

N E W Z E A L A N D



# College of Midwives

# JOURNAL

JANUARY 2001

**Education Forum**  
**The Importance of Evaluation**

**Practice Wisdom**  
**Mentoring: A Personal Analysis**

**Original Research**  
**Feeding Baby: The Experience of first-time mothers**

**Students Corner**  
**The Family remembers**

**Opinion Column**  
**Midwives should nurture their young not eat them**

**NZCOM Directors Report**  
**Midwifery Autonomy in New Zealand**





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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.

**Submissions:** Submit articles and letters to the Editor

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## Let me introduce you to some of the Editorial Board

### Anne Barlow

Anne Barlow is a midwifery teacher and researcher at Auckland University of Technology. Since completing midwifery education at St Helen's Hospital in 1972 she has worked in a variety of midwifery settings, completing five years, recently, as an independent midwife in West Auckland. During independent practice Anne developed skills using alternative therapies with women and strongly supported women's choice in these areas. Anne has a passionate interest in research, particularly in aspects of midwifery related to education, and in evaluation and case study methods. At home, Anne loves to go for bush and sea walks in the Titirangi/Waitakere ranges, and practice meditation yoga.

### Linda Hasan-Stein

Linda Hasan-Stein has been the Professional Adviser-Midwifery, at Waikato Hospital, since 1997. She obtained her Master's degree in Clinical Midwifery Practice in 1996, from the University of Surrey, UK. Linda lives in Hamilton with her husband, a scottie dog and two chickens and is currently very occupied with a new baby.

### Maralyn Rowley

Maralyn Rowley is Clinical Professor of Midwifery and Women's Health at Victoria University of Wellington and Capital Coast Health. Her research and academic interests are in the area of evaluation of efficacy and effectiveness in maternity care using methods as diverse as storytelling and randomised controlled trials. Maralyn's background includes nearly 15 years as an independent midwife at both undergraduate and postgraduate levels, and participation in a wide variety of research projects. Currently, she is learning to cook properly (at last) and playing the role of mother of the bride for one of her children and grandmother for the daughter of the other. As a member of the editorial panel Maralyn states that she is enthusiastic about making available to a national and international audience, the brilliant work new Zealand midwives.

### Elisabeth Smythe

Liz Smythe began her midwifery career as a student midwife at St Helen's Auckland in 1978. She then spent five wonderful years amidst the birthing culture of Middlemore Delivery Suite. The next chapter of her life took her to Massey University. As a full time student Liz delighted in the opportunity to wrestle with ideas and questions. Her doctoral study explored the meaning of 'being safe' in childbirth from a hermeneutic perspective. The method involved writing and re-writing. She has learned the importance of crafting 'what one is trying to say.' Currently Liz is at the Auckland University of Technology (AUT). She states that it has been a privilege to be involved with midwifery education over such an exciting and challenging era. Her teaching is focussed at the postgraduate level and has now extended to include the diverse range of disciplines with the AUT Health Faculty. As a writer Liz appreciates that not all reviewers are 'all wise and all knowing' yet they can also be helpful in developing a writer's skills.

### Other Members of the editorial committee are: (Profiles forthcoming)

Cheryl Benn  
Rea Daellenbach  
Karen Guilliland  
Patricia Lane  
Sally Pairman  
Alison Stewart  
Mina Timu Timu

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Gillian White PhD, Associate Professor  
Massey University, Wellington Campus

## TRANSFORMATION

Transformation begins on an individual level and changes our world. The transitional passage is experienced as a personal, psychological journey, rather than a socially constructive one and the significance is often unclear. The epiphany or the "ah ha" moment comes with the awareness that the transformation is irreversible. As individuals we undertake a personal transformation when we enter the midwifery profession. Becoming a midwife changes everything; nothing is ever the same again.

In New Zealand, the midwifery profession has undergone a transformation over the last decade. The passage involved a paradigm shift in our individual and collective ways of thinking and included the incorporation of the concept of partnership into our identity. The transformation was an extraordinary event in the history of midwifery.

Our partners, the women, also undergo a major transformation, into the world of motherhood. Their passage into motherhood is an extraordinary life event yet one that often remains socially invisible, overshadowed by the dramatic events of the birth. Indeed, many women in the world "offer up to motherhood nothing less than their lives" Maushart (1997). Becoming a mother changes everything. Nothing will ever be the same again.

Partners under the Treaty of Waitangi, Maori and pakeha, have also experienced a transformation within New Zealand. The passage has been tortuous yet rewarding as the people of this country learn to incorporate the best of ideals into our way of life. Events accompanying the transformation have been extraordinary and New Zealand has been changed forever.

As a midwifery profession we promoted partnership with women and tangata whenua, an extraordinary and transformational paradigm. We started the journey together, midwives, women and Maori. Have we, as a profession, left them behind? Indeed, is our transformation complete?

The midwifery profession has become accustomed to taking autonomy for granted. As we passed through the turbulence of our birth and adjusted, we matured, gained a strong ego boundary, a clear understanding about what midwifery is, and an associated way of life. Do we know how our partners have responded? Do we know if women have gained a strong understanding about being mothers? Do we hear our Maori midwives voices?

Transformation involves re-organisation on a massive personal, philosophical, political, professional, psychological and structural scale. There is a growing field of research around the trauma of re-organisation which indicates that trauma is a predictable and normal response to a set of extraordinary demands. Individual and collective responses to trauma, however, can either result in a code of silence or in communication that proceeds obliquely. As we experience our transformation as a midwifery profession many have remained silent and others have communicated obliquely, within the safety of our 'in-groups.' Both are natural responses.

Midwifery, as a profession, is 'with women' in perpetuity, but at any one time an individual midwife is with a woman for only a short cycle. What connects midwives and women, however, is powerful – a universal recognition that we are all of women born. As Dinnerstein (1987, p.61) remarks "...female power...the earliest and profoundest prototype of absolute power."

Professional maturity, can be disabling. The expectations of us as a profession and each of us as individual midwives are high and put us at risk. There is a danger of forgetting what it was like 'being on the journey' once we have 'arrived'. Tension exists between our power as midwives and the co-dependency we have with our partners, the women; the tangata whenua. It is possible that in arresting the power of a hegemonic, predominantly patriarchal medical

profession we have replaced it with the power of an autonomous, predominantly matriarchal, midwifery profession ... "the prototype of absolute power".

Transformations for the profession of midwifery, for women, and for Maori, are irreversible. As we celebrated birth in Aotearoa/New Zealand at the Sixth National Conference of the New Zealand College of Midwives, 2000, I witnessed symptoms suggestive of a trauma of re-organisation, codes of silence and oblique communication. A few strong voices told us what women and Maori want. Are we going to listen?

In this edition there is a stimulating mixture of articles and letters from midwives, Maori women, and other consumers, that challenge the midwifery profession to respond to issues around transformation and the trauma of re-organisation. Some of the main aims of the NZCOM Review process are explored by Anne Barliow as she invited midwives to discuss the challenge of shifting to a new paradigm of midwifery care. Dawn Holland discusses how mentors play a key part in the process of transformation.

Experiences of first-time mothers attempting to learn how to feed their babies are presented by Ann Karlake Hendricks, as part of the process of transformation to Motherhood. Reena Kainamu appeals for collaboration to support constructive transformation for Wahine Maori. Issues of power and control are revealed by Irene Calvert. The writers remind us that we have not yet arrived. We are still on a transformative journey and we have the collective power to change the track as long as we do not remain silent, we engage in direct communication, and, above all, we listen.

Dinnerstein, D. (1987). *The Rocking of the cradle and the ruling of the world*. London: The Women's Press.

Maushart, S. (1997). *The mask of motherhood*. Milsons Point, NSW: Random House.

Addendum to:

NZCOM Education Framework  
(NZCOM Journal Issue 22)

"Midwifery education acknowledges the unique learning needs of maori."



## Hon Tariana Turia

Associate Minister of Corrections, Associate Minister of Health,  
Associate Minister of Housing, Associate Minister of Māori Affairs,  
Associate Minister of Social Services & Employment

Thursday, 28 September 2000

### Speech Notes

## Speech to the New Zealand College of Midwives National Midwifery Conference, Hamilton

Tena Tatau a hui i tenei ra. Nga mihi ki a koutou ki Te Ata-i-rangi-kaahu, me te kahui arii, ki a Waikato, ki a Tainui. Anei tenei awa o Whanganui me ona maunga e mihi ana ki a Waikato me ona maunga rangatira. Waikato taniwha rau, tena koutou.

Distinguished midwives, grandmothers, mothers, aunts, sisters, daughters, granddaughters, wahine toa - tena koutou, tena koutou, tena koutou katoa.

Thankyou for the invitation to speak with you today.

I am a descendant of the river of whanganui and like any river there are twists and turns, there are rapids and turbulence and there are places of serenity and calm where one can marvel at the beauty which springs forth from mother nature, from Papatunuku herself.

Today, I want us to celebrate the marvels of nature and the beauty, which springs forth from the work that you as midwives do. I want to affirm the position that you play in the preparation of our children and of our parents for life, for sisterhood, for brotherhood and if they so choose, or it so happens, for parenthood.

I would like to pay tribute to you and your work by quoting a passage from the Robyn Kahukiwa book "Wahine Toa", the words are those of Patricia Grace.

This is the story of Papatunuku the earth mother. First however it is the origin of:

### TE PO

"I am aged in aeons, being Te Po, the Night, the Night, that came from Te Kore, the Nothing.

First came Te Kore that could neither be felt nor sensed. This was the void, the silence, where there was no movement and none to move no sound and none to hear no shape and none to see.

It was out of this nothingness that Increase and Consciousness, and I, Te Po were born.

I am aged in aeons, and I am Night of many nights, Night of many darkness.

Night of great darkness, long darkness, utter darkness, birth and death darkness; of darkness unseen, darkness touchable and untouchable, and of every kind of darkness that can be.

In my womb lay Papatunuku who was conceived in Darkness, born into darkness - and who matured in Darkness, and Darkness in darkness became mated with the Sky. (Ranginui)

Then Papatuanuku too conceived, and bore many children among the long ages of Te Po."

[Grace, 1984:16]

Papatuanuku and Ranginui were at one time, one.

They are now apart. Between them, but not separating them are their children to whom they had given life and whom they had nurtured, and into whose hands they had given future, life and growth.

Within the Maori world we continue to celebrate both Rangi the Sky Father and Papatuanuku the Earth Mother.

You as Midwives and we as women need to take the time to celebrate what we do for mothers, fathers and children.

You need to celebrate the fact that you play positive roles in allaying the anxieties of expectant mothers. You allay the fears of the nervous fathers.

You also need to celebrate that within this cultural context - the extended family, whanau or agia are important, that the pakeke, the elders are especially important and I know that you respect and value the role that they all play.

You need to celebrate that you are skilled and the very positive contributions you make to families often cannot be immediately measured.

A number of my staff, my families and my daughter in laws remember very fondly the experiences of care and the very

professionally human manner in which midwives interacted with them.

In July I became a great grandmother for the first time. My Granddaughter Brook gave birth to a beautiful baby girl. We have named her Mere-Aneta. Her mother calls her Jayden.

The arrival of my mokopuna has made me take time to reflect on a number of issues such as birthing, family, children, protection, naming and relationships, which are important to us all.

The meaning behind the words "tangata whenua" is basic to any understanding of wahinetanga or womanhood.

As maori women we trace our mana wahine (female status and power) to Papatua-nuku, or Earth Mother.

It is from Papa-tua-nuku that we claim our identity as being the land itself and not merely the people of the land as the general translation suggests.

When a women is pregnant, the "whenua" (placenta) is the lining of the womb by which the foetus is nourished.

Following birth the "whenua" is expelled with the foetus and the umbilical cord. Rauru is a name given to part of the umbilical cord. Nga Rauru is one of the iwi of which I am a member - another connection. "Whenua" is also the term used for "land", the physical body of Papa-tua-nuku who is the provider of nourishment and sustenance for all her children.

The relationship we have with our whenua is indeed a special one, a spiritual bond with our Mother, Papa-tua-nuku, and a connection with the very source of life itself.

It is no coincidence then that the world is a sustainer of life within the womb and the source of nourishment after birth, the earth itself, is, in both cases, "whenua".

Indeed the burying of a newborn baby's afterbirth or whenua in the land of their ancestors is a ritual, which is increasingly

being performed by many younger Maori parents;

A ritual in which they participate as they recognise their connectedness with who they are and the special place they and their whanau have in Aotearoa, particularly that part of Aotearoa to which they have genealogical ties.

My great grand daughter's whenua or arfterbirth is buried at our urupa at Whangaehu, along with the whenua of all my other mokopuna. We belong to the Iwi of Ngā Wairiki, Ngati Apa.

The word "whanau" as many of you know, means to be born of; the word "hapu" means to be pregnant with; and the word "iwi" to us, is taken from the word Koiwi - which is bone of my bone, flesh of my flesh.

The words whanau, hapu and iwi are words of identity and belonging.

In the final analysis, we are all people of the land because we come through the land. As women we are "whare tangata" - the house of the people.

## Disparities

With the birth of my great grand daughter and the recent birth of another grand son, the issue of the disparities are at a personal level, again bought in to very sharp focus for me.

There is much we have to do. In the last 20 years inequality in New Zealand has grown faster than in almost any other country in the developed world.

That is shameful and not fair. A just and decent society would not tolerate it.

In Aotearoa, that inequality is unique in that it is the indigenous people who have born the brunt with the growing disparities between the life chances of Maori and other New Zealanders. The experience it must be said is not unique to indigenous people.

It is intolerable to this coalition government to see whanau, hapu and iwi, dispatched permanently, it seems, to the status of disadvantaged citizens in their own land.

The government is committed to reducing disparities in that what strengthens Maori will contribute to the strengthening of our nation overall.

In other words what is good for Maori will be good for New Zealand and you have an important role to play in this.

This government will not be deterred by mischievous ill formed opponents who delight in attempting to gain political capital out of attacking Maori Whanau, hapu and iwi initiatives.

We need to be concerned about these people who are playing on fears and are seeking to divide Maori against other New Zealanders by creating the impression that Maori somehow will gain an unfair advantage over them with the policies being pursued by this government.

The initiatives by the government are

attempts to ensure Whanau, hapu & iwi get what they have not been getting, which is why the GAPS exist in the first place.

Building the capacity, particularly of our women is going to be critical because the majority of our children are being raised by their mothers. Finding ways for Māori and other women to train as midwives that doesn't require them to leave their families, will be another critical development that needs to take place. You may well want to consider this matter, and how this organisation could assist this development to occur.

I believe we all want a society, which strives for social, political, economic and cultural inclusion.

A society, where all Maori parents will know that to give birth to Maori children will not be consigning them to a social, economic, cultural and political scrap heap that the growing disparities from the past appear to be have done.

You as midwives are one of the role models for our expectant mothers, for children they carry, and for the whanau into whom those children will be born.

You contribute to the development pathway this child will travel on when they enter this physical world and you build the confidence of a mother in preparation for motherhood.

Educate a man, you educate an individual

Educate a women - you educate a nation.

You know that a child in utero is sensitive to all that is occurring with it's mother and the whanau.

You know that negative experiences and anxiety of a mother, can effect the child emotionally, psychologically and spiritually.

" Certainly our old people knew. Many in fact had the same knowledge that you as midwives now have.

What I would like is for our people to reclaim that traditional midwifery expertise and professionalism.

It concerns me at times to hear that Maori knowledge is referred to as "cultural knowledge" and western knowledge is referred to as professional or clinical.

What I want to say here is that all knowledge has a cultural basis to it. What all of us need to do is identify the cultural base to our professional and clinical expertise.

We need to listen to each other a lot more and learn that we all have much to contribute to each other's professionalism and skill base.

In doing that we all contribute to birthing and nurturing processes which will benefit our nation, but more importantly our future generations to come.

In conclusion, I want to personally thank you all for the part you have played in

bringing many Maori children safely into this world.

The many Maori children who have expelled that breath of life - Tihei Mauri Ora!

# Midwifery Autonomy in New Zealand: How has it influenced the birth outcomes of New Zealand women?

Karen Guilliland  
MA (Midwifery)  
Director  
New Zealand College of Midwives

Until recently New Zealand and Australian midwifery has had little access to comprehensive national birth outcome statistics. A recent Australian study in the British Medical Journal (Roberts, Tracy & Peat, 2000) has given us a valuable bench mark. It analysed 171,000 women having a live baby during 1996 and 1997 in New South Wales, Australia. The strength of this study is in its size and the validity of the population database it studied. The results are a salutary cause for serious reflection on how environment and choice of care provider can influence birth outcomes even in healthy "low risk" women.

