



NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

JOURNAL

Guest Editorial
Comment

The Honourable Annette King

Professional Issues
Riding the waves of change

Chris Hendry

Education Forum
Meeting the needs
of Maori women

Hope Tupara

International Perspective
From different horizons

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Original Research
Where do all the midwives go?

Sally Pairman and Sheridan Massey

Midwives cancer study

Dr C Wells

NZCOM position paper
Midwifery Standards Review

Sally Pairman and Karen Guilliland



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COLLEGE OF
MIDWIVES (INC)**

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Provoke discussion of midwifery issues.

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Submit articles and letters to the Editor:
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See page 37 for guidelines.

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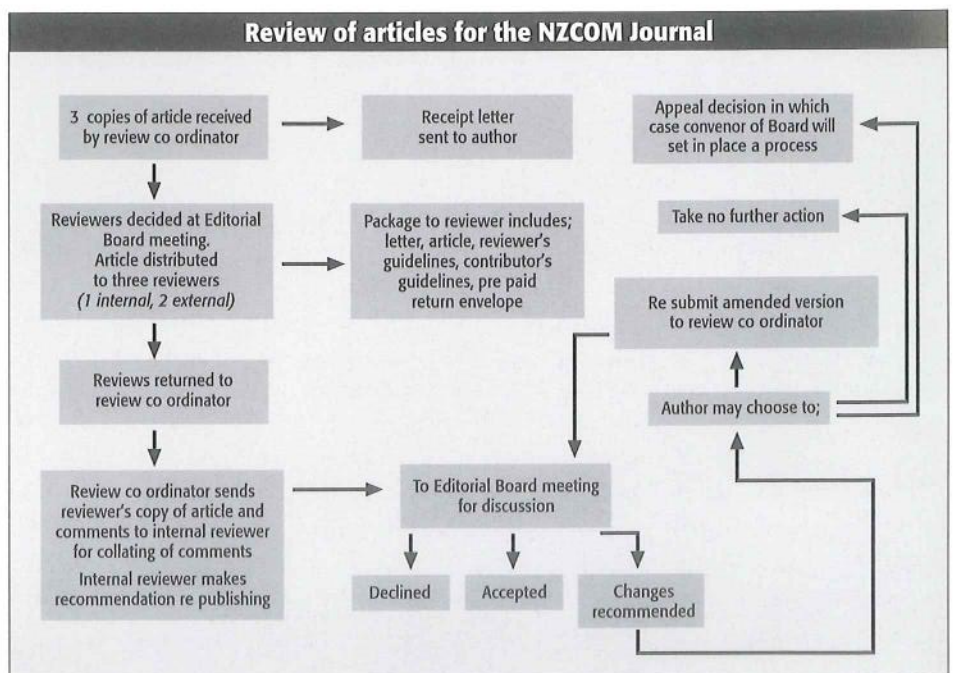
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Welcome to this issue of the journal.

Content in this issue

In this issue we are delighted to have an editorial comment from Annette King, Minister of Health, with her views on the impact of the current health reforms in relation to midwifery. There are regular features such as the column by Sarah Stewart on the internet for midwives, letters to the editor and book reviews. We also have a wide range of articles reflecting perspectives of individual midwives.

Chris Hendry traces changes in social policy and legislation of the past three decades and challenges midwives to learn from the successful strategies of the past in order to maximise opportunities for the future.

Sally Pairman and **Sheridan Massey** report the findings of a survey of graduates of the first two education institutions to offer direct entry midwifery in New Zealand. The results include factors which influence new graduates' decisions regarding initial and continuing employment in midwifery practice. This study is the first available information about direct entry graduates.

Hope Tupara raises concerns about the inaccuracy of information available in midwifery education institutions about Maori women's birth experiences. Through examination of the frameworks of cultural safety and partnership, Hope challenges midwifery education institutions to find ways to work effectively with Maori.

Dr. Chris Walls presents the findings of the first piece of research on the health of New Zealand midwives. A review of a cluster of cancer cases occurring amongst midwives who worked at National Women's Hospital from 1966 to 2000 was undertaken. The findings do not support an association between the workplace and subsequent development of cancer.

The College of Midwives provides a paper, written by **Sally Pairman** and **Karen Guilliland**, which sets out the College's position on credentialling. This is a topical issue, as the Ministry of Health has taken the lead in developing credentialling processes for medicine that may well be applied to other health professional groups. The College of Midwives offers an alternative model that integrates already existing processes such as

Midwifery Standards Review and Competency-based Practising Certificates.

Liz Smythe reflects on her experiences following a visit to Mali in her role as monitor for a World Vision project that is aimed at stopping Female Genital Mutilation (FGM). She also comments on the political context of maternity services and through this reflection links us to the New Zealand context: challenging us to acknowledge the cultural boundaries of knowledge and question some of our own traditional beliefs.

New Board

As you are aware the management and editorial responsibilities of the Journal have been taken over by a group from the Otago Region of NZCOM. We thank Gillian White for her efforts in producing the last two issues and acknowledge the huge amount of work that is involved. For this reason we have decided to work as a group to share the workload and responsibility and we look forward to the challenge of producing high quality Journals of which the NZCOM membership can be proud.

Membership of the board

The new Board is made up of the following people:

Alison Stewart

Alison Stewart teaches papers in both the School of Midwifery and the School of Nursing at Otago Polytechnic. She recently completed her doctoral thesis in the area of grandparent bereavement.

Sally Pairman

Sally is Head of School of Midwifery at Otago Polytechnic and is the immediate past president of NZCOM and has represented NZCOM in numerous forums. Sally has a Masters in Midwifery and is currently undertaking her Professional Doctorate in Midwifery through the University of Technology Sydney.

Deborah Davis

Deborah is a lecturer in Midwifery at Otago Polytechnic and continues to stay involved in practice by carrying a small caseload and providing back up for another independently practicing midwife. Deborah has a Masters degree and is currently working on her Ph.D.

Jean Patterson

Jean is currently working in midwifery education at the Otago Polytechnic School of Midwifery. She has been an active member of the College of Midwives since 1990. Jean is completing her MA thesis at the Nursing and Midwifery Department of Victoria University of Wellington.

Rhondda Davies

Rhondda is a self-employed independent midwife with a continuing involvement in research. She has a Masters (Applied) in Midwifery from Victoria University.

Future content in the journal

If you have an idea for an article or short comment for the journal and would like to discuss it then please contact Alison Stewart. We are always keen to hear about ideas and topics for future issues. Do read the notes for contributors (see page 37) which outline the style and formatting requirements for articles. Any article which is submitted for publication undergoes a process of review. This is outlined in the diagram opposite. In addition, where a member of the editorial board submits an article, then the author is excluded from discussions regarding the review process to avoid any conflict of interest. We are extremely grateful to the range of people who have agreed to be reviewers for the journal. Current reviewers are listed on the front inside page and we will update this list annually in consultation with the National Committee of NZCOM.

Feedback from you

We would welcome feedback on content of the journal and ideas for future directions. So, if you want to contact us then please write or email Alison at: School of Midwifery, Otago Polytechnic, Private Bag 1910, Dunedin. Email: alisons@tekotago.ac.nz.

Keen to discuss ideas with other people?

Then make sure that you read the advertisement in this issue for the NZCOM Conference in Dunedin, 2002 or check out the website at www.nzcom.org.nz. Other conferences that may be of interest are ICM in Austria 2002 (www.icm-congress.com/content.html). In addition, there is a conference in Auckland on Health Policy, Practice and Research in the 21st Century in 2002 with Professor Lesley Barclay as a keynote speaker (www.aut.ac.nz/conferences/healthpolicy/).

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The Honourable Annette King

Minister of Health, 30 August 2001

When I was asked to write the editorial for this issue, my first thought was "how am I going to be able to condense everything happening in the maternity sector into 500 words?" I decided that I couldn't realistically do this, so instead I will concentrate on just a couple of issues that I believe will be of most interest to you.

Retention of the midwifery workforce is something I feel very strongly about, because midwives are essential in the provision of maternity services. We need midwives working in both the hospital setting, and as lead maternity carers. Funding for the hospital sector has received some attention and it is accepted that we need to increase what we pay lead maternity carers. I expect to be able to give lead maternity carers a substantial price increase early next year, particularly supporting midwives in providing women with post-natal home visits.

Lead maternity care has been the cornerstone of maternity services since 1996 and continues to be viewed as an essential component of maternity.



It provides continuity of carer, making it possible for the woman to be involved as a partner in the management of her care. Women need to know that they can expect lead maternity care wherever they live in New Zealand. This Government will provide this certainty by moving all lead maternity care contracts to a standard national contract.

Maternity sits alongside the Government's broader changes to improve the health of New Zealanders and ensure more effective use of our health resources. The future of New Zealand health services, especially in the primary health care area, is to be one of greater coordination, continuity and teamwork. However, the gains that women have experienced in maternity care over the last decade must not be lost and a strong, independent midwifery profession is a key part of this. The Primary Health Care Strategy specifically ensures that maternity services are not forced in to hasty or unwelcome arrangements under Primary Health Organisations. This needs to happen before May 2002.

The Primary Health Care Strategy sets out how primary care services will be organised in the future. As part of the new vision, people will be part of local primary health care services that improve their health, keep them well, are easy to get to and coordinate their ongoing care. Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

As District Health Boards, the Ministry of Health and the primary health care sector move to implement the Primary Health Care Strategy, some changes will occur. These changes will be evolutionary, and aim to build upon the significant gains made over the recent years.

I am sure you will all agree that there is a long-term need to find sustainable models of primary health care in which nurses, doctors, midwives and others can combine to provide high quality, coordinated and continuing care to a population. However, the Government will not prescribe how such change will be achieved. It will take time and will require a mature approach from leaders in all the key professions, including your own. I know you will all rise to that challenge.

Are you a midwife interested in exploring and developing your practice?

If the answer is yes then try postgraduate study with Otago Polytechnic

The Otago Polytechnic School of Midwifery has developed three new postgraduate programmes with the help of practising midwives. These programmes meet the needs of midwives by:

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- Postgraduate Diploma in Midwifery (consists of four papers and is usually completed part-time over two years)
- Master of Midwifery (consists of eight papers and is usually completed part-time over four years)

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Meeting the needs of Maori women: The challenge for midwifery education

Hope Tupara RCPN, RM, MA

Self employed midwife, Levin

Ko Ngāi Te Rangihouhiri, ko Ngāi Tāmanuhiri

This paper is adapted from a dissertation completing an MA (Appl) in Midwifery at Victoria University in 2000, to identify sources of disparity between midwifery theory and practice in relation to Māori women.

Introduction

During the period that I was educated as a midwife in 1993/4 I began to notice discrepancies between what I was being taught about Māori women as part of my midwifery education and the reality of my personal experience of being Māori. My own pregnancy and birth did not seem to fit the description of Māori women's experiences being given by teachers or in New Zealand literature about childbirth. I began to question the accuracy of the information and the potential for that information to influence how midwives care for Māori women. Those discrepancies were further reinforced when I began to practice as a registered midwife and was exposed to the many different realities of Māori women in the community. I can recall a number of statements being made about Māori women's experiences of childbirth in my education programme, which suggested that these were relevant and applied to all Māori women. The assumption that Māori women would want to take home their placentas is one example. When Māori women are asked the question about keeping their placenta, responses range from absolute disgust at the mention of this practice to formal and meticulous arrangements. Another example is the assumption that whanau will be involved in the labour and birth process. The reality in practice is that Māori women might choose to have no whanau involvement for personal or situational reasons, or may involve a large group of carefully chosen family and friends.

One of the reasons why there is inaccurate information is because there is very little literature about Māori childbirth written by Māori. Therefore information that is available seems to be inappropriately applied to all Māori. Statements such as: 'A typical Māori lay midwife...' (Donley, 1998, pg 124), are misleading because, application of the

term 'Māori' to include 'all' Māori, reinforces stereotypical assumptions and views.

Eldson Best (1975) is sometimes cited in childbirth literature in relation to Māori experiences (Donley, 1998; Kainamu 2000). While some of his work may have its basis in fact, a critical mind must be applied to what has been written because of the way his interpretations would have been influenced by his own view of childbirth during the colonial context of New Zealand society. In this context, it is Best's reconstructed beliefs and ideas about Māori childbirth experiences that are represented in his work.

Control of Maori knowledge

The construction of knowledge about pregnancy and/or childbirth, and by whom and how it is controlled, has significance in education because of the influence that knowledge will have on midwifery students and how they relate and communicate with women, as practitioners. Education institutions use gate-keeping practices to ensure the interests of the dominant group are preserved. These practices include manipulating those who are to be consulted, restrictions on resources and appointment of decision-makers (Smith, 1986).

As Jones, McCulloch, Marshall, Smith & Smith (1990, p. 151) say:

The control over what counts as knowledge, and the control over institutions where such knowledge is practised, allows for dominant interest groups to perpetuate and maintain their positions of dominance and advantage

Ranginui Walker (1996) talks about the commodification of Māori knowledge. He gives the example of Sir George Grey's collection of Māori creation myths which were published in both Māori and English without acknowledging the Te Arawa chief, Te Rangikāheke, as their source. When John White was commissioned by Government to write *The Ancient History of the Māori*, published in 1887, he paid informants to write down their stories. According to Walker (1996) some informants were motivated by financial gain and stretched their imagination. Because of this, some of White's information is of dubious merit.

In the same way that Māori knowledge has been controlled and defined by Pākehā, so too has women's knowledge of childbirth been reconstructed by medicine. Marion McLauchlan's (1997) discourse analysis of current New Zealand childbirth experiences shows how the dominant discourse of medicine constructs knowledge and determines what is known about childbirth. McLauchlan (1997) shows how the end result of control over childbirth knowledge takes power from women, leading to the notion of the 'docile body'. In the same way knowledge relating to Māori is redefined and selected to fit western conventions of organizing and transmitting knowledge (Walker, 1996). Māori too, have absorbed western definitions of who they are. I recall one time when I was planning with two Māori health workers the development of antenatal classes for young Māori women. One of them told me that another Māori midwife, from outside the district, would be invited to speak about Māori birthing. In that instance, the knowledgeable person was being defined and I did not meet the criteria they were seeking.

Another contributing factor to Māori knowledge retention and development is the significant decline of the Māori language. Words are symbols of thought and in a culture where the written word was not dominant, those thoughts could also be expressed in other forms (Tau, 1999). Te Maire Tau makes this point by examining the word 'tapu'. Tau (1999, pp.15 - 16) says:

Tapu, a word that is everywhere in Māori society cannot be understood from an examination of a text. The word is represented and understood by the community through location, body movement, interaction with objects, carvings, facial expression, artwork and food gathering. Tapu is everywhere and consequently the language of tapu is represented in everything.

In addition, the written word and the spoken language should not be confused with a lived language. So for example, a Māori language expert, who is Pākehā, will not be able to enact their knowledge the same way a Māori person does when they have the lived experience of being Māori (Tau, 1999). Information written in Māori, may or may

not describe the world view of our ancestors in a way that is recognizable from a contemporary position. Analysis of this information requires fluency in the language, competency to interpret pre-colonial concepts and ideas, and a forum for this kind of analysis to take place.

In a Waitangi Tribunal Report (1999) on behalf of Te Tauihu o Ngā Wānanga Association, which comprises three Māori wānanga, Charles Royal explains that universities and polytechnics could be described as 'tikanga Pākehā' institutions, delivering education in a Pākehā cultural paradigm. As an example he discusses how Māori Studies represents the position that the western paradigm of knowledge has created for it, severely hindering its growth. The same argument applies in relation to Māori knowledge of childbirth and its position in a midwifery education context. In other words, some midwifery education institutions are contributing to the lack of Māori childbirth knowledge through use of inappropriate resources. With this in mind, I ask – how can the diverse needs of Māori women be met and how can midwives be appropriately prepared to meet these needs?

Relevant Maori knowledge

Childbirth literature by Māori midwives is indeed rare. Projects by Māori who are not midwives, such as Ukaipō (Rimene, Hassan & Broughton, 1998), have some value. This collection of stories was a joint project of the Ngai Tahu Māori Health Research Unit and Otago School of Medicine in Dunedin. They are valid stories of some Māori women's experiences, but they do not represent the attitudes and values of all Māori women. This point is emphasized because Māori women are as diverse as any other population (Durie, 1995). Probably the only true shared experience for Māori women is that of colonisation (Ramsden, 1994). As Cunningham (1998, pp. 395–396) says:

... future knowledge stems from past knowledge, yet it necessarily must take account of the recent and, as far as we can tell, future environment in which it is developed. Future knowledge, for the days in front of us "I ngā rā o mua", must take cognisance of the contemporary Māori

Worldview: social and cultural diversity, redress, protection and partnership in terms

of the Treaty of Waitangi, and responsiveness in terms of public sector interactions.

Kawa Whakaruruhau/Cultural Safety

The concept of Kawa Whakaruruhau/Cultural Safety developed from within the colonial context of New Zealand society to primarily improve the health of all people through the relationship between Māori and the Crown, based on the Treaty of Waitangi (Papps & Ramsden, 1996). This was in response to the poor health status of Māori and Māori insistence that service delivery, as a contributing factor to poor health must change profoundly. This led to a self-examination in nursing and midwifery education, with midwifery and nursing organisations moving to support this initiative (Papps & Ramsden, 1996).

Cultural safety is defined as:

The effective Midwifery care of women from other cultures by Midwives who have undertaken a process of reflection on their own cultural identity and recognize the impact of the Midwives' culture on their own practice (NZCOM, 1993, p.48).

Section 181 of the Education Act 1990, required polytechnics to acknowledge the principles of the Treaty of Waitangi and to encourage the greatest possible participation by the communities they served. In 1992 the Nursing Council responded by amending its Standards for Registration to include cultural safety in nursing and midwifery education (Nursing Council, 1996). Council also required that Schools of Nursing and Midwifery address their commitment to the Treaty relationship and explain its expression in their Schools. Thus, the Treaty must be translated into action enabling local responses (Nursing Council, 1996). The introduction and continued development of cultural safety education within Schools of Nursing and Midwifery has not been an easy road. A public debate, fuelled by media attention, questioning the notion of cultural safety in nursing and midwifery education, arose in the mid-1990s (Papps & Ramsden, 1996). Nurses appeared before the Select Committee on Education

and Science in 1995 but formal government inquiry did not eventuate (Ramsden, 2000a). Nursing Council, the student unit of NZNO, the Polytechnics Association and the Ministry of Health all held separate investigations. It became clear from their findings that cultural safety was important in nursing and midwifery education and should be retained, but that the process of teaching was an issue (Ramsden, 2000b). Cultural safety had become confused with Māori studies. The creation of Māori stereotypes invited students and graduates of nursing and midwifery to practise stereotypically (Ramsden, 2000a).

Since its inception into midwifery curricula, cultural safety has been refined to include the relationship between midwives

and those who use midwifery services, taking account of differences in age, sexual orientation, ethnic origin, disability and religious beliefs. Cultural safety is an examination of one's

own position of power as a midwife and the effect of that relationship on the women and families with whom the midwife works (Papps & Ramsden, 1996). Cultural safety in midwifery education provides a focus for the delivery and quality of care through changes in thinking about power relationships and women's rights (Papps & Ramsden, 1996). It has the potential to be relevant to all professional groups involved in health care. However, ten years on Ramsden (2000a) is not convinced that there is evidence of effective implementation of cultural safety guidelines at all education institutions. She states:

In response to the Education Act 1989, the Treaty of Waitangi should be effective in all educational institutions which are funded by the Crown, but because this has not happened, the Treaty has not been translated into measurable actions by many polytechnics and universities. This has made it difficult for nursing and midwifery to gain support for Treaty based activities and for Māori to make the institutions accountable for their own decision-making processes and outcomes (Ramsden, 2000a, p. 11).

continued over...

