

N E W Z E A L A N D

# College of Midwives



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# JOURNAL

APRIL 1998

**Developing & Crafting A Vision**

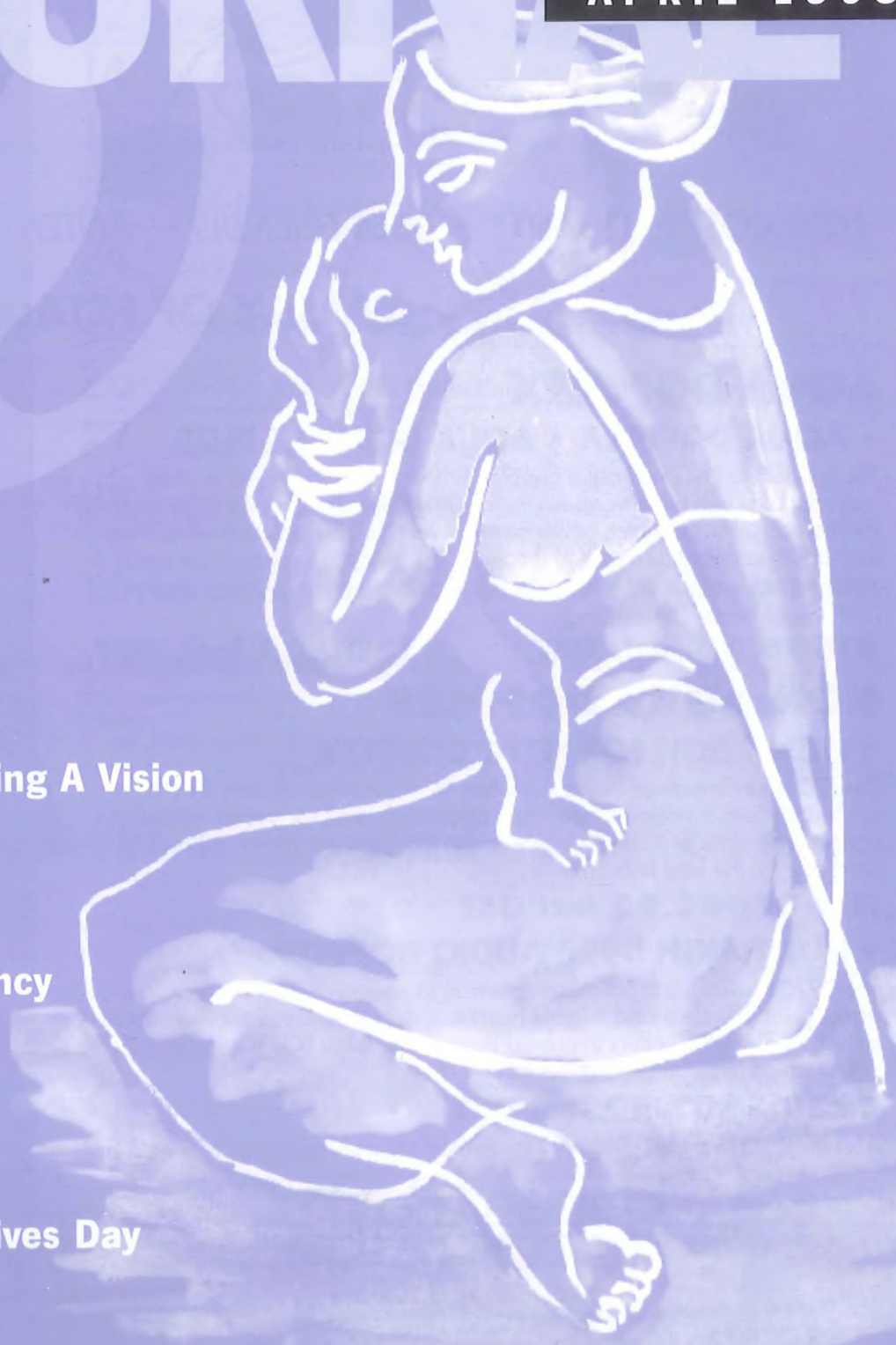
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ISSUE 18







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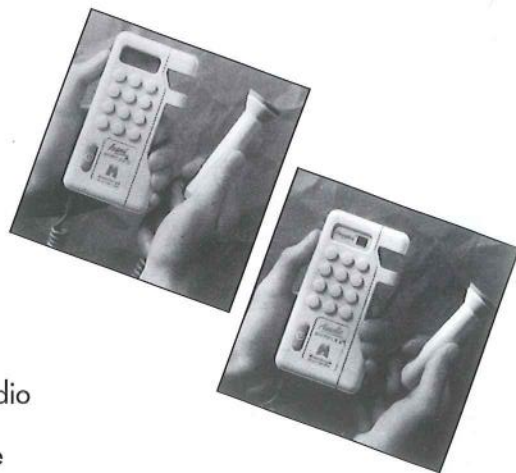
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ISSN. 0114-7870  
No. 18 - APRIL 1998

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

Single copies are \$6.00

**Editor:** Helen Manoharan  
PO Box 249  
Palmerston North

**Printed by:** Hannah & Young Printers  
120 King Street  
Palmerston North  
Ph: (06) 357-9039

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**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:**

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NZCOM Journal  
P.O. Box 249, Palmerston North  
Telephone: (06) 358-1917

**Submissions:**

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

**SUBSCRIPTIONS AND ENQUIRIES**

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

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# Contents

4	Editorial ~ Helen Manoharan - Letter to Editor ~ Sue Calvert (LEd SC)
5	Developing & Crafting A Vision ~ Sally Pairman
9	Surfing in Gisborne ~ Sarah Stewart
11	International Midwife's Day ~ Joan Donley O.B.E.
12	Women's Subjective Experience of Ultrasound in Pregnancy ~ Maggie Oakley
14	Reasons Why Nulliparous Women Continue to Smoke in Pregnancy ~ Catherine Mostyn Williams
18	Expectant Women & Inner Life ~ Joan Raphael-Leff
22	Wool Fibre Infections ~ Gelske Gardiner
24	Book Reviews
25	National Homebirth Conference Report ~ Rachel Clarke
26	The 5th Asia Pacific Conference ~ Karen Guillard
27	Poem - Midwifery ~ Martha Ponga
28	Nga Maia O Aotearoa's India Experience
31	Coming Events - Current NZ Vaccination Schedule

## Information for Authors

These notes are intended as a brief guide for contributors.

### Articles

Manuscripts submitted for publication should not have been published previously in any form. Ideal length is between 1,500-4,000 words plus figures, tables and references. Authors should use concise headings and subheadings to identify sections of the article. Diagrams should be supplied as computer generated or as high quality line illustrations drawn in black ink. Photographs should be of high quality. All illustrations and tables should be captioned. All pages should be numbered consecutively, beginning with the title page. Manuscripts should be submitted typewritten and double-spaced on A4 paper (one side only) with 2.5 cm margins all around.

Abbreviations should be written in full followed by the abbreviation in brackets for its first use, e.g. World Health Organisation (WHO).

Preferably the manuscript should be accompanied on a computer disk either Macintosh or IBM compatible. All submitted articles are peer-reviewed within the subject area of speciality.

### Author Details

Please provide the following details:

- Name(s)
- Occupation - if a midwife, what area of midwifery you are currently working in,
- Address for correspondence (this is not printed).
- Current telephone and fax numbers where the author can be reached.

### References (Harvard system)

In the text, cite the authors' names followed by the date of publication, e.g. Bowers and Thompson (1996). Where there are three or more authors, the first author's name followed by *et al.* will suffice. Style should follow:

Bowers, A.C. (1996). *Clinical Manual of Health Assessment*. 4th ed. London: Mosby.  
Bloch, S. and Harari, E. (1990). Family therapy: conceptual empirical and clinical aspects. *Current Opinion in Psychiatry*, 3 (3). pp. 359-367.



# When is a caesarian section not a caesarian section?

■ Helen Manoharan

**C**aesarian section: is it a childbirth operation or is it an operation performed in childbirth? We are reminded constantly of the ever increasing application of this procedure in the western world. With improved morbidity and mortality rates there is less chance of infection and anaemia, and a reduction of the risks of thrombosis.

There are many psychologically 'damaged' women who have not integrated their previous birth experience and are very fearful towards the imminent next one. Fundamentally, it's not that the previous birth was not a birth but an operation, as much as damage from attitudes of the professionals during her total care and the woman's feeling of loss of control.

Do we practise a philosophy of partnership? Are we honest - sharing knowledge in an unbiased way when there are deviations from normal and discuss different options and their pros and cons?

The period of greatest vulnerability is when a woman is deemed to be at risk or deviating from normal and is often subjected to 'tailored' information.

At this point, articulate questioning women may be interpreted as 'difficult' and non-trusting while some women / partners are afraid to ask, handing over control and direction unquestioningly. Once the decision has been made to perform a caesarian section, empowerment appears to be lost. This occurs because the powerbase is unequal, dominated by the negative sides of professionalism, institutionalism and its concomitant alienation.

Women and their partners should share the accountability and responsibility for

- the decision for a caesarian section
- who accompanies them to the operating theatre
- the subsequent care during and after the caesarian birth.

Sadly it is often carried out by professionals with the 'best of intentions' and in a value judgment of 'woman's best interests'.

Birth is an awesome process whether it is a normal delivery or a caesarian section. An operation performed to deliver the baby needs to be part of that process. We can then integrate their individual childbirth experience through empowerment physically, mentally and spiritually.

## Letter to the Editor

### Midwifery - The People Profession

Dear Editor,

One must congratulate Dr Cheryl Benn on her honest and thought provoking editorial about midwifery practice. Cheryl is so right, midwifery is a people profession, but midwives are frightened. The current atmosphere in practice is one of fear and trepidation. "Who will be: next" seems to be the coin phrase and many midwives appear to be waiting for that sealed envelope with 'confidential' stamped in red ink inviting them to the Nursing Council or to state their case for ACC.

One must question how we got to this point in practice. Sure, history can provide us with some examples of witch burning and the portrayal of the midwife as a drunk. But history can also provide us with examples of the midwife being a respected member of society. We could argue that some members of the medical profession have done their best to destroy midwifery since the 1990 Amendment to the Nurses Act gave midwives the right to practice independently, but to do so would be counter productive. Too much time and energy would be wasted on a pointless cause. We have to rise above this petty bickering when we have so much at stake.

What can we do to regain our sense of pride and indeed our professionalism? Sure 'united we must stand' and things have improved. New faces and fresh approaches have broken down the old guard and at least where I practice, the horizontal violence has dramatically decreased. Yet we need to ensure that we are perceived by the public as being a profession that has integrity and that we are the advocates for women and their children. Midwifery does have a place in New Zealand society yet as midwives we must act in a way that shows society that we are safe and we are a valid option. We can no longer be dogmatic, we must stop and listen to what others have to say. We must incorporate research into our practice and education must allow us to use read and speak the language of research at the same level as our competitors.

We must act now before we have our professionalism removed and we once again can only practice in the presence of a medical practitioner.

Yours faithfully,  
Sue Calvert



# Developing & Crafting A Vision: A Strategic Plan for Midwifery

■ Sally Pairman  
Midwifery Programme Leader  
Otago Polytechnic  
Past President NZCOM

A paper presentation at the NZ Nursing & Medico-Legal Forum, Wellington, 29 September, 1 October 1997.

## A Case Study

In the brief existence of only eight years the NZCOM has made huge strides in, firstly, developing its vision and, secondly, in identifying strategies through which to achieve this vision. It may be that some of our vision will strike a chord with you and help you understand that midwifery's determination to have control over its existence is totally to do with ensuring the continued existence of a woman centred, family-focused primary health maternity service in this country. Everything we are doing as a profession contributes to this vision. We want every pregnant woman to think 'midwife' when she discovers she is pregnant. We want every woman to approach childbirth and motherhood with confidence and joy. We want families to understand that birth is a normal, healthy life event which occurs within the community and over which the woman and her family have control. We want obstetric care to be easily available for those who need it, but not applied to those who don't. We want midwives to understand

what it means to be 'with women', for each midwife to have a personal relationship with the woman's ability to give birth and become a mother. We believe that when the majority of midwives in New Zealand practice independently and in partnership with women, the maternity system will undergo massive change in its power structures, women and their babies will have significantly better experiences and better outcomes, and society as a whole will recognise and uphold childbirth as a normal, healthy life event.

This is our vision. To show how we are achieving this it is necessary first to go back to the development of the NZCOM and show how we have come to understand partnership with women.

Partnership underpins midwifery at the individual/woman level, at the professional organisation level and at the political level. It is fundamental to our success and it guides the further development of our vision.

### Developing a Partnership between Women and Midwives

When New Zealand midwives regained their autonomy in August 1990, it was heralded as a triumph for all women in New Zealand. The years between 1988 to 1990 had seen deliberate political collaboration between women's groups and midwives in a planned national strategy to bring about legislative change. This political activity was organised through 'Save the Midwife' and then the 'Direct Entry Midwifery Taskforce', two organisations which brought together the combined energies of women and midwives in an organised way. Collaboration began when women and midwives recognised their common concerns and understood the potential strength of their combined political activity.