The study shows the often-talked about cascade effect of obstetric interventions when applied to low risk primiparous women. The more birth was managed, the more the interventions accumulated (epidural, induction, or augmentation). Among low risk nulliparous women in private hospitals only 18 per 100 achieved a vaginal birth without any intervention, compared with 28 per 100 private patients in public hospitals and 39 per 100 public patients. A similar pattern was shown for low risk multiparous women (39 per 100 private hospitals, 51 per 100 private in public hospital and 67 per 100 in public hospitals).

However for the purpose of this discussion, lets just look at the women whose birth experience ended with forceps or vacuum delivery.

**Table 1 Rates of Instrumental Birth by facility and intervention in NSW, Australia 1996/97.\*\***

Labour Management Before Birth	Forceps/Vacuum		
	Private Hospital	Private in Public Hospital	Public Hospital
No epidural, no induction, no episiotomy	3.9	4.4	3.1
No epidural, <u>induction*</u> , no episiotomy	6.0	5.1	4.3
<u>Epidural</u> , no induction, no episiotomy	15.7	15.3	8.3
<u>Epidural, induction*</u> , no episiotomy	14.7	12.4	9.5

\* included augmentation with oxytocics

\*\* Source: Roberts, et al 2000

The impact of an epidural particularly on instrumental birth outcomes is clearly demonstrated. New Zealand also has an increasing epidural rate. The Ministry of Health (1999) report found a significant correlation between instrumental vaginal births and epidurals.

The average rate of instrumental births for women in NSW, Australia is 25.7. How does this extraordinarily high figure compare to the New Zealand women's experience?

New Zealand's maternity services are different to New South Wales, Australia. Australian services are largely obstetric led with a high proportion of private obstetric care (33%). There is very little midwifery caseload management with 3.5% of Australian midwives believing they practice under the full ICM definition of a midwife (Commonwealth, 1996).

New Zealand has had 10 years of midwifery autonomy. In those 10 years maternity services have seen several major restructurings not only in relation to the overall health system but to maternity services in particular. Access to maternity service and outcome related data has been very limited as a result. This has made it difficult to measure the success or otherwise of the changes brought about by midwife autonomy.

Health providers have continuously called for the establishment of a standardised national perinatal database to bring some conformity to data entry and analysis.

Up until November 2000 the Health Funding Authority is the funder of all services and in charge of the \$350M national maternity budget. In 1999 the HFA convened a Maternal and Newborn Advisory committee to progress the establishment of a national perinatal database. The National Director of the New Zealand College of Midwives (NZCOM) is a member. The primary purpose of this group is to amalgamate and build upon the two major maternity data collection bodies of Health Benefits Ltd (HBL) and the New Zealand Health Information Service (NZHIS). The HBL data is around the actual service provider regardless of place of birth and is a payment based system where Lead Maternity Caregivers (LMCs) claim for services provided. Most claimants are self-employed midwives, general practitioners, obstetricians or hospitals which provide primary LMC services. Hospital midwives can be and are LMCs but are usually recorded as Health and Hospital Services (HHS) providers. The LMC concept was introduced in July 1996.



A woman registers with her chosen LMC and that LMC coordinates all carers during a woman's maternity experience, and is expected to provide the majority of care including being present during labour and birth. In 1998/99 over 50% of women had a self employed midwife LMC, 21% had a hospital employed midwife LMC, 13% had a general practitioner LMC and 12% an obstetrician LMC at the time of their labour and birth (HFA, 2000). These figures are approximate as there are difficulties around defining the LMC when care is transferred, especially for hospital midwives. Section 51 of the Health and Disability Services act advises of the terms, conditions and payments to LMCs. The advice notice sets out a comprehensive set of service specifications which the LMC is obliged to meet.

A woman can change her LMC when and as often as she wishes. Some LMC registrations (approximately 45%) have also been with providers (usually general practitioners) who do not intend attending the labour and birth and women must then re-register with another provider who will continue care. This changing of LMC can present problems when attributing outcomes to particular provider types.

The NZHIS data is based in the Ministry of Health and collects all hospital admissions, discharges and related diagnosis and treatments. It does not include the outside hospital services such as birthing units and home birth. This data is considered more robust than the HBL data.

The committee has experienced some difficulties with the merger of these two databases which make some of the data unreliable at the time of writing. These problems are solvable for prospective data.

It has however provided a significantly improved database on which to base some reasonably reliable trends and patterns in relation to maternity services. It has allowed us to start building on earlier findings (Ministry of Health, 1999; Health Funding Authority Review, 1999; Guilliland, 1998) and examine the health outcomes for women and babies in more depth.

Internationally the midwifery literature indicates there is also increasing opportunity for midwives to examine their outcomes (Declercq, 1995; Roberts, Tracey & Peat, 2000). This research gives New Zealand midwifery some useful benchmarks to measure its performance internationally.

Increasingly midwifery practice throughout the world indicates midwives do not only attend low risk screened women (Declercq, 1995, Miller, King, Lurie & Choitz, 1997). Guilliland's study of New Zealand self employed midwives and their clients also indicated New Zealand midwives attended the cross section of childbearing women (Guilliland, 1998). The LMC concept has further encouraged midwives to continue midwifery care utilising obstetric and/or other specialist consultations for advice rather than transferring the woman's care to secondary services. The practise of New Zealand midwives is probably more autonomous than most other western midwifery services as a result of the women centred LMC concept and the midwifery profession's commitment to a partnership continuity of care midwifery model. Women generally book with a primary health LMC, namely a midwife or general practitioner, and the care, which is largely around the woman's care plan, is delivered in the community. Postnatal day stay in hospital has dropped from 4.5 days in 1990 to two days in 1999 (MOH, 1999), and the LMC is responsible for providing midwifery postnatal care in the family home for four to six weeks depending upon need.

Just as the Australian context reflects Australian maternity services the health outcomes for New Zealand women and babies must also be viewed in the New Zealand context. It would appear that New Zealand may have a service delivery system that can make improvements in perinatal and maternal mortality and morbidity. Firstly though let us examine New Zealand data on instrumental birth outcomes.

The data on instrumental delivery in New Zealand is becoming more robust. The New Zealand Information Service (2000) provides information on the 1998/99 hospital National Minimum Data Set (NMDS). While this data is considered well populated and coded accurately particularly for method of delivery there may be some births not recorded under the NMDS.

**Table 2 Delivery Method**

DELIVERY METHOD	%
FORCEPS	6.05
VACUUM	5.56
BREECH	0.85
OTHER	0.06
<b>TOTAL</b>	<b>12.46</b>

Table 2 illustrates the national rate as 12.46, considerably lower than the NSW study but higher than the Netherlands 1995 level of 9%.

**Table 3 Instrumental Delivery (per 100) by ethnicity**

ETHNICITY	%
MAORI	5.09
PACIFIC ISLAND	4.79
ASIAN	13.17
PAKEHA	11.39
OTHER	11.50

Pacific Island and Maori women have a lower rate of instrumental delivery for their babies. Maori women also have lower caesarean section rates than Pakeha women. Asian women have the highest instrumental birth outcomes (16.22%) and the highest caesarean section rate (23.54%). Maori women are more likely to choose a midwife as their LMC whilst Asian women are more likely to choose an obstetrician. (HFA, 2000)

#### Place of birth

As in Australia, the environment or place of birth does impact on whether or not women will have a forceps or vacuum extraction. When broken down to where the mother is located by HFA sub-regions the rates range from 3.96% on the West Coast and 6.7% in Eastern Bay of Plenty to 22.6% in mid Canterbury and 24.93% in the Wairarapa.

When analysed by HHS however (Table 4) it becomes clear there is a number of women being referred out of their local birthing facility to the secondary and tertiary facilities. Provincial secondary facility rates are generally lower than the bigger centres. Wairarapa Health (25.4%) and Canterbury Health (23.3%) are showing the same unacceptably high instrumental birth rates as NSW. Some eight hospitals are above the New Zealand national average.

The fact that there is such a range in the instrumental delivery rate indicates that we have a provider problem rather than a population problem.

**Table 4 Instrument delivery rate by hospital facility 1998/99**

HHS Facility	Instrumental Delivery Rate
Coast Health Care	2.90
St George's (Primary Unit)	6.07
East Bay Health	6.70
Capital Coast Health	6.85
Taranaki Health Care	7.74
Northland Health	7.80
South Auckland Health	8.88
South Canterbury Health	9.06
Tairāwhiti Health	9.42
Health Waikato	9.85
Southern Health	10.00
Good Health Wanganui	11.06
Waitemata Health	11.10
Hawkes Bay Health	11.49
Lakeland Health	12.19
MidCentral Health	12.97
Nelson-Marlborough	13.80
Healthcare Otago	14.14
Auckland Healthcare	14.60
Western Bay Health	16.30
Hutt Valley Health	18.24
Canterbury Health	23.37
Wairarapa Health	25.49
<b>Comparative Values</b>	
New Zealand National Average	12.46
United States of America (1997)	15.00
New South Wales (1997)	25.70
Denmark (1998)	12.60
Netherlands (1998)	9.00

Whilst as midwives we do not actually perform the intervention, we have input into all births. What is the role we play in these outcomes? What is the role of the referral guidelines? Are our referral thresholds too low or are the politics of power and fear the driver of these outcomes? We need to find answers for these questions if women are to benefit from our care.

It is useful to consider the bigger picture when questioning practice as no outcome exists in isolation or is immune from the environment in which it happens. The New Zealand maternity environment has however achieved improvements in many outcome measures.

#### Perinatal and Maternal Mortality

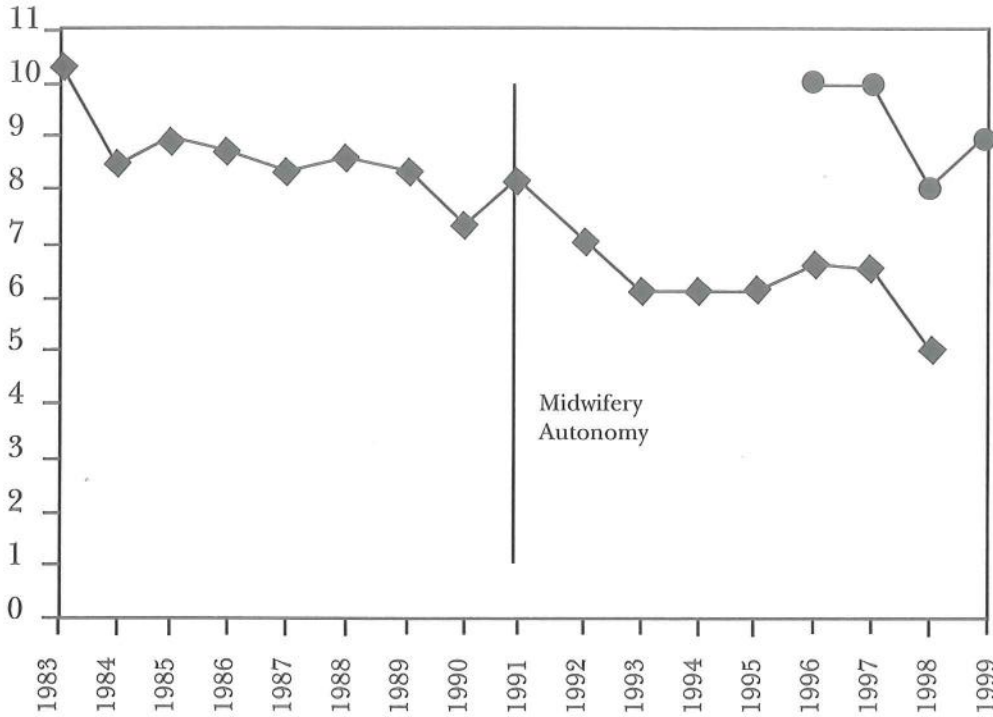
The latest data indicates perinatal mortality rates to be dropping overall and the 1998 and provisional 1999 figures are the lowest ever recorded. Other indicators of morbidity have remained static or slightly improved (Ministry of Health, 2000).

The definition of perinatal death changed in 1996 to include all deaths from 20 weeks gestation to 1 week postpartum.

Prior to 1996 deaths were recorded from 28 weeks gestation to 1 week postpartum.

Prior to 1996 the Perinatal Mortality Rate was defined as 28 weeks gestation to 1 week postpartum. In 1996 the definition was changed to 20 weeks gestation to 1 week postpartum.

**Figure 1 New Zealand Perinatal Mortality rate per 1000 live births (1983-99)**

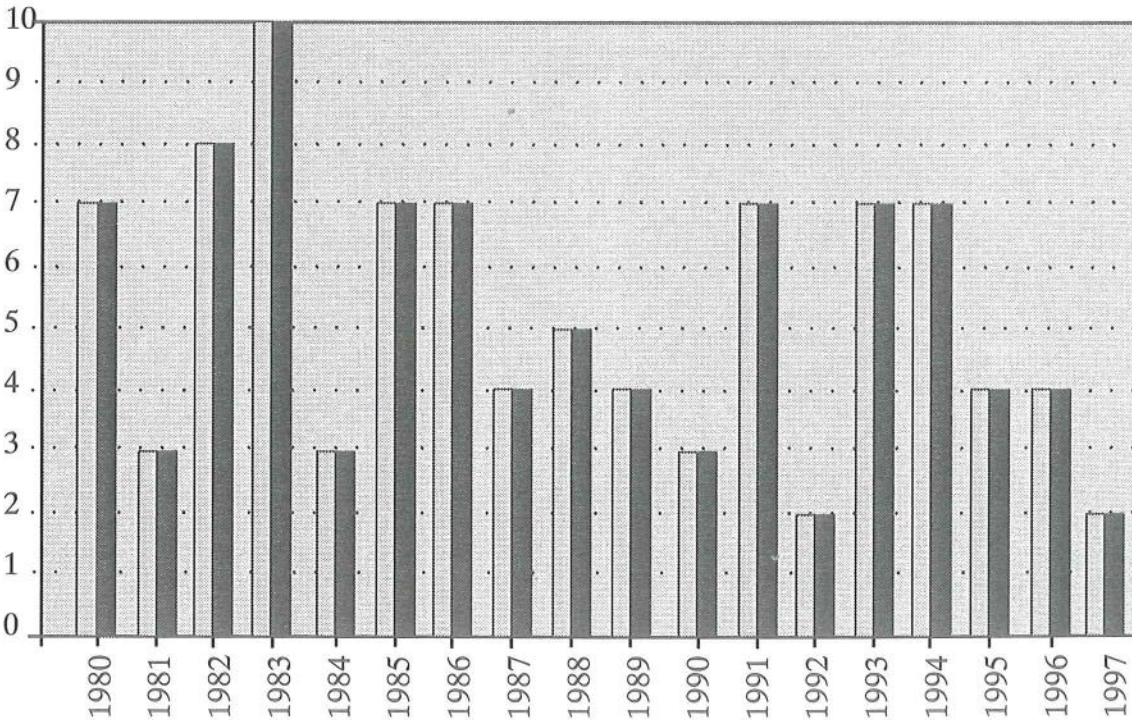


Source: New Zealand Health Information Service, Ministry of Health, 2000.

Figure 1 shows that perinatal mortality has slowly improved over the period and the latest two years are the lowest ever figures. The 1999 rate is provisional. Definitions of the term perinatal differ from country to country so comparisons can be misleading. Most countries' definitions start later than the New Zealand 20 week definition. When allowing for those differences New Zealand rates are better than Australia, Canada, United Kingdom, Holland and Denmark (Ministry of Health, 2000).

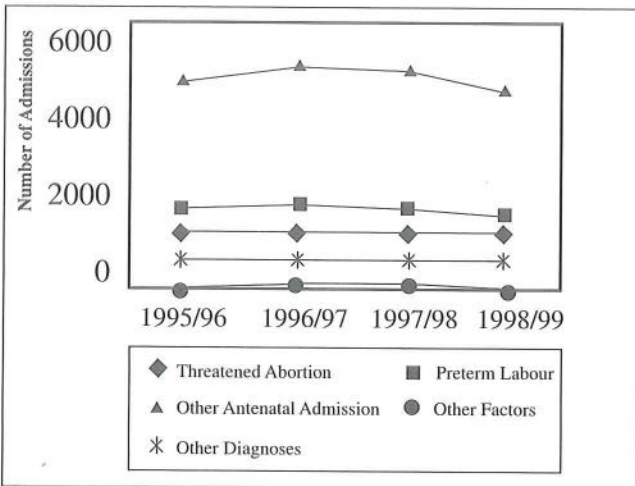
Maternal mortality rates (Figure 2) have also shown a continuing trend downward although the absolute numbers are small so rates fluctuate. New Zealand's 2/100,000 MMR in 2000 compares favourably to the USA rate of 8.4/100,000.