Meeting the needs of Maori women: The challenge for midwifery education *Hope Tupara*

The Treaty of Waitangi is the key to the application of cultural safety. It has become the negotiating basis for relationships between Māori and the Crown. The Crown, as provider of education resources for midwives, has an obligation to ensure that those education responsibilities are met (Ramsden, 2000a).

The Treaty of Waitangi

The British colonists recognised Māori sovereignty and independence by signing the Declaration of Independence in 1835 (Durie, 1998). The Treaty of Waitangi superseded this in 1840 and it was by this mechanism that Britain imposed its rule over the country (Durie, 1998). The signing of the Treaty by Māori and representatives of the Crown was intended as recognition of an equal partnership and as a foundation for future relationships between two parties. The Treaty of Waitangi was never intended as a basis for claims by Māori against the Crown. However, blatant disregard for Treaty principles over the past decades

has given Māori no alternative but to seek redress through the claims process of the Waitangi Tribunal. The claims process continues to evoke a range of feelings and opinions from many New Zealanders (Durie, 1998). According to Mansfield (1998) there is yet little recognition or public discussion of the fact that the relationships between Māori and the Crown and Māori and other New Zealanders are complex, many faceted, and ongoing. It is not envisaged that these relationships will end when the Treaty of Waitangi resolution process is complete. The state of those relationships will be of fundamental importance to the nature and quality of life in New Zealand in this century. If constitutionally significant relationships are to be effective, there needs to be a commitment by the parties to making the relationship work. A fundamental component to ensuring the relationship does work, is a willingness to accept the existence of differences in values, perceptions and objectives, as well as a willingness to reconsider and modify existing positions or viewpoints (Mansfield, 1998).

The trilogy of equally weighted relationships

is both implicit and explicit in the Treaty of Waitangi. It is new and uncharted territory for both Māori and the government. At the crux of this discourse is the recognition that it is a discourse on a multi-tiered relationship, not one on a social-political problem. It is not a problem to be solved but a relationship founded on mutual respect... it is an ongoing relationship where both parties have to contribute to their shared destinies (Maaka, 1998, pp. 204 - 205).

In 1988, the Royal Commission on Social Policy recommended three principles relevant to social policy and the Treaty of Waitangi: partnership, participation, and protection (Durie, 1994). These principles imply equity and economic and cultural security for both partners, all of which have been shown here and overseas to be impor-

The manifestation of partnership presumes active participation by each partner for the protection of each people's identity and well being.

tant determinants of health (Pomare, Keefe-Ormsby, Ormsby, Pearce, Reed, Robson & Watene-Haydon, 1995). Poor standards of Māori health may therefore be regarded, in part, as non-fulfilment of these treaty obligations (Pomare & de Boer, 1988). Treaty consciousness must be maintained in midwifery education and must be reinforced by the Nursing Council requirements, that the Treaty form the basis of cultural safety education. All students and staff must participate in Treaty of Waitangi education courses to understand its implications for Māori health. This should continue as long as the dominant education system does not adequately prepare New Zealanders to address treaty issues (Ramsden, 2000a). As Durie (1989, p. 285) says, "The Treaty of Waitangi is not a blueprint for good health nor a prescription for all ills. Nonetheless, good health is clearly an objective of the Treaty."

Partnerships

Sally Pairman (1999) discusses the development of "The Partnership Model of Midwifery" as representing the equal status of both partners. Reciprocity is intrinsic to equal relationships involving openness, mutual exchange, shared meanings and shared control. Joan Skinner (1999) advances the notion that women and midwives have contractual relationships and

make choices about their appropriate participation in these relationships. The Treaty of Waitangi can be defined as a 'partnership' or 'contract' that is specific to Māori women and significant to understanding relationships with Māori women. This is recognised by the New Zealand College of Midwives which states "Midwives recognise the status of Māori as Tangata Whenua of Aotearoa and honour the principles of partnership, protection and participation as an affirmation of the Treaty of Waitangi" (NZCOM, 1993, p. 11). The manifestation of partnership presumes active participation by each partner for the protection of each people's identity and wellbeing. Cultural Safety and the Treaty of Waitangi provide frameworks within which educational institutions and educators can critique their services in relation to Māori women and find ways forward that are congruent with the Midwifery Partnership (NZCOM, 1993).

The Nursing Council Standards for Registration of Midwives state that:

"The curriculum is written and reviewed in consultation with midwife teachers, midwives in practice, the tangata whenua, and consumers of midwifery services" (Nursing Council of New Zealand, 2000, p. 26). This means that tangata whenua should be a key partner with each midwifery education institution in the country. Teachers need to ensure their definition of tangata whenua is consistent with that of Māori. Furthermore, that representation by tangata whenua includes Māori women.

In 1994 the first Māori midwives hui was held at Waikato Polytechnic to form a group known as Ngā Māia, which has evolved to Ngā Māia o Aotearoa me Te Waipounamu. This group has a role as a representative body for some, but it does not represent all Māori women. Ngā Māia is one key Māori partner for midwifery organizations including educational institutions because its primary focus concerns childbirth-related issues for Māori. Other partners might include Māori Women's Welfare League and urban Māori health authorities; and government agencies for Māori development such as Te Puni Kōkiri and Te Taura Whiri i Te Reo Māori (Māori Language Commission).

It has been argued previously in this paper, that midwifery education institutions are not resourced to develop Māori knowledge

of childbirth. In addition, the advancement or growth of Māori knowledge is better placed within a tikanga Māori environment. In this respect, midwifery education would be enhanced by the positioning of a midwifery programme in a Māori wānanga, because of the potential for growth of childbirth knowledge relating to Māori women. Such a programme would be open to Māori and Pākehā students alike, who want preparation in their education, which is specifically aimed at Māori women. This will require careful planning to ensure it meets professional and academic standards of excellence and will be in addition to approaches taken by existing institutions, whose programmes are developed in conjunction with local Māori, to meet the needs of Māori women in their own communities. Different approaches are necessary to meet the diverse needs of Māori women in the midwifery education context.

Closing

The neo-colonial education system has been the most powerful perpetrator for the promotion of stereotypical constructs in New Zealand. From its inception, this system has taught a romantic mythology about colonial settlement while denying a much more vigorous and exciting history (Ramsden, 2000b). Māori were reconstructed in the colonial image and although the evolution of the Māori stereotype is not necessarily the fault of teachers, maintaining it can be. These stereotypes are deeply embedded in New Zealand society of which midwifery is a part. This means that it is crucial for midwives to be educated in the complexities of political and social science, colonial history and economics. Relating theory to midwifery practice and explaining it in the context of the Treaty of Waitangi is essential (Ramsden, 2000b).

Education policies and practices must take account of these broad concepts to encompass the diverse needs of women in New Zealand today. The identities of Māori women and Pākehā women contribute to understanding those diverse needs. But there has to be agreed understanding about how the needs of Māori women and Pākehā women can be met within midwifery programmes of learning. This means that Māori, with the relevant practical experience and qualifications must be involved in the ap-

proval, accreditation and delivery processes for all midwifery programmes. Māori must have representation on each midwifery approval panel and the ongoing monitoring panels.

In comparison to cultural safety, the Partnership Model for Midwifery Practice has been more widely accepted and encouraged. One explanation for this may be that it is dependent on those in power to see it implemented, and currently, the number of Māori in such positions of power are few. On the other hand, midwifery educators, midwives and the midwifery profession can be challenged about the apparent lack of implementation of cultural safety into education and midwifery practice. After all, cultural safety and midwifery partnership both require an examination of one's own position of power as a midwife and the effect of that relationship on women and families with whom the midwife works. Both are about relationships that are mutually negotiated and agreed, and which support and enhance both partners.

New Zealand midwives celebrate their autonomy of practice and at the same time must work towards ensuring that autonomy remains. What Māori and non-Māori midwives may not understand is that Māori struggle for autonomy of identity and that some midwifery education programmes have been guilty of not providing accurate information in order to represent the range and diversity of Māori realities.

This paper argues the need for significant progress toward partnerships between Māori and midwifery education organisations that encapsulate the principles of the Treaty of Waitangi and recognise the partnership philosophy of midwifery practice. Partnership has not secured a place for Māori in the midwifery education process because we are not equally contributing participants in our own development. This position is being perpetuated by Māori and Pākehā who have not considered the long term outcomes resulting from a loss of autonomy by Māori.

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Riding the waves of change: The development of modern midwifery within the New Zealand health sector

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ABSTRACT

Midwives do not work in social isolation. Most would probably agree that they work within a politically labile environment. This paper presents the case of New Zealand midwives' transition to autonomous practice, as an example of opportunistic positioning by the profession, enabling midwives to ride the waves of change in the last decade of the twentieth century. The socio-political environment that existed within New Zealand in the late 1980s fostered the passage of legislation in 1990 that enabled New Zealand midwives to practice independently from nurses and doctors. An historical review of the impact of key socio-political events and legislative changes on New Zealand midwifery will be presented, to illustrate that the profession in this country was well positioned by the late 1980s to take advantage of a rising consumer movement, the questioning of medical dominance and a government sympathetic to women's health issues. While achieving the milestone of legal autonomy in 1990, the challenges involved in developing the midwifery profession were complicated a few years later by complex market driven health reforms. Yet the midwives appeared to position themselves well to meet the challenge of this changed political environment. What can we learn from this experience?

INTRODUCTION:

Midwives in New Zealand achieved the legal right to practise independently from medical practitioners in 1990, with an amendment to the 1977 Nurses Act. This legislation enabled midwives, to provide care for women during their entire child-bearing experience, free of charge regardless of the service setting, without the supervision of a doctor or registered nurse. This achievement also entitled midwives to the same remuneration and rights of access to maternity hospitals as doctors. This was a significant achievement.

The work involved in maintaining the autonomy and scope of practice of midwifery in New Zealand is not over. Change is constantly with us, particularly as we go through yet another set of health reforms, which appear to focus on the concepts of collaboration and teamwork. Questions asked at this time, by both midwives and health service planners, centre on identifying where mid-

wifery belongs within the reforming health sector environment. This paper will not provide the answers, but plans to highlight the manner in which midwifery evolved over time in response to previous sociopolitical events. This involved reading the environment and adapting to meet the challenges. There are lessons to be learned from this process which may be useful in the future.

Examination and analysis of the philosophical and practical determinants of social policy and legislative developments will be used to position midwifery within the current New Zealand health care environment. The historical development of legislative and policy 'signposts' following the emergence of the welfare state in New Zealand in 1938 provide a framework within which the emergence of modern midwifery in this country will be investigated. The waves of change gathered over time and with astute positioning by midwifery leaders, the profession as a whole benefited through being able to ride the waves through the health reforms of the mid 1990s and into the twenty first century.

IMPACT OF THE ECONOMIC ENVIRONMENT ON THE DEVELOPMENT OF HEALTH POLICY OVER TIME

Social policy, in its most broad sense can be defined as actions that the government enshrines in legislation in order to shape the distribution of and access to goods and resources within society (Cheyenne, O'Brien & Belgrade, 1997). Health policy is inextricable linked with social policy because to the identification of health care as a social good (Blank, 1994). The midwifery profession and the services midwives provide appear to be intimately dependent on the nature of social policy direction taken by the government of the day. Social policy direction is in turn influenced by the economic environment which determines the level of social good available to be dispensed to citizens and at what cost (Cheyenne et al., 1997).

To understand the place of midwifery within New Zealand maternity services in the 1990s, it is necessary to reflect on key social policy initiatives and influences in the past that have shaped the development of these services. The parameters for the role of the state in health funding in New Zealand were laid out in the 1938 Social Security Act (Fougere, 1992). Maternity services were clearly included within "Health Services" from this point on. This Act provided the backdrop for the development of a comprehensive social welfare system

and gave future direction to social policy generally. More specifically it shaped citizens' expectations of access to health care which appear to persist to the present day, namely that it should be

- universally available regardless of personal economic status,
- easily accessible,
- responsive to consumer demand,
- based around medical practitioners as ideal agents for the consumer (Abel, 1997).

Economic buoyancy internationally and political stability internally enabled the continuation of universal access to relatively free and stable health services in New Zealand for the following forty years.

A change in focus was heralded by a 1973 Royal Commission on Social Security in New Zealand. The Commission's report articulated the need to develop greater community responsibility and a shift from total state responsibility for welfare was called for. The report was released within an increasingly unstable economic environment (Cheyenne et al., 1997). A seemingly necessary focus on the added cost of health care, largely compounded by an ageing population and greater reliance on pharmaceuticals and technology, precipitated a 'White Paper' on health the following year.

This paper entitled 'A Health Service for New Zealand' was hurriedly commissioned by the then Labour Government, in response to the Royal Commission's report, in order to provide a framework for its health policy in the light of a forthcoming election. This unpopular document predictably called for a rationalisation of health services in response to a looming economic crisis and a shift to individual responsibility. There was a change of government the following year and the key tenets that called for widespread structural reform were not seriously taken up for another ten years (Cheyenne et al. 1997). The three yearly election cycles in New Zealand are viewed by some commentators (Blank, 1994; Cheyenne et al. 1997) as a deterrent to the implementation of social policy which has the potential to significantly curb or constrain citizens' freedom of access to goods and resources. This includes the freedom to access social services, including health services, free of charge (Blank, 1994).

IMPACT OF THE CHANGING DIRECTION OF SOCIAL POLICY ON HEALTH SERVICES: Reigning in the professions.

The change in government following the release of the 1974 White Paper did not seem to lessen

the focus on developing strategies to deal with the impact on New Zealand's economy of the United Kingdom joining the EEC in 1973. This period saw the development of revisionist economic policy (Boston, 1992). There was a shift in focus from institutional to individual responsibility in social policy, impacting on all social services including health. However, a more incremental approach was made to cost containment than that recommended in the 1974 White Paper.

The emergence of managers and administrators within the health sector could be interpreted as the first attempts to reign in health professionals and increase individual accountability for the management of publicly funded resources. This environment also highlighted (possibly in some cases unintentionally) such issues as gender imbalances and fostered the development of 'consumerism' as individuals banded together to pursue their perceived rights of access, not just to services, but to influence over the mechanisms of service delivery (Blank, 1994; Cheyne et al., 1997). These activities placed the dominance of traditional professions, particularly medicine, under the spotlight.

By 1977 midwifery in New Zealand had literally and practically been subsumed within nursing by a new Nurses Act (1977). This Act implicitly defined midwifery as 'obstetric nursing' (Pairman, 1998). The philosophy supporting this move underpinned the acceptance of institutionalised childbearing and the 'technical assistant' role (Donley, 1998) expected of the midwife/nurse in the running of an efficient maternity hospital. The unforeseen outcomes of eliminating 'costly' student intensive apprenticeship learning by the early 1980s and the promotion of the concept of the generic comprehensive nurse who also gained obstetric experience, bought the skilled midwifery workforce to 'its lowest ebb' (Guilliland, 1998, p.50).

Few nurses gained midwifery registration during the 1980s when midwifery was incorporated into part of an advanced nursing course (Guilliland, 1998). For example, in the 1960s and 70s, the hospital based midwifery 'training' in Christchurch until its demise in 1979, 'trained' forty to fifty registered nurses and some obstetric nurses (who became the equivalent of direct entry midwives), per year. The demise of this programme and the incorporation of pre registration midwifery programmes into part of a one year Advanced Diploma in Nursing course, resulted in 6-8 midwifery registrations per year in

Christchurch by the end of the 1980s. (Personal knowledge as the midwifery lecturer in this course at the time).

The situation that midwifery found itself in at this time could be interpreted primarily as resulting from attempts to increase efficiency within health services, rather than some sinister attempt to destroy midwifery. Maybe from a manager's perspective a nurse, who is also a midwife, but paid the same as a nurse, represents two qualifications for the price of one. The de-hospitalisation of nursing (and midwifery) training would also seem to offer both the opportunity to break down professional hierarchies and shift the cost of training to another budget (vote: education rather than vote: health). Destabilising professional power within institutions would seem to be more likely if pre registration training is carried out by a separate agency, then the student is less likely to enter the workforce enculturated into the system.

Economic Rationalisation: regionalised health services.

In a persistent drive to harness the spending on health services, the Area Health Boards Act in 1993 devolved the previously centralised public health service into 14 regional Area Health Boards covering the country. This decentralisation of health funding enabled greater local influence over spending allocation and health initiatives (Boston, Dalziel & St. John, 1999). The main aim was to delegate decision making (which could also be interpreted as rationing) on health service expenditure to a local level. The majority of the board members were voted in during local body elections, enabling a midwife, Karen Guilliland, to obtain a seat on the Canterbury Area Health Board (Guilliland, 1998). This democratisation of health service development provided both midwifery and women with valuable exposure to the politics of health care provision and its associated networking.

While institutionalised health care providers, including midwives, were influenced by regional variations in health service provision, significantly, General Practitioner (GP) funding still remained centralised and uncapped (Abel, 1997). The maintenance of this nationally consistent centralised system which was not hooked into the institu-

tions, did later work in the favour of midwives when they obtained access to maternity service funding in their own right.

The nursification of midwifery: a profession in crisis.

By 1983 the midwifery workforce crisis precipitated an amendment to the Nurses Act (1977) enabling registered nurses that were not midwives to care for women in childbirth. A possibly unintended product of the 1983 amendment was the interpretation of this amendment in some parts of the country to exclude 'direct entry' midwives from being in charge of a maternity hospital or carrying out home births. This unique practitioner was denied the legal right to practice in settings where they could not be

supervised by a registered nurse. Women's choices over both provider and birthplace were reduced overnight in some areas. Cynically this move was viewed as intentional in order to placate the doctors who were requesting more centralised birthing services within institutions to better meet their own training needs (Donley, 1998).

The 1983 Amendment was seen by many as a turning point in the re-emergence of midwifery as a profession separate from nursing (Donley, 1998; Pairman, 1998; Abel, 1997). The 'Save the Midwife' consumer group was formed the same year. This group consisted mainly of women who had given birth at home with a midwife in attendance and were committed to supporting the future of home birth.

A growing unease was felt over this period by hospital midwives within the New Zealand Nurses Association (NZNA) which represented their professional and industrial voice. Midwives felt abandoned by their professional advocates for allowing the 1983 Amendment to proceed. A vote of 'no confidence' in the Association was put forward by midwives in 1984. This raised the profile of midwifery within the NZNA and at their conference the following year a remit supporting a separate midwifery education programme was passed and the International Confederation of Midwives definition of a midwife formally accepted. By 1987 The NZNA Policy Statement on 'Maternal and Infant Nursing' was rewritten to include the concepts of continuity, partnership,

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By 1977 midwifery in New Zealand had literally and practically been subsumed within nursing by a new Nurses Act.

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midwifery autonomy and preferential employment of midwives in maternity settings (Donley, 1998).

An increase in births during the 1985-90 period (Guilliland, 1998), which exacerbated the impact of a reduced midwifery workforce, enhanced the argument for a midwifery specific education. It was not until 1989 that pre registration midwifery courses for registered nurses, that were not also part of an advance nursing qualification, were established.

This period also saw consumer health groups, which had emerged out of the women's movement in the 60s and 70s, experience a watershed in NZ with the Cartwright Inquiry in 1988 (an investigation into non-consented participation of women in an experiment on non-treatment of cervical lesions). Following this debacle, women's health issues were highlighted by the media in this country. That same year the Midwife's Section of the NZNA split off into a separate entity and was inaugurated in 1989 as the New Zealand College of Midwives. Consumer support featured prominently in this move, the College recognising its importance by enabling consumers to obtain equal membership with midwives.