Women's need to regain control over their childbirth experience and midwives' desire to regain independence in their practice were complimentary. Women believed that the health professionals most likely to accept and support their right to control their childbirth experiences would be midwives. For midwives to have any power to change the way maternity services were delivered, they needed to have autonomy in their practice. Thus the initial focus of the campaign was on achieving autonomy and those women who wanted direct entry midwifery education as a way of preparing midwives who would better meet women's needs, were prepared to focus their energy on this in the first instance. The campaign involved repeated personal submissions by women and midwives to every politician in the country over an extended period of time, as well as formal submissions to the then Minister of Health, Helen Clark. Marilyn Waring provided strategic advice and the campaign was highly focused and effective.

Other contextual factors influenced the success of the campaign at that time. A Labour government was in power and women's issues were high on the agenda. There was a worldwide women's health movement and issues of consumer choice and control were increasingly being understood. In New Zealand the Cartwright Inquiry into the management of cervical cancer at National Women's Hospital and the subsequent report by Judge Cartwright highlighted issues of informed choice and consent, the consumers' right to control their own health care and the importance of involvement of consumers in policy and decision making in the health services. Pay equity was recognised as an issue for women as a women's health issue and women's right



to choice of providers of maternity care was accepted. Thus when Helen Clark introduced the Nurses Amendment Bill to Parliament it was supported by both sides of the house and women Members of Parliament, from all parties, added their support and assisted the passage of the Bill through the Select Committee stages.

The 1990 Amendment to the Nurses Act 1977 returned autonomy of practice to midwives enabling them to once again work independently of doctors in the provision of childbirth services. Midwives were able to once again work independently of doctors in the provision of childbirth services. Midwives were able to access necessary laboratory tests, prescribe drugs which may be necessary in the course of normal childbirth, admit women to hospital, continue to care for them there under their own responsibility and be paid at the same rate as doctors by the State from the Maternity Benefit Schedule. It also led to the development of direct entry midwifery education and gave the midwifery profession a place, as of right, on the Nursing Council of New Zealand, the regulatory body for midwives as well as nurses. The 1990 Amendment of the Nurses Act clearly established midwifery as a profession which is separate from nursing and also established midwives as practitioners of equal status with doctors in the provision of primary maternity services.

The achievement of midwifery autonomy in legislation was the result of conscious political collaboration between women and midwives. It was through reflection on this experience of partnership that midwives and women gained better understanding of the co-dependent nature of their relationship and recognised this relationship as one of partnership. This partnership was formalised with the formation of the New Zealand College of Midwives in 1989. The understanding midwives had of their partnership with women and its importance was evident when the constitution ratified by the profession established consumers as equal members at every level of the organisation (Guilliland 1989). The active involvement of women as consumers within the College has continued to strengthen midwifery. *"Women's participation in the midwifery profession has given midwives a public, legal and socially sanctioned mandate for practice"* (Guilliland & Pairman 1995, p.19). This social mandate carries with it a moral obligation for the midwifery profession to provide the kind of

**"Women's participation in the midwifery profession has given midwives a public, legal and socially sanctioned mandate for practice"**

Guilliland & Pairman 1995, p.19

service women want. Women's active involvement in the policy formation and processes of the New Zealand College of Midwives ensures that midwives uphold the needs and wishes of women.

The formation of the NZCOM was essential to give midwifery a 'voice' and the ability to influence its own future. This had proved impossible as part of the New Zealand Nurses Association where we were only a small part of a large organisation. At the same time midwifery recognised that its needs and those of nursing were often divergent. There was no recognition by nursing of midwifery as a separate profession. It was time to begin to dismantle the historical linkage to nursing and begin to re-establish midwifery as a profession in its own right. Midwives chose to do this in partnership with women rather than aligning ourselves with either medicine or nursing. The NZCOM consciously recognises that the only "real power base we have rests with the women we attend (Guilliland 1989, p14).

This experience of the midwife/woman partnership at a political and organisational level enables New Zealand midwives to recognise that their daily practice with women can also be one of partnership. It is this understanding of partnership which is expressed in the NZCOM Handbook for Practice (NZCOM 1993). Midwives see themselves as working together during their shared experience of childbirth. This practice of partnership is described in the monograph 'The Midwifery Partnership: a Model for Practice' (Guilliland & Pairman 1995).

What is important to understand is that it is through this partnership, or working together as equals, that midwives and women begin to experience childbirth differently and begin to challenge the still dominant medical model. Thus the partnership of the midwife and the woman through the childbirth process is one of emancipatory change which has

significant impact both within and outside of the relationship (Guilliland & Pairman 1995; Katz Rothman 1984). The midwifery partnership with women is, therefore, inherent in the political activity of midwifery, the professional organisation and the individual practice of many midwives in New Zealand.

### **Developing and Crafting a Vision for Midwifery**

Midwifery's vision is developed by the midwives and women who are part of the New Zealand College of Midwives. From a practising workforce of approximately 1800 midwives, the College represents over 1600. In addition there are consumer members in each of the ten regions of the College and consumer groups who join as affiliate members. The consumer members elect three representatives to the National Committee which is also made up of ten regional chairpeople (midwives), the President, the National Director and two midwifery students elected by the midwifery student body. The College is in partnership with the Maori midwives organisation and four Maori midwives from Nga Maia O Aotearoa me te Wai Pounamu are also part of the National Committee. The National Committee meets three times a year and develops policy for the College. The National Committee also shares and expresses the profession's vision for midwifery. This vision is created by midwives and women throughout the region, brought to National Committee by the regional representatives, shaped further at the national level and shared back to the membership through the regions. This consultative process of creating and shaping a vision is time consuming but it also enhances the shared sense of ownership as every member has a 'voice'. Our vision is further expressed through our publications, the Midwives Handbook for Practice, the Newsletter and the Journal through our actions as a College.

### **The Significance of Autonomy and Self Determination**

For midwifery our major goal is to achieve true autonomy and self determination in partnership with women. To be autonomous and self determining requires midwifery to be a profession and to have the ability to determine our own future.

Professions are granted legitimate autonomy by society. This autonomy enables professions to use the control of the tasks they claim as a source of power or authority



(Witz 1992). Professions are concerned with a unique body of knowledge to which access is limited and controlled by the professional group. In the same way entry to the profession is controlled and exclusive. Definitions of professions are underpinned with issues of control and the notion of 'expert' as separate and superior (Friedson 1970, Illich 1977, Witz 1992).

These interpretations of professionals do not sit comfortably with midwife's philosophical positions and definitions of their roles. The notion of 'with woman' is seen in stark contrast to the notion of 'expert'. Indeed, New Zealand midwives state in their Code of Ethics that: *the woman is the focus of midwifery care, and it is she, in partnership with the midwife, who defines her priorities for care*" (NZCOM 1993 p.49).

Barbara Ehrenreich and Deidre English acknowledge this tension when they say: "We must never confuse professionalism with expertise. Expertise is something to work for and to share: professionalism is - by definition elitist and exclusive, sexist, racist and classist" (1973 p.42).

Despite midwife's unease with usual definitions of professions, New Zealand midwives are conscious of the potential consequences of midwifery autonomy. As Ann Oakley and Susannah Houd (1990 p.114) point out: "the exclusion from childbirth of autonomous midwifery restricts the care options available to childbearing women and inevitably promotes the definition of childbirth as a pathological, medicalised process". Barbara Katz Rothman (1984) believes that for midwifery to develop an alternative body of knowledge about birth which can challenge medicine, midwifery requires to achieve professional status so it can control the setting of birth.

She says:

*I have come to see that it is not that birth is 'managed' the way it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed. And the way childbirth has been managed has been based on the underlying assumptions, beliefs, and ideology of medicine as a profession* (Katz Rothman 1984 p.304).

Katz Rothman argues that when a midwife starts doing homebirths, for example, she has to question "many of the taken-for-granted assumptions of the medical setting and the

medical model" (1984 p.304). The midwife develops a new way of explaining what she sees and thus develops a new, and a women-centred body of knowledge about childbirth.

For many NZ midwives it has been the move from being a dependent practitioner within the medical model to independent practitioner within the midwifery model that is the 'radicalising experience' which begins midwives questioning their previously held beliefs and understandings of childbirth. The medical model is understood to produce one kind of truth, the experience of normal birth in a context of continuity of care and independent midwifery produces another (Oakley & Houd 1990).

### Defining Independent Midwifery Practice

The midwifery profession has defined independent midwifery as the practice in which the midwife works in partnership with the woman to provide all care throughout pregnancy, labour, birth and the postnatal period on her own responsibility. The critical elements of 'independent practice' therefore, are the midwife's partnership with the woman, autonomy and continuity of care.

Independence is defined by the way in which the midwife practises and not by her employment status or where the woman chooses to give birth. Employed midwives can work independently as long as organisational structures support, rather than hinder, this independent status. The so called 'self-employed' midwives are, in fact, paid for their work through the state-funded health system which provides a free maternity service for all women in New Zealand. Not all self-employed midwives would be recognised as practising independently.

It is this independent status which makes midwifery a profession. The ability to provide the total childbirth service distinguishes midwifery from other disciplines involved in aspects of maternity care such as medicine and nursing. By using the notions of 'partnership' and 'woman-centred care' to identify its distinct professional identity, N.Z. midwifery has been reconstituted as a strongly feminist form of professional practice.

As Liz Tully and Belinda Mortlock explain (1997 p.7):

*In positioning midwives and birthing women as partners who share responsibility for the pregnancy/birth, midwives draw on feminist*

*understandings about the importance of the women taking control over their lives and health in general and their reproductive experiences in particular. This professional discourse of 'partnership' therefore puts feminist concerns about issues of responsibility, control, empowerment and choice in health/maternity care at the centre of midwifery's definition of itself as a profession with a 'moral obligation to work in partnership with women'. By redefining the professional-client relationship as one of 'partnership' in which each partner contributes knowledge and experience, it also embraces feminist criticisms of the hierarchical power relations inherent in the doctor-patient relationship and the consequent devaluing of women's knowledge.*

The current status of midwives as an autonomous and distinct professional group has disrupted "the former doctor/nurse organisation of the maternity field" (Tully 1993 p.57). New relations between the various professional groups have had to be negotiated. Key elements, such as 'partnership' in New Zealand midwifery's definition of its practice, can be seen as discursive resources which are used to make jurisdictional claims over normal birthing care. Partnership with consumers is an effective professionalising strategy for midwives (Tully & Mortlock 1977).

When articulating midwifery as a partnership of equal status NZ midwives have redefined the accepted view of professionalism. "Instead of seeking to control childbirth, midwifery seeks to control midwifery, in order that woman can control childbirth. Midwifery must maintain its women centred philosophy to ensure that its control of midwifery never leads to control of childbirth" (Guilliland & Pairman 1995, p.49).

**"the woman is the focus of midwifery care, and it is she, in partnership with the midwife, who defines her priorities for care"**

Midwives Code of Ethics Statement



## The Challenges

The status of midwives as autonomous practitioners has led to competition between midwives and general practitioners for the provision of primary childbirth services. Midwives, as a whole, now position themselves in significantly different ways in relation to doctors and in relation to birthing women, than they did prior to 1990. The dominance of medicine (obstetrics) over childbirth is being challenged by midwifery, with support from politically active consumer organisations, and professional boundaries are shifting. These competing claims are being played out against a backdrop of major reform of the health care system as a whole.

Since August 1990 significant numbers of midwives have left hospital employment to work as self-employed midwives in the community. Some of these midwives work in dependent relationships with doctors, but

"in 1997 the Regional Health Authority estimated that approximately 30% of all birthing women across the country are choosing 'midwife-only' care"

Sam Denny, personal communication, 20.6.97

many more now work independently offering 'midwife only' care or equal 'shared care' with doctors. At the same time hospital midwifery services have undergone massive change to reflect the care offered by self-employed colleagues. The growth of independent midwifery in hospitals was slower but is now a reality in most parts of the country. Continuity of midwifery care is a reality everywhere and in 1996 the NZCOM estimated that an average of 75% of all birthing women across the country knew their own midwife. Approximately 20% of these had 'midwife-only' care (Guilliland, personal communication 24-4-97). In 1997 the Regional Health Authority estimated that approximately 30% of all birthing women across the country are choosing 'midwife-only' care (Sam Denny, personal communication, 20.6.97).

It is clear that this massive change in the delivery of maternity care is challenging medicine, both financially and in terms of its domination of this part of the health system. Doctors are fighting back as the media is very

willing to be co-opted by doctors to spread their stories of doom and gloom about midwives in order to protect their interests. In fact it is not doom and gloom. The perinatal mortality rate has dropped since 1991 and we are beginning to see research evidence that the outcomes for women having 'midwife-only' care are significantly better than those having 'shared care'. The public is increasingly knowledgeable about who midwives are and how and where they practise. Our profile is high in the community. In a random survey of 3000 people by North Health, midwives polled top on the scale for extreme satisfaction from the client's last visit to specific health services (NZ Doctor, 3.9.97).

What has got worse for midwives and for women is the political climate. The women's agenda is no longer a priority and women have lost ground in the last six years. The philosophy is one of individualism, deregulation and competition. As Karen Guilliland said last year "despite New Zealand's claims to be an egalitarian society, women and midwives struggle to have their voices heard and their opinions valued when money and power are at stake" (1996 p.8).

We also have a Government largely of men who willingly believe doctors' public claims that their concerns are for safety and quality, despite their lack of evidence, and who seem to think that enabling doctors to gain control of the entire health system will somehow improve it. In this context, midwifery must fight hard to maintain its position and the gains it has made.

## Strategies for the Future

Essentially midwifery's strategies for the future are all part of achieving our overall vision.

### 1. Midwives Act

We need our own regulatory body and this will require a Midwives Act. A separate Midwifery Council would finally complete midwifery's control over its own profession and finally recognise that nursing and midwifery are two distinct professions.