**Figure 2 Maternal mortality rates / 100,000 births**

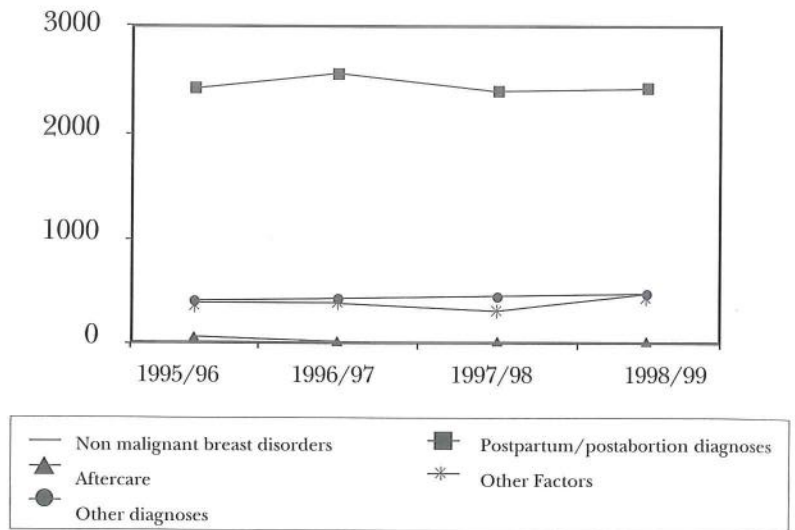


The National Minimum Dataset provided by NZHIS provides various information on factors used to measure morbidity. The Ministry of Health (MOH, 2000) looks at three indicators: antenatal admissions, pyrexia and infections around birth and postnatal admissions over the four year period since LMC services.

**Figure 3 Admissions after 20 weeks of Pregnancy**



**Figure 4 Admissions of mother within six weeks of delivery**



Actual admissions show a trend downward since 96/97. The advent of LMC midwifery coincides with this trend although we have no evidence of cause and effect. Fewer preterm labour and antenatal admissions is in line with international studies that examine midwife versus physician care (MacDorman & Singh, 1998).

Admissions for postpartum complications in mothers have remained static over the last four years. The categories "other factors" and "other diagnoses" include

- Headache
- Respiratory Infections
- Abdominal Pain (without complications)
- Oesophagitis/Gastroenteritis
- Disorders of biliary tract (without complications)
- Kidney and urinary tract infections
- Cholecystectomy
- Bronchitis and asthma

The actual numbers are very small in every category and therefore have no predictive value. However an increase worth noting under this category is headache. This is a known side effect of epidural/spinal and may be worth investigating in relation to those interventions.

**Table 5 Pyrexia and infections around birth and rates per live birth**

	1995/96		1996/97		1997/98	
	#	%	#	%	#	%
Maternal pyrexia in labour	510	1.0%	572	1.1%	673	1.3%
Major puerperal infection	120	0.2%	105	0.2%	91	0.2%
Total readmissions and rates/live birth	285	0.6%	284	0.5%	273	0.5%

As with postpartum admissions, maternal infections also appear static. The small increase in maternal pyrexia in labour (1% to 1.3%) is of unknown significance but may be related to the increase in induction and epidural rates.

Anecdotal stories of serious life threatening trauma to women and babies have arisen from time to time as some medical practitioners continue to believe LMC midwives threaten maternal and newborn safety if they practise without a medical presence (Ridley-Smith, 2000). Ridley-Smith and others in general practice have expressed concern that midwives would not recognise mental health disorders and that women would reach crisis situations which would impact on the secondary mental health services. The data in figures 2 and 3 and in tables 6 and 7 do not support these fears. The data on postpartum hysterectomy and major mental illness admissions were examined for trends and possible indicators for midwives and other maternity providers to consider. This data supports the finding of other outcome measures that the New Zealand LMC midwifery services has not been detrimental to women's health. In some instances it would appear women have benefited from the changes to the maternity services.

**Table 6 Hysterectomy rates per 10,000 deliveries**

Year	1995/96	1996/97	1997/98	1998/99
Rates per 10,000 deliveries	3.6	4.6	4.4	3.9

Table 7 Postnatal admissions For mental illness

Year	1995/96	1996/97	1997/98	1998/99
	#	#	#	#
Schizophrenia	6	4	4	4
Paranoia and acute psychotic disorders	1	2	1	0
Major affective disorders	2	2	9	9
Other affective and somatoform disorders	3	0	0	2
Anxiety disorders	1	0	1	0
Eating and obsessive compulsive disorders	0	0	1	0
Personality disorders and acute reactions	5	3	1	2
<b>Total</b>	<b>18</b>	<b>11</b>	<b>17</b>	<b>17</b>
<b>Rates per 1,000 deliveries</b>	<b>0.4</b>	<b>0.2</b>	<b>0.3</b>	<b>0.3</b>

Other measures such as breastfeeding also appear static although there is some evidence that exclusive breastfeeding has improved slightly (44% at six weeks), with the exception being Pacific Island women. These women are much more likely to choose general practitioners for their LMC. Chinese women are least likely to breastfeed and most likely to choose an obstetrician as their LMC (HFA, 1999).

Given New Zealand's breastfeeding rates are already high (80% breastfeeding at 6 weeks, 70% at three months) by international standards this slight increase in exclusive breastfeeding could be interpreted as pleasing (Plunket Society Report, 1999).

Another measure where New Zealand women achieve better outcomes is for the intervention of episiotomy. Some 7.8% of women had an episiotomy in 1999 compared with 39.5% in the United States and 50% in Japan.

### Maori Women's Health

Maori women would appear to have improved their status and that of their babies' health since 1990. As discussed previously they are more likely to have a midwife LMC. Maori women are also more likely to have a live born baby than any other ethnic group (MOH, 2000), they experience the least intervention in childbirth (fewer epidurals, fewer inductions, fewer episiotomies, fewer caesareans and instrumental births) than other ethnic groups. The number of Maori women breastfeeding is increasing slowly and the highest immunisation contact point for Maori babies is at six weeks when maternity providers refer their clients to the well child services. However midwives have made little impact on the number of pregnant Maori women smoking which is the highest for all ethnic groups. The NZCOM has recently won a contract to run courses for midwives which help them to encourage pregnant women to take up smoking cessation programmes.

### Women's Satisfaction with Midwifery LMCs

Finally, where New Zealand women have had the opportunity to give feedback on how they see the services, in all instances their feedback showed considerable constancy in expressing the highest satisfaction and lowest

level of dissatisfaction when their LMC was a midwife. (National Health Committee, 1999) Furthermore women said a midwife LMC was more likely to give them information, they felt more confident that a midwife would refer them as necessary and that they would receive more postnatal visits.

The data presented in this paper provides emerging evidence of the safety of midwifery and maternity care in New Zealand. As the Maternal and Newborn Information database matures we are likely to see more definitive outcomes. These will provide midwives and New Zealand women and their families with the information we all seek when making decisions in relation to maternity services and caregivers.

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## EDUCATION FORUM : The Importance of evaluation: The Aims and Purpose of the Review Process

Anne Barlow PhD

The NZCOM Review process has several major aims and the emphasis on certain of these goals has been changing over time. Some of the main NZCOM purposes for the Review will be explored:

### (i) Philosophical

Although initially established to provide quality assurance of the Midwifery Standards, the agenda for supporting a midwifery model of practice has been less well recognised by some midwives undertaking Reviews. Amongst the participants that I interviewed there was a feeling that there was a "pass or fail the standards" mentality in the early 1990's that was disconcerting when combined with an enthusiasm for a home birth/alternative model of practice. For example, many midwives who "went out" into the community from hospital practice left behind the safety of hospital protocols and policies and the technology of the medical model. Although, for some, a "shared care" approach meant that many still worked within a medical framework, independent midwives were required to make many personal, lifestyle and practice changes. Shifting to a new paradigm of midwifery care was challenging. At Reviews, midwives often felt anxious and vulnerable about having their practice evaluated – especially by home birth supporters. Some participants in the study believed that it was inappropriate and unfair that a group not representative of the women that they cared for reviewed their practice. They felt this particularly if they shared care or had a mainly hospital client base of women who they believed were satisfied with their midwifery approach.

Those midwives who did change their philosophy and perspectives were often met with resistance from their ex-colleagues in hospital. The reason for this, as one midwife explained was, "When you're in an institution it is very hard to question and survive" and "if you are one of those people who is for ever stirring you get sat on" (Review team midwife.) In addition to these institutional difficulties, obstetric technology such as routine cardiotocography recordings (CTGs) and syntocinon augmentation became a threat and a barrier to providing a midwifery model of care. Independent midwives were dealing with a multitude of professional and personal issues simultaneously and sometimes the Review did not always meet their needs for support. There was therefore a backlash against the actual Review process.

The MSRC responded by balancing the Review teams with hospital midwives and gradually more independent midwives joined the Auckland committee. Workshops were established to educate the teams about effective communication skills. Standards Review committee members worked hard to "plant a seed" for growth towards a midwifery model of practice (Donley, 1999). Although the pressure, from Reviews, to move midwives along a continuum towards greater acceptance of the midwifery model, was at first resisted, and the process deemed less than satisfactory by midwives in the early years, the study shows that there is a greater awareness and acceptance of this aspect of the Review. I expect this is partly related to the increased political exposure of midwives leaving hospital employment, who became involved in maternity 'turf' battles with general practitioners and also due to increasing numbers of graduates who have been educated within a midwifery philosophy. "New graduates more readily accept the need for reflection on practice in a Review situation" (MSRC co-ordinator).

### (ii) Partnership and accountability

The need for a Review based on a philosophy of partnership played a "very necessary and critical part in raising the credibility of midwifery as a profession....that we actually created something that could amalgamate the partnership yet conduct a Review" (Grey, 1999). It also "resurrected the profession" (Midwife A) and was noteworthy because there were no other health professions working as closely with consumers in ongoing practice evaluation or quality assurance programmes (Donley, 1999). Partnership was seen as "a way of giving women choices" (Midwife N) and at Reviews this aspect of care was closely examined. Review statistics and case stories were means of revealing practice issues.

### (iii) Quality assurance and audit of standards

An interview with Joan Donley provided a pragmatic perspective on the relevance of the Review process. She refers to the proposed Nursing Council (1999) requirements for Competence Based Practising Certificates for midwives after 2002, when midwives will be required to show evidence of having attended a NZCOM Review – or other Nursing Council approved process - as part of their practice portfolios. (Her comments relate to the proposed Health Professionals' Assurance Competency Bill).

"Well right now whether you think a review is a good idea – you are not really going to have any choice on it. That's going to be a legal requirement and as an autonomous profession then we have standards and if you don't know whether your midwives are adhering to those standards then there is not much use in having them in the first place...."

And if we are declaring that we have a partnership with women then it's really important that the women that we have a partnership with are satisfied with the service that we provide." Joan Donley (1999)

Most participants in the study acknowledged that monitoring and accountability was important, some midwives saying that attendance at Reviews helped them to maintain their

practice standards and "keep up to scratch."

"That's one way of doing it because otherwise, by human nature, we would let things slip and we wouldn't keep up to the practice standards that we should. I think that's one way of achieving it and monitoring.

And there are a lot of midwives that choose not to go to the Review. But I think there's definite advantage in it because you get your practice together, you get a chance to evaluate it. Whereas I don't think you would do that if you weren't having a review. You would have to be self-disciplined wouldn't you, that every time each year you looked at your practice, did your statistics. I think you would just cruise from one month to the next month and not get it done." Midwife E

One midwife made a similar comment saying that because she was so busy, if she wasn't forced to put it all on paper and have a look at it, she wouldn't get around to it. It had been good in that respect for her.

Others saw it as a safety net (because New Zealand midwives are currently 'litigation-conscious.')

"I think it's a safety net. That's why I do it. Because it's one way of knowing that your practice is OK. You could just carry on out there and do your own thing and if something happened, at least I know that well, I've had a review, received some positive feedback so...it's reassurance I guess". Midwife E

Several felt the Review to be positive – one saying that she found the Review a "positive learning process where ideas could be bounced off" other people on the panel and feedback from the midwives excellent.

"I don't know if I would feel particularly comfortable about midwives not doing Reviews, quite frankly...And I think it's a good thing and I'd be disappointed if a midwife didn't go and have a review at least every few years. They would be shooting themselves in the foot really. Well if I was a client, I would like to think that my midwife was being reviewed regularly".

Midwife B

(iv) Educative purpose of the Review: Support, reflection and professional development

At the 1998 NZCOM conference, the (then) National MSRC co-ordinator stated that the Review:

- is a midwifery-focused process
- is intended to be a supportive, educative process which will enhance one's practice through a reflective self-appraisal
- has no relationship to a complaints or a disciplinary process
- it is not a quality assurance pass/fail, and the purpose is to assist the midwife in her professional development, because the 'Standards' are standards of

excellence, rather than minimum requirements.

- A midwife must reflect on the responsibilities of autonomous practice.

Pelvin (1998)

The NZCOM believed that a midwife was a person who could reflect on practice and a Review was part of that reflection.

"We always believed that a midwife was a person who could reflect on practice and a Review is part of that reflection. It's a reflection with consumers and with your peers. So from that point of view it was a natural evolutionary part that had to come with autonomous independent practice.

And I think we've got something really worthwhile and something that, even though some people may not acknowledge it at the time, it does make you sit up and take a look at your practice". Grey (1999)

The educative aspects of the Review have become more formalised recently with notions of support emphasised and needs for reflection on practice and consideration of professional development goals clearly recognised, for example, in NZCOM Terms of Reference.<sup>2</sup> One participant intimated that this emphasis evolved out of the dissatisfactions with the pass-fail approach and a recognised need by MSRC s that practice changes were more likely to occur when learning new approaches happened – to use Carl Roger's (1969) term – in an atmosphere of mutual trust and positive regard.

Nonetheless, the aim of reflection in a Review was generally found to have value by participants in the study. Even though the concept of reflection may be difficult to grasp – or measure – at times there is an understanding by most midwives (particularly educators) that actions provide an indicator that reflection has taken place. One midwife, for example, believed:

"I think it's always really valuable to reflect upon one's practice. To look back and think "none of us are perfect in whatever we do". And it's always useful to look back and think "what should I have done - what could I have done better - how should I have changed it" or "what were the things that I thought I did well - what were the things I thought I did badly". I mean reflection is always a big part of the learning process isn't it?" Midwife N

Most midwives in the study related well to the need for reflection in Reviews:

"There's lots of things we should learn to reflect from ourselves and I think the Review should help midwives to learn from what they see". Midwife C

Overall, the midwives and consumers in the study made comments around the theme that the Review mainly provided good support to reflect on practice (every year) that may otherwise not have been available. It was also noted that many facets

of communication and the skilfulness of the Review team made a difference to their ability to reflect well in a Review situation. There is no scope in this paper to explore these thoughts except to note that the value of reflection was reduced if midwives had exceptionally busy personal or professional lives with limited 'down time,' previous unsatisfactory Review experiences or had heard reports of unsatisfactory experiences from other midwives.

## Conclusion: Seasons for Renewal – Looking to the Future

This brief view of historical and current perceptions about the NZCOM Standards Review process raises as many questions as it answers. Historically, there has been some tension amongst the NZCOM Review's overt aims and objectives and midwives' philosophies and between the needs for standards to be assessed and the needs for personal and professional development and reflection on practice.

I have not elaborated on the need for midwives to have evidence of their Reviews in their practice portfolios by 2002. On the face of it, it would seem that the future success of the Review process has been assured by the legislative changes negotiated between the NZCOM and the Nursing Council of New Zealand. Practice portfolios will be audited every five years and that will make Review attendance compulsory at least five-yearly. There was a concern amongst some study participants that the compulsory nature of the Review could negate some of its educational benefits of the Review. For example, deep reflection on practice and may lead to a more expedient superficial approach. Yet, others believed that this legislation will give the process the necessary "teeth" it is currently lacking. Further research following the implementation of this legislation may be worthwhile. Continuing dialogue amongst all the stakeholders is essential to ensure that the purpose of the Review is well understood and meets their needs.

In summary, I believe that aspects of the Review process are currently relevant for midwives personally and professionally. The development of the process has been a difficult path initiated and supported strongly by committed consumers and midwives. Some Auckland midwives have reserved their decision on its value. I believe that all midwives can play an active role in determining that the process is more meaningful to them by providing constructive feedback and consulting with committee members to find ways of achieving this. (For example, by becoming a MSRC member.) Midwives need to be involved otherwise – to coin an educational phrase – the assessment tail will wag the

assessment dog. That is, the assessment means will determine the assessment purpose and the reason for attending the Review will only be for portfolio purposes and the real value (that has been perceived by participants in the study) will be lost.

