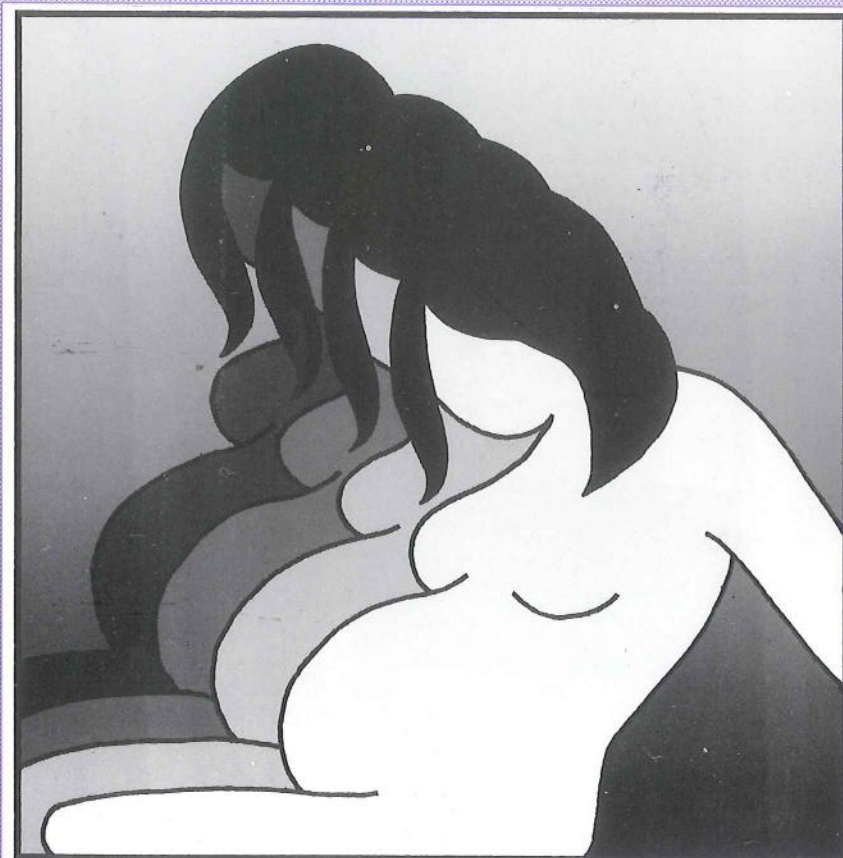




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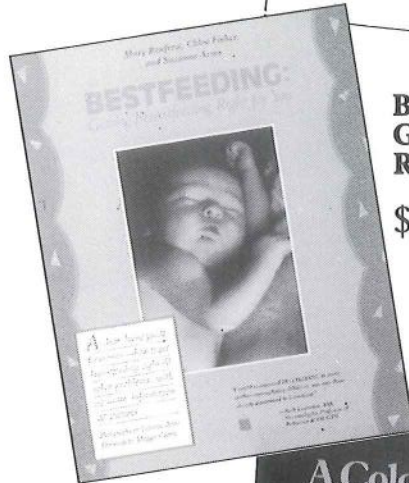
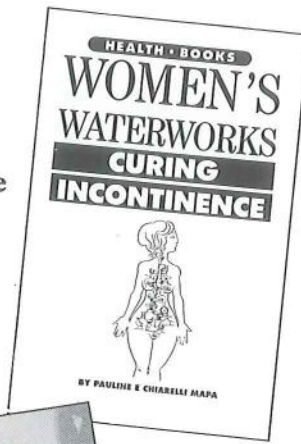


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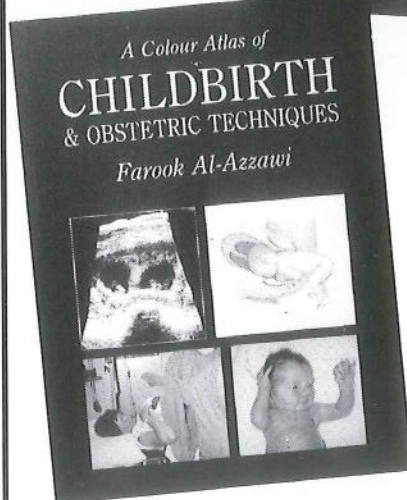
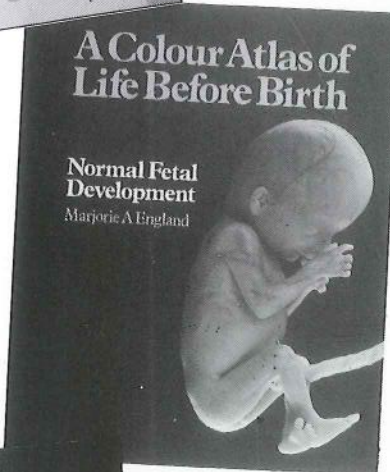


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C O N T E N T S



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Letters:
Letters that are addressed to the editorial collective or the editor are assumed to be intended for publication. Please indicate clearly if they are not.