Despite our best attempts and willingness to make the Nursing Council a 'Nursing and Midwifery Council' we do not believe this is possible. Our concerns are different. Our approach is different. Our separation is too recent and not well understood by many nurses. Finally dismantling nursing and midwifery through establishment of a separate Act will at last allow both professions to grow freely.

A Midwifery Council would provide clear lines of communication for midwives and for the public. The Council would be able to focus on midwifery issues to improve systems for ensuring midwife's accountability and competence. The partnership between consumers and midwives could be reflected in the membership of Council and therefore in the development of midwifery's regulatory functions. So too could the partnership between Pakeha and Maori. Nursing could then have nurses filling all of the professional places on the Nursing Council and could spend its time focusing on nursing issues.

### 2. Bachelor of Midwifery Degree as Entry to Practice

Despite the success of the three-year Bachelor of Midwifery programmes we have been unable to get the Ministry of Education to understand why we want the one-year programme for nurses to stop. Having two different programmes disadvantages nurses who find the one year programme (effectively 28 weeks in an academic year) is not long enough to allow them to make the shift to midwife and to acquire the skills and knowledge necessary to work as an independent midwife in today's climate. Instead they, and their lecturers, put in many more hours than are funded to make sure they can meet the standard. This is inequitous. It puts unnecessary stress on registered nurses and on the lecturers' limited resources within the midwifery programmes. Midwifery wishes to use the three year framework for all students, whatever their background, and through recognition of prior learning allow every student a programme which will meet her individual needs and take her to the same end competency level. Whilst the Ministry continues to insist that Polytechnics run the one year programme, and funds this at a higher level than the direct entry programme, registered nurses will continue to find midwifery education frustrating and stressful. It is not fair that they should not have the same opportunity as direct entry students to obtain the Bachelor of Midwifery degree and enter the profession with the same degree of competence and confidence.

### 3. Midwifery Provider Organisations

As doctors move more rapidly to form medical Independent Practitioner Associations (IPAs), and contract directly with the Transitional Health Authority (THA), the national maternity agreement known as Section 51 is undermined. Midwifery is



establishing its own Midwifery Provider Organisations so that midwives can continue to have a united voice and negotiate collectively. Our major concern is to maintain the 1990 recognition that midwives and general practitioners (GPs) provide work of equal value in the provision of primary maternity services. This pay equity was upheld by the 1993 Maternity Benefit Tribunal and by July 1996 Section 51 Advice Notice. The latest proposed amendment to Section 51 threatens to remove pay equity when midwives and GPs share care. At this time the College is considering its options under pay equity and human rights legislation.

## Conclusion

"To challenge and turn around decades of medical-centred maternity services to a consumer driven woman-centred service in such a short timeframe is a remarkable achievement. The challenge for women and midwives is to sustain the momentum of partnership and bring about long lasting and meaningful social change which continues to value women's status and experiences within the childbearing continuum. (Guilliland & Pairman 1995, p.51).

It is sharing a vision and understanding where this vision comes from and why it is important that gives midwives and women the ability to work together to plan the strategies to achieve the vision. Success will not be immediate and as we already know, challenging the power brokers has consequences. It is important that everyone within the movement has an analysis of the antagonism and personal abuse to which many midwives are subjected on a daily basis. It would be easy to lose heart. The most important strategy for midwives and women is to maintain their partnership. We can support each other, take heart from the daily increase in women who choose care from a midwife, watch with delight as more and more students leave our education programmes with confidence and political awareness, and recognise that by working together we have all the power we need. *References on request.*



# Surfing in Gisborne

■ Sarah Stewart - Midwife

I am a LMC midwife employed by Tairawhiti Healthcare in Gisborne. As an increasing number of midwives are becoming 'connected' it is an unique opportunity to share knowledge and support. I am not a computer expert, but I really enjoy being on-line, because it gives me access to an enormous amount of midwifery-related information and it allows me to be in contact with midwives throughout the world.

This column aims to share information about the internet - interesting web sites; midwifery mailing lists and useful e-mail addresses. So if you know of any, please contact me and the information can be shared with readers of this journal in future issues.

It is very pleasing to see last year that MIDIRS had internet access.

Their web site contains all their services such as book list and literature searches. One drawback of this service is you have to submit a credit card number to order books etc, if, like me you are uncomfortable with this concept, the answer is to order by phone. Another 'hitch' I have encountered is e-mails are not replied and several of my colleagues have found the same.

[Http://www.midirs.org](http://www.midirs.org) midirs@dial.pipex.com

Ace Graphics always reply very quickly to enquiries about book orders. Unfortunately, I am currently banned from contacting them, as I always end up spending a fortune!

[Http://www.acegraphics.com.au/](http://www.acegraphics.com.au/) ales@acegraphics.com.au

The British Journal of Midwifery went on-line last year as well as MIDIRS. Their home page contains articles about waterbirth, breastfeeding, epidurals and the cost of shared care compared to sole midwifery care in the British National Health Service. These articles have been published in previous journals, so are nothing new if you are a regular reader. I was unable to contact the staff through the page, and finally resorted to the good old telephone!

[Http://www.markallengroup.com/bjm.htm](http://www.markallengroup.com/bjm.htm)

The Midwifery Today magazine has an interesting home page.

[Http://efn.ora/~djz/birth/mt/mtbasic.html](http://efn.ora/~djz/birth/mt/mtbasic.html)

There is access to the Midwifery Today Directory of midwives and their e-mail addresses throughout the world. So, if you are not already in the Directory, register your name and details now. I have already had several enquiries about midwifery in New Zealand through this Directory. The directory, however, does not seem to be up-dated very often, so some details do become obsolete.

[Http://efn.ora/~djz/birth/mwlist952.html](http://efn.ora/~djz/birth/mwlist952.html)

There are also links to the Online Birth Centre free weekly newsletter, edited by Donna Dolezel Zelzer. This newsletter has news and articles, details of conferences, requests for information, and information about web sites and chat lines. I find that it is quite repetitious and dominated by North American issues, but it is very interesting none the less.

[Djz@efn.org](mailto:Djz@efn.org)

Other interesting links are to various mailing lists. A mailing list is an on-going opportunity to communicate with people with similar interests. One writes to an address and a copy of one's letter gets automatically sent to everyone on the list, and then people can reply if they wish. I have previously been on a midwifery list organised by Sabrina Cuddy, but proved to be too time consuming as there was a large amount of mail to wade through!

Sabrina also organises a list for people interested in VBAC and caesarian section called ICAN. I don't know anything about this list, except it especially supports women in the USA who are fighting for the right to have vaginal birth following a caesarian section, which is so much more of an issue than here in New Zealand. For further information, contact Sabrina Cuddy.

[Swnymph@fensende.com](mailto:Swnymph@fensende.com)

Nick Stanton set up a home birth list following the birth at home of one of his children, in Britain. The list consists of consumers as well as midwives, and there are always some lovely





home birth stories to read. I felt this list was very supportive of women wanting home birth, but I did not get the midwifery assistance that I was hoping for.

[Nick@kerensa.demon.co.uk](mailto:Nick@kerensa.demon.co.uk)

The American College of Nurse-Midwives (ACNM) has an attractive home page with links to various databases such as medline, and sites of interest for midwives as well as parenting sites. I could spend hours surfing the net from this homepage.

[Http://www.midwife.org/](http://www.midwife.org/)

The English National Board has connections with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, which is useful for British midwives such as myself, and New Zealand midwives wanting to work in Britain. It also has a free database, careers information and data about working in Britain. It is not as attractive or extensive as the ACNM, but is still very serviceable.

[Http://www.enb.org.uk](http://www.enb.org.uk)

If you are interested in breastfeeding, you will find the breastfeeding advocacy page useful. This site promotes breastfeeding, with connections to the Leche League and the Breastfeeding Hospital Initiative.

[Http://www.clark.net/pub/activist/bfpage/bfpage.html](http://www.clark.net/pub/activist/bfpage/bfpage.html)

If you want to know more about midwifery in America, visit Zelda Collett-Paule, who has a birthing centre in Alaska. Communicating with her and other midwives in America has made me realise just how lucky we are in New Zealand, in that we are virtually fully autonomous in our practice.

[Http://www.alaska.net/~zeldacrm](http://www.alaska.net/~zeldacrm)

One of my favourite web sites is the goodnews site, which belongs to Faith Gibson. She is a community midwife working in California, and her web site is full of information for midwives and parents. She also is very vocal in the fight for recognition of midwifery in America.

[Http://www.goodnewsnet.org](http://www.goodnewsnet.org)

I have not found many midwifery web sites in New Zealand, so look forward to hearing from anyone who has a web site here in New Zealand. The College of Midwifery is working on their own web site, so I will be very interested in visiting that site when it is up and running. One of my aims this year is to set up my own site, so any hints or tips on how to do this will be gratefully received.

Meanwhile, I want to start off a mailing list for midwives in New Zealand. Although there is a lot to learn from the midwives in North America, I would like to set up a list that is more relevant to midwives in the Southern Hemisphere. If you would like to subscribe, or have your e-mail address placed on a 'midwifery' list, please contact me at: [Mazza@clear.net.nz](mailto:Mazza@clear.net.nz)

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Last year the International Confederation of Midwives (ICM) theme was **Equity for Women**. The ICM urged midwives to highlight issues of unequal status of women within their countries and to bring these to the attention of their governments.

To date, the ICM theme has not yet been published. However, in view of the fact that during 1997 there has been no improvement in the status of mothers and babies, and since it is important to get publicity into the hands of the media early, we in the Auckland Region are proceeding with the unresolved 1997 foci - **Breastfeeding and Paid Maternity Leave**.

# International Midwife's Day

■ Joan Donley O.B.E.

## Breastfeeding

Breastfeeding rates continue to fall. In these market led health DEforms women and their babies are not getting the basic care and support to which they are entitled. They are turfed out of hospital in a matter of hours without any **subsidised home help**.

As a result, breastfeeding rates are falling with increasing numbers of babies being admitted to hospital with gastro-intestinal problems, the rates of postnatal depression are increasing, which is undermining parenting abilities. Meanwhile, the Prime Minister outlines her Code of Social Responsibility - for parents, not for Government.

This Government signed but **has not yet endorsed** the International Code and Supplementary Recommendations (Innocenti Declaration) approved by the World Health Assembly in 1990. This required that by 1995 all Governments should have:

- appointed a national breastfeeding coordinator and have established a multisectoral national breastfeeding committee... ;
- ensured that every facility providing maternity services fully practice all the 'Ten Steps to Successful Breastfeeding'
- enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

Although a three-member Taskforce to encourage breastfeeding in hospitals was set up by the Ministry of Health in 1994, the Ministry advised it would not provide ongoing funding in order to achieve the aims of the Code. The Government passed the buck to the RHAs. The RHAs saw the CHEs as the main focus and breastfeeding as a community activity. Finally, the Taskforce was told to go out and find its own funding (NZ Doctor 1994).

Following the UNICEF sponsored **World Alliance for Breastfeeding Action (WABA)** (Penang - 1996) **Karen Guilliland** and Ecuadorian paediatrician **Rolando Figuero** share coordination of the WABA Health Care Practices Taskforce. Karen therefore facilitated a NZCOM national **Breast Feeding Health Initiative (BFHI)** - July 1997 - to support the WHO / UNICEF 'Ten Steps to Successful Breastfeeding'.

Although, the Ministry of Health sees itself responsible for "strategic policy development" (Durham 1997) it did not consider it appropriate to be directly involved in NZCOM BFHI so did not attend the meeting to establish a nationwide breastfeeding promotion network (McLennan 1997).

Michele Lennan (Breastfeeding 1997) notes that the Ministry's perceived lack of commitment to breastfeeding is seen by many as a barrier. She also noted that society does not value women has mothers, therefore breastfeeding is not accorded the value it should have. Further, the Commerce Act (S27) supports the rights of infant formula makers - one 'can't restrict anti-competitive trade practices'.

In this free market economy, Ministry 'strategic policy development' does not include funding. BFHI is seen as a CHE enterprise lobbying for THA (now HFA) funding. Participants (who pay a membership fee) are committed to seek funding for the ongoing success of the BFHI project!

## Paid Maternity Leave

New Zealand along with the United States and Australia are only three unenlightened industrial countries NOT to provide paid maternity leave and health benefits under law. More than 120 countries, including many Third World ones, provide paid leave. The International Labour Organisation (ILO) to which NZ is a signatory requires 12 weeks paid maternity leave of at least two-thirds of regular earnings; no dismissal during maternity leave and two half-hour breastfeeding breaks during each working day.

## International Midwife's Day

- 5 May (Tuesday) serves to...

"highlight the unique role of the midwife as the person with the appropriate skills to care for women during pregnancy and childbirth, their families, and their newborn."

## References

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- McLennan, Jane. Nutritional Advisor for Mgr. Food and Nutrition. 20.11.97.
- Breastfeeding Scoping Project. Prepared for North Health, November 1997.



The United Nations revelation concerning NZ's backwardness has embarrassed the Government, although Jenny Shipley as Minister of Women's Affairs defends this delinquency on the grounds that NZ provides free maternity care!

That's a feeble excuse, especially since 25th January, when New Zealand took over the presidency of the WHO/UNICEF Board for one year. The role is to 'improve the welfare of mothers and children worldwide'. Now that we are talking about 'social responsibility' we could set a good example and start at home!