## ACKNOWLEDGEMENTS

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1 Standards for practice are detailed in NZCOM Midwives Handbook for Practice (1993). Ten practice standards are outlined with a Code of Ethics for practice.

2 National Terms of Reference have been written by the NZCOM and updated 2000. These clearly explain the objectives of the Review, the Committee purpose and guidelines for regional committees.

### Midwifery Positions Available Pukekohe Maternity Unit

This level 0 Maternity Unit is part of South Auckland Health's Maternity Service.

The base unit for Pukekohe Maternity Unit is Middlemore Hospital. 300+ women a year give birth in the Pukekohe unit and several hundred transfer to the unit for post natal care from Middlemore. Women using the unit have Independent Midwife or General Practitioner Lead Maternity care with in patient care being provided by South Auckland Health employed staff.

Full and part time positions are available for Midwives to work rostered shifts in the unit to provide the inpatient care for women.

For further information ring Jenny Woodley Midwife Manager (09) 2389359 (025) 761 403



## PRACTICE WISDOM: Mentoring- A Personal Analysis.

Dawn Holland BA

This paper presents a discussion of mentoring within Auckland midwifery practice. It emerged from my involvement in the debates within the New Zealand College of Midwives (NZCOM) about the need for new graduates to be mentored, and the requirements of Access Agreements from the different maternity hospitals. The exploration brought me to the literature regarding questions that were raised by the debate. It further involved a series of short interviews with 2 new graduate midwives, 4 potential mentors, 4 student midwives, and 3 women who had been cared for by a mentored midwife. Extracts from these interviews are included within the analysis that follows.

### The Notion of Mentoring

The origins of mentoring are found within the Classics. Homer, in his epic tale, *The Odyssey* introduces Mentor, the trusted son of Alimus. Mentor was appointed by Ulysses to be tutor-advisor to his son Telemachus, and guardian of his estates while he was away fighting the Trojan wars (Morton-Cooper & Palmer, 1993). The tradition was continued throughout the Ancient Greek and Roman Empires when young men, and later, generals in the armies had designated mentors by their side to advise, educate, and counsel them. This person was usually older and more experienced. In other words, a valued, knowledgeable, and trusted companion, sharing that particular episode of the journey of life.

It is this tradition that has carried through to our present day. The ideals of the Ancient Empires have become the ideals of sound business and professional practices of the 1990's. The 'old boys network' which encompasses mentoring has long been an integral part of many professions. With the resurgence and re-evaluation of more women orientated businesses and professions there has become a growing need for women leaders, role models and gender appropriate mentoring (Vance & Olsen, 1998).

Midwifery is no exception. Indeed, there has been a long and strong tradition of mentoring within the profession. We can probably all readily think of one or more midwives who advised, guided, encouraged and inspired us during some period of our midwifery careers and possibly still do. Whilst acknowledging the importance and value of ongoing mentoring throughout one's career and life, the focus of *this* discussion will be on new graduate midwives being mentored into independent midwifery practice. Such a discussion is by nature closely intertwined with the requirements of access agreements.

### Historical Overview

The passing of the Nurses Amendment Act (1990) enabled all midwives registered by the New Zealand Nursing Council to become autonomous practitioners. It is now possible for, not only experienced midwives, but also new graduate midwives, to enter independent midwifery practice and become primary caregivers. Shortly after this historic piece of legislation, a Direct Entry Midwifery degree programme was introduced into Auckland and Dunedin's midwifery curricula. Student midwives, for the first time in many years, no longer had to have a nursing background and consequently little or no knowledge of institutional behaviour as demonstrated by hospital systems.

Nursing has its origins within the patriarchal system of the military whereas the new emphasis of midwifery was based on the feminist theory of partnership as described by Guilliland and Pairman (1994).

The client and the midwife are equal participants in the planning and implementing of care within the partnership model. Hospitals, doctors, and administrators had to act quickly to retain some form of control over midwives and women. It appeared that the prevailing medical/ authoritarian discourse was being threatened.

Access Agreements were created. Hospitals placed restrictions on midwives, particularly new graduates by stipulating numbers of 'supervised' births and expectations of the supervisor/mentor, amongst other dictates. It was out of this discourse that the more formal process of mentoring for midwives evolved. The New Zealand College of Midwives developed and ratified a consensus statement on mentoring (1996) which remains unchanged at this time of writing. It refers to new graduates or returning practitioners, but could in fact apply to any mentoring situation within midwifery. Access Agreements differed depending on the geographical location but essentially the language remained the same.

Michel Foucault, French philosopher and historian, recognises the power of language in that it creates a discourse, which brings us perceptions of reality (Cheek, Shoebridge, Willis & Zaoroznyj, 1996). Foucault's concept of discourse has been described as a 'system of statements which cohere around common meanings and values that are a product of powers and practices, rather than an individual's sets of ideas' (Cheek et al 1996, p.174). It includes the written and spoken language, ideals, rituals, practices and social power relations. Foucault acknowledged the dynamic nature of power by characterising it as a 'ball in play' which creates tension and conflict between competing discourses. It was evident that there were, and still are, competing discourses within the nature and understanding of the midwifery mentoring process.

Midwifery language communicates ideals and expectations related to 'supporting', 'nurturing', 'guiding' and 'partnership'. The access agreements/hospitals' language, meanwhile, use terms such as 'supervision', 'access', 'protocols' and 'approval'. It was and continues to be a discourse of power and control. The arrangement between the mentor and the mentored was generally on an informal basis, one of trust and verbal agreement. It relied on the midwifery concept of partnership and did not contract numbers or the attendance requirements of the mentoring midwife. It was an arrangement made on individual needs. Hospitals, however, required formal written contracts, signed by both midwives and approved by the appropriate person or committee.

Without a designated mentor or mentors new graduate midwives were limited in their scope of practice. They could and did attend homebirths as fully autonomous practitioners but within hospitals were restricted by the laws of the institutions. In many areas, the power conflict continues to this day.

There have been several attempts to nationalise the Access Agreements and redefine the mentoring role. Early in 1999 the Health Funding Authority conceded that they and the institutions should relax their control over access agreements and place the issue of mentoring back into the hands of the various professional groups (Letter to NZCOM from B. Browne, Maternity Services Manager, HFA, June 24, 1999). For midwives the time is now right to re-examine the definition, roles and expectations of the mentorship process.

## What is mentoring?

The debate over access agreements has clouded the professional issues related to mentoring new graduate midwives. What are these issues? This is the question that needs to be discussed at local and national levels amongst the professional body of midwifery. We have the opportunity to develop a whole new concept of mentoring with particular emphasis on autonomous midwifery practice.

## We must start with a clear definition.

Cameron-Jones and O'Hara (1996), remind us that much of the recent literature around mentoring describes confusion of meaning and concern over lack of clearly defined roles. Hall (1997) designed a study looking at mentoring behaviour among New Zealand nurses. The initial research problem was to seek an explanation for the apparent lack of mentoring in New Zealand nursing. However as the study evolved the lack of agreement concerning the definition

of mentoring became a major research obstacle. I suspect the same would apply to midwifery.

The attempt to attach labels to the meaning of mentoring or the mentorship process has assisted in the confusion of definition. Descriptions and demands such as supporting, advising, teaching, counselling, role modelling and coaching may seem overwhelming to a potential mentor. What has to be remembered is that the level of mentoring requirements and input will vary. Morton-Cooper and Palmer (1996) describe mentoring as 'making the most of human potential.' The competence and requirement level will differ with each new graduate and so will the time required to maximise that potential. According to Barnum (1996), an effective mentor will recognise the differences between herself and the mentoree and foster them. It is therefore essential to develop an initial assessment tool or programme for the mentored midwife to ascertain a baseline on which to build her competence and confidence. This tool could be used as an ongoing self-assessment to ensure the needs of the mentorship are being met. Having planned goals and expectations will facilitate the communication between the partners of the mentorship.

The success or failure of a mentorship is dependent on the nature of the relationship between the mentor and mentored. Vance (1998, p.3) refers to "the collegial connection that potentiates and empowers each person." This collegial connection implies that the relationship must be mutually beneficial. Although benefits may involve a financial incentive for the mentor, the basis for an excellent mentoring relationship should be about mutual attraction and sharing of common values. Both parties must value the other's ideas and opinions. In midwifery a shared philosophy is an appropriate place to start negotiation when considering mentoring or being mentored.

Mentoring relationships and types differ depending on the circumstances in which they were created. Classical or informal mentoring is a naturally chosen relationship and the purposes, duration, and functions are determined by the participants. Contract or formal mentoring is an artificial relationship created for a specific purpose and duration. Both contain the essential elements of mentoring, that is, the helper functions, (teaching, guiding, etc.) and the sharing of common values. It is my belief that the midwifery mentorship process could incorporate both forms and that the success of the mentorship will be dependent on the integration in the relationship of the following principles:

- Supporting and nurturing the next generation of midwives.
- Maintaining the safety of the

women.

- Maintaining the safety of the practitioners (mentor and mentored).

## Supporting and nurturing the next generation

Mentoring is an issue that is vital to the survival of autonomous midwifery practice in New Zealand. The average age of independent midwives in New Zealand is 42yrs (B. Pelvin, personal correspondence, Feb 11, 1999). Almost ten years on from the Nurses Amendment Act a number of those 'pioneering' midwives who entered independent practice have moved on. It is a difficult lifestyle to maintain for a variety of reasons and like any profession if it is going to continue to flourish then there must be a strong commitment to supporting recent graduates especially in the form of mentoring. One of the rewards for the mentor is seeing the investment in the future of the profession. As one mentor midwife said:

*As I get to the end of my independent midwifery career, I feel happy to know that I have passed on some skills, knowledge and lots of experience to the future of midwifery.*

The reasons and circumstances for mentoring may differ. Another midwife decided to mentor a new graduate as she had a thriving practice that required another full-time midwife. Whatever the reasons the principles remain the same. It is about the sharing of knowledge and empowerment.

Cheek et al (1996) examine the notion of power from a critical theory perspective. Critical theory is concerned with the issues of knowledge and power. It states that power is attained through knowledge. The attaining of knowledge facilitates the process of enlightenment, empowerment and emancipation of individuals. This theory sits very well with the concept of the mentoring relationship. An inexperienced midwife working alongside an experienced midwife, gleaning knowledge therefore becomes a more powerful person in her own right.

However, critical theory goes beyond this simple explanation and questions the relationship between knowledge and power and how that relationship is evident in practice. It also states that reality is a social construction. It is constituted and mediated by the knowledge and power of language, texts and certain influential groups in society (Cheek et al., 1996). Individuals must consider their own place in the world as a consequence of their experience in the membership of social groups. Two midwives coming together in a mentoring relationship first must both acknowledge their own perspectives of 'reality' and

'truth'. It will probably be different for both of them.

By each being clear about their own belief systems about midwifery it is then possible to move through the stages of enlightenment, empowerment and emancipation. The process of enlightenment is part of the political aim of critical theory. Through enlightenment individuals are empowered and then emancipated. It is only then that people can be free from the social constraints on their actions and change will be created.

In the mentoring relationship enlightenment takes place as the mentored midwife attains more knowledge and information. Midwifery and mentoring both have strong political directions. By mentoring a new graduate midwife not only is she becoming more politically aware but also the action of mentoring is increasing the awareness of midwifery in the community at large. Mentoring helps increase the visibility of midwives and midwifery. It destroys the notion held by some that a 'good' midwife has to have senior years, both in experience and physical age.

The knowledge and experience the mentored midwife has gained will empower her and she will move on to the third stage, that of emancipation. Through emancipation she will create a new understanding for herself of the essence of midwifery unconstrained by her previous social context.

The mentoring midwife has an opportunity to go through a similar process. Exposure to the latest research and information via the recent graduate and the journey that she travels with her may also create a new understanding and meaning to her beliefs about midwifery. Through shared knowledge they have both acquired power and are free to create change. Midwifery is a dynamic profession and by enabling this process for change we can move forward to accommodate the new demands and changing midwifery environment.

## Safety of the women

Women have and continue to be extremely generous in the sharing of their lives, hopes and dreams with us as midwives. Partnership is a cornerstone of midwifery philosophy in New Zealand (Guilliland & Pairman, 1994). The planning and implementing of care is done jointly. However it must be remembered that the midwife is the professional with the midwifery expertise and knowledge. Women contract with midwives to utilise these skills. Pelvin (1992) acknowledges that the midwife is 'the experienced, accompanying, knowledgeable and supportive presence' to the woman. This

clearly does not apply to the new graduate midwife who is not experienced and sometimes lacks appropriate knowledge.

A woman who had recently birthed her second child expressed her opinion:

I didn't mind the prospect of having a new midwife attending me but I needed to know that there was an experienced midwife alongside her. I had a normal birth but what if something untoward had happened? I know it could happen anyway, but my immediate thoughts would have been about her lack of experience and what if...? That would be a hard issue for me to overcome.

Another woman told her story:

*I really like X, and I know she is recently graduated, but my husband really wants a doctor. I told him all about the mentoring arrangement and now he's happy. It's important that both of us feel right.*

Concerns over issues of safety, whether real or perceived, must always be treated with the utmost respect. If the woman feels she is not been listened to she will not form a trusting relationship with her midwife. However, if she does develop a strong trust she will become the profession's strongest ally and advocate.

## One new graduate put it succinctly:

The safety of women is dependent on the confidence and competence of the new practitioner. The safety of women could be easily be jeopardised if the new grad didn't have the support structures and the mentor didn't have full input.

## Safety of the practitioners

\* Mentored midwives are exactly that, they are midwives not students. They are practitioners in their own right, registered by the New Zealand Nursing Council. They are legally able to become Lead Maternity Carers. They are accountable for their own practice; the mentor is accountable for her own practice. Again these appear to be issues that seem to have created confusion.

New graduates are beginning practitioners and although deemed competent by Nursing Council, they may not be confident in certain areas. This is especially relevant in independent practice, which can frequently stretch the knowledge and skill of the most experienced practitioner. As a recent graduate, the midwife is often at her most knowledgeable in terms of recent research and familiarisation with the latest techniques. She will bring this latest evidence-based practice to the mentor relationship, which will benefit both members.

Generally the new midwife will not have a problem with the normal and highly abnormal events of pregnancy. Decision-making is fairly clear-cut in these

circumstances. However, in midwifery there are a lot of 'grey areas', situations which are not clearly documented in the latest text or research. These are the instances where the wisdom of the mentor is required, not to 'fix' it, but to guide and assist the mentoree to make her own decision.

Again a new graduate midwife speaks:

*Mentoring is about enabling you to have the confidence to put your knowledge into a practice situation.*

We live in litigious times. Midwives are especially aware of this. High profile cases, reported in the media, coupled with the increased number of disciplinary cases referred to Nursing Council, makes us all a bit nervous. We must be protective of ourselves as individuals and as a profession. By providing good mentoring and role modelling we can also assist the new midwives to develop self-preservation tactics.

The safety of the mentor must not be neglected either. Mentors are people too who require feedback and attention (Salmon, 1996). The mentor relationship is based on trust and therefore neither party should feel their safety has been compromised. Communication is vital to a good mentoring relationship. Having a mentoring relationship shared between several mentors is fraught with difficulty. It will require extremely careful communication, negotiation and clarification. It is much harder to maintain that relationship of trust and faith with several rather than one.

The establishment of a framework or guidelines will assist in clarifying the roles and expectations for all involved in different situations. It need not be prescriptive and restrictive as the Access Agreements often have been. More appropriately this framework could be seen as a user-friendly guide to the joys and pitfalls of mentoring or being mentored, especially for those who are new to the process.

## The Vision

Mentors are suffused with magic and play a key part in our transformation. Their purpose...is to remind us that we can, indeed, survive the terror of the coming journey and undergo the transformation by moving through, not around, our fear. Mentors give us the magic that allows us to enter the darkness: a talisman to protect us from the evil spells, a gem of wise advice, a map, and sometimes simply courage. But always the mentor appears near the outset of the journey as a helper, equipping us in some way for what is to come, a midwife to our dreams (Daloz, 1986).

In this paper I have examined what I consider to be the most immediate issues concerning mentoring new graduate midwives. These include:

- Development of a new definition of mentoring as it pertains to midwifery practice in New Zealand. This would perhaps require the rewriting of the NZCOM Consensus Statement.
- Development of some recommendations for best mentoring practice. i.e. guidelines/framework for both mentor and mentored.
- Development of an assessment and evaluation tool to ascertain that the requirements of the mentorship are being met.

There are many further issues to be discussed around the mentorship process as it relates to midwifery. If we are going to be that 'midwife to our dreams' then we need to be clear about our role. Mentoring is integral to the growth of our profession. It is a political activity and increases the visibility of midwives. It represents a conscious effort to invest in the future of midwives and midwifery.