Working in partnership with women, midwives started to become more involved in the development of maternity service strategy. The philosophical underpinnings of the New Zealand College of Midwives (NZCOM) could be identified in the sentiments of a Discussion Paper on Care in Pregnancy and Childbirth (1989) commissioned by the Department of Health Women's Policy Unit that was released the same year. The key tenets were:

- woman centredness,
- continuity of carer across the entire childbearing experience,
- midwifery equality with doctors in maternity care (autonomy and access to funding)
- consumer choice of carer, service setting, home, community or hospital,
- recognition of midwifery is a profession in its own right.

The working party on this document involved 15 women, of whom only 5 were health professionals, two were midwives. This was to mark the beginning of a number of reviews and consensus gathering exercises attempted by government agencies of the day to strategise an optimal maternity service.

This gradual build up of midwifery strength from 1983 onwards, appeared to solidify midwifery as a professional identity, in turn attracting more

midwives to stand up and be counted. The timing of this professional growth was fortuitous. There was a focus on consumer involvement in health care, there was a midwifery workforce crisis, a renaissance occurring in midwifery education, a push for the emergence of alternative health care providers (other than doctors) and a Labour Government in power over most of this time that supported community focused health services including midwifery.

While the passage of the Nurses Amendment Act through parliament in 1990, enabling midwifery independence from doctors in childbearing and equal access to funding and services, was seen as a crowning achievement for midwives, it was also congruent with social policy goals of the day. The Maternity strategy outlined in the 1989 Discussion Paper on Care in Pregnancy and Childbirth, clearly supported the notion of an autonomous midwifery practitioner.

THE RE-EMERGENCE OF MIDWIFERY INTO A CHANGING HEALTH CARE ENVIRONMENT

The environment in which the Nurses Amendment Act was passed in 1990 was complicated. Nationally there was a growing disenchantment by consumers with the medical profession (Abel, 1997). Midwives had unified in a newly formed national College of Midwives. Increasing numbers of nurses were gaining midwifery registration from 'midwifery only' programmes and there was still an acknowledged shortage of midwives in the face of an increasing birth rate.

The introduction of "The Health Goals and Targets" by the Labour Government in 1990 articulated its commitment to increasing the profile of primary health care and public health, including the demedicalisation of some services such as community and maternity (Boston et al., 1999). On another level, there was a female Minister of Health, who had been lobbied over a number of years by key midwifery figures and appeared to have clarity over the midwifery cause (Abel, 1997).

The NZCOM president was also an existing Labour representative on an Area Health Board. The Nurses Amendment Bill was passed rapidly through parliament. Urgency in its passage was also heightened by the forthcoming elections and desire to announce its successful passage by the Minister of Health as a special guest at the first National Conference of the College of Midwives in Dunedin in August of 1990.

The 1990 Nurses Amendment Act, added three

words to the 1977 Nurses Act "or registered midwife". This in turn required changes to five acts and twenty-two sets of regulations and "had a profound effect on the scope of midwifery practice, payment and status" (Abel, 1997, p.106). Midwives gained the right to prescribe, to order publicly funded medical supplies and access hospitals to provide care to women in childbirth without needing to become an employee. The maintenance of a nationally consistent government payment system for GPs included the Maternity Benefit Schedule. This enabled midwives to access an existing payment process for services if they chose to take their own maternity clients (whether the midwife was employed or self-employed). Midwives at last had a legal mandate to provide primary maternity care to women in any setting without requiring medical supervision.

It is estimated that in the first year of legislated autonomy, 50 midwives (3% of the workforce) were practising independently (self-employed) and commenced claiming the Maternity Benefit (Pairman, 1998). Most of these midwives had recently been, or were still currently, employed by maternity hospitals. The relationship between these midwives and the hospital provided a challenge for managers, doctors and midwifery colleagues. Justifiably midwives argued that if doctors could maintain public employment and privately take on clients, so could midwives. These emergent signs of competition finally triggered action from the medical profession, who had been relatively 'subdued' (Abel, 1997) during the passage of the Nurses Amendment Bill. Abel contends that they "did not anticipate the extent of the change to the midwifery scope of practice" (1997, p.105). Because of the intent of the legislation in granting equivalence to midwives with doctors, arrangements that had previously been made for doctors to gain maternity hospital access for the provision of their 'private' (self-employed) service, were also granted to midwives.

A CHANGING CLIMATE IN THE HEALTH SECTOR: THE PLACE OF MIDWIFERY

The achievement of midwifery autonomy was timely. Shortly after the passing of the Nurses Amendment Act (1990) the Labour Government was replaced by National which clearly had an agenda for change, culminating in drastic restructuring of the health services along market lines (managed competition) (Blank, 1994). A number of legislative initiatives paved the way for the introduction of these health reforms, most introduced during the term of the previous Labour Government. The Commerce Act (1986) enforced

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competition law in New Zealand. Such activities as price fixing and controlling of costs that contribute to a price were made illegal (Pearse, 1999). This legislation supported the notion of competition between different providers of the same service. The Public Finance Act (1989) legislated managerialism into the public sector. The focus of government advisors changed. While previously most came from the professions, the new wave emerged from financial and economic backgrounds. The use of international consultancy firms started to flourish. Collaborative facilitated discussions around health needs and strategies commenced, with the medical advisors 'opinions' being one of many (Blank, 1994; Kelsey, 1993; Cheyenne et al., 1997).

With a further reorganisation of New Zealand's health sector currently taking place, midwifery faces yet another hurdle in maintaining its autonomy as a profession

Cheyenne et al (1997) noted that the traditional basis of expertise was also being questioned at the time in other social services. Both vote: education and vote: social welfare had commenced 'encouraging more alternative and non traditional providers' (Cheyenne et al., 1997, p.180). The Children and Young Persons and their Families Act (1989) shifted responsibilities previously invested in 'experts', to family and community agencies (Cheyenne et al., 1997). The Health Goals and Targets produced by the Labour Government in 1990 increased the focus on primary health and wellness. Some commentators believe that this document set the scene for demedicalisation of some health services (Kelsey, 1993; Cheyenne et al., 1997). It was within this environment that the 1990 Nurses Amendment Act was passed.

By 1991 the new National Government released a Green and White paper on health, which outlined proposed health reforms which clearly mirrored the recommendations made in the 1974 report on 'A Health Service For New Zealand' (Blank, 1994; Kelsey, 1993; Cheyenne et al., 1997). The proposals outlined in the Green and White Paper (1991) were largely taken up by the time legislation was passed enshrining the changes through the Health and Disability Services Act (1993). This legislation effectively broke up the health system in New Zealand, not only geographically, but also split the funder from the service provider role, setting the scene for competitive contracting for services. The objectives of the health reforms were to improve efficiency, access, choice, flexibility and accountability of health serv-

ices to the consumer, the public, who indirectly funded them. Health services were to be run on a business model under the direction of appointed Boards (Blank, 1994; Cheyenne et al., 1997).

The disarray of health services that occurred between the release of the Green and White Paper in 1991 and the establishment of the reformed health service in 1993 appeared to advantage midwifery. By 1991 most midwives were new to self-employment and with no precedents set as to how health services should 'manage' them, the equity with GPs in maternity would seem an easy way out. To place midwifery in perspective, in 1991 there was a combined medical, nursing and midwifery workforce of 39,014 (NZHIS workforce statistics 2001) and an estimated 50 midwives in independent practice claiming from the Maternity Benefit Schedule (Pairman, 1998). It is possible that midwifery was not seen as a significant threat given the upheaval in the health sector generally at the time.

In 1992 a Maternity Services Tribunal was called. It was believed to have been instigated in response to the claim that midwives were 'blowing out the maternity budget' (Donley, 1998, p.19). With midwives pitted against doctors who claimed that there should be a separate payment schedule for midwives and doctors, a decision was made that the 'fee was for a service of equal value' (Donley, 1998, p.19). The 1993 Maternity Services Tribunal decision was enshrined in Section 51 of the Health and Disability Services Act (1993). Midwives retained their equity with doctors for remuneration which, although challenged regularly over the following three years, remained in tact during that time.

At the same period that the Maternity Tribunal was held, a National Advisory Committee on core health services was established. The mission of this Committee was to decide what services should be funded publicly (core services) and which services consumers should pay for privately (Cheyenne et al., 1997). In line with this directive and in an effort to make sense of maternity service provision within the new health climate as a whole, two key reports were produced in the following year. These were 'First steps towards an integrated maternity services framework' (1993) by Coopers and Lybrand and 'Care of the mother and baby

after normal delivery' (1993), a consensus workshop report to the National Advisory Committee on Core Health and Disability Support Services. Between them, they recommended essential structures, policies and processes to do with childbearing should be funded publicly and that there should be national consistency in self-employed midwives' and doctors' payment. Subsequently a great deal of midwives' time was spent negotiating with funding bodies to ensure payment equity for midwives with doctors for services in childbirth was maintained.

MIDWIFERY WITHIN A CONTRACTUAL ENVIRONMENT

A slowing down of the health reforms occurred in 1996 as a new coalition government called for a review of progress. The funder provider split had not provided the savings and quality anticipated (Boston, et al., 1999). The general practitioners had formed themselves into Practitioner Organisations, which provided them with a collective bargaining voice and budget holding as a means of buffering the impact on individual practitioners of competition. It was at this point that clarification over the framework for new modular maternity system was arrived at. A new Section 51 Advice Notice to the Health and Disability Services Act (1993) was issued by the Regional Health Authorities in 1996. This Notice required one named lead practitioner (midwife or doctor) for each pregnant woman, effectively rejecting the desire of doctors for a separate medical maternity schedule and stiffening the competition between the two providers to claim the dollars that went with the role of Lead Maternity Carer (LMC). With increasing numbers of midwives turning to independent practice in the role of Lead Maternity Carer, doctors increasingly sought midwifery care from employed midwives by negotiating arrangements with hospitals. Doctors gained an advantage in these negotiations through the development of Independent Provider Organisations (IPOs) which represented a number of practitioners and presented a greater fiscal advantage for hospitals. These groups also went on to successfully negotiate with the Regional Health Authorities for variations to the standard Section 51 Notice, giving their members a sometimes significant financial advantage over midwives who were accessing the standard Section 51.

The New Zealand College of Midwives, reading the political and commercial environment, initiated the establishment of a Midwifery and Maternity Provider Organisation (MMPO) in the

1997. With a vision, during developmental stages, of national coverage, it finally emerged as a South Island venture, contracted to the Health Funding Authority and a separate entity from the College. The MMPO is one of many IPOs throughout the country that self-employed midwives have chosen to join. Most other IPOs have multi-professional membership and are headed by medical practitioners. Many of these organisations obtain funding directly from the Ministry of Health, then disperse it to practitioners as negotiated. At the time of writing the MMPO has midwife members birthing about one fifth of women in the South Island of New Zealand.

With a further reorganisation of New Zealand's health sector currently taking place, midwifery faces yet another hurdle in maintaining its autonomy as a profession. The current fragmentation of the midwifery voice through membership of multidisciplinary IPOs will be further fragmented with the coming formation of twenty-one District Health Boards. Lack of long term clarity at present over how midwifery will be funded nationally (or regionally), does not enable visioning, at this point, as to how midwifery will overcome this challenge, but we can learn from strategies that have been successful in the past.

CONCLUSION

Midwifery services in New Zealand, have been responsive to a variety of social policy initiatives over the last sixty years. From a relatively independent existence in the earlier part of the century (Donley, 1998) midwifery became increasingly subsumed into the health sector as hospitalised childbirth became increasingly popular and available from the 1920s onwards. The formation of the social welfare system in 1938 established maternity services under the umbrella of 'health' and from then on midwives and maternity care remained at the whim of every social policy initiative that impacted on hospitals. The subtle and incidental erosion of midwifery as a profession distinct from nursing reached a point in 1977 when the term 'obstetric nurse' legally defined the role of a midwife.

A turning point for the midwifery profession occurred following the 1983 Amendment to the Nurses Act (1977), which effectively subordinated midwifery to nursing (Abel, 1997). Midwives chose to break away from their nursing colleagues and went on to form their own College in 1989. The power of the women's health consumer move-

ment and the democratisation of the political environment at the time must be seen as a key force in achieving this milestone. In other sectors of society at the time, social movements were being formed and people were standing up to be counted.

Midwifery autonomy was achieved through an amendment to the 1977 Nurses Act in 1990. This professionally liberating move was in reality the reflection of a more fundamental shift in health policy direction at the time, the result of astute positioning of the profession and the culmination of relationship development at the highest level by politically aware midwives. The opportunity presented itself and midwives were ready and prepared to take advantage (ride the wave).

The actual impact of this development could not really be seen with clarity at the time, but events quickly unfolded which seemed to give midwifery leaders an indication of the fact that the battle was not over. Midwives found themselves in direct competition with doctors for clients. The complexity of midwives plight was complicated by the fact that three years later the entire health sector was pushed into competition by the Health and Disability Services Act (1993). It could be argued that the preparation that midwives underwent to achieve autonomy in 1990 and the first few years of experiencing the reality of competition, positioned them well to tactically manage their way through the middle part of the 1990s.

Ten years following their landmark legislation, midwives in New Zealand find themselves repositioned within the health sector and facing perhaps an even greater challenge than ever before. The reformation of self employed midwives into IPOs with other health professionals may act to dissipate the consciousness raising necessary to work collectively through the next set of health reforms we are currently experiencing.

The role of the New Zealand College of Midwives cannot be underestimated in this entire process. The collective wisdom of midwives nationally can be viewed as a key strategy in negotiating our way through a very complex health care environment in New Zealand. The concepts of networking, mechanisms for allowing dissenting voices to be heard (for example, at workshops and National Committee meetings), achieving national representation and fostering consumer participation appear to have been successfully facilitated by the College over the last twelve years.

In summary, the learning for midwives that could be achieved by reflecting on our achievements over the last 10 years include the following: change is constant, it allows our profession to evolve; change is a mechanism we use to evolve and adapt to exist within our environment or we could risk extinction; communication fuels adaptation; we need to listen to dissenting voices as well as supporting ones in order to clarify our position (and threats) within our environment; midwives and midwifery do not and cannot exist in isolation from the rest of the health system; we are influenced by, and can have influence on, the environment we work and live in; knowledge of our history provides us with the potential to develop strategies for our future.

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Where do all the midwives go?

A report on the practice choices made by Bachelor of Midwifery graduates

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Introduction

Direct entry midwifery education has been available in New Zealand since 1992 when it was re-introduced as an 'experimental' programme following the 1990 Nurses Amendment Act. Five schools of midwifery (Auckland University of Technology, Waikato Polytechnic, Massey University in Wellington and Palmerston North, Christchurch Polytechnic Institute of Technology and Otago Polytechnic in Dunedin) now offer pre-registration midwifery programmes for both direct-entry and registered nurse students. All programmes are required to produce midwives who are capable of independent (autonomous) midwifery practice and able to take on the role of Lead Maternity Carer (LMC) within the New Zealand maternity services (Nursing Council of New Zealand, 1996).

Despite the evaluation and monitoring of these programmes that has occurred, graduates have not been followed up to discover whether they do in fact work independently after graduation.

This project aimed to begin this work by tracking all direct entry midwifery graduates from Auckland Institute of Technology (AIT; now Auckland University of Technology) and Otago Polytechnic between 1994 and 1998. It set out to trace their work histories as midwives and identify the major influences on the choices each made in this regard.

Background

The collaborative political activity of many consumer groups in partnership with midwives, culminated in the passage of the Nurses Amendment Act in August 1990. The passing of this statute meant that midwives regained their legal and social mandate for independent practice. Thanks to strong lobbying from consumer groups such as 'Save the Midwife' and the 'Direct Entry Mid-

wifery Taskforce' the same legislation also provided the opportunity for direct entry midwifery education. Section 39 of the Nurses Act 1977 was amended to allow the Nursing Council to approve direct entry midwifery programmes as experimental programmes in tertiary education facilities (Donley, 1990). Approval was given for two pilot programmes, one at AIT and one at Otago Polytechnic. Both programmes commenced in 1992 as three-year programmes, but Otago Polytechnic offered a Bachelor degree programme while AIT offered a diploma programme. Two years later AIT converted their programme to a degree, thus all of the first direct entry graduates in 1994 graduated with Bachelor degrees.

The programmes were monitored and audited closely over the first four years through a research team established jointly by the Departments of Health and Education. This monitoring found no reason for concern and graduates were found to be as safe and competent as their nurse-midwife colleagues (Harris, 1995). In 1996 further programmes commenced at polytechnics in Waikato and Wellington, and a year later in Christchurch. The three year Bachelor of Midwifery programme is now the recognised route to midwifery registration for all midwifery students in New Zealand, both direct entry and registered nurses (Nursing Council of New Zealand, 2000).

The programmes provide balanced integration of theory and practice within a context that supports and promotes critical thinking, research-based practice and reflective practice. Clinical experience focuses on continuity of care and independent practice and each student must have the opportunity to experience both community-based and institutional-based midwifery practice (Nursing Council of New Zealand, 2000).

The New Zealand College of Midwives (cited in Pairman, 2000, p.12) expects that midwifery graduates will be able to:

- Think critically and creatively
- Practice midwifery safely and competently
- Practice autonomously and in partnership with women in any maternity setting
- Utilise research evidence in practice
- Contribute to midwifery's body of knowledge
- Actively participate in the midwifery profession
- Take responsibility for ongoing learning and maintaining competence in practice

In the years from 1992 to the present, much work has gone on within the programmes and within the profession to develop and 'fine tune' these programmes to ensure that these outcomes are met. Despite this attention to programme development, there has been no national study to follow-up the graduates from any direct entry midwifery programmes to look at outcomes of the programmes.

This project began that work through the examination of the work histories of graduates from the AIT and Otago Polytechnic Bachelor of Midwifery programmes between 1994 and 1998. The project

sought to discover where and how these midwife-graduates have chosen to practice after graduation and the main reasons for these choices.

Literature review

Direct-entry midwifery education is being debated and implemented in many countries in the western world. The Netherlands has increased the length of its programme while direct entry midwifery education has been reintroduced in the United Kingdom (Megavand, 1998; English National Board (ENB), 1997). In countries such as Canada and Australia programmes are now being established. For all these countries the impetus for direct entry midwifery stems from a need to prepare midwives who can work in the full tradition of autonomous practice (MacKeith, 1995; Megavand, 1998; Tyson, 2000; Australian College of Midwives, 1999). Autonomous midwifery is seen as an essential strategy in changing the maternity services in these countries to more women-centred models.

Despite the increase in direct entry midwifery education programmes, only three evaluations of direct entry midwifery education programmes have been reported in the literature. Kent, MacKeith and Maggs (1994) evaluated the implementation of direct entry midwifery education in England. A study, commissioned by the English National Board for Nursing, Midwifery and Health Visiting, evaluated the effectiveness of the outcomes of pre-registration midwifery education programmes (ENB, 1997). In New Zealand a small working group consisting of representatives of the Ministry of Health, Ministry of Education and Nursing Council of New Zealand extensively evaluated the first two direct entry midwifery programmes in New Zealand (Ernst & Young, 1993a;

There has been no national study to follow up the graduates from any direct entry midwifery programmes.

Ernst & Young, 1993b; Harris, 1995). While there are aspects in all three studies that are of interest in relation to programme development, none focuses in detail on where the direct entry graduates go to work or why they make these choices.

Design

This research project was a quantitative study that sought to establish baseline descriptive statistics about the practice style and location of direct entry Bachelor of Midwifery graduates in New Zealand. Ethical approval was obtained from Otago Polytechnic Ethics Committee.

Sample

The group to be surveyed was restricted to graduates from direct entry midwifery programmes at AIT and Otago Polytechnic, as these two programmes had been running the longest and thus provided a greater opportunity to track changes over time. Only graduates who had no prior nursing qualification were sent a questionnaire package in order to increase the homogeneity of the group. A total of 144 graduates were sent a questionnaire – 77 from AIT and 67 from Otago Polytechnic. 94 questionnaires were returned constituting a total return rate of 65.2%. AIT graduates returned 47 questionnaires (59.7%). Otago

Polytechnic graduates returned 48 questionnaires (71.6%). All participants were female.