There will never be a better opportunity to 'enact imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement'. Surely, the WHO/UNICEF Board will reject the NZ Government's "expectations" that "Pregnant women will protect their own and their baby's health with the support of their partner."

Failure to provide paid maternity leave and financial support for BFHI can hardly be excused on the grounds of economic prudence when one sees the amounts squandered at the bureaucratic level.

CHEs, having to "work smarter" on less funding, are understaffed; CHE midwives are underpaid - but consultants/managers are doing very nicely. Under the latest restructuring - THA to HFA - Phil Pryke gets \$324,000 a year with 12 other managers getting between \$120,000 and \$200,000 each. The golden handshakes to the retiring RHA managers Garry Wilson, Chris Mules, Phil Edgington and Victor Klap - amounted to almost \$300,000. Early severance payments amounted to a further \$293,000.

To 'sell' the HFA Radio New Zealand was paid \$500,000 while Network communications is receiving \$19,000 a month. On top of that Australian consultants are being paid \$2.7 million to streamline the four RHAs into one HFA. One has to ask, for what are the new managers being paid? Treasury, the principal economic and financial advisor to Government, is advertising for a "Chief Health Analyst" offering a "competitive remuneration package." But, there is no money to improve the care for mothers and babies!

As ICM points out:

*Without healthy women, we will never have healthy children, and without healthy children, we will never have healthy nations.*

With its commitment to the world's women, ICM supports midwives in their efforts to provide safe and equitable care for women.

## Women's subjective experience of ultrasound in pregnancy

■ Thesis written by Maggie Oakley, Dunedin

A copy is available from the Library, University of Otago, Dunedin.

### Abstract

Virtually all pregnant women in New Zealand undergo an ultrasound examination during pregnancy. Previous studies have been conducted to find out how women feel about the ultrasound examination, however, these studies were carried out in specialist centres with adequate equipment and plenty of skilled staff. It is not known what happens to women and their families in busy hospital clinics or private facilities. This study has focussed on the ethical issues surrounding the use of ultrasound technology and the identification of any ethical issues raised by the women. By conducting this study I have a greater understanding of how much women appreciate ultrasound examinations. However, the study shows that we need quality standards so that all women in the region can benefit equally. Based on the findings of this study, there is evidently a discrepancy between theory and reality. Health professionals fell short in their obligation to respect the woman and to promote her autonomy as a patient, and failed, sometimes, to provide a quality service.

This study was carried out using semi-structured interviews. Altogether forty one women took part and were interviewed after the ultrasound examination. The survey included closed questions about the presence of any health disorders, or complications arising from this or previous pregnancies. The survey also had open-ended questions which collected more descriptive information. Quotes from the study participants are included in the discussion and serve to clarify and support the quantitative data. The data was analysed using qualitative and quantitative methods. This multiple approach to data collection and analysis in a single study has been referred to as triangulation. The questions were divided into six topics of interest; the reason or indication for the ultrasound examination; the nature of any costs or resource implications; the process of informed consent; the women's experience of the examination and what particular aspects they enjoyed; the possible issues of fetal or maternal rights; the influence of this technology upon women.

The results show that half of the women in this study had no clinical indication for the examination. Motivation for attending for an ultrasound was in the belief that it was appro-

priate health care and also a strong personal desire to find out more about the baby. The cost of ultrasound examination may be quite high in that it was found that routine examinations were frequently repeated. Women were not well informed about the purpose of the examination or prepared for possible adverse outcomes. The level of benefit gained by the women from the ultrasound examination varied. Those undergoing endo or transvaginal ultrasound examinations however found this technique to be humiliating and unpleasant. The ultrasound examination can provide potentially threatening information about the fetus. This is because termination of the pregnancy is the 'treatment' most often suggested. The control gained from this medical technology was felt by the women to have more benefits for the health professionals than for themselves. Although women valued the information as information about the baby just for its own sake. The predominant response by women to the examination was that it enhanced their personal knowledge of the baby. They felt an increased sense of attachment, and strengthened need to protect and relate to the baby.

The results of this study will be available for the women who participated, health professionals, and service providers. This research may help bridge the gap which currently exists in this area between women's subjective experience of technology, and the more objective attitudes as reported in the medical literature. The question of a clinically indicated ultrasound done well is not in question. The question of whether it is worth doing routinely involves values. At this level, elected representatives, the legal profession, patients advocates, or even better, women themselves should have a say. The Treaty of Waitangi establishes partnership as the foundation of social and political relationships in New Zealand. For this reason, if no other, experiences such as those described by women in this study should be recognised as valid evidence to be included in any debate about ultrasound services.

*We should be on our guard not to over estimate science and scientific methods when it is a question of human problems; and we should not assume that experts are the only ones who have a right to express themselves on questions affecting the organisation of society. Albert Einstein.*



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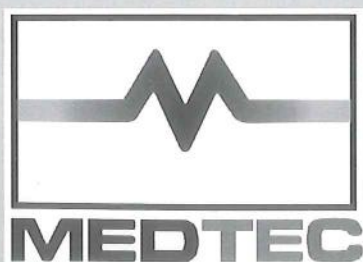
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# Reasons Why Nulliparous Women Continue To Smoke In Pregnancy

## Background and Information

A challenge to midwives, in their role as health educators, is to provide information about the risks of smoking in pregnancy in an appropriate, well-informed non-judgmental manner. As health professionals we are constantly made aware of the increased health risk of a women smoking whilst pregnant or after birth. As Cowan (1997 p.10) points out, influencing change in at-risk families requires a considered and skilled approach. One factor which seems to be missing in research evidence about the problems associated with smoking and pregnancy is an inquiry of women of why they smoke. We are presented with the evidence of the potential harm that smoking has upon pregnancy but very little evidence as to why women continue to smoke. It was this point which led me to formulate the research question 'Why do nulliparous women continue to smoke in pregnancy?'

## Literature Review

Cigarette smoking amongst women is a phenomenon of the twentieth century. The numbers of women who smoked increased after the first world war as a part of increasing female emancipation and sexual equality (Graham 1993, Floodgate 1989, Plant 1990). Following the second world war smoking had become an aspect of youth culture in both the sexes (Graham 1993). By the nineteen eighties cigarette smoking in females aged 20 years old or less had become a predominantly female habit. Smoking which had at the outset emerged as a symbol of female emancipation was to become a threat to their child-bearing role (Floodgate: 1989). The reason for this is the number of complications which are associated with smoking in pregnancy, such as premature delivery (Anderson et al, 1992), low birth weight (Sexton & Hebel 1984, MacArthur et al. 1987, Gillies 1992, Frank et al. 1994) still-birth and cot death (Golding 1994). A review of current research revealed that two previous researchers (Maclaine & Macleod-Clark 1991) had carried out an exploratory study into reasons why women smoked in pregnancy. This research's findings fell into three categories.

Firstly, there were women who disputed the evidence of the effects of smoking in pregnancy due to their own experiences or those of others.

Secondly, that the reasons that the women gave as to why they smoked were perceived by them to be too important to stop smoking and...

thirdly, it was related to the amount of support, both professionally and socially, which they received.

Gillies et al (1989) found that the two major reasons why women smoked in pregnancy was mood control and because of the addictive nature of cigarette smoking. Maclaine & Macleod-Clark's (1991) study was done whilst women were pregnant and involved both multigravid and primigravid women. Their paper summarised that the ineffectiveness of health promotion strategies with pregnant women could partly be explained by the relative poor awareness by the "scientific community" of what women's reasons for smoking were.

These researchers felt that it was a challenge to health professionals involved in the support of a pregnant smoker in pregnancy to investigate the multitude of reasons why they smoked. This challenge was supported by this writer.

## Research Method

How as a midwife researcher do you decide what type of research method to use for your study? Field & Morse (1985) and Strauss & Corbin (1990) suggest that it is the type of research question that determines which particular research method you use. The choice is either qualitative or quantitative methodology or a mixture of both, a process known as triangulation. As this combines both research methods it does appease the apparent necessity for research to be 'scientific' to be credible. I do not believe this to be a valid argument and give credence to qualitative research, which reveals rich data from the participants' perspective, to be of equal value.

A qualitative research method using the Grounded Theory approach was used in this study. Using this research method I hoped to be able to seek to understand and achieve an explanation for observed actions and situations. Davies (1995) makes the observation that this type of research methodology is a process of making sense of the everyday life of individuals within their social situation and presents a capacity to understand their social situation.

■ Catherine Mostyn Williams  
Academic Staff Member  
Waikato Polytechnic



The research question I had chosen to investigate embraces elements of social research, psychology and health promotion. Gilbert (1993) suggests that there are three elements to social research:

1. the construction of theory
2. the collection of data
3. the design of methods for gathering data

Grounded Theory embraces these three elements but the theory is discovered by a systematic data collection and analysis which leads to the formation of theory as recommended by Strauss & Corbin (1990). It obtains information based upon the participant's own perspective which means that theories are generated from the data collection, as opposed to quantitative research where a hypothesis or a null hypothesis is formed before data collection. In quantitative research the researcher has to make presumptions about the subject to prove or disprove their theory.

### Research Instruments

The research instrument used in this study was unstructured interviews. As Lofland (1971) says the objective of this type of interview is...

"to elicit rich, detailed materials that can be used in qualitative analysis. Its objective is to find out what is happening rather than to determine the frequency of predetermined kinds of things that the researcher believes can happen".

There is also greater scope for open-ended questions in an unstructured interview. Another advantage in using this type of interview technique is the potential for total freedom of expression by the respondents.

Of necessity the sample size was small. I interviewed 10 women who had birthed their first baby in the previous three weeks prior to when I interviewed them. To enhance the validity of the study I viewed the first two interviews as a pilot, but in fact these revealed excellent data which I subsequently used in the interview guide. I also transcribed the interviews verbatim as soon as possible after the interview.

I also remained true to the data to retain the 'credibility' or 'internal validity' of the study. The 'transferability' of 'external validity' is determined by how applicable the study's findings are to others. I would question how valid this is, is this the only reason for research? In Grounded Theory this occurs with a detailed description of the study population and their identification with a group (Strauss & Corbin 1990). I showed details about the study group in the appendix and the group they all belonged to was 'nulliparous pregnant smoking women'.

Finally 'reliability' another cannon of scientific research by which research studies are judged. This can be done by the potential replication of the study.

In reality a problem as in Grounded Theory the data analysis is completed by the researcher from the respondents' information, and it is dependent upon their analytical skill and creativity. This study was also an examination of human behaviour which can vary greatly in differing situations and at differing times, so replication of this study would not really be a viable proposition.

### Study Participants

These were a 'convenience sample' of ten women who birthed their babies in a maternity unit of a district general hospital south of central London. The selection was naturally occurring as they were the only primiparous women who delivered during the data collection period and fitted the selection criteria. These women birthed their babies in the time frame from December 1994 to March 1995. They had all had normal vaginal deliveries. Their ages ranged from 19 to 37 years old. It is interesting to note here that 80% of them had started to smoke by the time they were 16 years old. This reflects the findings of Scott (1985) and Cnattingius & Thorslund (1990) who reported similar findings. Each one of the interviews took place at a convenient time to the respondent in their home.

### Selection Criteria

1. First full term pregnancy of more than 37 weeks gestation
2. No recognised medical or obstetric complication in pregnancy
3. Normal vaginal delivery
4. Smoked throughout pregnancy
5. Consented to take part in the study

### Ethical Considerations

These were concerned with protecting the anonymity of the participants, the interviewing of newly delivered mothers and their potential vulnerability and the publication of the research findings. I also had to gain ethical permission from my employers to carry out the study. This was one of the most lengthy parts of the whole process.

### Data Analysis

The data from the study was analysed using constant comparative method of analysis. This method incorporates two features, namely asking questions of the data and making comparisons. This is known as open-coding. It is these two features which give the concepts in Grounded Theory their specificity and precision (Strauss & Corbin 1990). The data is broken down into small units, similarities become apparent and these are related to the phenomena under review.

### Research Findings and Discussion

The four categories which the researcher discovered in relationship to the phenomena were:

- **Conception of ability to change**
- **Women's views of cause and effect**
- **Avoidance of reality**
- **Coping behaviour**

I will now explain what I mean by these. The first one is **Conception of Ability to change**. This was the respondents' interpretation of their ability to change their behaviour. This category revealed some of their reasons for smoking and how they thought it affected them as in individuals. For example:

*"I tried at the beginning when I was pregnant and I have tried I would not like to say so many times... I think the longest I done was three weeks and then I was walking behind people sniffing their cigarette smoke... I can always find an excuse".*

or another woman said:

*"If I had tried to give it up I know what I am like when I go to give up I give everyone within a mile hell, so if I had tried to give up when I was pregnant it would have been impossible".*

Smokers' expectations of their abilities to change their behaviour is influenced by their previous attempts to quit. This could also be interpreted as a coping behaviour or as an indication of lack of motivation.