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## ORIGINAL RESEARCH: FEEDING BABY: THE EXPERIENCES OF FIRST- TIME MOTHERS

Anne Kerslake Hendricks MA (App)

The research formed the basis of a thesis for a Master of Arts (Applied) in Social Science Research and the research design and methodology can be found in Kerslake Hendricks (1999).

In this article the results of the research are presented as a summary of the experiences of the 12 first-time mothers as they attempt to learn to feed their babies, whether by breast or by bottle. Discussion about feeding issues arose during face-to-face semi-structured individual interviews, as the women talked about their postnatal support needs during the first six months following the birth of their babies. At the time the interviews were carried out, the women ranged in age from their early twenties to their late thirties, and their babies were aged between seven and eleven months old. All of the women had given birth at the same local public hospital, two by Caesarean section. Pseudonyms have been used to protect participants' confidentiality and other potentially identifying characteristics have been altered.

### RESULTS

All twelve women needed help with learning to feed their babies (whether by breast or by bottle). This was typically one of the first times that the women began to be faced with a barrage of information and advice, and had to learn whose advice to follow and what could be ignored. Feeding was associated with many changes, such as; in the mother's physical condition (when the milk came in, which was often a time of discomfort); lifestyle, (if outings and visits were linked to the baby's feeding schedule); postural, (related to assuming the most comfortable position for feeding); broken sleep; and in social life and the emotions (resulting from the realisation that learning to feed the baby was not as easy as women had assumed it would be).

### BREASTFEEDING

*I was very ignorant and I had this idea that breastfeeding would be lovely and easy and blissful, and even though I had known there were people that had problems, that happened to other people, and it wasn't going to happen to me...*

[Simone]

It is now generally acknowledged that breastfeeding is the ideal system for feeding a new baby. Breast milk provides a complete, easily digested diet, high in calories, protein, fats, carbohydrates, and fluid, and also contains vitamins, minerals, and immunoglobulins which help the baby to fight infections (Pullon, 1991). In Aotearoa/New Zealand, breastfeeding is encouraged, although data indicate a decline in the number of women who are fully breastfeeding. Tuohy (1997), reported in the *New Zealand Herald*, that the number of mothers breastfeeding when their infants are two weeks old had fallen from 83 percent in 1993 to 72 percent in 1997; similarly, at six weeks of age 75 percent of babies were being fully breastfed in 1994, compared with only 64 percent in 1997. Dr Touhy suggested that possible causes for the decline include early maternal discharge from hospital, changes in maternity services, and poorer co-ordination between health professionals.

More recently, the National Health Committee's *Review of Maternity Services in New Zealand* (1999) reported that data for the period between July 1998 and June 1999 showed that at four to six weeks after delivery, 53 percent of all mothers were exclusively breastfeeding, and an additional 9 percent were predominantly breastfeeding. However, the report cautions that data collected on breastfeeding rates after delivery are indicative only, as breastfeeding data are incomplete on nearly one quarter of the forms submitted by Lead Maternity Carers (LMCs) to the Health Funding Authority (HFA).

Despite mothers' good intentions to breastfeed, Oakley (1979) suggests that after a first baby is born, decisions about breastfeeding are apt to be challenged by "the reality of a screaming infant with gums like an iron clamp, a bottomless stomach and a rage of quite unimaginable proportions" (p. 165). She discusses the fact that breastfeeding is neither instinctive nor easy for mother or baby:

The mother has never fed a baby before, and the baby has never been fed. Like skateboarding or piano-playing, only practice makes perfect. (p. 172)

Inch (1990) reports that in some cultures breastfeeding skills and information are acquired subliminally through frequent observation of babies at the breast, and the social support received from other women following childbirth. In other cultures women are almost entirely dependent on the skill and knowledge of the professionals who are caring for them around the time of birth. Thus, health professionals (e.g. hospital staff, midwives, and Plunket nurses) play a very important role in promoting and establishing breastfeeding, which Inch, like Oakley, stresses is a learned skill. Crossland, a La Leche League administrator (in Kedgley, 1996), expresses concern that early discharge policies result in most women being sent home from hospital at the same time that their milk is first coming in, which she describes as "a make or break time":

If women go back home and pick up all the responsibilities of the household, and have very little support, they may give up [on breastfeeding] – especially new mothers who haven't built up a network of support to help them establish breastfeeding (Crossland, in Kedgley, 1996, p. 293).

Crossland reports that since early discharge policies have taken effect in Aotearoa/New Zealand, there has been an increasing demand for the counselling services offered by La Leche League, particularly for telephone counselling. Vowden (1997), a La Leche League leader, writes that the mother-to-mother support provided by the League is:

[A] sharing of wisdom and encouragement ... helping the mother to see the light at the end of the tunnel and giving her the confidence to achieve her goals as a parent. (p.25)

All but one of the 12 women I interviewed chose to breastfeed their babies. Although I did not specifically ask the length of time for which the babies had been breastfed, some mothers had obviously elected to continue with breastfeeding beyond the first few months, as they breastfed their babies during the interviews. Without exception, all women found breastfeeding to be a challenge initially, with difficulties ranging from temporary discomfort for the mothers to total breast refusal by a baby who lacked a sucking reflex. Baldwin (1996) also reports that problems with breastfeeding were common among the women she interviewed; some of these women accepted such problems as part of breastfeeding, while others appeared to be totally shocked and unprepared for what they encountered.

### Contradictory Advice

Many women I interviewed mentioned the contradictory advice about breastfeeding techniques received from hospital staff, and the impact this had on women's efforts to establish feeding:

*Everything one said, the next person demolished, so that was really hard.* [Esther]

*Every nurse I talked to [about breastfeeding] would tell me something different, and in the end I decided that my judgement was probably as good as theirs.* [Bev]

*One shift would say I must wake [the baby] every 3 hours to feed, and the other shift would come along and say, 'Oh look at him, he's doing alright, he's fine, leave him be.'* [Denise]

*[T]hey all tried [to held with breastfeeding] ... but because each [nurse] was coming on for a*

*shift of six hours [sic] and then going away again, there wasn't a consistent pattern, there wasn't a consistent person who was going to solve the problem.* [Clare]

My findings support those of other researchers. Bennet et al. (1993) report that almost 60 percent of women in a Victorian [Australian] survey said that they had received inconsistent advice on breastfeeding during their hospital stay, and that the imposition of rigid feeding routines had disturbed their efforts to establish breastfeeding. Dobbie (1997) reports that 49 percent of 168 women surveyed experienced problems with breastfeeding, with 29 percent receiving conflicting breastfeeding advice from nurses or midwives. Baldwin (1996) also found that many women she interviewed received conflicting information regarding breastfeeding, which often added to the stress and confusion they were already experiencing.

Thirty percent of the 2,192 women responding to a HFA survey reported that they had received conflicting advice about breastfeeding from different health Professionals. A quarter of women expressed concerns about the availability of breastfeeding advice and support from the LMC professionals (National Health Committee, 1999, p.26).

Although wanting to become independent, some of the women I interviewed felt that they had been left to their own devices in hospital a little too early, and would have welcomed more support:

*Because I was keen to go home early, [the staff] tended to keep on saying, 'Oh well, we will just leave you to [breastfeed] and see if you can do it on your own,' which is always a little bit more difficult than if you get a little more help.* [Pam]

*I asked for some people to check that she was [breastfeeding correctly]. I thought, this isn't right, I must be doing something wrong ... They would just come and look while she was on briefly, and say, 'Oh, yes, that looks alright,' and then go away – so there was no practical help at all, actually.* [Stephanie]

Laryea (1993) highlights the dual roles simultaneously acquired by women who give birth in hospital: the "motherhood role" and the "patient role". On the one hand a woman is seen as progressing by assuming new responsibilities and social status upon becoming a mother, yet on the other hand she is expected to regress to being a patient, thus giving up a considerable amount of control. This dichotomy is illustrated by Gabrielle's experience during the first night following her Caesarean section. She described her feelings of frustration when she was desperate to respond to her baby's crying, but was unable to move because of the after-effects of surgery:

*[T]he first night I was [in the hospital the*

*baby] was crying, and I was still paralysed, so I couldn't move anyway, even if I'd wanted to. And I buzzed, and it took them half an hour to answer, and by the time they came in [the baby] was just screaming. And I said, 'My baby needs feeding,' and they said, 'Well, why don't you do it?' and I said, 'I've just had a Caesarean, you know, and I can't do it.'*

Gabrielle faced a dilemma: as a mother, she wanted to respond urgently to her baby's need to be fed, yet as a patient she was entirely dependent upon hospital staff to place the baby in her arms, at their convenience. Hospital experiences such as this add further stress to women's attempts to establish breastfeeding. Other women also described how their confidence had been undermined by hospital staff, leading to feelings of inadequacy:

*He wasn't learning to breastfeed, and I found that the midwives in hospital were not going to solve this problem, they were just raising [my] anxiety levels.* [Clare]

*[I]t was a nightmare. And by the time I came out [of hospital] I was convinced I wasn't going to be able to feed her.* [Gabrielle]

Several women spoke about the perceived indifference of hospital staff to breastfeeding problems. Gabrielle's perception was that the staff really didn't care if breastfeeding was established or not by the time a new mother left the hospital. Clare, after expressing her concerns that there was no one person who had assumed responsibility for helping her to overcome breastfeeding problems, laughed as she explained her belief that everybody was just trying to ensure that the baby didn't lose weight on their shift. Both Clare and Simone felt pressured by hospital staff to give their babies a bottle, despite their strong desire to breastfeed. Based on her own experiences, Karen felt quite strongly that women who had chosen to breastfeed should not be allowed to leave hospital until breastfeeding had been successfully established. While a compulsory hospital stay to establish breastfeeding is unlikely to be an acceptable policy, women like Karen would undoubtedly appreciate having the option of a longer stay if they felt they would benefit.

After returning home, conflicting or confusing advice about breastfeeding was often offered to women by friends and relatives. For example, well-meaning advice-givers offered suggestions about the length of time for which babies should feed, how to supplement feeds with boiled water and brown sugar, whether to wake the babies to feed them, and how to ensure that breastfed babies were also able to take bottles from time to time. Lacking experience, it was hard for women to know what advice to follow and what to ignore. Eventually, they developed confidence in learning how to decide which advice was not appropriate;

this was true not only in relation to breastfeeding, but also to other aspects of motherhood:

*[O]ne of the things I found [after] reading quite extensively and talking with a number of different people, there's definitely a huge range of different opinions out there. I came to the conclusion that you gather as much information as you can, and you choose what works best for you and baby, and it's never going to line up with all of the advice that's out there. [Pam]*

There were many potential sources of information and advice, solicited and unsolicited, and women had to learn how to accept or reject what was offered. Learning how to rely on their own intuition was an important step in this process. The advice that was most appreciated tended to come from people who ultimately relied on the women themselves to make their own decisions about which advice to follow, without pressuring them.

## Difficulties Encountered

Crouch and Manderson (1993) suggest that demand feeding – promoted as being more natural than the rigidly scheduled feeds adhered to by the previous generation of mothers – can be problematic:

*[W]omen are expected to intuit hunger accurately (where previously timed feeds neatly dictated hunger at four-hourly intervals); feel obliged to assess adequate milk consumption for an unspecified time-interval (where previously compensation would in any case be forthcoming in precisely four hour's time)... (Crouch and Manderson, 1993, p. 140)*

In their study of 93 first-time mothers, Crouch and Manderson found that many women were preoccupied with the appropriate posture for breastfeeding, with creating an atmosphere of relaxation and calm, monitoring their diets in relation to the quality of their milk, and so on. They conclude that it takes a "particularly confident and relaxed new mother to master that which comes naturally" (Crouch and Manderson, 1993, p. 141).

Sarah laughed as she reminisced with me about how assuming the "correct" breastfeeding position was so crucial to her during the early stages:

*[I] started – after a couple of weeks – feeding [my son] in bed, lying down, because I was still so sore and someone had suggested that it would be easier. So I got into a habit of doing that and became unable to feed him sitting up, which wasn't too much of a problem. But if ever I went out to someone's house, I'd have to say, 'Um, can I use your bed?!' [laughs]*

She was glad to report that over time breastfeeding became much easier, and positioning was not longer as critical.

Despite, or perhaps because of, "expert" advice, women may feel guilty if they are having breastfeeding problems. Simone,

who continued to experience major difficulties with her attempts to breastfeed when interviewed nine months after her son's birth, reflected on what she perhaps should have done. There is a considerable amount of self-blame evident in the following excerpt:

*I think I should have gone to La Leche League right from when I was in the hospital having initial difficulties. And that's my own fault that I didn't, because I was told that they're there if you want and at that stage people almost had to do things for me, putting the onus on me to do it. I wasn't being very self-responsible at that stage, I was too exhausted or something. [Y]ou know that people have problems in the first few days, so you don't know that it's any different to the problems that everyone has in the first few days that then get better ... knowing what I know now, La Leche's approach is quite different [from the other advice received] and it would have been good if I had gone to them [sooner] ... you do the best you can at the time. [I] should have really fed him with a dropper or spoon, I shouldn't have really kept giving him milk in a bottle if I was wanting to [breastfeed], but it just seemed like that was so much effort, and I didn't weigh up the short-term effort versus the long-term effort.*

Simone continued to harbour some negative feelings towards the hospital nursing staff, believing that if they had been better informed about feeding practices her life now might have been quite different. Not only had difficulties with breastfeeding caused emotional heartache, a significant part of her day was given over to expressing milk using a pump. At the time the interview took place, Simone was spending approximately four hours a day expressing breast milk for her son, who was still reluctant to drink from the breast.

Grandmothers, drawing upon the experiences of their generation, added additional stress to the lives of some women. Esther's mother-in-law, for example, had bottle fed her babies and felt strongly that babies should be fed four-hourly:

*[My mother-in-law] was absolutely appalled that I was feeding on demand, but that's what the books say these days ... you can tell [people] that [opinions on feeding have changed] until you are blue in the face!*

Another woman spoke about conflicts with her partner's parents over feeding (as well as other issues):

*They don't believe in breastfeeding, they don't think it's natural. So that was really quite difficult, because I was having so much trouble, and I just wanted people around who thought that it was beneficial to keep going, and they didn't.*

My research findings suggest that it is important for midwives and others providing support to new mothers to be aware of the multiple, contradictory influences at work as women are getting breastfeeding established. In particular, hospital experiences and the social and

emotional support provided, or *not* provided, by women's friends and family/whanau can have a significant impact.

## Sources of Support for Breastfeeding Women

Midwives, partners, friends and relatives were often mentioned as primary support-providers for women as they mastered breastfeeding. Some women also turned to books for advice, with the *Womanly Art of Breastfeeding* and *Best Feeding* specifically mentioned.

Perhaps not surprisingly, some women I interviewed found that it wasn't until they got home that they were able to overcome breastfeeding problems, with the support and encouragement of their partners and midwives. Being more relaxed in their own environment undoubtedly contributed to their success as well. One woman who had difficulty breastfeeding had made a deal with her partner before their baby was born. Because she was so keen to breastfeed, "if the going got tough" he was to help her to persevere. He kept to his part of the bargain by encouraging her, leading to a mutual feeling of accomplishment and pride:

*And that was the support I wanted, I didn't want him to say, 'This is looking really rough, flag it away.' And I told him that I wanted to forget the deal, but he wouldn't let me! He was really good. He was so proud of me for doing it!*

Eventually all the women I interviewed – with the exception of Simone, and Theresa (whose experiences are summarised later in this article) – mastered breastfeeding, some much sooner and easier than others. Simone persevered with her valiant attempts to encourage her son to breastfeed, ever hopeful that as he got older there would be more chance that he would take the breast. She was particularly grateful for the "incredible" support she had received from La Leche League, crediting members with giving her the power to believe in herself and supporting her philosophy that her breast milk was the best for her baby. Karen also spoke highly of the support she had received from La Leche League. She believed that the foundations of her ability to breastfeed successfully were set up before her baby was born, when she attended a League meeting during which group members went through the basic steps involved.

Other women succeeded in breastfeeding due largely to their determination and heavy reliance on support, both practical and social and emotional, from those around them. Gabrielle emphasised the importance of a new mother surrounding herself with people who would encourage and support her in her attempts to establish breastfeeding:

*[I]f you want to breastfeed, make that very [clear] – make sure that people all around you*

know that's important to you, and that [your] midwife knows that's important. And get as much support and advice as you can. [Gabrielle]

## Lactation Consultants

Over recent years, the profession of "lactation consultant" has emerged within Aotearoa/New Zealand. Suitably qualified or experienced women must undertake professional training and sit examinations before they can offer their services as lactation consultants. Although none of the women I interviewed reported working with a lactation consultant (perhaps because there are very few in the region as yet), Dobbie (1997) notes that a number of women responding to a Parents Centre survey had received help from one. One woman who participated in their survey commented that she could not rate the lactation consultant employed by her local hospital highly enough, adding that "... she made the difference between continuing breastfeeding or not".