Data Collection Tool

As no previous study had examined the employment patterns of direct entry midwifery graduates in New Zealand, it was necessary to develop a questionnaire specific to this study. The questionnaire was pre-tested by 6 midwives. The final questionnaire consisted of ninety-three questions and took about 15 minutes to complete.

The questionnaire began with the title, consent statement and a brief synopsis titled 'Frequently Asked Questions' (FAQ). The FAQ outlined what respondents could expect in the questionnaire, and anticipated respondents' queries about the rationale behind questions and how they should go about answering them.

The main body of the questionnaire had four sections beginning with 'Part A – Demographics'. Eight questions were asked to collect details of age, marital status, dependent children, ethnic group, institution of graduation, year of graduation, year of registration as a midwife and whether respondents had practised as a midwife since registration.

Section B – Description of Midwifery Practice

sought information about each position the respondent had held as a midwife since graduation. Questions related to when, where and why the position was taken as well as the employer, hours, practice style and caseload (if any) involved in the position.

Section C – Continuity of Practice sought information about any breaks (other than holidays) that respondents may have taken from practising midwifery. Section D – Other Career Choices gathered information only from respondents who had not practised as a midwife since graduation about their alternative career choice.

Section E – Plans for future practice brought the questionnaire to its conclusion. These questions related to where respondents were headed in the future and allowed for comparison between respondents' practice at the time of the survey and their intentions for future practice.

Method

A list of all 144 graduates from the two three-year midwifery programmes at Otago Polytechnic and AIT was compiled using graduation lists and registration details available in the public domain. Contact addresses for graduates from both programmes were found through the electoral rolls, telephone directory, advertisements and peer and

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Where do all the midwives go? *Sally Pairman and Sheridan Massey*

personal contact elicited by an advertisement placed in the NZCOM Journal. The graduates were sent an information sheet and questionnaire by mail and were invited to participate by completing and returning the questionnaire.

Graduates were informed that by returning the questionnaire they had understood the information sheet and given consent to taking part in the study. A 'reminder' letter was sent to non-respondents when the response rate reached 50%. Letters and questionnaires were given to the Nursing Council of New Zealand (Nursing Council) to post on our behalf, for a small number of graduates whose addresses could not be confirmed without access to the registration database. Contact details were kept separate from questionnaires at all times to ensure the anonymity of respondents. Data was refined using Microsoft Excel and analysed using 'Statistical Packages for Social Science 9.0 for Windows' (SPSS).

Results

All the data analysed was nominal. Mode, skewness and range were used to measure distribution and the chi square test was used to measure relatedness ($\alpha=0.05$ or 0.01).

Demographics: with the exception of 'Ethnic group', the distributions of all demographic details were normal (skewness $<+/- 1.00$). When compared to national figures on women over the age of twenty in the work force, respondents were more likely to be over thirty years of age ($\chi^2=4.6$, $df=1$, $\alpha=0.05$) (Department of Statistics, 1992). This difference disappeared when looking specifically at women employed as Life Science and Health Professionals ($\chi^2=0.96$, $df=1$, $\alpha=0.05$) (Department of Statistics, 1992). Compared to national figures for women in the workforce, respondents were also more likely to be married or in a marriage-like relationship (Department of Statistics, 1992). Some 5.5% ($n=5$) of respondents identified their ethnicity as Maori. New Zealand graduates are significantly older than their counterparts in the UK ($\chi^2=22.5$, $df=1$, $\alpha=0.01$) (ENB, 1997).

Regions: Most respondents remained in the regions surrounding the institution from which they graduated. No respondent took up an initial position outside of New Zealand and they tended not to move between regions once they had obtained a position. Otago graduates were more likely to take positions in a wider variety of regions ($\chi^2=115.6$, $df=10$, $\alpha=0.01$) (see Figure 1).

Practicing in a rural/urban/combination area: The majority of positions taken up were in an

Figure 1. Percentage of respondents who remained in the region in which they studied

	1994	1995	1996	1997	1998
AIT	4/8 = 50%	9/10 = 90%	9/10 = 90%	5/8 = 60%	9/9 = 100%
Otago Polytechnic	3/10 = 30%	3/10 = 30%	4/10 = 40%	5/9 = 60%	4/8 = 50%

urban setting (69.5%) and respondents from AIT were more likely to be working in an urban area than respondents from Otago. ($\chi^2=7.8$, $df=2$, $\alpha=0.05$). Respondents working in rural settings were more likely to be carrying their own caseload ($\chi^2=20.1$, $df=2$, $\alpha=0.01$).

Employment category: When looking at all positions taken up, most were in a hospital setting (61.2%); this was followed by those in self-employment claiming from the national maternity funding schedule, known as Section 51 (26.1%). However, employment category did not determine the type of practice with respondents taking on a variety of roles in both settings (see Figure 2). Across all positions 45.8% of respondents were caseloading, 51.6% worked in core facility positions and 2.6% worked in other positions such as management, education and casual postnatal.

Figure 2. Comparison of employment categories and settings

Employment categories for respondents employed by hospitals	
Core facility midwives	46.3%
Caseloading midwives	13.3%
Multi-role in small units	1%
Midwifery management	0.5%
Employment categories where respondents were caseloading	
Self employment	26.1%
Employed by a public hospital	13.3%
Working under a contract outside Section 51	2.1%
Working for a tertiary education institution	1%
Subcontracted to an independent midwife	0.5%

Trends in practice style: In the first position, respondents from Otago were more likely to be caseloading than those from AIT ($\chi^2=8.1$, $df=1$, $\alpha=0.01$). However, in their current positions this difference between AIT & Otago disappeared. The overall trend was toward caseloading for both groups of respondents ($\chi^2=12.1$, $df=1$, $\alpha=0.01$).

Reasons for taking up positions: In the first position, for all graduates, practice style was the most frequently occurring reason for taking up the position (see Figure 3). Respondents who were self-employed were more likely to indicate practice style (49.5%) than any other reason for taking up a position. While practice style continued to domi-

nate (32.3%), respondents employed in a hospital setting were more likely to indicate that they were also influenced by issues related to 'finances' (25.85%), 'family' (20.4%) and 'compromise / expedience' (22.6%). In the hospital setting, specific reasons for taking up a position differed between core facility and case loading respondents (see Figure 4).

In their current position – changes in reason for taking up the position: Overall 'practice style' remained the most important reason for taking up a position. For those who had taken more than one position, 'family' and 'supportive work environment' became more important influences and 'compromise / expedience' became less so. These reasons mirrored those of respondents who had remained in their first position (see Figure 5).

Continuity of work as a midwife: The majority of respondents had worked continuously since graduation (excluding holidays). 28% of respondents took a break at some stage and the reasons are outlined in Figure 6.

Future practice intentions: 91.2% of respondents intended to continue to work as a midwife. 71.6% intended practising case loading midwifery in the future, citing reasons

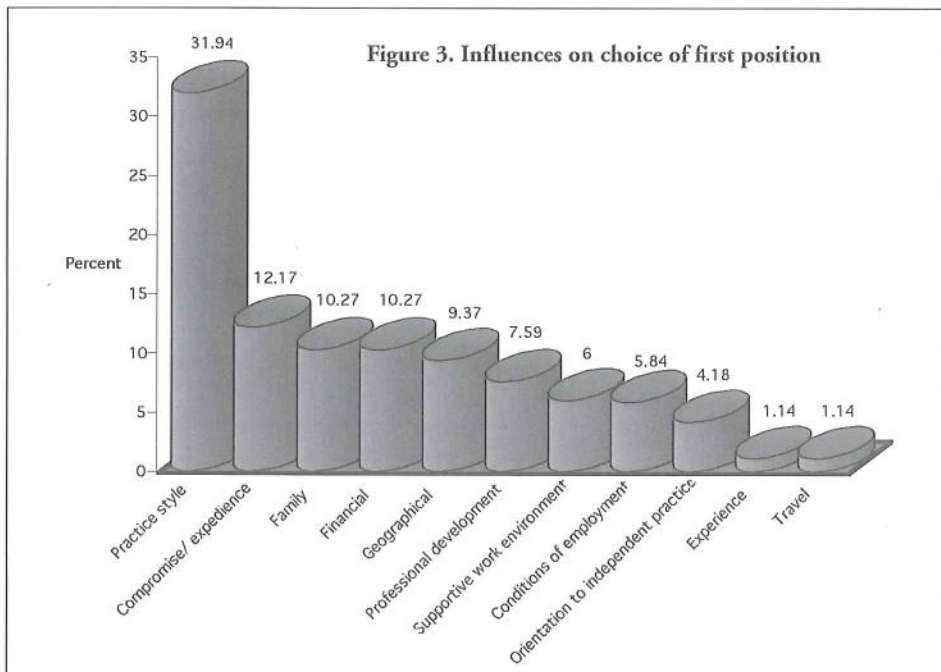
related to practice style (68.9%). Practice style and wanting to practice independently were the main reasons given for planning to caseload in future practice. Those who were case loading intended to continue and those who weren't were significantly likely to state that they intended to case load in the future ($\chi^2=5.3$, $df=1$, $\alpha=0.05$). Those who did not plan to caseload in the future gave professional development opportunities as the most important reason for not doing so.

Movement between caseloading and non-caseloading positions: Movement between caseloading and non caseloading practice was relatively even for each year of graduation, where to-

tal movement remained static for the 1994 respondents ranging up to a net movement of 44% for the 1997 graduates (see Figure 7). In the main,

Ethnicity

We had hoped to gather data from a larger group of Maori graduates as anecdotal evidence from



movement was between caseloading and core facility midwifery practice, resulting in experience for these graduates in both the primary and secondary maternity services.

Discussion

An ageing population?

The data collected in this study adds support to the concern (Guilliland 1998) that the midwifery population is ageing. Over 72% of midwives working in New Zealand in 2000 were over 40 years of age (New Zealand Health Information Service, 2000). If the current midwifery programmes are able to produce sufficient graduates to meet current and future workforce requirements, the fact that existing midwives are older is not, of itself, an issue. However, there is currently no national system for establishing and planning workforce requirements that could inform decisions about graduate numbers. Further study needs to be undertaken to establish current and future midwifery workforce requirements within the context of the current maternity services. If the current midwifery educational programmes are not producing sufficient graduates to meet workforce requirements then consideration must be given by educational institutions and government to increasing both the intakes of students and the accessibility of existing programmes for prospective students outside of the main centres.

midwifery educators indicates that the uptake of direct entry midwifery by Maori is increasing (NZCOM Education Committee, 1994 – 1999). Pakeha (non-Maori) respondents appear to be over-represented in this study. Current New Zealand data relating to ethnicity of midwives is incomplete (Guilliland, 1998) so it is difficult to draw a comparison between the cohort studied and the wider midwife population without further study.

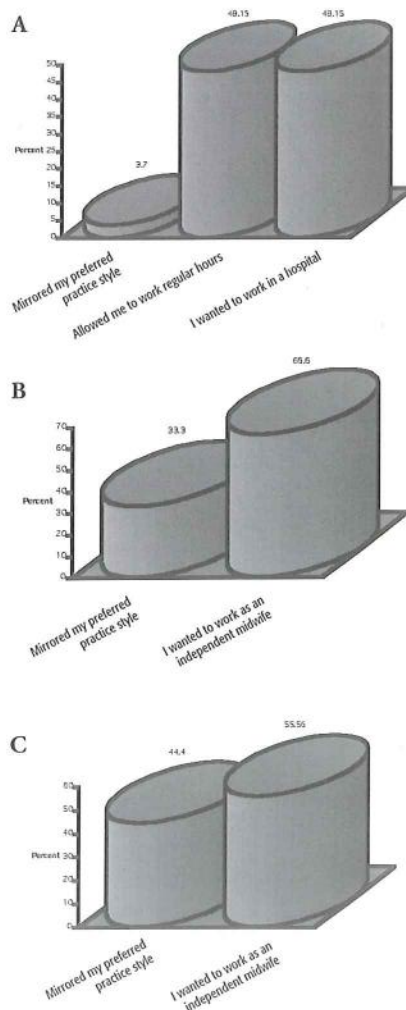
Respondent profile

The profile of New Zealand direct entry midwifery graduates appears to differ somewhat from that of direct entry graduates in the United Kingdom (ENB, 1997). While more than half of both groups have children and are married, there is a significant difference in age. The age difference between the two groups may be explained by the different impetus for the development of direct entry programmes in each country. The United Kingdom (UK) began offering direct entry midwifery programmes as a way of recruiting midwives into the profession and of preparing midwives who were capable of working to the full scope of midwifery practice (ENB, 1997). The UK direct entry programmes have accepted school leavers. In New Zealand the impetus for direct entry midwifery programmes came from consumer demand for autonomous midwives who could offer women an alternative to the medical

model of maternity care. Criteria for entry to these programmes have always emphasised life experience and maturity, with a recommended minimum age of 20 years (NZCOM Education committee, 1994 – 1999). Maturity and confidence are necessary for the demands of midwifery in New Zealand. These demands include autonomous practice, self-employment, continuity of care and the intimacy and complexity of the midwife/woman relationship when practised in a partnership model (Pairman, 1999). This preference for older students appears to be supported by the fact

Figure 4

- A) Reasons given by those employed in hospital as core midwives for taking up the first position
- B) Reasons given by those employed in hospital as case loading midwives for taking up the first position
- C) Reasons given by midwives who were self-employed in the first position



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that only 2.8% of all direct entry midwives working in New Zealand in 2000 were under 25 years of age (New Zealand Health Information Service, 2000). Overall, it appears that respondents in this study were drawn to midwifery later in life and after they had had children of their own.

Regions where positions are taken up

Following graduation no respondents took an initial position outside of New Zealand, choosing instead to consolidate their educational preparation by working as midwives in New Zealand first. That respondents from Otago Polytechnic were more likely to take positions in a wider variety of regions may be a reflection of the greater employment opportunities available to Auckland graduates in the Auckland region as compared with

employment opportunities in Otago (Guilliland, 1998; National Health Committee, 1999). Another possible explanation for the dispersion of respondents from Otago is that a large number of students in the Otago Polytechnic programme, particularly in the early years, came from outside the Otago region and may have returned home after graduation (Otago Polytechnic Nursing and Midwifery Department Admissions Committee, 1992 - 1998). A third possible explanation is that in their third year of study, Otago Polytechnic students have the opportunity for clinical placements throughout New Zealand. Many use this as an opportunity to network, to 'try out' working in locations of interest, and to establish themselves in regions outside Otago. Until recently, AIT students have tended to have the majority of their placements in Auckland (NZCOM Education Committee, 1994 - 1999).

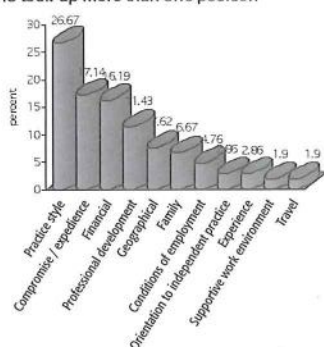
Although caseloading might be the preferred practice style, a guaranteed income, paid holidays, and the opportunity for professional development strongly influenced the respondents' decisions to take up caseloading as employees within a hospital. As expected, reasons related to family and compromise and expedience figured more prominently for all respondents with dependent children than those without.

Current employment position

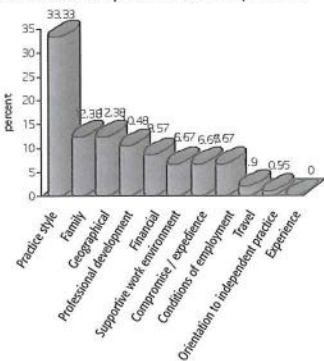
In the current position practice style remained the most important influence in all positions. However, for those respondents who had more than one position, their reasons for taking up their current position differed by employer. For hospital-employed, caseloading midwives, reasons relating to family and conditions of employment were most frequently stated while self-employed, caseloading midwives most frequently indicated reasons relating to location.

Figure 5.

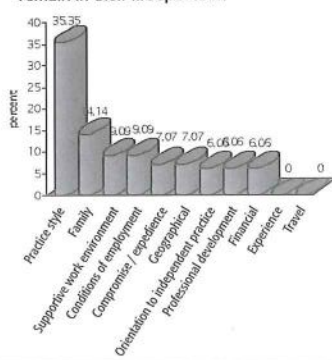
Influences on choice of first position for respondents who took up more than one position



Influences on choice of current position for respondents who took up more than one position



Influences on choice of position for respondents who remain in their first position



Urban/rural/combination

Respondents were asked to indicate for each position whether they worked in a rural setting, urban setting or a combination of the two. These terms were not defined in the questionnaire, so some discrepancy may exist amongst respondents in what they considered to be rural or urban. However, there is a possibility that the programmes had an influence on where graduates went to find work. Unlike AIT, Otago Polytechnic students have a compulsory rural placement in the third year of their programme, thus providing an opportunity for experience of rural midwifery practice and this may be related to a larger number of Otago respondents who worked in rural areas. Guilliland (1998) found that rural and provincial women relied heavily on self-employed midwives for any maternity service and that these women also had fewer choices of maternity carer. Further studies should examine whether formal experience of rural placement in midwifery programmes would increase the number of graduates willing to work in New Zealand's rural areas. It may be necessary to develop strategies to increase access to midwifery education programmes for rural women who wish to practise midwifery in their own areas.

Reasons for taking up employment positions

First employment position

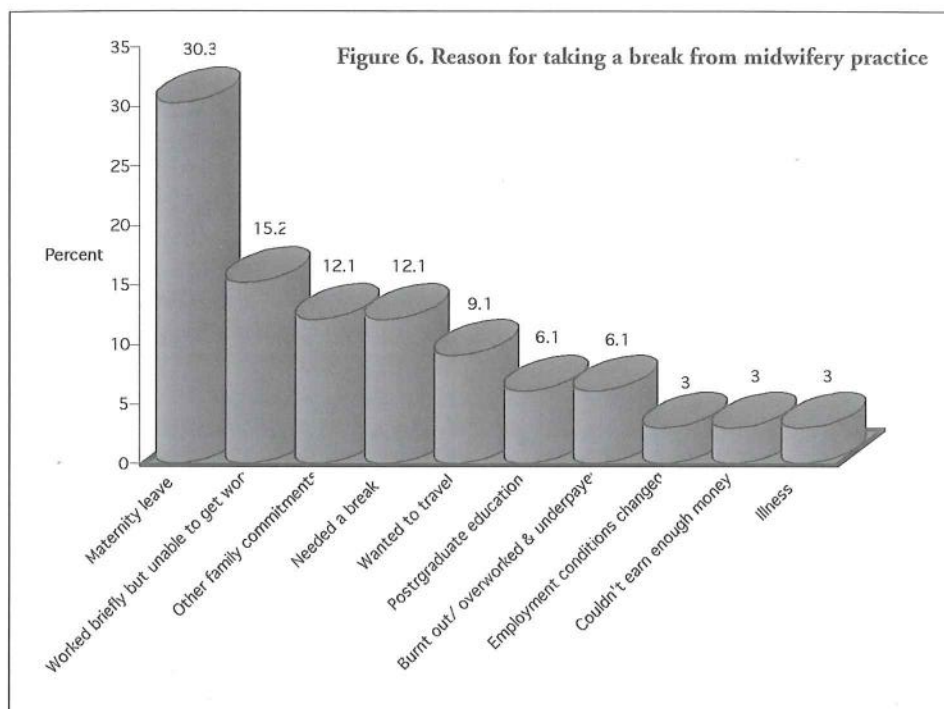
The majority of respondents (57%) were employed in a public hospital in their first position followed by 33.3% in self-employment claiming from Section 51. However, practice type was not confined by employer category as 11.3% of hospital-employed graduates were caseloading in their first position. This reflects the current maternity services where most base hospitals run their own independent midwifery service.