The second major category is **Women's Views of Cause and Effect**. This was how they explained their reasons for not quitting



such as:

*"so many people said to me sort of, my family and friends, that they had not stopped smoking when they were pregnant and their children had grown up quite healthy... so I didn't feel that I needed to".*

This type of response demonstrates how women are influenced by what they see as role models, other women smoking whilst pregnant or stories from those who have done. It was also interesting what they thought of women who smoked whilst pregnant for example:

*"in the past I have always been very scathing of women who smoked when they were pregnant and always thought it would be the one thing that would make me give up. I have always thought there is nothing worse than seeing a very heavily pregnant woman with a fag hanging out of her mouth".*

The third category **Avoidance of Reality** was the one that I found the most interesting, especially as I only interviewed nulliparous women. They expressed not only denial of pregnancy but voiced resentment towards the change in their identity with impending motherhood, two illustrative examples of this are:

*"I think for nine months its the last chance you are going to have in your life, well for some normality in your life, before the baby turns up".*

*"They tell you so many things now I think when you are pregnant and I know that it is good for the baby and I kept thinking well I am not allowed to do this I am not allowed to drink, I am not allowed to eat this I am not allowed to do that well I thought the only thing I am not going to give up is my smoking".*

These are interesting comments about how these women responded to the information given to them by health professionals. It makes you consider how information is received, do we just provide a list of do's and don'ts?

You could think that the comments made such as:

*"You are not really with it I don't think any way, are you when you are pregnant".*

*"I don't think for a long time that I did believe that I was pregnant it was not until the late stages and he was active and mobile that it dawned on me OH GOD I am pregnant and this thing is for real".*

## The main theory was 'inductively derived' with reference to literature about the subject which the researcher termed **Rationalisation of Smoking Behaviour in Pregnancy.**

are just examples of denial which these women use to cope with the guilt feelings of smoking in pregnancy. I found it thought provoking when combined with the comments previously made, how women might be responding to health advice in pregnancy. Graham [1976] maintains that the decision to smoke rests upon the dilemma of weighing up maternal happiness and the baby's health. The rationale explanation for this denial is "why stop if I don't believe I am pregnant".

The final category identified from the data is **Coping Behaviour**. This was because they gave the reasons why they continued to smoke as mechanisms for coping. Stress, from a variety of sources such as lifestyle changes, work, family problems, being pregnant, trying to stop smoking, was perceived by some to be the main decision for continuation of their behaviour. An example of this was:

*"I think, as I say it probably sounds an incredible cop out, but we are under incredible strain at the moment with our personal lives and somehow I have never felt strong enough to give that [smoking] up as well as everything else".*

One respondent found trying to quit smoking caused her stress in its self:

*"I did keep cutting down and then going back up and then cutting down in the end I just blocked it out of my mind and didn't think about it and just carried on with what I was doing".*

Again the concept of lifestyle changes relates to this coping behaviour. One respondent spoke quite lucidly of how she saw her actions and why:

*"Basically I could not drink which I don't do a lot anyway. I could not eat my favourite foods... and I just felt that all my little, my rights in life like having my favourite foods, had been taken away and smoking was the only vice left so that made me all the more*

*determined not to give up, because everything else had gone".*

Another said:

*"I am quite a drinker... you do have to change a hell of a lot of things you feel like you are giving up, I felt like for nine months I had to sit out of life".*

Why did they both refer to quitting drinking but continuing to smoke? Perhaps a greater emphasis was given to stopping drinking rather than stopping smoking?

These four major categories interlinked to one another and were conceptualised into two main categories which were **Justification of Actions and Perception of Pregnancy**.

The main theory was 'inductively derived' with reference to literature about the subject which the researcher termed **Rationalisation of Smoking Behaviour in Pregnancy**.

## Conclusion

This study only focuses upon a small number of women who had experienced one full term pregnancy. I hoped that the findings might influence midwives in their practice as health educators. As with other research into smoking behaviour in pregnancy this study also identified that pregnant smokers are influenced by the images of others, the addictive qualities of smoking, smoking as a coping mechanism and the influence that health professionals have upon their ability to quit.

It has been argued that smoking is increasingly associated with the lower socio-economic groups and social deprivation (Graham 1989). In this study three women were unemployed, four were employed in clerical posts and two were nurses which may support her argument.

The two factors which the researcher felt to be of the greatest significance are, firstly the respondents expressions about the unreality of their pregnancy and the effect this had upon their decision to smoke, and secondly the pressure of potential lifestyle changes required by others during their pregnancy. Their response to this experience and the expectations which they felt that others had of them could be viewed as a form of rebellion and part of the reason why they did not change their behaviour. They felt able to comply with certain types of health instruction but not all. It is apparent from this study that women are aware their rationale of why they smoked but they felt unable to change their behaviour at this time, which some might feel is the ideal time to do so.



Midwives providing care based upon a women-centred approach as recommended by the philosophy of the New Zealand Midwives Handbook for Practice (1993) should be aware of any behavioural action which potentially could cause harm to themselves or their baby. Midwives must appreciate the real problem that women may experience in quitting smoking during pregnancy. It is not sufficient to just ask the question "do you smoke" followed by "how many"? These questions should be followed by a sensitive inquiry about smoking and its place in their lifestyle and family. It is a challenge to midwives to understand why a woman smokes and to provide an appropriate support mechanism to each individual which may at some time enable them to potentially alter their behaviour.

### Acknowledgement

I would like to thank my two supervisors Betty Sweet and Margaret Adams, and the women whom took part, for their support in completion of this work.

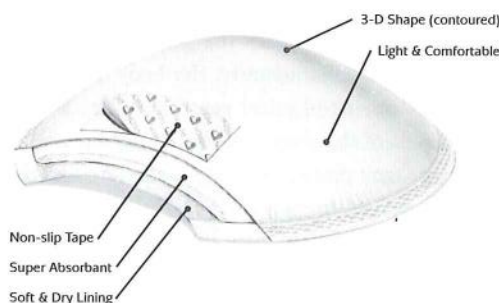
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### Footnote:

- Catherine's thesis is available in England-
- University of Surrey, Guildfield
  - Library, Royal College of Midwives, London

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**T**o my mind, the best way of ensuring the mental health of infants is to foster the psychological well-being of those caring for the baby before and after birth.

For the 40 weeks before being born a baby is in continuous intimate visceral contact with the mother, absorbing not only nutrients but as new research evidence shows, subtle biochemical changes of her emotional ambience.

Pregnancy is as old as humankind; physiologically it has hardly changed over the millennia but culturally it varies a great deal in terms of societal practices and personal expectations and in terms of each individual woman's representation of herself and experience of her baby to come.

# Expectant Women & Inner Life

■ Joan Raphael-Leff

Even in those many societies in which reproduction is defined as a natural and immutable process, pregnancy and childbirth are regarded as a time of increased emotional and social vulnerability during which the woman occupies a marginal position between past and future. As in adolescence, a pregnant woman is in a state of transition and having to reassess her identity. No longer only a daughter to her parents, she is about to become a mother - a transition which reactivates unverballed experiences of her originary relationship with the woman who carried her inside her womb as she now carries her own fetus. The pregnant woman's current psychic impression of her archaic mother will colour the way she experiences this pregnancy and it clearly makes a difference whether this 'internal' mother seems generously supportive of her daughter's pregnancy or resentful and vindictive about being usurped. An expectant mother is often beset by anxieties about transferring her affections to a new family of her own making which necessitates some loosening of primary bonds to her family of origin. In the case of a subsequent baby, she may feel disloyal or find it difficult to conceive of loving another child as she loves her first.

One disturbing facet of pregnancy relates to doubts about her capacity to live up to her own template of being a good parent, mingled with anxieties about meeting expectations of her partner and others and/or fears of repeating patterns of mothering she herself has experienced, for better and for worse.

During this time of emotional turmoil the pregnant woman oscillates between unconscious confusion and fusion with her mother pregnant with herself and also with the baby residing inside her who feels part of her, and who may represent her baby self as she imagines herself to have been in relation to her mother during her own gestation and infancy.

If we schematically delineate *three maturational stages* of pregnancy, we may describe the emotional preoccupations of the first trimester as *acute involvement with being pregnant*. In addition to these interchangeable identifications, the fear of being dispossessed now she is no longer in sole possession of her body, is exacerbated as in adolescence, by rapid bodily changes which dissolve the solidity of her familiar identity. Her body image vacillates, as, swamped by unfamiliar and sometimes distressing physical sensations, she looks into the mirror and a stranger stares back. Alterations of the shape and feel of her breasts, thickening of her waist, subtle changes in hair texture, complexion and expression modify her appearance. Her posture changes with the shift in her centre of gravity, her own bodily odours smell different and taken-for-granted attributes such as temperature registers, acuity of smell, familiar sensation of her touch pads and taste buds, bladder control, appetite, energy levels - all undergo unexpected variations which affect her sensual impressions and influence her habitual life-style. Heightened sensitivity, hormonal changes and increased vascularity of the pelvic area due to changes in her circulatory system all contribute to an intensity of sexual experience which she may inhibit if it feels like a frightening unleashing of unknown passions or seems immoral now she is about to become a mother.

Paradoxically, at this very time when she and her partner if she has one, are creating a child together, she may feel very much alone. Even among egalitarian couples pregnancy in-

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tensifies the sexual divide - she is the one experiencing the bewildering range of symptoms; *they* are having a baby but she is the one with pregnancy sickness and the bulging midriff.

Similarly, at this very moment when she seems at her most quintessentially feminine and doing what only females can, her fertilised ovum contains the residue of a male sperm, a genetically foreign element growing inside her, with a 52% chance of being male. Furthermore, having spent her life learning that we are each different, distinct and separate, suddenly someone else is occupying her insides raising further anxieties about being taken over. She feels that no one really can understand what a bizarre experience it is to have two people living inside one body - no one that is except other pregnant women. It is for this reason that for the past 20 years I have advocated that facilitating contact between pregnant women must be one of the prime aims of antenatal care.

Once movement is felt or seen on ultrasound, the woman enters a *second maturational phase* and preoccupation with the 'pregnancy' is replaced by awareness of the fetus who takes on a new significance as she realises she has to tolerate sharing her body with an autonomous being who is beyond her control. In the absence of knowledge about the baby growing inside her, the womb becomes a receptacle for the woman's fantasies, fears, desires, conflicts and expectations as she unconsciously weaves the representation of her baby from the stuff of her dreams and past experiences. Simultaneously, her partner too is engaged in composing his own fantasy baby and the two imaginary babies may not coincide at all!

In addition, the couple may have different ideas about their sex life or the nature of optimal birth, they may diverge in responses to ultrasound imaging or differ in their decisions about fetal screening tests.

Gradually as time goes on the pregnant woman becomes uneasily aware that in ad-

dition to her capricious occupant, a new organ, the placenta has come into being inside her within a hitherto inert space. The idea of the *two-way placental process* of give and take between herself and the fetus may give her pleasure and a sense of communion and/or may fill her with concern about not being sufficiently nurturing or alarm at being on the receiving end of the baby's waste products. Depending on her mood, she will focus on positive or negative aspects of this interchange, seeing herself as bountiful and nurturing or deficient and withholding. Likewise, her baby may appear benign, demanding or potentially harmful. Depending on her psychohistory and the configuration of her original family, the baby inhabiting her body may come to represent a silent repudiated part of herself or an emotionally charged figure from her past, such as one of her siblings. In cases where this idea of being inhabited by an alien or dangerous being becomes intolerable, a woman may resort to expelling awareness of the baby from her mind or actually having a medical abortion to rid herself of the bad aspect the baby concretely symbolizes. On the other hand, when a woman has a healthy degree of inner security and self esteem she may be flexible enough to tolerate uncertainty and to accept the losses her pregnancy and entails as well as the joys it represents. This acceptance of ambivalence enables her to elaborate a whole variety of both positive and negative day-dreams about her baby and herself as mother. If however her own self-image depends on defending herself against any awareness of imperfections she may feel compelled to suppress disturbing or painful emotions, idealising the experience of pregnancy, seeing herself as generous and superior and imagining her baby blissfully residing in an intrauterine paradise of her own provision. Ideally she would like to reinstate womb-like conditions postnatally and hopes for a natural birth that will provide a smooth transition from inside to an external state of undisturbed fusion. Needless to say, any complications in pregnancy, a premature birth or technological interventions during delivery may feel to her as if everything is spoiled since she has failed to give her baby the perfect start she envisaged. Likewise, if her ordinary baby fails to live up to the perfect one she imagined, she may fall into deep depression at having failed to maintain her lovely ideal.

But depression can have many sources:

another woman becomes depressed because she feels lacking in the necessary resources to nourish her baby, seeing herself as empty or worse, full of badness which endanger the vulnerable fetus. Unable to emulate her imagined mother she may have to resort to making a conscious effort - eating special foods or thinking good thoughts to compensate the baby for her own deficits. She may end up spending much of the pregnancy anxiously in need of external reassurance, in constant trepidation that something is doomed to 'go wrong' due to her harmful influence.

Conversely a woman may feel not depressed but persecuted: to her, she herself is excellent but feels she's been taken over by a parasitic invader who is sapping all her internal resources, or poisoning her with its waste products. This image of the bad fetus may represent some messy, needy or greedy split-off aspect of her own infantile self that she cannot bear to acknowledge. Resented symptoms such as nausea, tiredness or flatulence are ascribed to the baby's contaminating influence. Unless she can recover from this sense of persecution before the birth the newborn will seem exploitative, and breastfeeding feels draining or even cannibalistic. If her defences fail, 'retaliatory' thoughts of punitive vengeance may erupt, with possible enactment of violence.

*"When that baby looks at me with his glittering eyes, I feel like sticking my scissors into him"*

confesses a mother who has referred herself for therapy when her son is two weeks old.

*"He looks so evil, like a smug toad, just like my brother did when he was born. I can't stand the thought of him sucking at me and when he starts making demands I want to bash his head against a wall"*.