## Development of Breastfeeding Policies

Concern over the lack of breastfeeding support for mothers is not new. For example, nearly 20 years ago the Maternity Services Committee of the Board of Health prepared a policy statement, which read in part:

*Much misery can be avoided by consistency of advice with breast-feeding, and we should not muddle our patients with each new shift of nurses proffering contradictory suggestions.* (Maternity Services Committee of the Board of Health policy statement, October, 1979)

Continued recognition of the need for more support for mothers who choose to breastfeed is shown by the attention that has been directed at breastfeeding policies and practices in the past few years. In 1993, the Auckland Maternity Services Consumer Council published "Quality Indicators for Auckland Maternity Services". Amongst other recommendations, the Consumer Council would like all breastfeeding information and support in Crown Health Enterprises to be coordinated by a qualified lactation consultant, and all practitioners working in the area of maternity services to undertake an annual in-service training course on breastfeeding. Confirming my findings, they also noted that women they surveyed reported receiving conflicting advice regarding breastfeeding, further highlighting a need for consistent advice from all practitioners.

As part of a drive to improve maternity services, members of Parents Centres New Zealand are also currently lobbying for better support for breastfeeding.

In June 1997, the Ministry of Health/Manatu Hauora released *Infant Feeding:*

*Guidelines for New Zealand Healthworkers,* intended as a resource document for public health service providers actively involved with infant feeding.

The authors acknowledge that efforts must be made to help women acquire the necessary knowledge and practices in order to breastfeed satisfactorily, recognising that many women need counselling and education on breastfeeding.

## Bottle Feeding

Theresa was the only woman I interviewed who had elected to bottle feed her daughter from birth. She explained that it was a personal decision (for reasons she did not elaborate on), and a hard decision to make. Although the hospital staff had been supportive, providing her with ready-mixed formula, she spoke about the pressures she felt from others to breastfeed:

*It's a very social thing to breastfeed, and it's really pushed on you ... I mean society just presumes that every mother will breastfeed their child, and [whether it's because] you can't, or [because] you don't want to, [the reasons are] really not taken into account.*

Theresa described her initial concerns that perhaps her daughter was "missing out", and she went through a time of feeling very guilty about her decision. She would have appreciated more reassurance that the choice she had made to bottle feed was the right choice for her:

*[T]here wasn't any support for that whatsoever. There's no support for mothers that don't want to breastfeed ... to me it comes down to quite a psychological thing - that it needs not counselling over, but reassurance that you're not any different from anyone else, just because you've made that decision [to bottle feed] ... [B]reastfeeding might be the best thing for the baby, and I accept that, but ... you're just confronted with it the whole time, and it does make you stop and think, well, am I not giving my child the best?*

Theresa's midwife had been understanding, warning Theresa that she might face adverse reactions from others, which did eventuate:

*[I]ve had people in the street say to me, 'Are you still feeding?' and I feel like saying to them, 'What business is it of yours?' ... I don't know why they come out with these questions. And when I've said she's bottle fed, [the reaction is] 'Oh, why haven't you breastfed her then?'*

Theresa reported that everything she had been taught about feeding had been related to breastfeeding. She felt that bottle feeding was more-or-less dismissed, with the underlying message being: "If you choose to do that, you can find out for yourself." Theresa suggested that antenatal classes could spend more time on bottle feeding, so that women for whom breastfeeding was not an option

would be better prepared.

## "Breast Versus Bottle": The Dilemma Faced by Support Providers

It must be acknowledged that professionals providing ante- and postnatal education may be limited in the amount of information about bottle feeding they can provide, due to restrictions resulting from Aotearoa/New Zealand's voluntary compliance with the International Code on Marketing of Breast Milk Substitutes.<sup>1</sup> Kirton (1995, p. 16) discusses the Code's "pervasive authority":

The Code's intention is to promote and protect breastfeeding, and while it creates an encouraging and supportive environment for breastfeeding mothers, those who choose to bottle feed find it also restricts information on alternative infant nutrition.

*Mothers looking for the best alternative way to feed their children are confronted with an information black out. From the time a mother attends antenatal classes, she is exposed to messages emphasising the importance of breastfeeding for optimum infant care and development.* (Kirton, 1995, p. 16)

The correspondence column of *Little Treasures* magazine frequently includes letters from parents addressing the "breast versus bottle" debate, with pleas from those who have chosen to bottle feed for greater acceptance of their decision. Tomson (1994), a Plunket nurse, explains in her reply to a correspondent appealing for help, support and encouragement for bottle feeding mothers that she treads a fine line daily. She describes the dilemma she faces in choosing whether to support a mother by not making her feel guilty about her decision to give up breastfeeding (often when she is "at the end of her tether"), or whether to encourage the mother to persevere when she can see that given a little more time the problem currently faced will pass.

The comments of Simone (who was having great difficulty with breastfeeding) illustrate how professional advice may be misinterpreted or resisted:

*[The staff at the Plunket-Karitane Family Centre] were probably looking at it from my point of view - and thinking it's very exhausting and hard work to express - and it would be better for me to give it away. So I think they were trying to let me know that if I chose to give up, that was an OK thing to do. Whereas that wasn't what I was wanting, so I guess I didn't hear that as support really.*

## CONCLUSION

Learning to feed a baby successfully - whether by breast or by bottle - is one of the first challenges for all new mothers. The Ministry of Health/Manatu Hauora (1997)



guidelines on infant feeding provide an excellent starting point for professional and voluntary groups developing policies regarding the provision of education and support to new mothers about feeding practices. In particular, the guidelines encourage support providers to establish policies which will "protect, promote and support breastfeeding". For example, they advocate policies which will reinforce a "breastfeeding culture", by encouraging the development of baby-friendly facilities.

My research findings support conclusions from related studies (e.g. Baldwin, 1996; Bennett, Etherington & Hewson, 1993; Crouch & Manderson, 1993), indicating that when advice about feeding practices is inconsistent or incomplete, confusion will occur; this is particularly true with regard to breastfeeding. Considerable determination is often needed to overcome problems, and the support of people who are knowledgeable about breastfeeding is essential. Women should be aware that those who choose to breastfeed may encounter initial difficulties and discomfort. They should be well-informed regarding those who can support them with breastfeeding advice in hospital, so that staff working different shifts do not confuse new mothers. Kirton (1995) makes an important point when stating that although breastfeeding is widely accepted as the optimum method of infant feeding, women should be able to have free access to information on alternative feeding practices so that they can make informed decisions. Although only one of the women in my sample chose to bottle feed, her experiences suggest that women who choose to bottle feed should also be offered comprehensive support, with recognition that they may require additional social and emotional support to help them to handle any negative reactions they may encounter from others.

## ACKNOWLEDGEMENTS

I would like to express my thanks and gratitude to the twelve women who so willingly shared their stories with me. The thesis was supervised by Dr Jenny Neale, Victoria University of Wellington, whose support and advice was greatly appreciated. A Sarah Anne Rhodes Research Fellowship and a Victoria University of Wellington Graduate Award contributed to the funding of the research.

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1 The Code controls education and information on infant feeding practices. It was adopted at a World Health Assembly in 1981, following an international meeting of the World Health Organisation (WHO) and UNICEF held in 1979 where feeding of infants and young children was discussed. In 1990 the Innocenti Declaration called for all countries to adopt the Code in its entirety by 1995. In Aotearoa/New Zealand, compliance with the code is by voluntary agreement with manufacturers, distributors, advertisers and media.

## STUDENTS' CORNER

### E Mahara Ana Te Whanau The Family Remembers

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Indigenous New Zealand women live in two worlds, the world of the predominant Anglo-Saxon culture (Walker, 1990) and, the world of taha Maori. The interface among the cultures brings about a tension between traditional and modern definitions of childbirth and motherhood (Daviss, 1997) for wahine Maori. Wahine Maori come from diverse backgrounds (Durie, 1998; Ministry of Women's Affairs, 1993) and share a universality (Rabuzzi, 1994) with women in general in wanting; to have sovereignty over the birth process; to have a safe birth; and to retain their mana as wahine and as members of whanau, hapu and iwi. Women are central to the transmission of traditional cultural wisdom (Long & Curry, 1998) encompassing childbirth beliefs and practices (Daviss, 1997). Among the Maori are tribal elders, kuia, aunts and mothers who are pivotal in the journey of wahine Maori towards childbirth and motherhood. Colonisation (Durie, 1998; Walker, 1990) and the medicalisation of birthing processes (Abel, 1997; Ramsden, 1994) have been factors that have resulted in the breakdown of cultural transmission (Daviss, 1997; Long & Curry, 1998). This paper reviews the need for health services to collaborate with Maori communities traditional or otherwise to support constructive transformation for wahine Maori and the role of government policy making in sustaining Maori values and beliefs.

#### Te Timatanga/The Beginning

Te Po Nui	The Great Night
Te Po Roa	The Long Night
Te Po	The Night
Te Po	The Night
Te Po	The Night

The creation story begins within the realm of Te Korekore, The Nothingness (Marsden, 1992; Walker, 1990; Walker 1992), the realm between non-being and being, that is potential being. Following Te Korekore is the realm of Te Po with its stages of night. It is here that the 'seed-stuff of the universe and all created things gestate...it is the womb from which all things proceed (Marsden, 1992)'.

As the nannies and mothers we sung the above verse with our tamariki at kohanga reo. This waiata held special significance for one of our mokopuna named Te Po Muriwai. Te Po is prominent in my thoughts as I write of motherhood and creation. We sung this waiata repeatedly at Te Po's tangihanga last year. At age 11 years she had died.

We sing this song and we the mothers remember.

Ki Te Po Uriuri	To the Deepest Night
Ki Te Potangotango	To the Intense Night
Te Po	The Night
Te Po	The Night
Te Po	The Night

The creation story is universal (Rabuzzi, 1994; Walker, 1992) and the creation myths serve as a substructure from which traditional beliefs and practices are understood in the modern context (Walker, 1992). Ranginui, the sky father and Papatuanuku the earth mother embraced tightly while their numerous sons lay between them in the blackness. The elder son Tane Mahuta had grown tired of living in the packed dark conditions and forcibly separated Ranginui from Papatuanuku. This separation heralded the beginning of the world of mankind Te Ao Marama. From the earth Tane created the female Hineahuone and they begat Hinetitama the first born human. Tane consummated the incestuous relationship with Hinetitama and they begat the beginnings of the human race. Upon discovering that her lover was her father Hinetitama fled in shame from Te Ao Marama to the underworld. To signify this event she changed her name to Hinenuitepo, the woman of the great night.

It was the connection to Papatuanuku, the earth mother, and through the activities of Hineahuone, Hinetitama, Hinenuitepo and other fabled Maori heroines that the mana of wahine was derived in traditional Maori society.

#### Mana Wahine/The Authority of Women

The status of wahine Maori is linked to Papatuanuku the earth mother (Makereti, 1986; Rimene, Hassan & Broughton, 1998; Taylor, 1996; Te Awekotuku, 1991). Maori believe that the earth is the elemental womb to which mankind must return in death (Marden, 1992; Te Awekotuku, 1991). The first female Hineahuone was created from the sacred red clay of Papatuanuku. Women are tapu and noa at the same time (Kahukiwa & Potiki, 1999; Pere, 1991; Rimene, Hassan & Broughton, 1998). Tapu due to their sacred and spiritual beginnings and by virtue of their gender women are considered noa and have the ability to whakanoa or undo tapu. Hinetitama was the first born human female and from her originates Te Whare Tangata.

#### Te Whare Tangata/House of Mankind

Te Whare Tangata translates as the house of mankind (Makereti, 1986; Ratima, Ratima, Durie & Potaka, 1994; Rimene, Hassan & Broughton, 1998; Taylor, 1996). Te Whare Tangata

identifies the uniqueness of woman to conceive (Long & Curry, 1998; Rabuzzi, 1994) and establishes whakapapa (Makereti, 1986; Rimene et al.,) and therefore mana. Mana makes childbirth a phenomenal event. Te Whare Tangata is the place where those yet to be born wait until they are welcomed into the world of Te Ao Marama (Rimene et al.,).

#### Te Whare Kohanga/The Nesting House

Te Whare Kohanga initially referred to the ancient custom of building a birthing house for high born Maori women (Best, 1975; Rimene, Hassan & Broughton, 1998). The term Te Whare Kohanga now commonly refers to pregnancy (Rimene et al., 1998). To safeguard the wairua of the wahine, pepi and the whanau there are specific conventions pertaining to pregnancy and birth (Best, 1976; Makereti, 1986; Rimene et al., 1998; Te Rahuitanga Te Kohanga Reo, 1983).

The wahine Maori is instructed by other women to not cut her hair while hapu. The head is considered tapu and the wairua of the mother and the unborn child is to be protected. She is informed of; te manaakitanga o te tamaiti i roto o te whare tangata, to care for the child within her; and te whakahanga o te tamaiti whanau hou, the growth of the newborn child. The recollections of others prompts her to select names of significance for the pepi – after a tupuna or an important event. She is reminded of customs specific to childbirth; te whenua o te tamaiti, the placenta of the child; te pito o te tamaiti, the umbilical chord; and te whakaputanga o te whaea, the discharges of the mother. Te whenua ki te whenua or placenta of the newborn is given into the earth, back into the embrace of Papatuanuku (Best, 1975; Makereti, 1986; Rimene et al., 1998). Once the pito or umbilical chord detaches from the infant it too is returned to the earth. All birth membranes of the pepi and mother constituent Te Whare Kohanga and due to the woman's wider role as Te Whare Tangata these membranes require particular spiritual handling.

Knowledge and competency in pregnancy and childbirth comes mainly from the older women within the whanau and hapu (Makereti, 1986; Rimene et al., 1998). Mothers remember.

#### Te Ao Tane/The World of Men

In traditional Maori society the role of the man is both reciprocal and complimentary to that of the woman (Rimene, Hassan & Broughton, 1998; Walker, 1990). The mana of men is associated with the deeds of the gods like Ranginui, the sky father, his son Tane Mahuta (Rimene, Hassan & Broughton, 1998) and their male

descendants. Men are the kaitiaki of Te Whare Tangata. In conception the whakapapa of the male unites with the whakapapa of the female (Kahikiwa & Potiki, 1999). The role of the tane is to protect the wahine, thereby protecting his whakapapa. It has been said of some Maori men that they have forgotten this aspect of their role (Rimene et al., 1998). The immediate physical environment of the hapu wahine is the chiefly concern of the tane. He must ensure the safety of the wahine and child from negative and harmful elements. His lineage is nurtured by woman and lives on in the pepi.

#### Te Whanau/The Family

In traditional Maori society people had close kinship ties with their immediate whanau members, their hapu and iwi (Haines, 1987; Hiroa, 1949; Walker, 1990). The whanau is the smallest social unit (Rangi Hiroa, 1949; Walker, 1990) and although extended whanau members no longer live together Maori continue to interact closely with aunts, uncles, cousins and nannies (Durie, 1998; Ratima, Ratima, Durie & Potaka, 1994; Rimene, Hassan & Broughton, 1998). Whanaungatanga as a philosophy is the sharing of accumulated knowledge, experience and wisdom for the benefit of the whanau, hapu and iwi (Durie, 1998; Kahukiwa & Potiki, 1999; Pere, 1991; Walker, 1990). These days of living apart from traditional rural communities means whanaungatanga is extended to non-kinship ties within urban communities (Kainamu, 1996).

The contribution from the whanau towards new parents can include; physical and emotional tautoko; as guides in parenthood; and as kaitiaki for the tamaiti. Adults become parentis locus for all tamariki within the whanau and hapu (Makereti, 1986; Pere, 1991). The whanau draws on it's collective experience to make room for the new parental status of its younger whanau members. The whanau remember.

Kaumataua continue to be the leaders of whanau (Durie, Allan, Cunningham, Edwards, Forster, Gillies, Kingi, Ratima & Waldon, 1997). Kaumatua are advisers and spiritual leaders, keepers of tribal lore and messengers of wisdom. Traditional cultural wisdom (Long & Curry, 1998) is passed down to the next generation through the recollections of kuia and kaumatua. Their role is purposeful; to instruct new mothers in matters of birth; to safeguard the wairua of the whanau through the observance of particular rites; and to guide whanau and hapu in the maintenance of support for the new parents. Kaumatua are the link with the past. Kaumatua remember.