When comparing the two caseloading groups in their current position both still gave practice style as the most important reason for taking up the position. However, hospital-employed caseloading midwives identified professional development, financial and conditions of employment as being more important while self-employed midwives identified reasons related to a supportive work environment. It is noteworthy that those for whom reasons of professional development and conditions of employment were important were primarily employed in a hospital either as caseloading or core facility midwives. This might be because hospital employment may offer a variety of paid leave including study leave that is not available in the same way to self-employed midwives.

First position versus current position - trends in practice style

Over time, from the first position taken following graduation to the current position held by respondents, there was a trend toward caseloading. As most respondents stated that they wished to 'caseload' in their future practice it was clear that they were on their way to achieving this goal. As preparation of graduates for self-employed caseloading practice was a stated aim of both programmes it would appear that Otago Polytechnic and AIT have succeeded in this aim.

Equally important was the number of graduates who worked in public hospitals as core facility midwives. There was consistent movement between caseloading and core facility midwifery practice, resulting in experience for these gradu-



ates in both the primary and secondary maternity services. Understanding of both aspects of the service can only benefit the maternity service in the long term as the Ministry of Health moves to further integrate the primary and secondary services. As Guilliland (1998) points out there has been concern in the midwifery profession about the lack of experience of midwives remaining in the core

after large numbers of midwives moved into self-employed practice from the hospitals over recent years. The midwifery profession is working to redefine the role of the core facility midwife to that of a 'wise woman' in the institutions,

who uses her knowledge and expertise in secondary maternity care to support the primary midwife/woman partnership as necessary (Pairman, 1999). The fact that direct entry midwifery graduates have increasingly gained experience in both core facility and caseloading midwifery will help this process of redefinition of midwifery roles. Cooperation between core and caseloading midwives is essential for successful integration of primary and secondary maternity services in New Zealand. For the midwifery profession to continue to exert significant influence over the development of the maternity services in New Zealand, requires midwives who can work autonomously and confidently in all areas of the maternity service.

Respondents from these programmes are experienced in both core facility midwifery and caseloading midwifery and the trend is towards caseloading midwifery.

Future practice

It was heartening to see that most respondents intend to continue to work as a midwife in the future and that so many intend to either continue or to begin to practice caseloading midwifery. Midwives already provide the majority of the maternity services in New Zealand with 73% of women having chosen a midwife as their Lead

Maternity Carer in 2000 (Health Funding Authority, 2000).

The challenge for the Ministry of Health is to ensure that there are enough independent midwives to meet the demand

and that their work conditions support caseloading practice. That professional development opportunities influenced respondents who chose hospital employment rather than self-employment, suggests that consideration needs to be given to increasing the professional development support available for self-employed midwives.

Conclusion and recommendations for future study

These findings support the preparation midwifery students receive at Otago Polytechnic and AIT. These programmes set out to produce graduates who are able to work independently in any area of the maternity service, and clearly they have achieved this aim. Respondents from these programmes are experienced in both core facility mid-

wifery and caseloading midwifery and the trend is towards caseloading midwifery.

Midwives are the core of the maternity service and increasingly are the only providers for women experiencing normal childbirth. It is essential that enough midwives are educationally prepared for this demand and that midwives can be attracted to work in all areas of New Zealand. While job satisfaction appears to be important in choosing caseloading practice, it may also be important for the profession and government to consider the impact of other factors such as professional development opportunities and financial security if it becomes necessary to provide further incentives for caseloading midwifery practice.

This study raises possibilities for further research. Maori have the fastest growing population and Maori women have higher fertility rates than non-Maori women (Ministry of Women's Affairs, 2000). The number of Maori women entering and completing midwifery programmes needs to be examined as well as wider issues of retention of Maori midwives after registration. This study could also be replicated with graduates from all five midwifery schools to see whether findings are repeated and if there are any differences between educational institutions.

One of the limitations of this study was that we were unable to obtain any meaningful data about midwifery practice in terms of numbers of clients, numbers of women for whom the midwife was the lead maternity carer and hours of work. A further study could examine the practice of midwives and compare various groups of midwives such as rural and non-rural midwives or caseloading and non-caseloading midwives. This kind of information could be useful to the profession and to Government when looking at funding of midwifery services and structuring of maternity services.

This study has been a small descriptive study but it has provided interesting and useful information. It is the only picture we have to date of the midwifery practice of direct entry midwives and it provides a starting point for further research.

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Figure 7. Movement between caseloading and non-caseloading practice by year end of graduation

Caseloading in the first position - by year of graduation

Count		Caseloading in first position		Total
		Yes	No	
Year of graduation	1994	12	7	19
	1995	7	13	20
	1996	7	13	20
	1997	8	9	17
	1998	6	11	17
Total		40	53	93

Caseloading in the current position - by year of graduation

Count		Are they caseloading now?		
		Yes	No	Total
Year of graduation	1994	12	7	19
	1995	10	10	20
	1996	11	9	20
	1997	12	5	17
	1998	8	9	17
Total		53	40	93

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Midwifery Standards Review: a strategy for credentialling

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Introduction

This paper outlines the New Zealand College of Midwives' (NZCOM) perspective on credentialling and demonstrates how existing mechanisms can be utilised as a credentialling strategy for midwives. The paper was written in November 2000 and updated in September 2001 in response to the College's concerns that Ministry of Health work with doctors over credentialling could be inappropriately applied to other health professional groups, including midwives.

Background to credentialling

From 1999 the Ministry of Health has worked with medical groups to develop a national credentialling framework for senior medical officers employed within District Health Boards (Ministry of Health, 2001). The purpose of credentialling is "to protect patients by carefully defining the clinical responsibilities of practitioners. In doing so it also protects the hospital and District Health Board (DHB), which are required to ensure that appropriate systems are in place to manage service quality" (Ministry of Health, 2001, p.1). The definition of credentialling in the New Zealand context is:

A process used to assign specific clinical responsibilities (scope of practice) to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. This context includes the facilities and support services available and the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient. It is an employer responsibility with a professional focus that commences on appointment and continues throughout the period of employment (Ministry of Health, 2001, p.2).

The Ministry of Health (2001) further states that the funding agency is considered the 'employer' where practitioners are self-employed and publicly funded. The notion that credentialling could become part of access agreements to facilities is implicit in the document (Ministry of Health, 2001).

A recent Commerce Commission opinion rein-

forces the College's concerns that facilities have the potential to use their dominant position to unduly restrict self-employed practitioners from accessing their facility (Commerce commission letter to NZCOM 5/9/01). Facilities can (and some do) restrict access by requiring inappropriate conditions relating to training and competency which are related to their service and organisational needs rather than enhancing women-centered primary care. The effects of giving secondary care acute services control over primary practise is to "hospitalise" community maternity care.

Credentialling is about defining and monitoring the competence of a practitioner within a given scope of practice. It makes a distinction between the scope of practice defined by the professional body responsible for registration and the scope of practice defined by an organisation, which is likely to be narrower and more specific (Ministry of Health, 2001). Decisions about credentialling status are seen to belong to the organisation and are not necessarily transportable (Ministry of Health, 2001).

While in the first instance the credentialling framework has been developed for senior medical officers employed in hospitals by District Health Boards, the Ministry of Health is clear that it expects the development of credentialling processes for all health professional groups. The Ministry of Health states that the 'four-step' credentialling process is generic but that the process of credentialling may differ between professions (Credentialling Workshop Notes, 2001; Ministry of Health, 2001).

The 'four-step' credentialling process commences with initial credentialling on appointment and continues with ongoing credentialling or recredentialling for the term of the appointment. The two stages of initial credentialling and ongoing credentialling each have two steps. Step one involves verification of training, qualifications, experience and registration status and is the responsibility of the registration authority. Steps two to four are seen to be the responsibility of the organisation (employer). Step two is the determination of the scope of practice within the organisation. Step three is the ongoing collection of data for monitoring practice and recredentialling. Step

four is the review and redefinition of practitioner scope of practice (Ministry of Health, 2001).

Issues for the midwifery profession

The New Zealand College of Midwives (NZCOM) is concerned that the credentialling process developed between the Ministry of Health and senior medical officers may, in the future, be applied to both employed and self-employed midwives by hospitals and District Health Boards. The credentialling framework developed by the Ministry of Health (2001) comes out of a 'managed care' ideology that is based on a reductionist or task approach and an outmoded economic model. Further, it focuses primarily on secondary care and

organisational needs. While it purports to reduce risk to hospitals and District Health Boards, the College argues that it does the opposite. By judging the clinical competence of their staff, (a role currently reserved for the

registration authority), employers may increase their risk if employed practitioners then go on to make an error. The College considers that credentialling in its current form would be entirely inappropriate for midwifery.

Midwifery is, in itself, a specialised and defined scope of practice for which midwives are educationally prepared and registered. Midwifery situates itself in primary health care. All midwives, no matter where they are employed, are educationally prepared to work in the full scope of midwifery practice. The College does not support any mechanism that has the potential to limit or redefine the scope of practice of midwives; particularly those who are employed by hospitals that offer secondary and tertiary maternity care services. It is the role of the profession and the registration authority to determine scope of practice and competency of practitioners, not the employer. The College provides other mechanisms, already in place, that can ensure at least the same level of protection to women and babies within the maternity service as that suggested by the proposed credentialling framework discussed above.

The last twelve years have expressly developed the midwife to her full role in order to provide women with continuity of care throughout their total maternity experience.

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Midwifery Standards Review: a strategy for credentialling *Sally Pairman and Karen Guilliland*

This scope of practice cannot be redefined once again into tasks and altered by employers according to their organisational needs rather than the needs of women. On this basis the 'four-step' credentialling framework developed for doctors cannot be used for midwives. However steps one and three are an essential part of an employer's responsibilities. The NZCOM framework therefore incorporates certain aspects of the Ministry of Health doctor model but clarifies mechanisms that may be used by employers for the ongoing monitoring and support of midwives in their professional development and competency assessment. This alternative NZCOM credentialling framework is set out at the end of this paper.

Current mechanisms for midwifery competence and professional development

The NZCOM, in conjunction with a number of maternity hospitals throughout New Zealand, has already developed and implemented a cohesive process for ensuring that midwives remain competent in their practice. This process, known as "Midwifery Standards Review", also enables midwives to also meet the Nursing Council of New Zealand requirements for competency-based practising certificates.

The mechanisms that midwives and employers already have in place to maintain competency of midwifery staff are outlined below. The College suggests that this framework provides a mechanism for midwifery credentialling for other employers who may not yet be aware of the work done by the midwifery profession.

New Zealand College of Midwives

The New Zealand College of Midwives is the professional body for midwives in New Zealand. It currently represents 80% of the practising midwifery workforce. It members are both employed and self-employed midwives. The College encourages consumer involvement and makes places on all its national and regional committees for consumer membership. There are ten autonomous regional committees and five sub-committees in the smaller provincial centres. It is these committees, together with consumers and Maori, who make up the National Committee of the NZCOM. The National Committee sets the policy and direction for the midwifery profession through consultation and consensus within its membership.

NZCOM Midwifery Standards Review Process

Each region of the NZCOM has a Midwifery Standards Review Committee that operates as part of a nationally agreed Midwifery Standards Review Process. The purpose of the Midwifery Stand-

ards review process is to assist midwives with their ongoing professional development by engaging in critical reflection of each midwife's work in the previous year with midwifery peers and consumers of midwifery services.

By participating in a Midwifery Standards Review, the midwife is involved in a supportive and educative process that gives her the opportunity to reflect on her practice in relation to the "Standards of Practice" as defined by the New Zealand College of Midwives (Inc) Midwives Handbook (NZCOM, 1993).

The Midwifery Standards Review team

- annually reviews the practice of member midwives;
- acts in partnership with consumers of midwifery services to ensure the accountability of midwifery practices;
- provides a supportive environment in which to reflect on and review a midwife's practice;
- provides a special review when requested by a midwife in any case of difficulty, unexpected outcome or special interest;
- reports identified themes and issues from midwifery practice to the region of the College and/or the National Committee.

The New Zealand College of Midwives Midwifery Standards Review committee consists of two midwives elected by their respective NZCOM region and two consumer representatives elected by their consumer organisation and/or by the NZCOM region.

Nursing Council of New Zealand Competence-based Practising Certificates

The Nursing Council of New Zealand is at present the regulatory body for midwives. When the Health Professionals Competency Assurance Bill becomes law the Midwifery Council will take over the regulation of midwives. Nursing Council policy requires every registered midwife to demonstrate ongoing competency in order to obtain a practising certificate. This policy will take effect in 2001 (following expected legislative change), and the Council has released guidelines for midwives to prepare them for this new system (Nursing Council of New Zealand, 1999). These guidelines were developed by the Council in partnership with the NZCOM.

To obtain a practising certificate midwives are required to provide evidence of their participation in either:

- The New Zealand College of Midwives (NZCOM) Midwifery Standards Review, or
- A recognised midwifery review process

Both processes include the following components:

- Description of individual midwifery practice
- Reflection on individual midwifery practice
- Assessment of practice in relation to the Nursing Council of New Zealand Competencies for Entry to the Register of Midwives
- Evidence of consumer feedback in relation to individual practice
- Involvement in professional activities
- Evidence of ongoing education

Midwives will record this information and evidence in personal professional portfolios and a percentage of midwives will be audited each year to ensure that they are meeting the requirements. Practising certificates are likely to be issued every three to five years, with each midwife likely to be audited once within this period.

Many hospitals throughout New Zealand are already supporting their caseload midwifery staff through the NZCOM Midwifery Standards review process annually as a way of ensuring ongoing competency, and in preparation for the Nursing Council process. Other hospitals are running in-service education for all midwifery staff about how to establish and maintain portfolios and how to assess individual practice against Nursing Council Competencies for entry to the Register of Midwives. The schools of midwifery and the NZCOM also offer continuing education opportunities for midwives to maintain their competency. NZCOM is currently working with core-facility midwives to refine the Midwifery Standards Review process to meet their specific needs.

Hospital Professional Development Programmes and/or Clinical Career Pathways

For the last several years many of the larger hospitals have developed programmes that measure nursing and, in some cases, midwifery staff competency and skill acquisition and experience in order to identify appropriate levels of practice for staff. These levels are used as a 'credentialling' mechanism through which employers can value, recognise and support staff in their practice development. The framework is intended to provide structured support; learning and feedback to assist nurses and midwives to further develop their knowledge and skills to provide safe and effective client care (Auckland Health, 1999; HealthCare Otago, 2000a).

Most programmes have the following components:

- *Structured orientation and familiarisation with a preceptor*

- *Competencies* described for each level of practice
- Coaching and *structured learning* opportunities integrated into the programme to assist development of expertise
- Processes to assist *reflection on practice* using exemplar and case review
- Consistent feedback using performance management
- Mechanisms for *recognition of expertise (level of practice progression)* (HealthCare Otago, 2000a).

Unlike the NZCOM Midwifery Standards Review process, consumers have not been involved in the development of these models and consumer feedback about midwives is not an inherent part of the processes.

Nurses (and some midwives) are assessed to determine the 'level' of their practice and then are required to present evidence annually to demonstrate that they have maintained this level of competence. They can also apply to move to another level and are required to provide evidence of their practice to substantiate this. There is an expectation that the employer provides assistance to enable the staff member to maintain or develop knowledge and skills.

In some areas the professional development framework used for nurses has been adapted and amended for midwives (Good Health Wanganui, 1999). In these cases the competencies reflect the New Zealand College of Midwives' Standards and the Midwifery Standards Review process is recognised as one mechanism for midwives to review their practice and competencies.

HealthCare Otago is currently attempting to develop a new framework for the professional development of its midwifery staff that fits midwifery better than the adapted nursing models (Health Care Otago, 2000b). This framework recognises that midwives are competent on registration but that midwives do develop their practice over time through experience, ongoing education and reflection on practice. 'Domains of practice' are described in an evolving attempt to describe how this practice might develop and what expectation hospital employers should have of the skills and attributes of their employed midwives in these different domains. By using 'domains' rather than 'levels' HealthCare Otago is attempting to describe a flat structure in which the individual's practice experience and confidence expands while remaining within the scope of midwifery practice and in partnership with women. Unlike the hierarchy implicit in the term 'levels' HealthCare Otago is

attempting to recognise that all midwives practice within the same scope of practice but that within the organisation there is a need for some midwives to be confident and experienced in both case-loading and core-facility midwifery and for some midwives to be further prepared for additional roles such as mentor, resource midwife or midwifery practice leader. The competencies described for each domain are based on the NZCOM (1993) Standards for Practice and show how midwives might develop their practice to meet these organisational needs.

Integration of existing processes

The HealthCare Otago Professional Development Programme for Midwives articulates an emerging model of how existing processes can be integrated to ensure the ongoing competency of midwives and public safety. In this model the NZCOM Midwifery Standards Review process is central to the development of a programme that enables midwives to meet the requirements for competency assessment of the Nursing Council, the requirements for competency assessment of the employer, and the requirements for standards review of the professional organisation. By ensuring consistency of requirements and centralising the Midwifery Standards Review process as a mechanism to meet these requirements, midwives are able to complete all requirements effectively and without unnecessary repetition. The programme is not linked to the employment contracts of midwives and processes for assessment of

salary reviews or pay scales are separate to the processes for assessment of competency and practice development in the Professional Development Programme.

Issues for midwives

Despite the good intentions of many organisations such as HealthCare Otago in developing professional development programmes appropriate for midwifery, NZCOM still has some concerns.

The midwifery profession has identified its model of practice as a partnership with women. The development of expertise is in partnership with women. Therefore, expertise will differ from partnership to partnership depending on the qualities each woman brings. The quality contract that nursing has developed is around a practitioner moving from novice to expert. Therefore, adaptation of nursing professional development programmes appear to inevitably result in distinctions being made between practitioners and the notion of a hierarchy is implicit even when real attempts have been made to overcome this.

This notion of levels can become even more obvious when professional development programmes are intertwined with employment contract and salary issues as clinical career pathways. For professional development to work best it needs to be about support and ongoing education for the maintenance of competence and development of

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practice. When it is linked to salary it risks becoming a punitive process in which salary increases become confused with professional development.

The question needs to be asked as to why employers want to have these professional development programmes or why they would want a process for credentialling their midwifery employees. The midwifery profession and the employers need to clearly define what it is they want to assess and why. Unless they do there is a risk that any credentialling mechanism, no matter how well intentioned, and regardless of the words used to describe it, could become restrictive and controlling rather than enabling and empowering best practice.

If the purpose of credentialling or professional development programmes is to ensure that organisations have appropriate staff for the various roles in the institution then surely current human resource mechanisms can be used to achieve this. Position descriptions, ongoing support of professional development of staff and annual performance appraisal can achieve the same end for employers.

Any attempt to restrict or redefine the midwifery scope of practice or to privilege certain midwifery skills over others is not in the best interests of midwifery as a whole. The profession has worked hard to develop a model of practice that is based on individual midwife/woman partnership relationships within a defined scope of practice. The midwifery partnership philosophy believes that growth in practice is always reliant on the woman's involvement and this is the area on which midwifery needs to concentrate.

A midwifery model of credentialling

NZCOM believes that processes already exist that allow for the assessment and maintenance of midwifery competencies. The Midwifery Standards Review process provides a mechanism by which the requirements of the employer, the registration authority and the profession can be integrated in one seamless process. This mechanism ensures that all midwives meet the same standards through consistent processes that will enable a high quality midwifery service for the woman and babies of New Zealand.

It is suggested that, rather than develop further credentialling mechanisms for midwives, the Ministry of Health encourage hospitals and other employers to utilise processes already in place. This existing framework, and how it can be used as a credentialling process, is described opposite.