Perhaps even more suffering is experienced by a woman who feels that both she and the baby are bad for each other. This dangerous state of connected incompatibility may feel intolerable but she is stuck with it for the duration of the pregnancy. To protect herself she has to construct an emotional barrier of detachment. However, denying her emotional distress prevents her engaging with her own inner life, exacerbating the need to expel bad feelings by projecting them outside her orbit, which in turn may increase her sense of persecution by external forces. As she continues living her life as if she were not pregnant, she may unconsciously be putting the baby to the test of whether it can survive despite her bad-

She feels that no one really can understand what a bizarre experience it is to have two people living inside one body - no one that is except other pregnant women.



ness. In fact, she may resort to risk-taking in a gamble to prove concretely that her creative capacities will override destructive ones. The sense of the damage they can mutually inflict upon each other increases her conviction of the need for expert technological intervention to ensure the safe delivery of both herself and her baby.

Entering the third trimester, increasingly the pregnant woman's attention is diverted from the external world by ever-more vigorous activity within. Finally she reaches that moment in her pregnancy when, suffering from overweight, breathlessness, constipation and heartburn, she begins to believe that her occupant should now be viable outside her. Timing of this *third maturational phase* varies from woman to woman in accordance with her personal orientation, such that an expectant mother who idealises the baby's prenatal experience may wish it never ended while another who is concerned about her own negative influence on the baby or his on her may feel she can't wait for it to be over. During this last stage, preoccupation with the fantasy baby is gradually replaced with a realisation that there is a *REAL* baby inside who will soon be outside her and who is unreturnable.

For many mothers this is an alarming thought - not only because of anxieties about being given total responsibility for a fragile or ferocious being despite her own lack of experience with newborn babies but, as we have seen, because the baby can open a door to her own unresolved emotional past. Twenty-four hour a-day close and unmitigated contact with primitive feelings and primal substances are bound to evoke the eruption of suppressed infantile experiences in the mother herself.

Recognising pregnancy as a highly volatile period, most traditional societies provide a female guide to act as an intermediary between society and the woman, between internal forces and external demands. This 'mid' woman shelters her and acts as a bridge during this turbulent time of transition between the pregnant woman's familiar previous life and the monumental changes to come. Over the generations, midwives were known as 'wise women' - responsible not only for delivering an expectant woman but accompanying her throughout the stages of her reproductive journey. Available to advise a new bride on optimal ways of conceiving the baby of her choice, offering support, herbal and ritual remedies to aid fertility. During

pregnancy, the midwife ensures that the expectant woman follows strategies to encourage the baby's appropriate growth. These may include particular dietary instructions, avoidance of various foods, places, noxious substances or refraining from activities such as tying knots, deemed harmful to herself and/or the baby. In addition she may be expected to engage in proscribed activities and rituals to maximise positive influences and keep evil forces, mortality and morbidity at bay. In some societies her partner too may be expected to safeguard the baby's well-being by 'feeding' it regularly with his semen or ensuring the woman's cravings are met. Many of these rites acknowledge the emotional aspects of pregnancy, making prospective parents feel there is a constructive contribution they can make and helping them address anxieties about themselves and the baby during the slow transition to parenthood.

Pregnancy and birth are deeply arousing experiences - not only for the woman herself but for those involved with her. We have all gestated in and emerged from a labouring female body, and as Freud observed, birth is the prototype of all separations.

Increasingly, with industrialisation and urbanisation, the sense of traditional community is lost as are shared customs and continuity of female lore. I suggest that in the West the professional now replaces many functions of the extended family and conversely, in some cases, a whole variety of primary health carers may each take over one facet of care previously undertaken by one designated individual.

Some emotional concerns during pregnancy appear to be universal - experienced by pregnant women over the generations and in my experience while travelling over five continents, throughout many places around the world. I have referred to these as the 'Feminine Mysteries' centring around issues of containment, formation, preservation and transformation.

Thus, since the beginning of recorded history maternity care has been in the hands of women [illustrated by midwives Shifra and Puah who participated in the birth of Moses]. However, over the past few centuries in the West, pregnancy and childbirth have undergone a transformation. With the establishment of the Barber-Surgeon's Guild in 13th century England and rise of medical professionalism and exclusive right to use surgical instruments, maternity began to be regarded as an abnormal event requiring male clinical intervention. Delineation of the province of obstetrics was accompanied by suppression of wisewomen healers followed by several centuries of prosecution, witch hunting and even execution, until 1872 when female midwifery was finally officially reintroduced, albeit restricted to 'normal' labour. However, with medicalisation came control, professional distancing, centralisation in hospital care, pathologisation and technological re-structuring of midwifery too, within a *medical model*.

Pregnancy and birth are deeply arousing experiences - not only for the woman herself but for those involved with her. We have all gestated in and emerged from a labouring female body, and as Freud observed, birth is the prototype of all separations. Studying organisations, psychoanalysts Elliott Jaques and Isabel Menzies found that where the objective work-situation threatens to evoke primitive responses in professionals, the institution itself evolves strategies for protecting its members from the risk of being flooded by unmanageable anxieties. In hospitals, these mechanisms include treating patients as interchangeable and minimising recognition of them as individuals with emotional needs; maintaining an impersonal professional stance based on detachment from one's own feelings; depersonalisation of encounters by fragmentation of care, uniformity and routinisation of performance such that staff too are seen as interchangeable with each other.

In the wake of the Women's Movement, there has been greater consciousness of every woman's right to be treated as a 'whole' person, entitled to make decisions about her own body and to have her emotional needs acknowledged. Similarly, midwives have become conscious of the losses they themselves have incurred through depersonalisation of care. As a result since the mid-nineteen seventies a two pronged movement of dissatisfied female 'consumers' on the one hand and dissatisfied female mid-



wives on the other have brought about a shift from a medical model back to reinstatement of the wise-female intermediary.

Furthermore, this now has *official backing*. In April this year the Audit Commission's Report, (U.K.) acknowledged the double requirements in maternity care - the need for provision of 'women centred' services and the need to ensure job satisfaction for midwives. The Audit Commissioners observe that these goals mean recognising that emotional and interpersonal aspects of care are as important as clinical ones, necessitating both *individualised and personalised services*. This goal can only be achieved by midwives learning to understand the emotional aspects of pregnancy and the complex interpersonal dynamics and transference of highly charged emotions from past figures inherent in their work with pregnant women. Dealing as they do with the most intimate physical aspects of the pregnancy, midwives inevitably draw into themselves some investment of the early caregivers, and are therefore well-placed to provide succour in addition to rendering physical care. However, they may also come to represent forbidding or envious facets of past figures, and their benign acceptance is therefore very important in giving the woman permission to experience pregnancy in her own way.

There is a common belief that pregnant women ought to be docile and undisturbed and that to allow them to speak their anxieties is to open a Pandora's box.

However, a midwife who is not afraid of her own feelings can facilitate discussion and, by offering a listening ear to the concerns of each woman in her care can absorb, lessen and dispel some of the inevitable anxiety. However, in some cases, far from one carer, a woman may be seen by up to 40 different NHS healthcare professionals during a single pregnancy.

Recent projects such as Know your Midwife and the One-to-One project show that reducing to just a handful or less of known and trusted midwives can considerably enhance the woman's experience of antenatal care and reduces use of epidural, pain relief and monitoring during labour.

In a massive epidemiological study about to be published by the National Birthday Trust virtually all respondents expressed their preference to be delivered by a *known* midwife. Interestingly, this vast research project confirmed what I have shown in my own study with a very small sample of 80 parturients - that women vary in their conception of optimal provision during pregnancy and labour. In my in-depth study as I have described, I found that dictated by representations of themselves and their babies, women's subjective needs vary with some regarding birth as a medical event which must take place in hospital; they feel safe knowing they have the backing of technological interventions, and someone to wash and hold the baby while she recuperates from the birth. Others crave not this controlled 'civilised' birth but a 'natural' one with minimum 'interference', and want the safety of giving birth in their own bed amongst family, with a midwife there merely to 'catch' the baby before she puts it to her breast.

This difference is corroborated by the large Birthday Trust study which questioned over 10,000 women and found that given the birth place of their choosing, 98% of those having home births and 90% of the hospital group felt satisfied with their care, although neither would have preferred the other's choice.

Finally, to end on a practical note - when resources are scarce (as they are increasingly becoming in the National Health Service) it is my contention that Mental Health priorities must centre on three foci:

### 1. Preventive Measures

Given the loss of cumulative family experience and community support, I suggest that these must now be replaced by antenatal discussion groups in clinics and by preconceptional education long before that, in schools with class discussions about relationships, parenting experience and the emotional needs and capacities of babies. During pregnancy, I believe that female women-centred personalised maternity care is needed to foster a 'hierarchy of care' - enabling the expectant mother to feel 'held' so she can learn to hold her baby in her mind long before she holds him or her in her arms. For some women, this may be the warmest experience of mothering they have ever encountered and by learning to entrust herself to her trustworthy midwife's non-impinging support, not only is labour facilitated by this but fosters her capacity to trust her own body to give birth and for loving care of her baby.

A second priority in promoting infant mental health must be:

### 2. Detection of High-risk Groups

During pregnancy there are very high attendance rates in antenatal clinics for physiological monitoring. Increasingly, midwives tend to see the same clients over time and both these factors allow for simple screening of the emotional well-being of all expectant parents. This assessment may take the form of simple self-administered questionnaires to be filled out in the antenatal clinic coupled with training of midwives and health visitors to utilise their own powers of observation along lines such as the paradigm I have described. Inevitably, this will necessitate including a greater psychological component in the training of midwives and health visitors and their continuing education, now endorsed by the Royal Colleges of Nursing and Midwives.

Finally a third priority must be:

### 3. Having identified people in need of help, the next step is facilitating their early referral for treatment as soon as possible

Making psychotherapeutic help readily available during pregnancy makes emotional and practical sense - alleviating suffering and pre-empting future distortions in emotional contact with the baby, thereby reducing the difficulties, not to mention cost, of treating established conditions between mother and infant. Finally, early mother-infant therapy and/or postnatal support groups can mitigate maternal distress and restore the balance in a troubled relationship, thereby promoting the infant's mental health.

## The fifth National Conference of the NEW ZEALAND COLLEGE OF MIDWIVES INC.

26 - 28 August 1998,

Ellerslie Convention Centre, Auckland.

Followed by **the Homebirth National Conference**  
30th August 1998 (Venue to be advised)

**The journey from past to present - A decade of change**

Keynote Speaker - **Beverley Lawrence Beech**

Beverley is Honorary Chair of the Association for Improvements  
in the Maternity Service (AIMS) in Britain.

**Nicky Leap - Midwife / Author - Jackie Pearse - Legal Advisor**



**T**he risk of wool fibre infection is generally well known within the wool industry. However, a great number of doctors, midwives and nurses are unaware of this occupational hazard.

This survey was undertaken to measure the incidence and severity of wool fibre infections in female wool handlers.

# Wool Fibre Infections

■ Gelske Gardiner  
Previous Matron  
of Rangiora Maternity Unit  
Independent Midwife

The survey was undertaken with the assistance of Wools of New Zealand in the photocopying, distribution and collection of the survey papers. The help was greatly appreciated.

It was divided into two groups. One contacted through shearing contractors in North Canterbury and Otago using stamped self-addressed envelopes, the other group by Wools of New Zealand instructor Kerri Mann at wool handlers training courses in the South Island.

## Survey

Women were asked about their age group, their work in the industry and the number of years of service.

Further questions were asked regarding obstetric and breastfeeding history. The women were also asked if they had any wool fibre infections, what part of the body was affected, what treatment if any, and what they did to prevent infection.

The last question dealt with the effect of infection on their work, ie. time off and A.C.C. involvement.

## Results

The response overall was 43%; 42% in the postal sample and 44% in the training course sample. (One paper had to be discarded in the course sample as it was left blank).

## Age Groups

The largest number of workers fell in the 21 - 40 year age group. Only 10 respondents were outside this age group -

6	younger than 21	
4	older than 41	There were none over 61 years of age.

## Work

The majority of women were employed as shed hands. Some were employed in more than one position such as wool classer and shearer. Some respondents preferred the title "Wool Handler" instead of Shed Hand, more so in the training course group than the postal group.

## Years of Service

The average service time in the postal group was 10.07 years ranging from 1 - 20 years. The average in the training course group was 8.4 years ranging from 1 - 25 years.

There was a slightly larger number of women in the younger age group (16-25 years) in the training course group.

## Obstetric History

There were 13 nulliparous women (those who had not had a child) in the postal sample. Three did not answer the question. The average number of children was 2.2. In the training course sample there were 17 nulliparous women. The average number of children was 3.03.

## Breastfeeding History

Of those women who had had children, 79.24% breastfed their babies; 76.92% in the postal group and 81.48% in the training course group. The average period of breastfeeding in the postal sample was 3.79 months and 11.9 months in the training course group.

The result in the training course group could be incorrect as one respondent stated she had breast fed for 6 years - a most unusual feat in the New Zealand culture.

Of those women who did not breastfeed, the reason for not doing so was "did not want to" or "no milk". Of those who were not able to breastfeed, 50% had had breast infections.



## Infection Rate

41.8% of women reported having had wool fibre infections. That is 50% of the postal group and 38.6% of the training course group.

The infection ranged from skin rash to full blown abscess formation.

The area most affected was the breast - 81.5% of those affected. The next most affected area was the arms, following by hands and fingers, next legs and axilla with umbilicus last.

## Treatment

There was a marked difference in the two groups' response to this question.

