fully trained to provide antenatal care, assist at the birth and provide postnatal follow up.

Under this paragraph 'Domiciliary Midwives: ... Independent Midwives ... and Postnatal Care. Only Midwives' are the divisions made with a paragraph on each. McLoughlin (1993) interviews an independent midwife who states: 'When you become autonomous, you suddenly realise the responsibility you are taking on. Hospital midwives are as capable as us but they are undervalued.'

So again, do we need to define midwifery? Thompson *et al.* (1989) state:

Patton has argued that, 'A classification system is critical; without classification there is chaos. Simplifying the complexity of reality into some manageable classification scheme is the first step of analysis'. For nurse-midwifery to proceed in analysing practice and its effectiveness on health outcomes, some conceptual categories will have to be identified. We have proceeded to do just that.

Seven original concepts that describe the process of nurse-midwifery care have been identified. According to the ACNM philosophy, nurse-midwifery:

- is safe
- is satisfying
- respects human dignity
- respects cultural and ethnic diversity
- promotes self-determination
- is family centred
- promotes health.

In addition, cultural differences must be taken into account when defining any profession.

Conclusion

I still believe in the importance of a definition for midwifery.

However, I no longer can quote this definition word for word. The definition, like midwifery itself, is flexible, personal, and ever changing. This has been highlighted by the many different reports of how people view a midwife. There are guidelines which can help us to keep an overall cohesive philosophy, and the guidelines from the New Zealand College of Midwives encompass the important aspects a midwife practises in her day-to-day life. In considering it essential for each midwife to ponder on what she does and why, I challenge midwives to formulate individual definitions of midwifery, and to update these definitions as a midwife learns and grows truly wiser with the passage of time. For, there are many names for midwife: friend, sister, mother, confidant, confessor and comforter, nutritionist, psychologist, sociologist, herbalist, minister, advisor in well-woman care, and in truth, the 'Sage Femme' or wise woman, in whom the childbearing woman places her trust and confidence (El Halta, 1990).



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COMING EVENTS

**The 24th Triennial Congress of
The International Confederation of Midwives**
26-31 May 1996
Oslo, Norway

Theme: The Art and Science of Midwifery
gives Birth to a Better Future

Contact: Team Congress
PO Box 6
N-6860 Sandane, Norway

**Breastfeeding: Refresh, Renew, Revitalise+
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**Teaching Skills Courses for Childbirth
Educators and other Health Professionals**
6-9 May 1995, Adelaide
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Workshops conducted by Ronnie Pratt. All
workshops:

Contact: CAPERS 07-266 9573
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PO Box 567, Nundah
QLD 4012, Australia

ACMI National Conference
12-15 September 1995
Darling Harbour, Sydney

Speakers include:
Professor Lesley Page
Contact: Secretariat
PO Box 787, Potts Point
NSW 2011, Australia

**International Symposium:
The Vaccination Dilemma II**
1-2 April 1995
Aotea Centre, Auckland

Contact: The Immunisation Awareness
Society
PO Box 24, Kaukapakapa
Auckland 1250
Ph: 09-420 5801

National Sexual Health Education Workshop
20-22 April 1995
Lincoln University Conference Centre,
Canterbury

Contact: Diane Shannon
Public Health Service
Healthline South
PO Box 1475, Christchurch
Ph: 03-379 9480 ext 2214

Midwives Homebirth Workshop
May 27-28 1995
Thames

Speakers: Joan Donley, Maggie Banks, Jenny
Johnston and others

Organised by Kauraki Homebirth Midwives
Contact: Jenny Johnston
c/- PDC Waiamu 2850
Ph.: 07-868 2116

**Primary Prevention of Child Abuse and
Neglect**

1-2 May 1995, Auckland
4 May 1995, Wellington
5 May 1995, Christchurch

Contact: Claire Hurst, Co-ordinator
Building 43, Auckland Hospital
Private Bag 92024, Auckland
Ph: 09-379 7440 ext 6788

Paediatric Conference
27-29 September 1995
Sheraton Hotel, Auckland

Contact: Organising Committee
1995 Paediatric Conference
PO Box 12-736
Penrose, Auckland

**Australian College of Midwives, 9th Biennial
Conference**

12-15 September 1995
Sydney Convention Centre, Darling Harbour

Theme: Knowledge and Wisdom – The Key
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