Framework for Competency Assurance for Midwives within hospitals and self employed

Component of credentialling framework	HHS employed midwife	Self-employed midwife claiming from Section 88
<i>Step One:</i> Initial Employment Verification of training, qualifications, experience and registration status	<ul style="list-style-type: none"> • Employer checks Annual Practising Certificate (registration details are verified by Nursing Council of New Zealand) • Employer checks referee reports 	<ul style="list-style-type: none"> • Ministry of Health requires Annual Practising Certificate for authorised providers • HHS access to facility agreements require APC and referee reports for access agreement for LMC Midwife.
<i>Step Two:</i> The scope of midwifery practice	<ul style="list-style-type: none"> • NZCOM and Nursing Council of New Zealand define scope of practice of a midwife • Job description describes position and expectations of employee. This will be either as a caseloading midwife, managing an independent practice within the hospital, or as a core facility midwife working set duties within the hospital. • Employer provides orientation process 	<ul style="list-style-type: none"> • NZCOM and Nursing Council of New Zealand define scope of practice of a midwife • Section 88 sets out expectations of Lead Maternity Carer • Access agreement requires orientation
<i>Step Three:</i> Ongoing monitoring of practice	<ul style="list-style-type: none"> • Employer requires participation by midwife employee in professional development programme of the hospital • Nursing Council of New Zealand requires competency based practising certificates (maintenance of portfolios and measurement of practice against standards for registration) • Employers can utilise NZCOM Midwifery Standards Review process for caseloading midwifery staff and core-facility staff, enabling them to also meet Nursing Council competency requirements 	<ul style="list-style-type: none"> • Self-employed midwives undergo annual Midwifery Standards Review through NZCOM • Nursing Council of New Zealand requires competency based practising certificates (maintenance of portfolios and measurement of practice against standards for registration) • Self-employed midwives can use NZCOM Midwifery Standards Review process to meet this requirement
<i>Step four:</i> Identification of professional development needs	<ul style="list-style-type: none"> • NZCOM Standards Review process and Nursing Council Competency-based practising certificate process both identify professional development needs for either core or caseloading midwives • Employers can assist midwives to meet these needs in preparation for their next review. This information can form part of the hospital professional development programme assessments and guide employers about ongoing education needs of midwives 	<ul style="list-style-type: none"> • NZCOM Midwifery Standards Review process develops a professional development plan with the midwife under review • Nursing Council Competency-based practising certificate process identifies professional development needs • Midwives can undertake necessary professional development in preparation for next review. • Local regions of NZCOM provide workshops for midwives guided by their identified professional development needs
<i>Step Five:</i> Monitoring process begins again	<ul style="list-style-type: none"> • As above for steps three and four 	<ul style="list-style-type: none"> • As above for steps three and four

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Miranda's book, Homeopathy for Mother and Baby is a wonderful resource. Many midwives have this book and consider it an essential tool they take to births. It is also a popular resource for consumers, homœopaths supporting birthing women and birth educators. This one day workshop will cover key aspects to the successful use of homœopathy in the perinatal context. It is intended for midwives and anyone else wanting to effectively assist mothers and newborns with homœopathic treatment. No prior knowledge of homœopathy is assumed - and even 'seasoned' users will be able to extend their knowledge of perinatal homœopathy.

Venue: The seminar will be held at:

Auckland University of Technology (AUT), North Shore Campus, Akoranga Drive, Auckland.

9.30 am - 5.30 pm Lunch: 1.00 pm - 2.00 pm Check in from 9.00 am

Venue details and map will be posted on receipt of registration

Seminar Fee: \$150.00 **10%Discount** if registration received with the form below before 30th October 2001

Registration form

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10% Early Registration discount

Midwife

Cheque enclosed: \$

Other

Please make cheque payable to: BOP College of Homœopathy

Midwifery Standards Review: a strategy for credentialling *Sally Pairman and Karen Guillard*

Conclusion

As can be seen the NZCOM Midwifery Standards Review process provides a seamless process for ongoing monitoring and assessment of midwives to ensure that midwives remain competent to practise. At the same time this process allows midwives to meet the separate requirements of the NZCOM, the Nursing Council of New Zealand and employers through the one congruent process. Measurement against standards is consistent and midwives are able to see competency assessment as a useful exercise that is also an effective use of their time and has positive outcomes for each midwife.

Rather than developing professional development programmes or clinical career pathways, the NZCOM encourages employers to consider how

to integrate their processes with those required by the Nursing Council and the College by utilising the Midwifery Standards Review process.

As a strategy for credentialling, Midwifery Standards Review is very effective and works well for midwives. The credentialling process outlined above provides a positive alternative to the medical model credentialling process and will achieve improved outcomes for hospitals and health services. The midwifery credentialling process is by definition a comprehensive, reflective and educative process based on the midwife's complete scope of practice. It therefore provides for task credentialling but within an holistic, woman centred model involving both the practitioner and the consumer.

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S U R F I N G T H E N E T

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One of the highlights of this year so far has been the death of my old computer. I was very pleased to have a legitimate excuse to bamboozle my husband into buying me a new computer. This new computer has enabled me to extend my abilities to 'surf' and find new sites that I would like to recommend to you.

The first site is that of the NZCOM 2002 Conference being held in Dunedin. The site includes information about the conference, as well as the facility to register on-line. By the time you read this, the site should include information about accommodation. www.nzcom.org.nz

If you want to know more about Dunedin, I would recommend the following two sites. These sites will help you with finding accommodation, as well as inform you about shopping, restaurants and places of interest to visit, such as the world famous albatross colony. www.visit-dunedin.co.nz/
www.dunedin-tourism.co.nz

I have just found the Minister of Health, Annette King's home page. The site includes a newsletter from Annette called Health Moves in which she discusses the latest news from the Ministry of Health. One of the on-going features of Health Moves will be information given by District Health Boards about initiatives being carried out in their areas. www.executive.govt.nz/minister/king/healthmoves

For midwives like myself who want to know more about District Health Boards (DHBs), the Ministry of Health has a Frequently Asked Questions (FAQs) page. This web page answers questions about the structure and role of DHBs. www.moh.govt.nz/electionsdhb

I have found a few more web sites belonging to midwives in New Zealand. www.aut.ac.nz/groups/autmidwives

The Auckland University of Technology midwives have a comprehensive site explaining their philosophy and services. I was especially interested to see that there is a facility whereby women can e-mail questions to the midwives. This is very interesting because I have only come across medical sites in New Zealand that offer this facility, such as Xtra's 'Ask the expert': www.xtra.co.nz/health

There's no doubt that there are an increasing number of consumers using the Internet to search for health information, so I'm pleased to see midwives offering women this service. I think it is very important that midwives don't get left behind by the medical profession in this area. Another organisation of midwives with a web site is Mothers and Midwives Associated. I liked the information they presented on how to choose a midwife but would have loved to see some photos of the midwives. www.mama-midwives.co.nz

The Women's Health Action Trust is a charitable trust based in Auckland. It's aims are to provide women with high quality information and education services to enable them to maintain their health and make informed choices about their health care. Their web site has a range of links to a number of issues facing women's health

such as menopause, contraceptives and hysterectomy. www.womens-health.org.nz

I have also recently discovered a great site that is more of a newsletter, called Midwife Info. Whilst it has a North American emphasis, there are a large number of links that will keep midwives occupied for ages including midwifery education, resources, conferences and practice development. www.midwifeinfo.com

A very useful resource for clinical practice is the 'New Guidelines for Midwife Led Care in Labour'. These guidelines have been developed by Helen Spiby and Jane Munroe, who are midwives in the UK. The guidelines cover issues ranging from supporting women in labour to when to refer to an obstetrician, and were developed from searches of electronic databases and literature, as well as consultation with midwife researchers and peer review. www.fons.org/networks/ebm/guide.htm

I am very excited because I have acquired a couple of clients through advertising my details on the NZCOM web site's 'Search for a midwife'. So to remind you, NZCOM's new web address is: www.midwife.org.nz

The New Zealand Midwives' Email List is under new management. If you wish to subscribe, e-mail Vanessa at: midwife@kiwiessie.net

My favourite non-midwifery web site at the moment is supposedly for children but I am absolutely hooked. It has a multitude of games, puzzles, competitions and activities that will keep you and the children entertained for hours, or cause major family fights over whose turn it is to play! www.neopets.com

Comment from Safe T Sleep (NZ) Ltd

Tackling preventable sleep deaths and injuries

National and international research shows that SIDS (Sudden Infant Death Syndrome) is not the only danger to our babies and young children while they're sleeping and many of the deaths that do occur are preventable.

Safe sleep campaigner and managing director of Safe T Sleep (NZ) Ltd, Miriam Rutherford, says the high incidence of SIDS in the "developed" world has put the spotlight on safe sleep practices for infants and young children, a focus which has revealed wider sleep safety issues that could be addressed.

"The fact that injuries, falls, entrapment and suffocation are all commonly occurring accidents occurring in and around sleep times is well supported by research and the new problem of "head moulding" as a result of sleeping babies continuously on their backs has recently been highlighted" she says.

"Greater public awareness is the key to keeping such preventable deaths and injuries to a minimum".

Statistics provided to the Ministry of Consumer Affairs' Infant Products Safety Forum in 1998 by Dr David Chalmers - Injury Prevention Unit, University of Otago and Professor Joan Ozanne-Smith - Monash University Accident Research Centre, indicate that a high percentage of infant deaths and injuries involve cots, bunks and beds.

Among these statistics were the following:

- There were 35 infant product related deaths in New Zealand in the period 1985-1994:
- 94% of deaths comprised children aged between 0 and 2
- stationary cots and portable cots were responsible for 68% and bunk beds were responsible for 20% of infant product related deaths.
- There were 200 infant-product related hospitalisations in New Zealand for the period 1985-1994, 58% of which occurred in under three year olds:
- beds/bunks were the most common product (68%)
- falls were the most common cause (92%)

Professor Ozanne-Smith's Australian study recorded 13 deaths between 1985-1994, over 75% of those were associated with the use of cots. "Cots: falls, entrapment - including modifications, protrusions and cot environs" were listed as a major hazard, highlighting the fact that children can, and do, die during and around sleep times. Dr Chalmers' study also noted that suffocation and respiratory obstruction accounted for 71% of the 35 infant deaths recorded in the 1985-1994 study (in which cots were the most common product involved - 62%). While the introduction of cot standards will help ensure their structural safety, there are many other considerations, says Miriam.

"Caregivers should be concerned not only with the structural soundness and suitability of the bassinet, cot or bed that they're using, but should also ensure they have a snug fitting mattress and avoid access to toys, cot mobiles, blind or curtain cords, bumper pads etc. that can be the cause of fatal accidents."

Correct bedding is also vital to a safe sleeping environment, says Miriam. Large tuck under sheets and blankets should be used in preference to smaller blankets or duvets. Natural fibres such as cotton and wool are preferable to synthetic alternatives.

"Some traditional approaches to cot hygiene such as regular airing of mattresses, especially in the sun, have a lot to offer as sunlight helps to kill mould, bacterial and fungi that can develop," she says.

In the Netherlands officials recommend caregivers do not

use a duvet with children under two years of age because of the dangers of overheating and suffocation, says Miriam. "The lightweight nature of duvets belies the fact that they can provide warmth equivalent to that of three or four blankets. Also they are often not designed to be tucked in and therefore can easily be kicked or pulled up over a babies head creating potentially suffocating circumstances."

The need to keep babies' heads clear of bedding and other obstructions is well documented. In the New Zealand Cot Death Study 15.7% of SIDS babies were found with their heads covered.

The US Consumer Products Safety Commission Report called "Infant Suffocation Project" final report January 1995, noted that "about 30 percent of the infants diagnosed as SIDS were found in potentially suffocating circumstances with their nose and mouth covered by soft bedding".

"Many parents recognise a pattern of finding their baby jammed in a 'favourite' end or corner of the cot which is the result of a natural physiological ability for babies to creep either forward or backwards in their sleep, even before they can crawl," says Miriam.

One New Zealand survey of infant sleep position by IB Hassall and M vandenBerg, published in the New Zealand Medical Journal 1985 revealed that, "During the peak age of incidence of cot death, i.e. 2-3 months, infants can have powerful thrusting movements of their legs but be unable to raise their shoulders or even their heads because of relatively underdeveloped strength and co-ordination of their upper bodies."

"The dangers this 'creeping' ability presents include potential suffocation if children become trapped under bedding or toys or jammed in cot corners and the like," Miriam says. More recently the "back to sleep" campaign encouraging a back sleeping position for babies has been linked to an increased incidence of undesirable head "moulding" among babies.

"For those who have had to cope with such "head moulding" the problem is not 'merely cosmetic' it can be devastating, involving intensive procedures and intervention, even surgery, to correct their baby's head shape." Whilst alternately turning a baby's head when sleeping may prevent this problem, a significant number of babies still turn to a preferred 'flat spot', says Miriam. "Community education about the potential problem and its prevention are essential to preserve the integrity of current safe sleep campaigns", she says. Medical professionals have reported that such head moulding incidents were increasing and linked it to the promotion of sleeping babies on their backs. A plastic surgeon specialising in craniofacial problems at Middlemore Hospital and in private practice, Dr Tristan de Chalain, was reported as saying there was an increase in referrals to a facial cranial clinic in the US when the 'Back to Sleep' campaign was promoted, and the same happened in New Zealand. There is an increase of over 300% in hospital admissions worldwide due to plagiocephaly.

"There is no doubt that tummy sleeping and/or head or face covered are not desirable and are significant cot death risk factors. Public education campaigns have done a good job of creating an awareness of this irrefutable fact. However, parents and professionals will need to be aware of the potential for head moulding and falls, and provide safe options for preventing such development."

For further information contact Miriam Rutherford, Safe T Sleep (NZ) Ltd on (09) 299 7589 or 025 736 645.

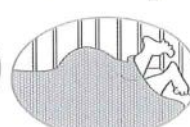
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PEACE OF MIND FOR YOU

An Investigation of a Cluster of Cancer Cases occurring amongst Midwives who had worked at National Women's Hospital from 1966 to 2000.

Dr C Walls

Occupational Medical Specialist

Occupational Medicine Unit, Auckland Healthcare

This report provides a brief overview of a study carried out in Auckland, and completed in July 2001, into a group of midwives who had worked at National Women's hospital and had developed cancer. A copy of the full report, including appendices, can be obtained from the National Office of the New Zealand College of Midwives.

Summary

- After becoming aware of concern about the number of midwives with cancer who had worked, or were working, at National Women's Hospital (NWH), Mr Gary Henry, General Manager, National Women's Hospital, instructed the Occupational Health Unit of Auckland Healthcare Services to investigate the association.
- Although after reviewing the initial data it was felt that no causative link existed it was decided to explore the possibility of a formal study amongst this group because of the widespread concern amongst midwives and the interest of media organisations.
- Ethical approval was obtained for a formal cohort study comparing cancer rates between midwives who had worked at NWH with the rates amongst general nurses trained at Greenlane Hospital (GLH) during the same period of time.
- Unfortunately data polling of pay records showed that insufficient numbers of staff could be identified to make this proposed investigation statistically valid.
- The cancer cluster investigation was completed including a review of potential exposures at NWH. Those midwives who had been identified as suffering from cancer (or their immediate relatives in the case of those midwives who had died) were interviewed after obtaining their permission.
 - 12 midwives were identified.
 - Their exposure at NWH ranged from less than 12 months to more than 240 months (mean 114 months, median 100 months)
 - This cluster of midwives had suffered from several different types of cancer. One case did not suffer from a malignancy.
- It was felt that this cluster of cancer cases did not indicate an association between a work place

exposure and subsequent disease. This cluster has most likely arisen by chance.

- Further investigations would have to be undertaken on a nationwide scale, a project well outside the scope of Auckland Healthcare. This would blunt the exposure definition (given different workplace practices) making any association harder to define.

Introduction

In 1999 Mrs Jocelyn Boddie, a midwife who had worked at National Woman's Hospital (NWH), approached Mr Gary Henry expressing her concern at the number of midwives who had worked at NWH who had been recently diagnosed as suffering from cancer. Her letter raised the possibility of a workplace association causing or contributing to this cluster of cases.

Mr Henry consulted with Dr Tony Baird, (then Clinical Director, Obstetrics and Gynaecology) and subsequently asked Occupational Health to prepare a proposal to investigate the matter further.

After reviewing the initial data and in consultation with Dr Robert Scragg (Epidemiologist, School of Medicine, Auckland University) and Dr Evan Dryson (Occupational Medical Specialist, Department of Labour Occupational Safety and Health Service), and it proposed that a two step investigation retrospective cohort study be undertaken. Initially the payroll records at Auckland Healthcare Services would be polled to establish whether an exposure group of midwives (1000 midwives) and a control group of 4000 general nurses who had worked at Green Lane Hospital (GLH) during the same period of time could be identified.

- i) If this initial polling showed sufficient numbers to give the study statistical credibility then a formal cohort study would be launched.
- ii) If the initial polling showed that no statistically significant result could be obtained then the investigation would be restricted to:
 - (a) interviewing the affected staff (those that could be identified) and
 - (b) reviewing the literature with respect to exposures that midwives would experience in the course of their work and any known associations between midwifery and any types of cancer.

Ethical approval for this proposal was obtained from the Auckland Ethics Committee.

Polling the payroll records was undertaken by Dr Debbie Ryan-Sheridan (Australasian Faculty of Occupational Medicine trainee). The payroll records proved to be of limited usefulness. Those records that were computerised were quite recent and fell outside the exposure envelope (occupational cancers typically show a period of elapsed time from exposure to diagnosis of disease).

Other records were quite limited in terms of the years available. Many payroll records had been destroyed and a search of all the available records showed only 105 midwives and 3,056 general nurses at Greenlane Hospital were identified. With regret the cohort study was abandoned.

Mrs Boddie and Karen Guilliland (NZCOM) were approached asking them to contact those midwives who they knew had developed cancer and seek their permission for their names and addresses to be forwarded to the investigators. These midwives (or their nearest surviving relative) were then approached and their permission obtained to be interviewed.

The results, together with a review of potential exposures and cancer causation mechanisms are presented below.

Identified Occupational Cancers in Healthcare Workers (HCWs)

Alderson (1986) reviewed the state of knowledge in 1986 concerning HCW occupational exposures and subsequent cancer development. He discussed the following associations that may occur in healthcare settings (see table one).

Alderson (1986, p.135) commented that studies of health professionals showed that:

the range of studies, variation in the work environment and inconsistent results fail to provide a clear picture of increased risk of cancer. The topics of (a) staff handling anti-neoplastic agents, and (b) outcome of pregnancy in laboratory staff warrant further study.

Andersen, Barlow, Engeland & Kjaerheim (1999) recently reviewed the incidence of work related cancer in Nordic countries. Their summary for Occupational Group 1 (technical, chemical, physical and biological workers) reported:

Results: This group of occupations showed a significant excess risk for skin melanoma and cancer of the prostate among men in all Nordic

TABLE ONE

Putative Agent	Possibly Associated Cancer and Strength of Association
Anaesthetics (page 35)	IARC (1976) concluded that available studies indicated that working in operating theatres was associated with an increased risk of cancer, teratogenic effects and possibly mutagenic effects. It was not possible to determine which particular factor was responsible
Ethylene Oxide (page 58)	When ethylene oxide was reviewed by the IARC (1976) there was no published study of workers for evaluation. Though there have been 2 reports from Seende of excess leukaemia in exposed workers, these have not been replicated in other studies.
Fluorescent lighting (page 79)	There is an inadequate base to evaluate an association between exposure to fluorescent light and cancer in humans
Formaldehyde (page 80)	IARC (1982) considered that though there was sufficient evidence that formaldehyde was carcinogenic to rats, there was insufficient epidemiological evidence to assess the hazard to man.
Radiation (page 87)	The International Labour Office (1998) Encyclopaedia recognises HCWs as being at risk from skin cancers and leukaemia from ionising radiation.