In the training course group nearly half of the women required no medical treatment (47%), however in the postal group only 14% had no medical treatment. Medical treatment for those who needed it ranged from the use of antibiotic, cortisone and antihistamine ointment to oral antibiotics, lancing of the abscess and in one case eventual bilateral mastectomy. Only one respondent reported use of a poultice but failed to give further information.

## Prevention

A small number of women felt there was no point in preventing fibres penetrating the skin as in their words "nothing works, the fibres get into your clothes and no amount of washing gets them out".

The majority of women used glad wrap to cover the nipples, some used tape.

The next most frequent practice was

checking in the shower or bath and using tweezers to remove the fibres. Nursing pads and tissues inside the bra were next in line, followed by wearing a special bra, (ie. seamless or thick material), or Baa Bra, or wearing clothes considered most effective such as cotton shirts, long sleeved shirts and gloves. Some women preferred not to wear a bra, just a cotton T-shirt as they believed wearing a bra would trap the fibre in the bra and create problems. Four women remarked they found a Baa Bra too restrictive while working - 12 failed to answer the question.

## Effect on Employment

50% of those affected by wool fibre infections and requiring treatment had time off work. One respondent did not state the actual time off work merely saying days, weeks, months, so it is difficult to give an exact percentage. The shortest stated time was 1 week the longest 4 months. Only three women had claimed A.C.C., the rest were either unaware that this is a work-related condition or didn't bother to claim.

## Conclusion

As with all research, this survey raises more questions than those that were asked. However, it did give a clear answer to the incidence of wool fibre infection.

41.8% of respondents were affected, which is nearly half of the women taking part in the survey, and of those affected 71% required medical treatment. This has obvious implica-

tions as far as women's health is concerned and a woman's ability to breastfeed. All infections create damage to tissue and milk ducts are easily damaged and narrowed.

Time off work and lost earnings are of concern to those employed in the industry but also to the Wool Industry as a whole.

Further research is needed to determine if certain types of wool are more likely to cause problems. Some women felt cross-bred wool was worse, others stated fine wool was more likely to get into the pores.

Research is also needed into effective protective clothing to prevent wool fibre infections.

Length of time in the industry seems to affect the likelihood of infection. In both groups, those who had had infections and required medical treatment had an average of 12.4 years in the industry. Those with infections and not requiring medical treatment had an average of 9.3 years of service.

Those women who had not had infections worked an average of 7.2 years in the industry. Does the risk increase with years? From the above figures it seem so. Or do women become complacent about taking precautions? Are those women attending training courses more aware? Has prevention become more of an issue over the last few years?

These are questions that can only be answered by further research.

I would like to thank the women who took time to fill in the questionnaires and the shearing contractors for their help in handling them out.

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**PIGEON**



# BOOK REVIEWS

Author **Rosemary Jenkins.**  
Book Title **The Law and the Midwife**  
Publishers **Blackwell Science Ltd.**  
**London**  
Published **1995**  
Reviewed by **Jackie Pearse NZCOM**  
**Legal Advisor.**

It is always difficult to review the usefulness of overseas publications for midwives as the New Zealand position is so unique. Firstly, as registered health professionals, New Zealand midwives are largely protected from civil action due to the Accident Rehabilitation Compensation and Insurance Acts. Secondly, New Zealand midwives have a statutory recognition of their autonomy and concurrent responsibilities that is not found in other jurisdictions. Finally, an increasing number of New Zealand midwives work as independent practitioners and so fall outside traditional employer/employee relationships.

Despite these marked differences Rosemary Jenkins book is a useful addition to the current, very sparse literature on the law and the midwife. What is even more helpful is the fact that she writes in a clear and lucid manner which is very accessible to non-legal persons.

The first part of the book relates primarily to the English Health Care System but this is of interest to any scholar of international midwifery. Jenkins' discussion of common law principles is useful for midwives

wherever they practice. The insidious increase of exemplary damages actions against health professionals underlines the importance of midwives knowing what the law requires of them. Chapter five gives excellent practical examples of how things go wrong and some of the factors a midwife should consider if she is involved in a complaint.

Chapter six concisely covers the general legal principles of consent and then relates these to midwifery practice. Later chapters address the subjects of holding information, confidentiality, ownership of records and general employment issues.

Students are often critical of having to buy texts that don't directly relate to practice and I am therefore reluctant to make a blanket recommendation. The large amount of material that is peculiar to the British situation does tend to detract from its usefulness. I would however recommend Jenkins' text as a useful and very readable resource for nursing and midwifery departments or to anyone with a particular interest in medico legal issues and the health professional.

Author **Black, R.F., Jarman, L.**  
**Simpson, J.**  
Title **The Support of**  
**Breastfeeding**  
Publishers **Jones and Bartlett**  
Country and Date Published **Boston USA - 1998**  
**ISBN No. 0-7637-0208-0**  
Price **A\$ 72.00**  
Reviewed by **Sally McNeill**  
**Midwifery Lecturer**  
**Otago Polytechnic.**

The Support of Breastfeeding is Module One in a four module series designed as a self study aid for Lactation Consultants. This series was initiated in the USA recognising that there was no widespread educational programme of study for lactation consultants and varying degrees of preparation amongst the professions that support women breastfeeding.

This module is well laid out, with each chapter having a useful pre-and post-test section for the reader with the correct answers included at the end of the module.

The content takes a global and historical viewpoint as the development of breastfeeding in today's society is examined.

This is a useful guide for those midwives wanting to increase or review their knowledge in relation to the various determinants of breastfeeding or for those studying as Lactation Consultants.

Student midwives would also find this useful even though the focus is not a midwifery one and the social context set within American society.

Author **Pyne R.**  
Book Title **Professional Discipline in Nursing,**  
**Midwifery and Health Visiting - Third Edition**  
Publishers **Blackwell Science**  
Date Published - **1998**  
**ISBN No. 0-632-04086-6**  
Recommended Retail Price - **\$A50.00**  
Reviewed by **Helen Manoharan.**  
**Lecturer Manawatu Polytechnic.**

As with previous editions, Reg Pyne (the author) examines the concepts of profession and professional discipline. As you proceed through this book you encounter a number of case studies based directly on the UKCC Professional Conduct Committee cases heard during 1995-6, which invite readers to regard themselves as members of that committee and consider the judgments they would have made if faced with the facts presented. The question 'could this happen where you work?' is repeatedly posed as a challenge to the reader.

This book explores the territory of professional regulation and

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offers arguments by the proponents of deregulation.

The author explains his view of the essential elements and care principles of professional regulation and uses the UK system as an example of professional regulation in operation. This book is also about the standards and ethics of professional practice.

Overall, this book should assist you in developing knowledge and understanding of the conceptual issues inherent in theorising and the analysis of theory. Well worth reading and an invaluable guide to professional accountability.



**The National Homebirth Conference was held last year on the 17,18,19 October at Tapu Te Ranga Marae in Island Bay, Wellington.**

**The conference was the culmination of many, many months of work by the committee**

# National Homebirth Conference Report

■ Rachel Clarke  
Conference Co-ordinator

**W**e received a very positive response from most attendees at the conference. The venue was 'magical', the food was great, the organisation good and the atmosphere welcoming and friendly if not slightly noisy at times due to the large number of children and babies who attended. The best feedback received was from a long

standing homebirth midwife who said "it was the best homebirth conference she had ever attended". Some constructive criticism was also received which will be helpful to pass on to the committee who has undertaken to host the next homebirth conference.

The number of workshops offered was felt to be satisfactory, although some attendees noted they would have liked more workshops and more that catered to those without babies or children. Some felt there was too much business and not enough socialising! Ain't that always the case!???

For the committee the highlight was the presentation of our story by Play-back Theatre. The aim of Play-back Theatre is to honour people's stories and connect people to each other creating a deeper sense of community. For the committee it encapsulated our journey of exploring the issues connected with the Treaty of Waitangi and what this meant for us as individuals, as a committee, members of the Homebirth Association and conference hosts. There were many challenges and much learning along the way and though the conference is over, we are still very much at the beginning of our journey towards honouring the Treaty of Waitangi in the way the Association works. Our hope was that conference participants would take our story away with them in order to reflect on it and for it to bring a challenge to themselves as individuals and Homebirth Association members to deal with the meaning of the Treaty within their lives - personal and political.

We were fortunate and privileged to have Irihapeti Ramsden as our keynote speaker on

the Friday night. Irihapeti spoke about cross-cultural communication. She provided a framework for exploring Treaty issues and developing appropriate relationship with Maori - something the Wellington committee could have done with before we started!! Her message held some challenges for those of us who are Pakeha and how we think about issues relating to Tangata Whenua.

We were also deeply honoured to have Joan Donley - homebirth midwife and political activist extraordinaire share with us 'herstory' of the homebirth movement in New Zealand over the past fifteen years. I think that many people came away feeling informed and much more 'on board' with the work that has gone on in the past and the need for Homebirth Associations to continue to be politically active in the future. It was also a privilege to have Joan cut our 'conference cake' which was made for us by Ruve Kent-Johnston. It felt very uniting to hold hands and sing the words of the old favourite "We shall not be moved".

By now you will all be very familiar with our conference illustration which was the work of one of our committee members. We received many positive comments about the logo. There was, however, also much learning for the committee in relation to the logo, as issues were raised about the significance of the gecko on the original design. It was amended following feedback about the meaning of the gecko for some tribes and the



inappropriateness of this symbol for a homebirth conference. The gecko was removed from the design (but by mishap did end up on the cover page of the Journal). As a committee we accepted responsibility for our many mistakes and moved on with a greater awareness of the processes we needed to use in future re consultation.

To conclude I wish to thank all the committee members for their huge amount of hard work and to thank those consumers, students and midwives who attended and made it the warm, friendly and connected conference which people experienced. Thanks also for your financial support through purchase of raffles, products and t/sweat shirts.



In February this year Nga Maia representatives and I attended, on behalf of the New Zealand College of Midwives, the 5th ICM Asia Pacific Regional conference.

The first day's symposium was specifically for the 55 invited countries of the South East Asia Pacific area to examine the Safe Motherhood issues in that area. Speakers included the WHO personnel involved in women's health issues and ICM leaders who presented their views on midwife's responsibilities in Safe Motherhood. Curricula and regulation issues which affect safe motherhood were also addressed.

# The 5th Asia Pacific Conference

■ Karen Guilliland  
Director NZCOM

The second day was the open conference and was again a fairly set format with invited speakers. The luxury hotel and the formal proceedings were, in New Zealand's view, somewhat at odds with the culture of Asia Pacific and India in particular. The appropriateness of confining countries like Nepal, Cambodia, Papua New Guinea and India to a ten minute slot to try and explain their countries massive problems was seriously questionable. Organisers had obviously worked hard to produce a diverse programme but on reflection a more women-centred approach may have been to let the participants talk rather than be talked to. Nga Maia's presentation, in their own wonderful way, provided an example of how effective communal presentations can be.

Regardless, the enormity of maternal mortality was clearly articulated over the two days by some impressive and dedicated women.

There are 585,000 women dying in childbirth every year. The women in some countries have a 1:10 risk of death and/or a 15 to 20 percent risk of being left seriously harmed. The gap between male and female mortality is widening in many developing countries. The reasons include the low status of women, low literacy, poor nutrition, inadequate antenatal care and lack of trained assistance at birth. Insufficient essential obstetric services, poor referral and transport systems compound the situation.

We know that midwifery can make a difference. Government commitment to prevention at a top authoritative level is essential before anything will change but maternal mortality is preventable. The development of standards helps to make change happen. Countries must establish Safe Motherhood as a human right and realise that Safe Motherhood and social investment in women empowers women to ensure choices and facilitate the delay of childbearing and spacing of children. A skilled attendant at birth is another essential (only 53% of women in developing countries have access). Issues such as unwanted pregnancy and unsafe abortions must be addressed as does improved access to quality health services. The development and implementation of safe motherhood programmes need to consider and evaluate the cultural appropriateness, safety, and the physician's outcomes for women and their babies, if they are to be successful. Programmes need to be evaluated carefully.

Midwives have a powerful contribution to make. They must influence policy makers to a whole system approach, build partnerships, and promote teamwork and fusion of the traditional and modern. Advocacy, role modelling and health educators are roles for midwives. Midwives must remain up to date in their knowledge, maintain standards of practice, and provide holistic management of total care.

The midwifery profession must promote and support:

- Continuing professional education and development
- The removal of legal restrictions to midwifery scope of practice
- Community based midwifery skills
- Better data and information
- Improvements in female literacy
- Midwives in top policy making positions
- Resource investment

**New Delhi  
February  
1998**



The issues for both women and midwives are universal but the degree of hardship and misery which results in them not being met in developing countries is shame for us all.

New Zealand midwives can offer much. The evolution of our unique Polynesian influenced partnership culture is eminently shareable especially in the Asia Pacific region. Nga Maia o Aotearoa Te Wai Pounamu gave the ICM meeting some exposure to a collective whanau based service provision which was received very warmly. It was easily understood by the Asia Pacific nations and Nga Maia's overwhelming generosity of presentation role modelled a different way for many. Mina Timu Timu, Sarah McGhee, Joanne Rama and Estelle Marmont brought tears to the "seasoned" conference participants as the waiata rang out. Nga Maia's presentation of pounamu to ICM President Alice Sanz de la Gente of the Philippines will remain with ICM from conference to conference to remind the world of the plight and pride of indigenous peoples.