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EDITORIAL

THIS FOURTH ISSUE OF NEW ZEALAND College of Midwives Journal comes nine months after the Nurses' Amendment Act 1990 was enacted in Parliament. Midwives around the country have since picked up the opportunities to practise independently, thereby giving the women of New Zealand a greater choice in childbirth related health care.

Since the last issue, we have undergone changes to the editorial collective.

We have:

- farewelled Andrea Gilkison who worked long and hard for issue three - thanks Andrea - and good luck this year in completing your BA.
- organised a 'local' collective consisting of Sue Feschè, Sue Geard,

Judy Hedwig, Helen Manoharan and Heather Woodfield. We are already shaping up to be a dynamic team!

- retained the National Editorial Committee for help and advice in their specialist areas - a valuable asset.

Congratulations go to the new Wellington based Board of Management - Christine Griffiths, Lynley Davidson, Beryl Davies, Jenny Sage, Jeanie Douché and Marjorie Morgan - we wish them well for their 'time in office'.

Twelve midwives from New Zealand attended the 22nd International Confederation of Midwives Conference in Kobe, Japan last October along with 6,000 other midwives. The conference entitled "A Mid-

wives Gift - Love, Skill and Knowledge" was a great success for all of those who attended. Bev Crombie describes the experience in her article.

A larger group of midwives attended the "Vision 2000" workshop in Auckland in March along with clinical nurses, educationalists and managers to formalise strategies for a national educational framework for nursing and midwifery in NZ. The NZCOM statement on midwifery education, hot off the press, is here for your reference. Good reading!

*Editorial Collective
May 1991*

College Update...

Beryl Davies

National Committee BOM



The new Board of Management has completed its first six months! What a time of rapid learning!

Jennifer Sage, has been busy developing an understanding with the college computer, and reports currently there are 1055 College members and numbers are growing.....

Christine Griffiths, treasurer, reports that the College was successful in gaining finance from the Department of Health Workforce Development Fund, consequently the College now has to pay GST - Christine's workload doubled overnight!

Lynley Davidson's responsibilities include collating information and monitoring educational developments.

Jeanie Douché has taken over the secretarial responsibilities from Chris Hannah, who regretfully had to resign due to pressure of work.

Marjorie Morgan has joined the team taking Jeanie's vacant position of co-ordinating and liaison.

The major task of the BOM is dealing with the mountains of correspondence which necessitates action. It is very heart warming though, that the College is increasingly recognised as the voice of midwives in NZ. Undoubtedly, this has been achieved primarily by the high public profile and political acumen of our President - Karen Guilliland.

Another large pool of people with energy is required for various meetings and negotiations that are attended nationally, and then the dissemination of the information to members, mainly by:

- a) information sent to Regional Chairpersons,
- b) the national newsletter.

The newsletter comes under my umbrella so please forward your thoughts, comments, suggestions.

We are all enjoying our exciting, challenging new jobs with the College and thank you for your support. Here's to a great 1991 for all of us.

Midwifery Education - A National Perspective -

The New Zealand College of Midwives

Karen Guilliland
Sally Pairman

*Paper presented at Vision 2000 in
Auckland 13th and 14th March 1991*

IN OUR HISTORY, THE SUBMERSION OF THE MIDWIFERY profession into nursing can be directly linked to the medicalisation of childbirth. The traditional "with women's" role of the midwife is difficult if not impossible to maintain when the power base has shifted from the woman to obstetrical and nursing management.

It is important to introduce measures to encourage and empower the Midwifery profession to support women's choices. Education is the key to social change. We must acknowledge that Midwifery education is more than a professional issue for us as health providers. Change in maternity care is a women's issue and a fundamental social issue. The purpose of the amendment to the Nurses' Act was to protect women and provide them with choices for maternity care. Our Midwifery education system must reflect this.

The New Zealand Maternity Services today, despite the evidence to the contrary still reflects the belief that the medical model is safest for the woman and her baby.

The World Health Organisation document on "The Role of Nursing and Midwifery Personnel" reports their concerns that while national policies affect the progress of reorientation, they can also either facilitate or *defer* change. It is vital we have a national policy which recognises the current New Zealand practice environment.