Note: page numbers refer to Alderson (1986)

countries. There was also an excess risk for pleural cancer for men in all countries except Norway. The group showed a consistent low risk for alcohol or smoking-related types of cancer. For women, excess risks of cancers of the lung and breast were observed in every country except Denmark.

Comments: A high risk of breast cancer in women is often observed in higher social classes, probably due to a reproductive pattern with less children and a higher age at first birth. An increased risk of malignant melanoma in occupations with higher education is believed to be related to sunburn during leisure-time activities. The high risk of pleural cancer was an unexpected finding. (Andersen, Barlow, Engeland & Kjaerheim, 1999, p.13).

Their results were further refined to Nurses (Occupational Group 5) and were reported as:

Results: Breast cancer represented almost 40% of all cancers among nurses, and an excess of breast cancer was found for all the Nordic countries. Skin cancers showed a 20% excess risk in all the countries. For thyroid cancer, the SIR was elevated in all 4 countries except Sweden. Significantly low risks were seen for cancer of the larynx, gallbladder, cervix uteri, oesophagus, lung and pancreas. The incidence of cancers with an unknown primary site was significantly below the average for the population.

Comments: This is one of the most homogenous groups included in our study. The increased risk of thyroid cancer, malignant melanoma, and other skin cancer may be related to increased diagnostic activity. Reproductive factors, such as a high proportion of nulliparous women, are likely to explain the elevated risks of cancers of the breast and endometrium. The former association between

nursing and religion may reflect the relatively low risk of cancers related to alcohol, smoking and sexual activity. (Andersen et al., 1999, p.19).

Although not directly applicable to healthcare workers Baysson, Laurier, Tirmarche, Valenty & Giraud (2000) reported on a cohort study of workers exposed to a mixture of radiological and chemical hazards following a cluster of cancer cases amongst workers. They found a weak association with "all cancer types" and the duration of exposure to chemicals. The authors note however that: *These results, none the less, are difficult to interpret and must be considered with caution. In particular, due to the small size of the population*

it was not possible to analyse separately each of the chemicals involved or to consider the combined exposure to several carcinogenic agents (Baysson et al., 2000, p.193).

Thus there are no clear-cut associations between being a HCW and developing any cancer at a greater rate than the rest of the community, apart from hepatocellular carcinoma as a consequence of occupationally acquired Hepatitis B infection.

Occupational Exposures of Midwives at NWH

A hazard identification was undertaken at NWH and is presented below. A group of midwives with 20 years service at NWH were interviewed by Dr Ryan-Sheridan and used to check the relevance of the hazard identification over that period of time. See tables two, three and four.

Discussion

Because of shortcomings in pay-roll records polling of these records indicated that insufficient numbers could be obtained to make a full epidemiological study valid. The investigation was reduced to identifying and interviewing those midwives (or their nearest surviving relative or friend) known to have developed or to have died from a malignancy.

There appears to be neither any consistent occupational exposure at NWH nor any consistent disease outcome amongst this group of midwives.

continued over...

SITUATIONS VACANT

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An Investigation of a Cluster of Cancer Cases occurring amongst Midwives who had worked at National Women's Hospital from 1966 to 2000 *Dr C Walls*

TABLE TWO

The following potential hazards were identified:		
Physical	Radiation including:	<u>Potential for Exposure</u>
	Diagnostic Xrays	Usually only during special procedures
	Radiotherapy treatment of gynaecology cancer patients	Not a typical task for a midwife
	The use of radioactive "pellets" for the treatment of cervical and uterine cancers in patients.	Not a typical task for a midwife
Chemical	Glutaraldehyde	A high level disinfectant. Potentially present in delivery rooms.
	Formaldehyde	Not identified as an exposure
	Ethylene Oxide	EO unit situated in theatre is side room
	Cytotoxic drugs	Reserved for gynaecology patients, not a typical midwife task
Biological	Blood/body fluid exposures leading to the risk of major transmissible viral illnesses and other infectious diseases	Constant potential for occupational exposure as a midwife
Social	Shift work, demanding profession	A constant demand for midwives but without evidence that this directly translates to an increased proclivity to cancer
"Ergonomic"	Various	A constant demand for midwives but without evidence that this directly translates to an increased proclivity to cancer

As noted, one of the "cases" did not have a malignancy, reducing the cluster to a total of 11 cases.

Only two of the women had similar types of cancer (bowel). The other 9 women had different conditions and for at least one of these women there appeared to be a family history. Of interest is the absence of breast cancers in this study cluster although the author is aware of anecdotal information of three cases of breast cancer who have not, as yet, indicated consent to be interviewed. As noted Andersen et al (1999) found that breast cancer

represented almost 40% of all cancers amongst Nordic nurses, which they felt to be due to reproductive factors (delayed or nulliparity).

Confounding factors such as smoking and alcohol consumption (as far as could be estimated) appeared to play little part in the occurrence of these conditions. Only two women (20%) smoked and one of these is still working. Estimates of alcohol intake were similarly low for this group.

Workplace exposures were on the whole not significant. Those exposures that would attract sus-

picion (exposure to excess radiological procedures, administering oncology radiotherapy etc.) occurred to only one woman who is still working at NWH. Her own estimate of this exposure was not high but her comments outlined work practices that perhaps would not be used today. Similarly no midwives (or their close relatives) recalled being involved with cytotoxic drug administration.

A story that lead shielding in one of the NWH delivery suites was found to have "slipped" when renovations took place (thus exposing delivery room personnel to excess radiation) was not confirmed by the radiology and building service departments.

All midwives reported regular and constant exposure to Nitrous Oxide, an estimate supported by published material (Gray, 1989). This exposure, initially at least, would have occurred via giving apparatus without local extraction in environments relying on general ventilation. In the past it has been recognised that general operating theatres could exceed the recommended levels (Gray, 1989) and that exposure to Nitrous Oxide is associated with adverse reproductive outcomes (in association with shiftwork) (Bodin, Axelsson & Ahlberg, 1999; Ahlberg, Axelsson & Bodin, 1996). Appropriate ventilation brings these exposures within recommended limits (Newton, Fitz-Henry & Bogod, 1998). No correlation has been reported between Nitrous Oxide exposure and cancers of any kind.

In contrast, all except one midwife considered that they had had minimal exposure to other anaesthetic gases such as Halothane. Other chemical exposures (predominantly to Glutaraldehyde) did not play a part in this group's estimates.

TABLE THREE

Cluster Interview results								
All midwives were female. Interviews were obtained from next of kin in cases marked with *.								
Demographic and Disease Data								
No	Year of Birth	Months worked at NWH	Year started at NWH	Year finished at NWH	Year illness diagnosed	Type of cancer	Health status	Standard drinks / day in last year
1	1944	240	1969	Current	1997	Myelofibrosis	At work	0
2	1945	15	1976	1977	1990	Ovarian	At work	2
3	1955	240			1995	Non Hodgkins Lymphoma	At work	1
4*	1955	< 12			1992	Mucinous Cyst Adenocarcinoma	At work	0
5	1939	> 240	1966	Current	1993	Thyroid cancer	At work	0
6*	1948	> 25 & < 60			1996	Adrenal Cortical Cancer	At work	0
7*	1952	18	1996	1998	1998	Oesophageal Cancer	Deceased	1
8	1959	144			1991	Squamous cell Cancer	Deceased	0
9*	1955	81	1991	1998	1998	Bladder Cancer	Deceased	0
10*	1936	> 61 & < 120			1986	Ovarian Cancer		
					1997	Bowel Cancer	Deceased	0
11*	1949	132	1975	1996	1995	Bowel Cancer	Deceased	0
12	1951	60	1989	1994	1998	Acute lymphoblastic leukaemia	Retired	1

TABLE FOUR

Estimated Exposure Data							
No	Nitrous Oxide	Other Anaesthetic Gases	Cytotoxic Drug Administration	Other Chemicals	Radiation including Radiotherapy	Biological Exposures	Other Exposures
1	Daily for 24 months General ventilation only	Low to minimal	Nil	None remembered	Low (assisted special procedures 1 year with PPE)	No excess exposure	None remembered
2	Daily for 6 months General ventilation only	Low to minimal	Nil	None remembered	Minimal	No excess exposure	None remembered
3	Low to minimal	Low to minimal	Nil	None remembered	Minimal (at NWH)	No excess exposure	None remembered
4	Daily for 6 months General ventilation only + PPE	Minimal	Nil	None remembered	Minimal	No excess exposure	None remembered
5	Daily for > 240 months General ventilation only	Some exposure to Halothane, Ether and Trichlorethylene Anaesthetic "scrubbing" introduced 15 years ago	Nil	Some exposure to small amounts of Formaldehyde & Glutaraldehyde – 28 years General ventilation only	Exposed to Xrays (with PPE) 3/week for 12 years. Assisted with radiotherapy (removal of seeds) on a monthly basis for 2 years	Frequent excess exposure	Stress and shift work for 35 years
6	Low	Nil	Nil	None remembered	Minimal	No excess exposure	None remembered
7	Moderate	Low to minimal	Nil	None remembered	Minimal	No excess exposure	None remembered
8	Mild to moderate	Minimal	Minimal	None remembered	Minimal	Occasional exposure	None remembered
9	Daily for 72 months General ventilation only	Low to minimal	Minimal	None remembered	Minimal	Occasional exposure	None remembered
10	Daily for 100 months General ventilation only	Low to minimal	Nil	None remembered	Minimal	Frequent exposure Suffered from Hepatitis B while adult	None remembered
11	Not recalled by next of kin	Not recalled	Not recalled	Not recalled	Not recalled	Not recalled	Not recalled
12	Daily for 60 months	Low to minimal	Minimal	None remembered	Minimal	Occasional excess exposure	Long exposure to ultrasound via foetal monitoring. Concern expressed about effect of building glues during renovation

As expected all midwives reported exposure to blood and body fluids on a regular basis throughout their career. Two reported "frequent excess" exposures and one of these midwives had developed Hepatitis B as an adult. Although infectious disease is a recognised hazard for healthcare workers of all types, there appears no plausible connection between blood and body fluid exposures and cancer in general. The exception to this is hepatocellular carcinoma subsequent to occupationally acquired Hepatitis B infection (International Labour Office, 1998). Amongst other work groups potentially exposed to blood and body fluids Andersen et al (1999) note an excess of colon cancer in male physicians (they speculate this may relate to high meat consumption), breast cancer in female physicians (delayed parity or nulliparous) and population average cancer risks in nurse assistants. They suggest that blood and body fluid exposures in themselves do not increase the risk of developing cancer.

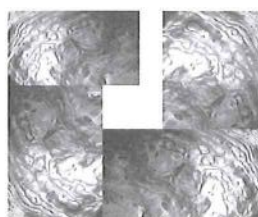
No other exposures of concern were reported apart from one participant noting that they had worked shift work for over three decades, frequently at times when they were emotionally and physically

fatigued. There is no reported association between shift work and cancer of any type.

Although two midwives (20%) had worked at NWH for 20 years or more, 50% had worked

there for 10 years or less meaning that their cumulative exposures at NWH would have been slight or mild.

continued over...



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Celebrating diversity within unity

An Investigation of a Cluster of Cancer Cases occurring amongst Midwives who had worked at National Women's Hospital from 1966 to 2000 *Dr C Walls*

Occupational cancers typically have a long latency period (time from exposure to the diagnosis of the disease) and have had years of exposure (or very high exposure for a short time) to a recognised carcinogen (International Labour Office, 1998). Latency could only be estimated in 50% of the cluster (excluding the non-cancer case) but ranged from 2 years to 27 years (average 13.8 years, median 13 years) suggesting differing causes not related to workplace exposures.

The principal objections to this cluster of cases having a common causal workplace exposure are:

- The disparity of types of cancer suffered i.e. there was not one common pathological outcome.
- One of the "cancer cases" did not have a malignancy
- The short exposure times of 3 (25%) of the cases (< 24 months)
- The lack of a definable and plausible exposure

Although exposures are generically similar throughout New Zealand it is likely that extending the study to other hospitals would introduce such variety in exposures that any study would be unlikely to return a reliable answer.

Recommendations

- 1) That this report be distributed to other New

Zealand hospitals, the College of Midwives and the Nurses Organisation so that they may advertise the possible association and lack of findings to their members.

- 2) That hospital-based occupational health services keep abreast of the issues surrounding healthcare workers and that the District Health Board Occupational Health Groups review any literature developments on an annual basis.
- 3) It is not recommended that this study be extended to other New Zealand hospitals until a more definitive disease endpoint is established or overseas data identifies a more plausible exposure.

Acknowledgements

Auckland Healthcare Services would like to thank Dr Robert Scragg, Department of Community Medicine for his epidemiological advice throughout this project.

Karen Guilliland, Director, New Zealand College of Midwives acted as a resource for the investigation as did Dr Evan Dryson, Convenor, Occupational Safety and Health (Department of Labour) Occupational Cancer Panel and thanks are due to them both for their advice and support.

This investigation would not have been successful without the co-operation and help from the midwives, their families and friends.

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INTERNATIONAL PERSPECTIVE

From different horizons: childbirth, tradition and politics

Liz Smythe PhD, RGN, RM

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I wish to share with you a unique opportunity I had to consider childbirth from a different horizon, and to ponder on how the political, cultural context shapes midwifery practice. I further seek to show the courage, commitment and innovation that needs to be enacted to take people to a new standpoint. In January 2001 I had the privilege of visiting Mali to monitor World Vision projects. My role was within the partnership philosophy of World Vision, where each partner holds the other accountable. Funding from World Vision New Zealand (WVNZ) subsidised by the New Zealand Government, had been invested in particular projects. My role, together with Sharon Bell from WVNZ, was to ascertain the effectiveness of each project. One project related specifically to the eradication of female genital mutilation (FGM), and through this encounter I made

a brief visit to a maternity hospital. This paper makes no pretence at representing a comprehensive description of childbirth in Mali. It has, however, been my experience that in coming face to face with 'difference' one more clearly comes to see the things that are taken for granted within the New Zealand maternity services. I therefore share with you a series of my 'encounters'.

The 'encountering region'

When one is situated within one's own cultural experience there is a horizon or a range of vision that determines what can or cannot be seen (Gadamer, 1960/1982). To seek new understandings we need "to be open to what is other" (ibid, p.17). Heidegger talks of horizon in relation to objects, in that when we look at an object, we can only see one side. He calls us to move to the more fundamental concept of the 'encountering region' which becomes less dependent on our position and enables release of understanding (Inwood, 1999).

Perhaps, in New Zealand and the western world, we see childbirth through the horizon of the advances brought by science, technology, and the corresponding professional education of doctors and midwives (Papps & Olsen, 1997). At the same time, we are ever mindful of the horizon, revealed to us by the consumers, of childbirth as a natural life event (Donley, 1992). The two horizons co-exist in a society where childbirth choices are expanding (Cole, 1996). Ours is a society where the expectation is that the mother and baby will come to no harm through the experience of childbirth (Smythe, 1998). However, if we step back from these horizons to an encountering region, it may be that the limits of our horizons will be revealed in a new way.

Encountering Mali

Mali is situated in the midst of West Africa, encroached upon by the Sahara desert. It is a country of ancient history, with famous eras of civilisation going back to the 13th and 14th centuries

(Lonely Planet Publications, 2000). Childbirth, therefore, has a very long history within the generations of women. My encounter with Mali was as a post-French-colony. Ely Keita, the Director of World Vision Mali, told me about the recent history. In 1960 Mali gained independence from France. Eight years later a military coup initiated a 23 year military regime:

During that regime it was very difficult because no one was trusting no one, even in the same family, you didn't know who was who so you wouldn't talk about what was happening around you, or you might have found yourself in jail
(Interview with Ely Keita)

This era of military repression spanned the seventies and eighties, an era where in New Zealand the consumer lobbies were actively challenging the medicalisation of childbirth (Dobbie, 1990; Donley, 1992). In Mali it is likely that there was careful maintenance of the status quo. It was my impression that the customs of childbirth had been firmly established by the colonisers, with the regimented, medicalised procedures that dominated western maternity services of the 1950s still dictating how birth should be. Walking into a maternity ward in rural Mali revealed a delivery room with three high, narrow plinths lined up in a row, separated by curtains. The sage femme (midwife) assured me that all women were required to deliver on their backs, on those beds. When I described the manner in which some women in New Zealand choose to give birth, she appeared horrified. We were both understanding birth through different horizons. She was locked into the birthing practices that had been bequeathed to the women of Mali, while my mind, open to the notions of 'natural birth' was wondering how birth had been in Mali before the days of western colonisation.

Encountering political context

Standing in the 'encountering region' of understanding it seems to me that childbirth is always situated within a political context with gives rise to both possibilities and constraints. We ignore the determinants of that political context at our peril. Similarly, we have a responsibility to seize whatever opportunities emerge from changes of power base.

Ely Keita went on to describe the changes in Mali in the last decade:

In 1990, people were really fed up with that kind of [oppressive] power, and they went out in the streets and the street pressure was so high that there was another coup early in 1991. Another military took over and arranged to organise elections to al

low democracy to happen. So for one year of transition, we worked on a national conference to design a new constitution which is really open, a secular one, guaranteeing a lot of freedom. In 1992, we went for our first democratic elections, and since then Mali is a democratic country. Of course we are still learning. We wouldn't hope that a country where 60% of the people are illiterate would understand fully the principles of democracy, so we are learning, but we are good learners.

The possibilities are changing in Mali. There is now a freedom to express ideas and opinions, to even dare to challenge, yet first people must be given the confidence to believe in themselves. Ely told how when World Vision first started working in one rural area it had taken them a year to persuade the men that they should allow their wives to attend a three week literacy course. Now those women are teaching others, and are active participants in community development projects.

As I sat in the village of the ex-circumcisor, the feet of the three Mali women sitting with me intrigued me. They provoked the accompanying photograph and writing:

The feet of courage

*Old and worn,
ingrained with tradition,
washed by the unsteeped blood of circumcision,
following the footsteps of all who have gone before
these feet have stepped aside
have chosen to go 'no further'*

*Between two worlds
the middle feet know the dirt of the village
and the polished floors of the health centre
they have a place in both
and a knowing of both
when they lead forward
on a new path
others follow in trust*

*Young and educated
wearing shoes with heels
up in the world
yet still on the ground
these feet are the feet
of the new generation
exploring the options
daring to be different
the feet of the global village*

*These feet
together
bring the courage
the wisdom
and the strategies
that change the minds
and hearts
of a people.*



continued over...

From different horizons: childbirth, tradition and politics *Liz Smythe*

I was intrigued by Ely's remark that they are getting the Constitution translated into their local language so the women can read it for themselves. How aware are the women of New Zealand of both the privilege and the right of being an active participant in processes of government? Perhaps it is only after having such rights taken away that a society learns the true meaning of political power.

Encountering female circumcision

Within this new context of freedom is the programme to eradicate female circumcision. In New Zealand midwives have been exposed to the literature on FGM which has revealed unclean surgical excision on vulnerable young girls causing them a lifetime of deprivation and distress (McConville, 1998;

Rawlings-Anderson & Cameron, 2000; Raynor & Morgan, 2000). My experience as a midwife teacher suggests that as women of New Zealand we have been collectively horrified. Some midwives have come face to face with the need to understand because refugee women have birthed within our services. Wise women, like Nicki Denholm (1997), strive to help us understand the complexities of the issues rooted in a culture that is so different from our own. Our government has passed law to prevent FGM happening in New Zealand (New Zealand Crimes Act Amendment, 1995). Throughout our vantage point has been from the outsider perspective looking in.