# MIDWIFERY

*When a woman first conceives, a lot of mixed emotions generate from within.*

*With most woman joy, fear, and most times a lot of questions.*

*The greatest needs for a woman, during her pregnancy is support,  
love and understanding.*

*I had the pleasure of playing a major role in supporting  
a woman during her first pregnancy.*

*However, I also had the pleasure to observe midwife at work.*

*To have a baby is a blessing, though to have a midwife is a good choice  
towards support and understanding.*

*But most of all, you 're given open choices, a choice to decide.*

*How? When? What? Where?*

*Your midwife is there from the start to finish.*

*They bring you comfort, knowledge, support and understanding.*

*Every woman needs to know the pro's and con's meaning:*

- Health during pregnancy,
- Home births,
- Personal changes,
- What's available,
- Your needs & wants,
- Education during pregnancy.

*Furthermore their love and care. It's a great thing to have a midwife, who loves and  
cares for you and your baby, no matter where!*

*Martha Ponga*



# Nga Maia O Aotearoa's India Experience

Nga Maia representatives from the four corners of Te Ika A Maui (North Island) attended the above conference with their NZCOM Treaty Partner Karen Guilliland.

It was great to have Karen's whanau along to awahi and support us. Rukmini Maya and Sian Burgess from Auckland were helpful. Rukmini could speak the language and understood the culture. Her bartering skills and advice on how to cope with breastfeeding mothers who were begging on the streets helped to "save us from ourselves..".

"Stone is the ancestor of us all"  
(from Song of the Stone)

**O**n Friday 20th we were allocated a 15 minute slot in the conference proceedings which overlapped a little into the lunch hour. Karen Guilliland introduced the Nga Maia presentation. She said that Nga Maia means brave, focused and courageous. It was her belief that Nga Maia (founded in February 1994) is the first professional midwifery organisation of indigenous midwives. Karen went on to say that in New Zealand, Maori and Polynesians have the highest incidence of poor health with alarmingly high rates of diabetes, obesity, hypertension and asthma. The formation of Nga Maia was maori midwives response to the needs of their people. The good news was that where there were accessible midwives offering continuity of care the birth outcomes for women were improved.

Mina Timu Timu, NZ College of Midwives Kuia or Elder, provided the beginning "karanga" to acknowledge the spirit of all indigenous peoples of the land and prepared the way for Joanne Rama of Auckland..

Joanne's korero (talk) outlined Nga Maia's spiritual and whanau (family) connections to the marae, the people, and to the land, mountains and rivers. She explained that we are always aware through whakapapa (genealogy) that the women we are working with and their whanau have similar and connecting links. Joanne spoke of her Grandfather's heritage and whanau links to the South of India; that this journey was special.

Joanne presented a pounamu (greenstone) that had walked the Peace Trails of Aotearoa (New Zealand) to ICM President Alice Sanz de la Gente of the Philippines.

This taonga (treasure) was gifted by Barry Brailsford, author of "Song of the Stone". The bowl with the pounamu (treasure) was inside the kete (basket of knowledge) with Nga Maia's vision that it would be the taonga (treasure) to start the indigenous midwives gathering at the International Conference in Manila next year.

It is stated by the elders that the pounamu goes to those with the greatest hurt and pain and those who have the greatest need...

Estelle Marment of Upper Hutt spoke about our partnership with the New Zealand College of Midwives. That the standards of practice are the same for Nga Maia as they are for pakeha midwives except there are cultural traditions and kawa (practices) that vary from tribe to tribe which Nga Maia practitioners need to know and understand. The Nga Maia Midwifery Standards Review process is similar to that of NZCOM's process. However a Nga Maia midwife can choose to be reviewed on the marae where she can present in a traditional manner using visual aids and be supported by her whanau. Nga Maia students use these opportunities as a learning experience.

Estelle also talked about the history of midwives in New Zealand and the legislation which gave us autonomy.

Sarah McGhee of Gisborne sang the Nga Maia Waiata Mihi Mihi to the indigenous people of the land:





Nga Maia O Aotearoa me to Waipounamu  
E Tu ake nei

*We are maori midwives from New Zealand  
who stand before you*

Nga Maia; E Karanga atu nei  
E mihi ki a koutou  
E Tangi kia ratou ma

*We; maori midwives call to you;  
We greet you all  
We grieve with you for those who  
have departed this life*

Nga Kaitiaki o Te Whenua; O Nga Maunga Nui;  
O Nga Awa Roa

*The guardian angels of the motherland,  
of the big mountains and the long rivers*

Awhi Mai; Awhi Atu; Aroha mai; Nga Maia

*We love you... Love us in return; Nga Maia*

Sarah then spoke of the ABC's of a marae based practice:

### A. Acknowledgement

The uniqueness of being individual. Ourselves as practitioners and ourselves as women. That we all have a very sacred or tapu aspect of ourselves. 'The aura.'

That this aura sheathe can become fragile through ill health, abuse or trauma. She cautioned the use of unnecessary vaginals which can further traumatise the aura sheathe for these women.

### Accessible and Appropriate Practice

Reclaiming traditional birthing practices.

### B. Baby, the woman's Body, Breastfeeding, Birth Experience, the Birth Plan.

Through the birth plan the women and whanau are empowered to take control of their birthing experience.

The importance of whanau participation and reclaiming traditional practices where birthing is seen as a normal part of life and death.

### C. Culture, Consent and Confidentiality

Whatever the culture, there are expectations and implications that can vary widely e.g. New Zealand Privacy Act legislation and the Code of Rights where women have the right to the information they need to make informed decisions.

As well as their oral presentation Nga Maia provided a visual display which included:

- Whanau participation - wharekohanga births
- Pool births
- Physiological third stage
- Breastfeeding
- Poster displays - no smoking or alcohol during pregnancy
- Nga Maia aura photographs - sharing how unique and diverse we look spiritually

The photographs and logos of "Baby girls are delicious", "Women can do anything" and "Women are wonderful" were particularly popular.

A set of "Te Mana Hauora" posters painted by Robyn Kahukiwa was requested by a Japanese midwife who loved the energy and colours. Another set of the posters went to Sister Anne Thompson of WHO to hang in her office in Geneva.

The display was centred around a large painting of the tree of life sharing the relationship of the unborn child to Papatuanuku (Earth Mother). This tree was surrounded by a priceless collection of gifts - kete, pounamu, taonga (treasures), bone carvings and paua shell jewellery. At the end of the conference each midwife was invited to take a gift and make a donation into the kete to help fund future indigenous midwives to future conferences. This raised \$5,000.

Nga Maia was given the privilege of closing the conference. Mina offered a prayer for the safe journey home and gave thanks to our matna (parent).

Sarah invited each midwife to find a midwife that she had not spoken to during the conference. They were to say 'my name is ..and may the spirit of the birth mother be with you'. Much joy and emotion for all midwives united by the conference experience. We all joined hands and sang "Now is the Hour" waving like gentle beings that we truly are.

The highlight of the conference for Nga Maia was being able to sit and listen to other indigenous midwives from the South Pacific Basin talking about their practices. As herbal support is a feature of Nga Maia's practice it was interesting to see that the herbs available in New Zealand grew also in sparse areas in New Delhi and Agra - specifically chickweed, lambs quarters and plantain. Calendula was grown widely in the few gardens to be seen.

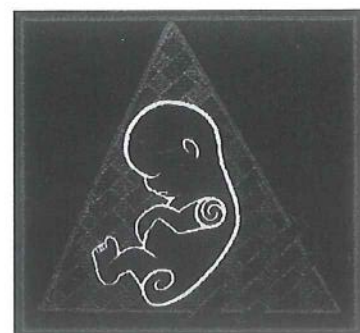
Indigenous midwives from New Zealand have travelled the path of the effects of colonisation in midwifery practices and women. This was acknowledged by other indigenous midwives. They too can make a difference wherever they are, and the ideas that we shared during our presentation were theirs to explore.

Sarah concludes, in closing let me share a conversation that I had with a hospital midwife from Calcutta. I asked her what care was given a mother immediately after birth. "The mother and baby share a bed with another mother and her baby. The next day (day two) both of these mothers and their babies are given a space under the bed." This is seen as a 'rest' before going home.

Noho ora mai.

"In the beginning we were rocks and mountains"  
(Psalms)

Nga Maia





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# COMING EVENTS

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- Salem, Massachusetts ..... March 5-8, 1998
- Portland Oregon ..... June 4-7, 1998
- London, England ..... September 10-1\* 1998
- Kyoto, Japan ..... November 30-December 3, 1998
- Ann Arbor, Michigan ..... May 12-16, 1999
- Mexico ..... Tentative for 1999

Further information from: -

Midwifery Today  
P.O. Box 2672, Eugene, OR 97402, USA.  
(541)344-7438 (800)743-0974  
midwifery@aol.com  
<http://members.aol.com/midwifery/>

## Birth Among Friends Conference

Hyatt Hotel, Canberra

Thursday 17 & Friday 18 September 1998

Hosted by the Australian College of Midwives Incorporated ACT Branch Speakers will come from overseas and Australia, and include Robbie Davis-Floyd, Karen Guilliland, Sally Pairman and Susan Maushart. The invited speakers will offer their wisdom around the topics of friendships in birth, women centred midwifery, technology, spirituality, power and knowledge in the birthing process, and mothering and fathering and midwifery.

If you would like more information contact: -

CONSEC  
PO BOX 3127  
Belconnen Delivery Centre  
ACT 2617 Australia.  
Phone: 02 6258 3681, Fax : 02 6258 0687

## 12th Birth Conference

### Innovations in Perinatal Care: Assessing Benefits and Risks

June 5-7, 1998

The Westin Hotel, Waltham, Boston, Massachusetts.

More details from

NZCOM  
P.O. Box 21106, Christchurch.  
ph. 03 377 2732

## Tairawhiti Healthcare presents: Maternity Care for the Future

Friday 30th & Saturday 31st  
October 1998

Venue - Boardroom, Gisborne  
Hospital,  
Ormond Road, Gisborne.

Tairawhiti Healthcare are pleased to present two days of learning and reflection for anyone involved in the maternity services.

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e-mail: [Mazza@clear.net.nz](mailto:Mazza@clear.net.nz)



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At Age	Injection	Injection	Sip	Cumulative Total
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3 months	DPTH	Hepatitis B	Oral Polio	=12 vaccines at 3 months
5 months	DPTH	Hepatitis B	Oral Polio	=18 vaccines at 5 months
15 months	DPTH	MMR		= 25 vaccines at 15 months
11 years	DT	MMR	Oral Polio	= 31 vaccines at 11 years
Total: 10 injections			4 Sips	= 31 vaccines

*In the next few years, introduction of vaccine combinations with more antigens combined in the same syringe ... will make more changes likely.*

Immunisation Handbook, Ministry of Health.

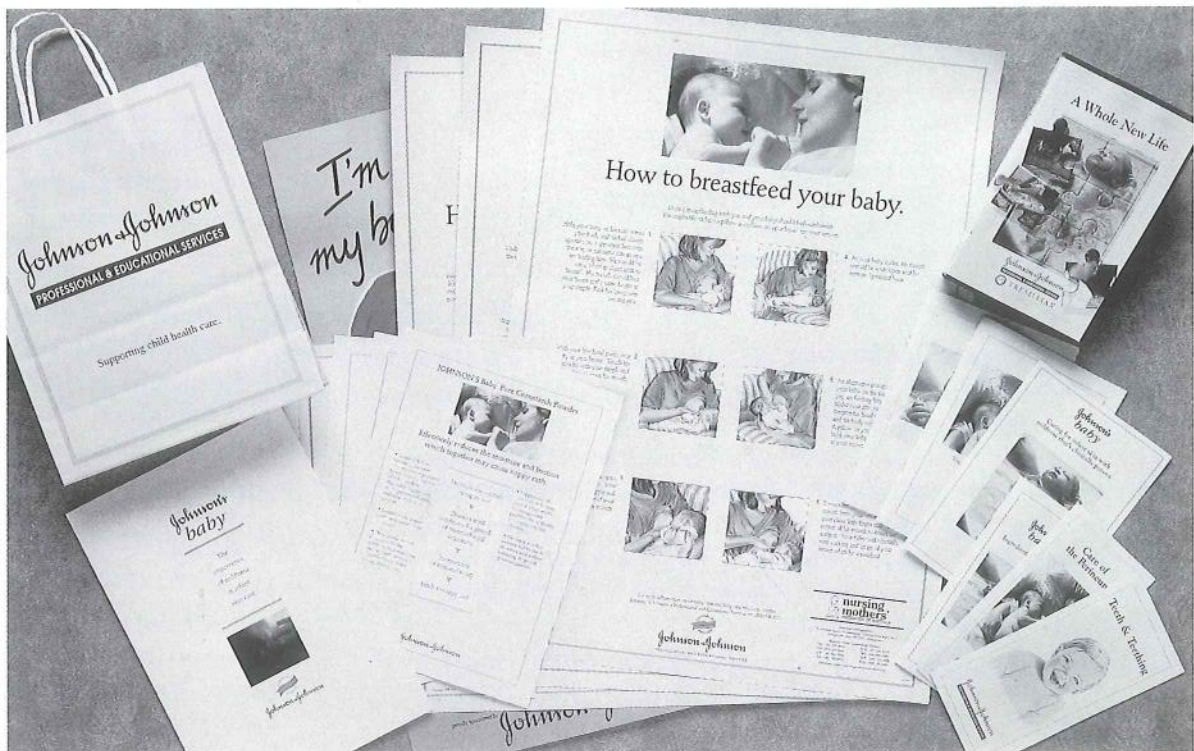
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