Kaumataua are the kaitiaki and teachers of young children (Makereti, 1986; Rimene et

al., 1998; Te Awekotuku, 1991). The relationship between kaumatua and mokopuna is special (Rimene et al., 1998; Te Rahuitanga Te Kohanga Reo, 1983).

#### Kotahi te ha o te tupuna me te mokopuna

The heartbeat of the tupuna and the mokopuna beat as one

Nga taonga tuku iho (Pere, 1991; Te Rahuitanga Te Kohanga Reo, 1983), treasures that have come down are passed on to the child through relationships with kaumatua. While the parents, and members of whanau and hapu, provide the physical and mental day to day nurturing of the child, it is the older whanau members, the kaumatua, who nourish the child spiritually. The active participation of kaumatua in rearing mokopuna ensures that tamariki are recipients of traditional cultural wisdom. Tamariki remember.

#### Tari Hauora/Health Services

Wahine Maori mostly had births on tribal lands as recent as 50 years ago (Abel, 1997; Makereti, 1986) attended by elders and whanau members experienced in birthing matters. The medicalisation of Maori birthing practices was a response to the high morbidity and mortality rates among women and infants (Abel, 1997) and came on top of wider colonisation processes (Ramsden, 1994). The take over of native birthing practices by the medical profession combined with components of colonisation resulted in a breakdown in the transmission of traditional beliefs and practices (Daviss, 1997; Long & Curry, 1998; Ramsden, 1994).

Following the demedicalisation of birthing services there has been an increase in numbers of Maori providers of maternity care, more Maori midwives and greater scope of midwifery practice in the community (Abel, 1997; Ramsden, 1994). However there remain identifiable gaps in prenatal and postnatal care (Ratima, Ratima, Durie & Potaka, 1994; Rimene, Hassan & Broughton, 1998) in that Maori understandings of health are different to those of health professionals and western medicine (Durie, 1998; Ramsden, 1994). The result has been that Maori women and whanau have been reluctant in accessing childbirth services. Maori are not homogenous therefore health services need to provide a range of strategies to meet the diverse lifestyles (Durie, 1998) of wahine Maori as well as the provision of culturally appropriate maternity and midwifery care (Ratima et al., 1994; Taylor, 1996). There remains an urgency for Maori participation in maternity services at all levels, as health professionals, as well as tribal elders and women experienced in birthing matters.

Health providers would do well to collaborate with Maori communities in the delivery of maternity care.

## Kaupapa Kawanatanga/ Government Policy

Wahine Maori are the primary caregivers of children, caring for large families including whangai (Murchie, 1984). Maori women form the cutting edge of cultural restoration (Ministry of Women's Affairs, 1993) and are at the forefront of the successful growth of Kohanga Reo. Wahine Maori are often in poorly paid work to subsidize the low income of their spouses. Maori generally experience inferior health, are poorly educated and live in substandard housing conditions.

The government as the treaty partner has a constitutional obligation under the Treaty of Waitangi (Durie, 1998; Ministry of Women's Affairs, 1993; Walker, 1990) to improve the socio-economic position of Maori in general. Article One of the Treaty of Waitangi, kawanatanga, is the provision for the Government to govern through central, state owned and local structures. Article Two, tino rangatiratanga, guarantees the authority of hapu and iwi to self-determination. Maori are often seen and understood to be one nation rather than various hapu and iwi with distinct identities. Article Three, oritanga, is the provision of equality and equity for Maori compared to non-Maori. The negative socio-economic disparities between Maori and non-Maori continue to expand (Durie, 1998; Ministry of Women's Affairs, 1993).

The status of Maori women and Maori motherhood will get better when there are improvements in circumstances for Maori in general and for women in general (Ministry of Women's Affairs, 1993). When the Government recognizes the extraordinary place of Maori in the constitution as tangata whenua then there will be benefits for New Zealand as a nation (Durie, 1998).

## Te Whakamutunga Korero/End Discussion

Successful transformation to childbirth and motherhood is more complex than having safe births, healthy babies and healthy mothers. The elimination of risks associated with birth and the modernisation of childbirth and motherhood need not come at the expense of other dimensions of health such as mental, spiritual and whanau. Maori women are members of whanau, of community, of hapu, of iwi and of nations. As Te Whare Tangata women carry the values and beliefs reflected by their communities. Kaumatua remember, Whanau remember, Mothers remember so that Tamariki remember.

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## Glossary

Hapu	Sub-tribe/pregnancy
Hineahuone	First female
Hinenuitepo	Goddess of the underworld
	previously known as Hinetitama
Hinetitama	Child begat by Tane and Hineahuone
Ha	Breath
Iwi	Tribe/bones
Kaitiaki	Guardians
Kaumatua	Elderly male or female/status title
Kawanatanga	Governorship
Kohanga reo	Maori language nest
Kotahi	One
Kuia	Elderly woman
Mana	Authority, prestige, power
Manaakitanga	Care for
Maori	Native people of New Zealand
Mokopuna	Grandchild/younger children of whanau
Nga taonga tuku ihu	Spiritual gifts
Nui	Great

Oriori Lullaby, chant	
Oritetanga	Sameness/equality
Pakeha	Anglo-Saxon settlers to New Zealand
Papatuanuku	Earth Mother
Pepi	Baby
Pito	Umbilical cord
Potangotango	Intense night
Rangatiratanga	Self-determination
Ranginui	Sky Father
Roa	Long
Roto	In
Tamaiti	Small child
Tamariki	Children
Tane	Man
Tane Mahuta	God of the forest/ one of many sons of Papatuanuku and Ranginui
Tangata Whenua	People of the land/ indigenous people
Tangihanga	Funeral
Tapu	Sacred
Tautoko	Support
Te Ao	The World
Te Ao MaramaTe	World of Light/ world of mankind
Te Korekore	The realm of Great Nothingness
Te Po	The Night
Te reo	Language
Te Whare Atua	House of God
Te Whare Kohanga	Nesting House/ referring to pregnancy
Te Whare Tangata	The House Of Mankind/ referring to continuation of whakapapa
Tikanga	Customs
Tupuna	Ancestors/elderly
Uriuri (Te Po)	Deepest (night)
Waiata	Song
Wahine	Woman
Whakahanga	Development/ growth
Whakanoa	Make common, undo the sacredness, make safe
Whakapapa	Lineage
Whakaputanga	Discharges
Whanau	Family/birthing
Whanau hou	Newborn
Whanaungatanga	Family relationships
Whangai	Adopted child
Whenua	Land/placenta

**Papatuanuku - He Pikitia na Marama Kainamu - Wheeler, 1994, Tau 4 1/2 (yrs)**



**Te Whenua Ki Te Whenua**

I am an important being.  
I am a treasure, a sacred woman,  
tapu, as all women are and noa also.  
(Kahukiwa & Potiki, 1999)

**urgently needed**  
**midwives**  
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An Evangelical Christian Mission working in Africa, Asia & South America

## OPINION COLUMN : MIDWIVES SHOULD NURTURE THEIR YOUNG NOT EAT THEM.

Irene Calvert MA (Midwifery)

I recently received an article from an Australian midwife whom I met when at the International Confederation of Midwives in the Philippines in May 1999. The title of the article intrigued me. "Midwives eat their young don't they?" Hastie (1995). These were the words expressed by the friend of a midwife who had recently committed suicide. The article discusses *Horizontal Violence* in the midwifery workforce.

At the 1998 New Zealand College of Midwives conference in Auckland students from one New Zealand Polytechnic performed a very moving account of the treatment, both positive and negative, they received from some members of the midwifery profession. I recall feeling both empathy and disappointment that students still encountered similar treatment from midwives that my student colleagues and I experienced in the early 1980's during our midwifery clinical experience.

Over the past two years several midwifery students have expressed concern to me about certain behaviours that they were subjected to during their clinical placements. These incidents occurred both in the hospital and the community settings. To be treated with respect is a basic human right (Johnson, 1996), yet one that some students and midwives appear to be denied. This type of behaviour does not reflect the modern concepts of midwifery care but more that of oppression.

To be oppressed is to be dominated, criticised and bullied by a person or group of people who perceive themselves to be superior or more powerful than the oppressed. The values and beliefs of the dominant group are seen as superior to that of the oppressed group. Therefore, in an attempt to succeed the oppressed take on the values of the dominant group in the hope that it will give them power and control. This creates submissive behaviour when confronted with the dominant group. It also creates tension within the oppressed group which lead to horizontal violence (Roberts, 1983; Duffy, 1995).

Since the medicalisation of childbirth, the medical profession has used its power to dominate midwifery. It controlled the way in which midwives were educated and produced hospital policies that restricted midwifery practice. This meant midwives lost their autonomy. In order to succeed in this environment midwives adopted the norms and values of the dominant group, midwifery became entrenched in the medical model. The pregnant woman became a passive recipient of obstetric care.

Despite the 1990 Amendment to the Nurses Act which once again gives New Zealand midwives autonomy, accountability and control over the care that they provide (Pairman, 1998), the values and beliefs of many midwives remain unchanged. Their practice is greatly influenced by the medical model that dominated their education system. Fear of change maintains the *status quo*; horizontal violence is perpetuated.

Student midwives in New Zealand are educated within the social model of care. They expect to actively work in partnership with women and health professionals. They find this dominant behaviour difficult to cope with and believe it unnecessary.

Power lies within the midwifery profession to eliminate horizontal violence.

Midwives need to recognise the way domination and oppression are introduced and maintained (Duffy, 1995). To truly regain our freedom we need to free ourselves from the norms and values of the medical model and adopt those of midwifery. All midwives need to make a paradigm swing to the social model of care. This does not imply that the medical and social models cannot work well together. Although the models are different they can complement one another (Bassett-Smith, 1988; Wagner, 1994). Midwives would still be able to work with an obstetrician or general practitioner but would expect an environment of mutual trust and respect not dominance. It is not where, or with whom you work, that is of importance but the philosophy that governs your practice.

The lay person perceives midwifery as a caring profession and it is this perception that the student brings to the course (Hunt & Symonds, 1995). The socialisation process the student receives from the educational institute as well as their clinical environment provides them with the values, attitudes and norms of the midwifery culture. If horizontal violence is something that the students are exposed to when in the clinical environment and/or in the classroom, then it will continue to be part of our culture unless we use this knowledge in a positive way to implement change.

Towards the end of the 20<sup>th</sup> century the midwives of New Zealand regained their independence to practice without the control of the medical profession. One of the reasons they were able to do this was that they worked in partnership with women, particularly those of the homebirth movement, to effectively bring about a law change (Pairman, 1998). This was a tremendous achievement and acclaimed

world-wide (Enkin, 1994; Guilliland, 1997; Lewis, 1999).

May I suggest that as we move into the 21<sup>st</sup> century the midwives of New Zealand extend this partnership to midwifery students and become facilitators of their learning? As midwives we must recognise students have knowledge and skills yet they require our expertise to develop them. This would enable the student to reflect on their clinical experience in a positive light and implement a behavioural change in the profession for the future. Midwives should develop strategies to nurture not eat their young (students and new qualified midwives), for surely these are the people who will have to continue to strive to maintain our independence!

Irene Calvert

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### Your Article Published June 2000 Edition 'Understanding Toxoplasmosis'

Dear Editor,

Thank you for the well presented article on toxoplasmosis in Issue 22. Unfortunately there are some inaccuracies in this article regarding the screening and management of toxoplasma in pregnancy in New Zealand.

The author states that a positive IgG should be treated. This is incorrect; a positive IgG alone indicates previous infection and immunity. Approximately 1/3 of the pregnant population in Auckland is IgG positive, (A. Morris personal communication, September 27, 2000). An even greater number could be assumed to be positive in rural New Zealand due to an increased risk of transmission sources. Following the author's recommendation would, therefore, result in the unnecessary treatment of many pregnant woman. A Ministry of Health publication (1999) states that with few exceptions, vertical transmission of toxoplasmosis will not occur if there is pre-existing maternal antibody.

With regard to the author's conclusion

I agree that the best way to reduce the incidence of congenital toxoplasmosis is prevention. This is supported by the recommendations of a multidisciplinary group organised by the Royal College of Obstetricians and Gynaecologists in the United Kingdom (Rajan, 1993). Unfortunately nothing has changed in the availability of improved screening and treatments since then. As recently as February of this year Moor, Stone, Purdie and Weinstein (2000) commented that screening remains controversial and that more evidence is required before it could be recommended for New Zealand. As toxoplasma infection is relatively asymptomatic in the majority of cases (Moor et al. 2000), we should continue to recommend caregivers provide women with information about the importance of avoiding risk factors for the transmission of toxoplasma infection in pregnancy.

As pregnancy caregivers we should follow the author's recommendation that midwives work with other health

professionals to improve education pre-conceptually.

Lesley MacLennan  
Clinical Charge Midwife  
High Risk Clinics  
National Woman's Hospital

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Dear Editor,

I read with interest Erwin Alber's views headed *The Female Principle* in the last NZCMJ. Upon observing our society, the disrespect for the feminine virtues is clearly evident to me. These gentle virtues are often devalued to the point where they are not seen as virtues at all, but as weaknesses.

As the planet becomes overridden with violence, power struggles, political unrest, economic failures and disrupted nature system, it has become apparent that the feminine impulse is urgently required. At present we have a system struggling to function while denying an essential part of itself.

The current struggle for equality should include an equal standing for the qualities of nurture, compassion and relatedness. These are true strengths of the feminine and can be powerful attributes indeed. Such qualities are essential to an ailing planet saturated with the need to control, domination and material gain at all cost.

If we can combine the strong propelling forces of the masculine with the nurturing, compassionate ways of the feminine then the planet can experience true harmony.

There has been a trend towards the degrading of natural feminine virtues. In society a woman is often only seen as an equal if she exhibits male attributes, rather than using the feminine ways to bring balance and respect. To effect the changes required to heal this planet, feminine virtues must come more to the fore so that decision making can be tempered with a

compassionate conscience. For example, education can consist of material with as much emphasis on art, music and beauty as there is on academic and sporting results.

Not only should we choose leaders successful in business and politics but also those with the wisdom to show compassion, be able to laugh, cry and play. Periods of activity can be alternated with moments of peace and stillness, so essential to rejuvenation of the human system.

Feminine relatedness sees the equal value of the street cleaner and factory worker with that of the surgeon and lawyer, both being deserving of the same respect. This is the motherly love that does not judge one above the other, and realises the need to nurture, love and protect all.

The masculine virtues are to be truly admired and when used appropriately, in conjunction with those of the feminine, have the ability to uplift our planet and enhance the life of every individual currently residing and those yet to be born.

On a personal front we can effect change by acknowledging both the feminine and the masculine in all we do. Our children can be raised with an equal respect for both. The foundations of the status quo are being shaken with divine intent as the feminine re-emerges to balance human consciousness and bring healing to a wounded planet.

May we celebrate the return of the feminine and seize this opportunity to renew our planet with the era that has dawned. Let us pay attention to our daily

lives and the behaviour we exhibit inwardly and outwardly. May we set a fine example to those who wish to follow and to those who are yet to be born.

Midwives play a crucial role in all this. They are the strength of midwifery in New Zealand are an inspiration and ray of hope for the whole world.

Teresa Cameron  
28 George Street  
Waiuku



Dear Editor

I was interested to read Mr Erwin Alber's letter in the New Zealand College of Midwives Journal 22 June 2000, and to note that he (a male) has used a journal predominantly read by females to get his anti-immunisation, anti-medical message published.

If immunisation is the hoax that he would have us believe why is it that countries who have low immunisation rates have higher death rates from vaccine preventable diseases? More importantly, why is it that countries like Japan and Sweden, who stopped pertussis vaccination due to concerns about vaccine side-effects, have re-introduced pertussis vaccination because they have suffered the consequences of this disease on unimmunised children?

And why is it that during the current pertussis outbreak in New Zealand our service has had calls from many parents who chose not to immunise their children based on information from organisations like Mr Alber's – and who said if they had known what pertussis was really like they wouldn't

have put their children through the trauma of this disease. Yes, immunised children still get it but generally in a milder form.

It is also interesting that we are noting numbers of parents who had been involved with, and committed to, anti-immunisation groups and who have walked away because they were "fed up" with the anti-medical stance. Medical science is far from perfect but it has achieved a lot of good things – in my own case saving both my own life and also that of 2 of my 4 children. Also I would not have had those children without medical intervention.

Midwives in particular, nurses and women in general, did endure much in the past. There are some areas where improvement is needed but generally women in New Zealand are in a stronger position than 100 years ago, or even 50 years ago. It seems to me that now is the time to put mistakes from the past behind us and move forward together to promote and support excellent health outcomes for mothers and especially for children – New Zealand's future.