Encountering Stop FGM

How exciting and refreshing it was to be an outsider in Mali, and to see the people of Mali taking up their own challenge to Stop FGM. These were the people who not only understood the culture, but in most cases had experienced circumcision themselves. Now, both men and women were taking a stand, and speaking out with courage. This is how Ely described it to me:

FGM is female circumcision, which is done almost in all parts of Mali. It's called a cultural practice even though we couldn't find after some studies what was the cultural linkage. Some people say that it came with Islam, even though in their holy book there is no verse that says that it should be done. But I heard that it came from Egypt in the 13th century. What is important for me, is that my generation, the current generation, has come to understand that this is a harmful practice and should be stopped. So we are now doing a kind of education, because things that people were doing for many, many years, they will not stop it overnight.

I remember for my own child I had to argue very hard with my Mom not to take my daughter for it, and she was so frustrated, because for her it is her responsibility as grandmother to take the child, to take my daughter for FGM. So she couldn't understand why I am saying 'no' to that. So we had a long dispute, but I made it clear that my daughter is my daughter, she is your grand-daughter, but she is my daughter, I am the first responsible for her life, so please, please, don't do it, never do it to her. So finally, she agreed. I don't think she has fully understood why, but at least she has agreed not to do it. So my daughter is safe.

Most people do it just because they have seen people doing it, no other reason, at least no other reason they can tell about. So we are now having this project

which is talking to people, showing videos, playing cassettes, going into the village of people to get their endorsement about this project. Right now we have seen the change. Some people are now understanding that they should not do it.

It is going to take some time, I'm sure, but this project is making an impact. Now there is a network of NGO's putting pressure on parliament to make a law so whoever is doing it can be penalised. I think once we get to that level, that will help a lot. I think the world should understand that this is like polio, this is like any disease, which can kill a child. If we want to be living in a healthy world, the entire world should join with us in education about FGM in our countries (Ely Keita, 25.1.01).

Encountering 'the call to stop'

I met with the two workers who were going out into their communities to train other people to how to educate about the dangers of FGM. One was a woman with four daughters. She had had the first two circumcised. Both had bled excessively and had infections. She bravely chose not to allow her younger two daughters to be circumcised. She told us her oldest daughter had recently had a baby that was brain damaged. She believed that might have been because she had such a difficult birth due to all the scar tissue and the tightness of the perineum. When we talked to the sage femme, our interpreter searched for a particular English word. We finally established it was 'keloid', the massive scarring. That was a big problem.

Encountering 'calling others' to stop

I saw the video used in training, and was amazed at its impact, especially as I couldn't understand

the language. It was a drama of a man who felt very strongly that his only daughter should not be circumcised because of the danger of bleeding. When the time of the circumcision ceremony came, he was away, so his wife (who believed equally as strongly that her daughter needed to be 'done') took the girl for circumcision. We witnessed the women-focused ceremony of song and dance, and then saw the vulnerable young girls dressed in black with white hoods being led into a small hut. The daughter bled heavily. She was taken to hospital. The husband returned and was livid that his daughter had been circumcised. We return to the hospital to hear the news that the daughter had died. There was much grief. This was a story that I was to hear several times over in the short time I was in Mali. There was enough truth in this video drama for it to be real. With a portable generator this video was being taken into village life to challenge deeply held customs.

Encountering 'speaking out'

I met with the local mayor who had three young daughters. He had no intention of having them circumcised, and spoke out very strongly about the risks of bleeding and infection. He was a powerful role model for the community. Perhaps equally as significant was a happenstance of our visit. A young nineteen-year-old woman came to tell us that she had not been circumcised as a girl, and she was strongly against it. The mayor had arrived prior to her telling her story, yet she proceeded to talk in front of him, and to speak briefly of the sexual deprivation of FGM. In later discussion with Ely Keita, who had not accompanied us on this visit because it was sensitive 'women's business', he was delighted that there was now such a sense of openness. That men and women can sit together and openly discuss female circumcision is an important step in the process of change.

Encountering 'the decision to stop'

I went to a village and met with a woman who for many years had been the circumcisor of that village. She described how she had learnt this skill of circumcision from her grandmother. She would receive 10-15 girls at a time and excise them. Sometimes there was much blood loss. As a result of the education programme she had made the decision to stop circumcising. People still came to her and some got angry when she wouldn't help them.

Encountering 'the cost of stopping'

There are still many circumcisors who continue to practise. There is not yet any village in Mali where FGM has stopped completely. World Vi-

sion is mindful of the economic determinants that drive the on-going practice. Circumcision is a major source of income for these women. Why would circumcisors choose to stop when it would deprive them of their means of making money? Thus, the Stop FGM programme is going to incorporate training for circumcisors in other income generating activities.

Encountering courage

I was impressed by the courage, innovation, and foresight of the Stop FGM programme. I wondered if an outsider coming into our culture would be able to find education programmes of a similar nature. Are there any strongly held traditional beliefs that are being confronted? Is funding put aside to enable innovative education resources to be developed? Are educators encouraged to go to the people and meet them in their own communities? Do projects embrace the broader social ramifications for initiating change, and incorporate proactive strategies towards overcoming barriers?

Encountering new standpoints

Mali is literally on the other side of the world, and culturally very 'different' from New Zealand. Yet, it is said we live in a global village, where none

of us can ignore the plight or the strength of our neighbours (Ricupero, 2001). I believe Mali, in a new era of democracy, is undergoing a period of rapid change. Change brings challenge and tension. It raises questions and unearths innovative solutions. Perhaps there is much we could learn from being partners on such a journey. Let us not assume that we, in the developed world, have the answers. Let us even bring to question the notion that we are 'developed'. The people of Mali have the opportunity to seek out their own answers, in their own way. They have their own horizon, or boundary. Inwood says "This boundary is finite at any given time, but it can be extended indefinitely, since we can always conceive of a standpoint enabling us to transcend the current boundary of our knowledge" (1999, p.98). Some courageous people in Mali have transcended the boundary of knowledge related to FGM, weathering the scorn of their own families and communities. The challenge for us in New Zealand is to identify our own new standpoints that need to be conceived, to step into them and to hold our ground within them.

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Articles should be typed on one side of white A4 paper with double spacing and a left margin of 3 cm. Authors should use section headings and label any diagrams or tables which are included. Diagrams, tables or photographs should be supplied as computer generated items. Three copies of the article should be supplied. In addition, authors are requested to provide the following details on a separate sheet, which is not sent to the reviewers. Name, occupation (current area of practice/expertise), qualifications, address for correspondence during the review process including day time phone number, contact details such as email address which can be published if the journal accepts the article. Where the article is co-authored, these details should be provided for all authors. ALL authors of the article should sign an accompanying letter stating that they wish to submit it for publication.

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Review process

All articles are sent out for external review to two reviewers who have expertise relevant to the article content. In addition, a member of the Editorial Board acts as a reviewer and collates feedback from the two external reviewers. The process of review is outlined in the October 2001 issue, page 4.

Acceptance

On acceptance of an article authors will be requested to submit the article by a specified date as either a Word document or a RTF file for a PC. Articles, which are accepted and published, become the copyright of the Journal. In the future this may include placing articles as part of an on-line publication of the Journal. As part of the electronic process of printing the Journal, the Editorial Board reserves the right to modify any article which is accepted with regard to formatting and layout.

Dear Editors

5 June 2001

I am writing in response to an article which was printed in the NZCOM Journal in April 2001, "Cultural Adequacy: aspects of a case study."¹ Although it is not altogether clear, my understanding is that this article has been written by Anne Barlow reporting back on aspects of the current New Zealand College of Midwives Standard Review Process for midwives and specifically the adequacy or not of that process from Maori midwives' perspectives.

The issue I would like to raise with the author is that the article has reported information which has no current basis in fact. Specifically, I refer to the references made to a) the Native Health Act forbidding the traditional practice of burying the placenta and b) the Tohunga Suppression Act and how Maori midwifery and breastfeeding were outlawed.¹

I would refer readers to the February 2001 issue of Kai Tiaki Nursing New Zealand in which Irihapeti Ramsden² has addressed in detail two of the issues raised in Barlow's article regarding the Tohunga Suppression Act and the legislation forbidding Maori women from breastfeeding in public. I would reinforce what Ramsden has said in her article namely that there is not and never has been any legislation enacted in New Zealand forbidding Maori women from breastfeeding ("in public" is usually what is referred to). Secondly, the Tohunga Suppression Act³ was designed by Maori to stop the practice of so called "cures" being sold by charlatans (both pakeha and Maori) to the unsuspecting population, many of whom were Maori. It was later in 1916 that the Act was used to imprison Tuhoe leader, Rua Kenana, and consequently suppress Maori rights to tino rangatiratanga under the Treaty of Waitangi. Again, a full recounting and explanation of how these "myths" have arisen is discussed in Ramsden's article.²

I completed a literature search in 1996 as part of my M.A thesis looking at factors influencing Maori women's experiences of breastfeeding⁴ and undertook a search for the Maori Health Act (as it was often referred to as the Act relating to the forbidding of breastfeeding by Maori women). I did not then nor have I since found a Maori Health Act. I have never heard of an Act that forbade the burying of placenta and in light of the non-existence of the Native Health Act, it certainly cannot have been the one that was used to enforce this "legislation." Lastly, I am unsure whether Barlow's article is inferring that the Tohunga Suppression Act was used to forbid Maori midwifery, which, as it has been explained, was not the purpose of the Act at all. This is the first time that I have ever heard of "Maori midwifery" (the meaning of this term requires some clarification) having been outlawed in New Zealand.

While I accept that the author is reporting information given to her, it does indeed raise questions about the adequacy of the Standard Review Process from the point of view that historical inaccuracies may be presented that go unchallenged and consequently find their way into publications such as this. I would also like to say that on a number of occasions the recounting of such "myths" to me have actually come from people teaching in midwifery education programmes who similarly have failed to do their homework in this respect. That this level of misunderstanding and inaccuracy about such important historical legislation as the Tohunga Suppression Act, or the existence of "legislation" regarding Maori women being forbidden to breastfeed, may still be being taught to student midwives is very disturbing.

In terms of scholarly work, I believe the checking of secondary sources of information is still a viable practice and that if terms such as "Claytons" and "Jake Heke" can be referenced, then similarly, information about relevant Acts of Parliament should also be checked and supplied. Had this been done, it would have brought to light the issues raised in this letter and changes to the content of the paper, prior to publication, could have been made accordingly.

Lis Ellison-Loschmann

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¹ Barlow A. (2001). *Cultural Adequacy: aspects of a case study. New Zealand College of Midwives Journal*, (24), 15-17.

² Ramsden I. (2001). *Improving practice through research. Kai Tiaki Nursing New Zealand*, 7, 23-26.

³ Tohunga Suppression Act 1907 No. 13 / 1908 No.193

⁴ Ellison-Loschmann L. (1997). *Maori Women's Experiences of Breastfeeding. Unpublished Masters Thesis, Victoria University of Wellington.*

Editorial Board comment in response to Lis Ellison-Loschmann's letter

We appreciate the debate and dialogue which Lis offers and look forward to any further discussion in future 'letters to the editor'. With regard to the process for checking article references, please note that responsibility lies with the author to provide complete and accurate references (see Notes for Contributors on page 37). The review process used with articles which are submitted for publication relies on the expertise of reviewers and the NZCOM Journal is fortunate to have an increasing pool of reviewers (see Review Process chart on page 2).

We invited Anne Barlow to reply and her comments follow.

Dear Editors

23 July 2001

Thank you for giving me the opportunity to reply to the letter sent to the NZCOM Journal Editor regarding my recent article, "Cultural Adequacy: Aspects of a Case Study". My response is as follows.

The reference to the Tohunga Suppression Act (1908) was contained within the data provided by a research participant and therefore not formally referenced. The scope of the research was not to carry out a detailed examination of every piece of legislation affecting New Zealand midwifery, and that being the case I am happy to stand corrected on the finer points of this Act. I have had confirmed by the midwifery teachers at the Auckland University of Technology who specifically teach cultural safety that their views concur with the facts about the Act as detailed by Lis Ellison-Loschmann, and that this is what is taught to students.

While it is important what happened in fact in 1908, it is also true that interpretations **today** may differ. The fact is that myth exists and becomes a socially constructed reality. The information provided by Lis Ellison-Loschmann does not diminish the value of what has been said by the research participants, and in no way affects the validity of what happens today in terms of how people think and act. The reality of the here and now is that these "mistaken" views of the Tohunga Suppression Act (1908) are widely believed and have influenced midwifery practice for some Maori midwives.

I appreciate the comments made by Lis Ellison-Loschmann. It remains within the context of the New Zealand College of Midwives Standards Review process there is always a need for adequate sensitivity and respect towards cultural aspects of practice.

Anne Barlow

School of Nursing and Midwifery, Auckland University of Technology, Private Bag 92006, Auckland

Dear Editors

Midwives, Partnership, and Women's Names: a comment

Partnership is a cornerstone of Midwifery Philosophy. When a midwife is dealing with a woman, in any midwifery context it is a basic courtesy to acknowledge the woman's name correctly.

It takes, but a few seconds to listen and or read and make sure you have the name correct.

In speaking and or writing the name correctly the midwife acknowledges the status, the mana, of the woman she is interacting with as a valued member of our wider community.

Maryanne Vella

Student midwife, Auckland University of Technology.

Ethics and Midwifery

Author: Lucy Frith (Editor)

Publisher: Butterworth Heinemann

Date of Publication: 1998 (Reprint). Price: \$77.56

Many authors contribute to this valuable book on ethics including representatives from midwifery education and research, health ethics, psychology, nursing, bioethics, antenatal education, medicine and the law. The editor, Lucy Frith, brings together for consideration topics that have relevance to midwifery practice. She justifies that the book is necessary because of the changing structure of midwifery as a profession and the distinctive woman-centred care midwives provide.

In her introduction Frith argues that a midwife must have an understanding of the ethical issues that surround maternity care in order to be an able practitioner and accept increased professional responsibility as a lead maternity carer. She also emphasises that midwives are in the best position to facilitate choices yet paradoxically deal with the issues when choices conflict or are detrimental to health and wellbeing. Here the dilemma is between the promotion of self-determination (autonomy) and beneficence (best interests). Frith offers a further compelling justification for acquiring skills through the consideration of ethical issues and that is their transferability to educational processes such as critical reflection, defining and solving problems, clarifying the significant points, making comparative analyses and articulating a reasoned argument.

The book is divided into three parts concerned with everyday issues, technological issues and professional issues. The central themes are autonomy

and choice. Through studying the ethical problems within the practical contexts, outlined in this book, tensions and conflicts are raised and pragmatic approaches are formulated. Included is a focus on ethical aspects of research.

Although the book refers to landmarks in the British childbirth scene the ethical issues are universal. The book is therefore recommended as a guide through everyday dilemmas to all midwives, midwifery students and others involved in maternity care.

Pregnancy and drug misuse

Author: Catherine Siney (Editor)

Publisher: Books for Midwives Press

Date of Publication: 1999. Price: \$55.96

During the 19th century European society freely used opiates for self-medication, experimentation and intoxicants. Women and infants were frequently doped with remedies containing opium and laudanum. Morphine and opium could be bought in grocery shops. Drug taking was legitimate. Following changes in the law during the early the 20th century drug addiction became a criminal activity and prescribing was controlled by the medical profession.

Popularity of drugs such as amphetamines, barbiturates, benzodiazepines, cannabis, caffeine, cocaine, codeine, hallucinogens, heroin and nicotine increased through the the 20th century. Drug misuse, while commonly associated with areas of social deprivation, is prevalent at all levels of society and among all ages. Misuse is more easily hidden by the privileged and educated. The intake of alcoholic beverages is accepted and even encouraged as an art. Boundaries of acceptability, misuse and abuse are blurred.

Pregnant women or those planning a pregnancy, who are dependent on drugs or alcohol need to be encouraged to tell their maternity carer. To tell is an empowering act. It gives a woman the opportunity to take control of this aspect of her life. It takes courage, as the normal anxieties that surround having a child are added to those contributing toward her addiction. Guilt over using drugs when pregnant is exacerbated when the woman is heavily addicted and cannot give up. Fear of losing her child to social welfare and of social stigmatisation is an additional burden when entering the health care system. Some women are dependent and not aware of it e.g. the very young cigarette smoker, the excessive coffee drinker, the imbibor of 'social cocktails'.

In this book, edited by Catherine Siney, a specialist midwife in England, providing services for the women who are drug dependent, HIV and/or hepatitis positive, key issues for pregnant women, mothers and their children, are explored. The importance of antenatal care is stressed, confidentiality and child protection aspects are raised, effects of drugs on pregnancy and the neonate are discussed, screening in pregnancy is described, fetal rights versus maternal rights are debated, and sexually transmitted infections are investigated. While the reader will not find detailed information about drugs in this book, the medical problems and management of pregnant women who are drug dependent or illicit drug users are comprehensively and sensitively explored. In addition, a step by step approach to counselling the pregnant drug user, using an exemplar, is given.

The book has particular relevance for midwives who work with drug or alcohol dependent women or women who are HIV or hepatitis positive. It is also a valuable resource for educational institutes, hospitals or midwifery practice libraries.

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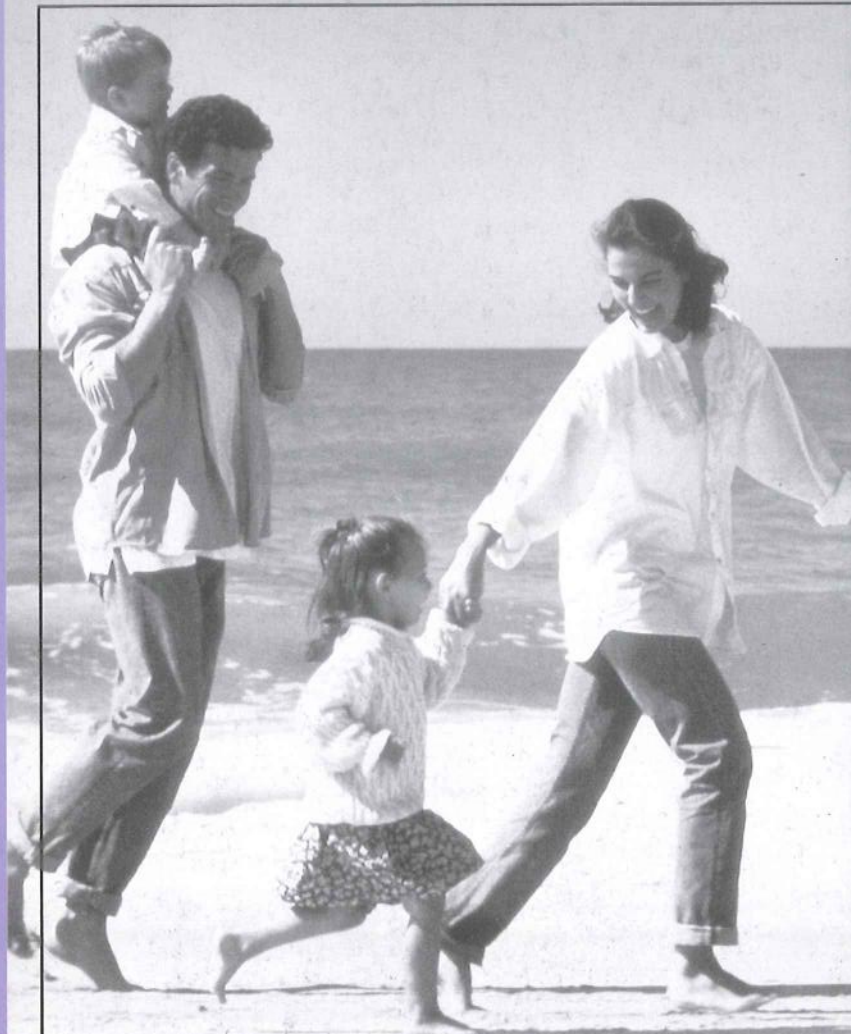
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