If readers would like factual evidence-based immunisation information about immunisation for themselves or the mothers they support they are welcome to contact us at:-

Immunisation Advisory Centre  
PO Box 17 360  
Greenlane  
Auckland  
Ph: 0800 466 863  
Fax: (09) 373 7006  
www.imac.auckland.ac.nz  
email: imac@auckland.ac.nz

Yours sincerely

Elaine Boyd  
Nurse Consultant  
Immunisation Advisory Centre

Dear Editor

Mr Erwin Alber wrote a stirring letter in the New Zealand College of Midwives Journal 22nd June 2000 edition about the history of midwifery, the church and the male-dominated medical profession. He finished his letter with "A typical example of this is vaccination, a barbaric and insane practice which could only have been invented by male scientists devoid of the female principle. "Immunisation" is a monument to the stupidity of modern man who has been brain-washed to such an extent that he still accepts a hoax as a fact".

Midwifery is an ancient profession. The word "midwife" comes from the Anglo-Saxon word *med-wyf* meaning "wise-women". The arts of medicine remained almost exclusively in the hands of "wise-women" in the first half of the Christian era. However medieval Christianity detested midwives for their connections with pagan matriarchy and Goddess-worship. Patriarchal religion forbade midwives to assist their patients with contraceptive advice, relieving themselves of unwanted pregnancies or easing their labour pains.

When James Simpson proposed to relieve women's labour pains with the newly discovered anesthetic chloroform and ether there was a great outcry from the clergy who called it a sinful denial of God's wishes. According to Scottish clergymen, to relieve labour pains would be "vitiating the primal curse against women". The matter was resolved when Queen Victoria allowed her doctor to give her chloroform during the delivery of her eighth child and publicly hailed the new pain-reliever as a

great blessing.

Since then medical science has provided many life-saving advances for women and their babies. Who now would use herbs to treat conditions such as pre-eclampsia, Rhesus iso-immunisation, placenta previa or puerperal sepsis?

In recent times medical science has dramatically reduced infant and maternal morbidity and mortality. The discovery of micro-organisms, subsequent improvements in hygiene and the discovery of antibiotics have improved quality of life and has saved many lives threatened by invasive pathogens.

Immunisation is another example of a life saving advance. Some vaccines are more effective than others are. I have had personal experience with the effectiveness of vaccination. Prior to 1988 we used to have 30 cases of hepatitis B notified each year in Northland. Since universal vaccination in 1988 the number has steadily fallen. We now only see 3-6 hepatitis B infections per year in unvaccinated people. Hepatitis B can be a very serious disease. We had an unvaccinated 28-year-old mother die from acute hepatitis B in Whangarei hospital in 1996.

Invasive *Haemophilus influenzae* type b is another example of a very successful vaccine. Prior to 1994 we used to see 5 to 10 cases each year in Northland. Vaccination against this disease started in February 1994 with excellent uptake.

Last year we did not have cases of invasive Hib disease. Hib meningitis is now a disease of the past.

These amazing statistics can only be

attributed to the introduction and uptake of the Hepatitis B and Hib vaccines. The living standards of most Northland families have not dramatically improved over this period of time. However should vaccination coverage rates fall, these diseases could easily claim the lives of our precious babies.

Nursing is an art but also a science. "Best practice" is based on solid scientific evidence that is a result of well-constructed research, trials and studies. A well-rounded health professional has a practice that is grounded in both the female principle and the scientific approach. Both approaches have their place in midwifery. A practitioner would be unwise not to embrace both.

I do not agree with Erwin Alber's closing statement and I find myself wondering if he owns a telephone, a computer or even a motor vehicle.

Coralie Zimmer  
Immunisation Co-ordinator  
Northland Health Ltd  
PO Box 742 Whangarei  
New Zealand

Dear Editor

The New Zealand Venereological Society is contacting all providers involved with sexual and reproductive health care in regard to the continuing increase in gonorrhoea in all parts of the country. The Auckland region is part of the World Health Organisation Western Pacific Gonococcal Surveillance Programme. Data from Auckland laboratories both hospital and community indicate that gonorrhoea is the second most common bacterial sexually transmitted infection, with high rates in adolescents and young adults. Gonorrhoea has more than doubled in the last three years. There were 309 cases diagnosed in 1997, 461 in 1998 and 638 in 1999.

A significant number of infections are occurring in pregnant women and their partners. It is well recognised that risk of infection is highest among lower socio-economic groups and young people, where compliance with medication is often an

issue. Gonorrhoea has high associated morbidity with PID, tubal disease, infertility and neonatal disease. Sexually transmitted infection screening is therefore essential during the antenatal period. Control of gonorrhoea is a difficult and complex area, an essential component is the provision of effective antibiotics. In pregnancy and during breast feeding Ceftriaxone 250 mg IM stat should be administered. Another essential component of effective treatment is partner notification. Sexual Health services can be of assistance in this regard. The recommendations of The Centres for Disease Control and Prevention (CDC) and the UK National Guidelines on sexually transmitted infections are single dose therapy, with ciprofloxacin as standard treatment for uncomplicated gonorrhoea for non pregnant or breast-feeding persons. Additionally a regimen effective against possible chlamydial coinfection should be given at the same time, for pregnant and

breast-feeding women erithromycin mg bd for 10 days for their partners azithromycin 1 g oral dose stat. Currently ciprofloxacin is a specialist endorsed prescription. Specialist venereologists in sexual health services can be approached for assistance in this regard. It is important that all providers intensify their efforts to contain the ever increasing incidence of this disease.

Yours sincerely

Kitty Flannery  
President NZVS  
The New Zealand Venereological Society

1 Ref. Circulate letter to Health Professionals Toxoplasmosis testing in Pregnancy, Ministry of Health January 1999

# A CONSENSUS STATEMENT VITAMIN K PROPHYLAXIS IN THE NEWBORN

Fetus and Newborn Committee of the Paediatric Society of New Zealand  
New Zealand College of Midwives (Inc.)  
New Zealand Nurses Organisation  
Royal New Zealand College of Obstetricians and Gynaecologists June 2000

The fetus and Newborn Committee of the paediatric Society of New Zealand issued a statement on vitamin K prophylaxis for haemorrhagic disease of the newborn (now preferably called vitamin K deficiency bleeding: VKDB) in 1995. In 1992 a British report had suggested a possible association between intramuscular vitamin K and an increased risk of childhood cancer. By 1995 several large epidemiological studies from North America and Europe had been published, none of which supported such an association. Evidence also suggesting that the alternative route for vitamin K administration was not as successful at preventing the late form of VKDB. The 1995 statement, therefore, recommended that "all newborn infants should have vitamin K prophylaxis and that the preferred route of administration is intramuscular".

Since 1995 there has been continuing debate on this issue, a number of further studies published and importantly, ongoing surveillance of cases of VKDB in several countries. In addition, the launch of a new vitamin K product (Konakion MM®, which will replace konakion®) in New Zealand demands a review of previous recommendations.

As with earlier studies of a possible link between intramuscular vitamin K prophylaxis and childhood cancer, the most recent have been of variable design and not without methodological problems. Whilst most reviewers have interpreted these studies as not demonstrating any such link at least one editorial<sup>3</sup> concluded a small risk of leukaemia (but not other cancers) could not be excluded, although "the potential risk...seems more hypothetical than real". The risk of leukaemia may be small but does nevertheless influence the decision making of some families.

Neonatal bleeding is not always due to vitamin K deficiency and vitamin K deficiency often occurs after the four week neonatal period, hence the specific term, vitamin K deficiency bleeding has been adopted internationally<sup>4</sup>. VKDB is bleeding due to inadequate activity of vitamin K dependant coagulation factors (II, VII, IX X). In a bleeding infant a prolonged prothrombin time (PT) together with normal fibrinogen level and platelet count is almost diagnostic and rapid correction of the PT and/or cessation of bleeding after vitamin K administration are confirmative<sup>4</sup>.

VKDB is an uncommon but potentially fatal disorder which presents with the spontaneous bleeding, or bruising. Internal haemorrhage including intracranial bleeding, may occur. There are three recognised forms:

**EARLY:** This is very rare, and occurs on the first day of life in infants whose mothers are taking anticonvulsant (particularly phenobarbitone or phenytoin), anti-tuberculous therapy or vitamin K antagonist anticoagulants. Consideration should be given to treating such mothers with oral vitamin K, 20mg/day, for 2 weeks prior to delivery<sup>2</sup>.

**CLASSIC:** Bleeding occurs from the 2<sup>nd</sup> to 7<sup>th</sup> day of life. Older data suggests the incidence in babies who do not receive vitamin K Prophylaxis is in the order of 400 to 1700 per 100,000 births<sup>2</sup>.

**LATE:** This occurs between one week and six months of age, almost exclusively in breast fed babies, and often in association with unrecognised liver disease or malabsorption syndrome.

Recent surveillance in Australia<sup>5</sup> and Europe<sup>2,6</sup> gives the risk of late VKDB per 100,000 babies as being:

	Australia	Europe
No vitamin K	33.4	
1 dose oral Konakion®	20	
2 doses oral Konakion MM®		5
3 doses oral Konakion®	4.1	2.6
I.M. Konakion® at birth	0.2	0

Konakion®, the only form of vitamin K available in New Zealand for many years, has not been licenced for the oral use (although practitioners may still prescribe it by that route). It contains phytomenadione (vitamin K<sub>1</sub>) as the active ingredient but also polyethoxylated castor oil, propylene glycol and phenol, which some practitioners consider are mucosal irritants for the infant. The new Konkion MM® is designed specifically for oral, as well as intramuscular, use and contains phytonadione and the naturally occurring products, glycocholic acid and lecithin. The advent of this form of vitamin K should allay any concerns about oral administration related to the phenol content of the former preparation.

The international debate and uncertainties in the last decade over the safety of vitamin K administration to newborns requires maternity providers to ensure that patients have

access to discussion and information that recognises the complexity around their decision making in newborn care. The following recommendations are based on current evidence, which supports the administration of vitamin K to prevent VKDB in susceptible babies.

**Recommendations**

1. It is the responsibility of the lead maternity carer (LMC) to discuss vitamin K prophylaxis and ensure that parents are aware of the recommendation that all babies should receive vitamin K prophylaxis.
2. The recommended route of administration is intramuscular; 1mg (of Konakion MM®, 2mg/0.2ml) being given at birth. Preterm infants may receive 0.5mg.
3. If parents do not agree to an intramuscular injection, the alternative is for the infant to receive Konakion MM®, 2mg orally at birth. These infants should then receive a repeat oral dose (2mg) at 3-5 days 4-6 weeks of age. If the infant vomits or regurgitates within 1 hour of an oral dose, this dose should be repeated.
4. The oral regime is not recommended in "high risk" situations, such as maternal anticonvulsant or anticoagulant therapy (warfarin or phenindione), tuberculosis drugs (such as rifampicin and isoniazid), prematurity, birth asphyxia or other conditions which will delay oral feeding.
5. If the parents opt for repeat oral doses of vitamin K, both the LMC and the parents themselves carry responsibility to see that the infant receives these doses.
6. Most cases of severe VKDB are preceded by "warning bleeds" and it is important for practitioners and parents to be aware of spontaneous bruising and black bowel motions. Parents who have opted for no vitamin K prophylaxis should particularly be made aware of these signs.
7. Many cases of late VKDB occur when there is liver dysfunction. Prolonged jaundice in the newborn needs to be investigated.
8. Infants who are suspected of having VKDB should normally be admitted to hospital for investigation. Consideration should be given to the intravenous vitamin K administration and fresh frozen plasma or other source of clotting factors.

9. A written record of the date, dose and method of administration of vitamin K should be kept in the Child Health Record Book.

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## ICM Position Statement : Appropriate Intervention in Childbirth

### Statement of belief

The International Confederation of Midwives support the belief that childbearing for the great majority of woman throughout the world is a normal, physiological process influenced by culture, traditions, religion, and psychosocial factors. The Confederation further believes that childbearing is a family event and requires a health-orientated rather than a disease-oriented model of care from providers.

The Confederation also believes that for many women in the resource poor nations of the world, pregnancy and birth can be life-threatening and every attempt should be made to reduce the risk of death or illness through the use of evidence-based, low cost technological interventions when needed.

In keeping with the ICM International Code of Ethics for Midwives, the Confederation also believes that women are active participants in decision making that affect their health services. Making informed decisions about the use or non-use of technology in childbirth requires that women have up-to-date, complete and understandable information on the risks and benefits of each technological intervention proposed in their care.

### Proposed policy

In keeping with the last basic premises that childbirth is a normal, life cycle event for the majority of women in the world, the midwives of the world will use technology during childbirth only when indicated to enhance the well being of mothers and babies and improve outcomes. In keeping with this premise, the midwife will:

- provide information to woman and their families that promotes the understanding of birth as a normal life process and enables woman to make informed choices during health care;
- promote childbirth practices that enhance the normal physiological processes of labour and birth as well as the psychological, spiritual and cultural aspects;
- advocate for the fair allocation of health resources that support the basic needs of women and their babies as priority;
- participate in the design and evaluation of interventions during childbirth, include's the ethical use of technology according to the following criteria;
- when there is a clear and present danger to the health of mother or baby that can be removed by using technology;

## BOOK REVIEW

Irene Calvert  
Midwifery lecturer,  
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The book incorporates both the Art and Science of Midwifery. Unlike most midwifery texts this book is not based on the medical model of care. The main focus is on areas that are central to midwifery in the 21<sup>st</sup> century:

- women centred care which is evidenced based
- physiology of pregnancy, fetal and early neonatal development
- adjustment to parenthood.

The book discusses the emerging model of midwifery. There is advice on how to set up a midwifery practice as well as recognising the health structures that may influence the project.

The importance of providing evidence based care as a means to alter the *status quo* is stressed. Five steps required to provide evidence-based care are described. How to interpret research and apply it to a current situation is also demonstrated. An introduction to statistics is included.

The chapter on the Attachment Theory and the long term implications for society is very relevant particularly as the government of New Zealand is requesting all health professionals assist in the prevention of child abuse. The author recognises the effect that birthing in a hospital environment may have on parent/infant attachment and the unique opportunity the midwife providing one-to-one midwifery care has in identifying parent who may require extra support.

The move to university midwifery education as a pre-requisite for registration is acknowledged. This requires the student to work self-directed using inquiry based learning. Scenarios are used throughout the text to demonstrate the subject under discussion. Each chapter contains important pointers for practice.

Midwifery is undergoing a cultural change and this book will help midwives understand the new methods of midwifery care and of student learning. This is an excellent book and I would recommend it for all midwives irrespective of their place of employment. It is also very reasonably priced.

Page L. (2000). *The New Midwifery Science and Sensitivity in Practice*. London: Churchill Livingstone.

## Guidelines for Contributors

Manuscripts submitted for publication should not have been published previously in any form. Contributors should be aware of copyright and comply with accurate referencing or acknowledgements. The ideal length is between 1500 - 4000 words including figures and tables. Concise headings and sub-headings are advised. 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 and presented on a separate page. Abbreviations should be written in full followed by the abbreviation in brackets for its first use, e.g. World Health Organisation (WHO). All pages should be numbered consecutively, beginning with the title page. Manuscripts should be typewritten and double spaced on A4 paper (one side only) with 2.5 cm margins all around. PLEASE SUPPLY THREE COPIES and where possible these should be accompanied by a computer disk either Macintosh or IBM compatible. The Editor has the right to modify any article submitted with regard to format. Major changes will be referred to the author.

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### References - American Psychological Association (APA)

In the text, cite the authors' names followed by the date of publication, e.g. Bowers (1996). Where there are three or more authors, all authors' names should appear first and thereafter *et al.* will suffice. Where there are six or more authors *et al.* can be used throughout. In the reference section only include those authors referenced in the text. Please check references carefully.

Style as follows:

- Pairman, S. (1999). Partnership revisited: Towards a midwifery theory. *New Zealand College of Midwives Journal*, 21, 6-12.  
Bryar, R.M. (1995). *Theory for midwifery practice*. London: Macmillan Press.



### How to change your baby's nappy.

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### A Whole New Life

Change Skin Problems in Babies

Tooth & Tummy

Baby's First Year

Infant Massage

How to change

How to change

How to change

How to change

How to change

How to change

How to change

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### INFANT MASSAGE PROGRAMME

The Importance of Loving Touch



### INFANT MASSAGE PROGRAMME

The Importance of Loving Touch



### The touch of love



### Spring your baby



Johnson's baby



Fat is important for babies

Johnson's baby



Fat is important for babies

Johnson's baby



Fat is important for babies

Johnson's baby



Fat is important for babies

Johnson's baby



Fat is important for babies

Johnson's baby



Fat is important for babies

Johnson's baby



Fat is important for babies

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Fat is important for babies