Midwifery education must be responsive to the changes in legislation and prepare Midwives for independent practice and continuity of care. Graduates must not only understand the meaning of accountability and responsibility but the power structures which govern real choice for women. This cannot be achieved satisfactorily in the present hospital-based, treatment oriented climate of current clinical experience.

If Midwifery education is to be successful and we are to prepare Midwives capable of providing appropriate care, the education system must develop a Midwife who fits into the social order.

Midwives are justifiably wary about the future of their education in association with nursing. In 1979 nursing largely ignored the Midwifery representation of the time and their recommendation of a separate year long midwifery course. Midwifery as an option within the Advance Diploma of Nursing was never accepted by the midwifery profession and proved to be a less than ideal forum for recruitment and retention of a self-sustaining Midwifery workforce.

The Nursing Education System in New Zealand today does not yet acknowledge that Midwifery is a separate profession, whereas from our perspective a positive direction for Midwifery hinges on the belief that Midwifery is a profession in its own right.

The combined ICM, WHO and UNICEF workshop in Kobe, Japan, 1990 supports

our stand and states categorically that Midwifery education programmes must be recognised as separate from general nurse education in order to achieve their safe motherhood goals.

Inevitably the outcome of a separate professional identity is a separate educational structure. A comprehensive, three year direct entry programme is the appropriate way to educate the Midwifery workforce. This is our priority.

Direct Entry Midwifery must be inevitable, such is the strength of purpose of New Zealand women. We are an increasingly egalitarian society in which women can afford to be strong. Marsden Wagner, Director, WHO, says "Strong women tend to strengthen Midwifery and a strong autonomous Midwifery profession tends to increase the strength of women in society".

It will be tragic if these women are forced underground to practise in a lay Midwifery system as has happened in the USA and Canada.

*Direct Entry Midwifery
must be inevitable, such is
the strength of purpose of
New Zealand women.*

The Midwifery philosophy is all about women controlling their own lives and enabling them to realise their own potential. This is also true for Midwifery students. "The primary goal of education is to elicit and fortify whatever creative impulse (people) may possess," (Bertrand Russell). In order for students to be effective Midwives it is important that they are socialised early into their own profession. Whilst not impossible, it is much more difficult to focus as a Midwife when your original professional identity has been nursing. The New Zealand College of Midwives acknowledges however that a modular comprehensive nursing course may more easily facilitate entry of registered nurses into a Midwifery course.

We see a broad base entry into a three year programme with creditation of hours for relevant qualifications and experience as being appropriate and in line with the current New Zealand Qualification Authority thinking. Entry to a course would therefore be by individual assessment.

While our long term aim is to have all Midwife graduates coming from the comprehensive Midwifery course there will need to be a period of transition from the post basic nursing focus to direct entry Midwifery.

The new legislation has opened the way for an experimental course in Direct Entry Midwifery. We believe the purpose of this

experimental status should be to make the refinements and adjustments necessary before mainstreaming all courses into direct entry. It is important that there is a time frame for these adjustments and decisions about the future of Midwifery education or women in New Zealand will be left without the support of a Midwifery model in which to give birth. There is already increasing medical opposition to Midwifery autonomy throughout New Zealand as doctors see their power base threatened. As Area Health Boards fail to recognise childbirth as primary health and continue to close small maternity units women in New Zealand are threatened with a bleak future.

The ground work for Direct Entry Midwifery has already been done by the Direct Entry Task Force. There is an identified need and well established consumer support.

The Department of Health Discussion paper 1989 on 'Care for Pregnancy and Childbirth' recommends direct entry. This paper had extensive consultation with women's groups, Midwives and allied health professionals. Consumer groups such as National Council of Women, Parents' Centres NZ and Home Birth Association and many others have all supported Direct Entry as an appropriate choice for Midwifery education.

An area of need identified by the Direct Entry Task Force was the desperate shortage of Maori and Pacific Island Midwives. The poor health status of young Maori women and their babies is well established. Direct Entry gives us an opportunity to develop, in consultation with the Maori community, an acceptable bicultural model which will ensure successful and fulfilling outcomes in childbirth for Maori women. The philosophical base of Direct Entry more easily allows for different cultural definitions of childbirth.

The changes in legislation also require a re-evaluation of the roles and clinical needs of both nursing and medical students. In a future of independent Midwifery and continuity of care, fragmented maternity service provision should disappear and the need for an obstetric nurse decline. As women gain more control over their birth experience it is no longer appropriate for every student nurse or doctor to be at the birth. Nursing and medical students need an understanding of birth as a family event but *specific* Midwifery and obstetric knowledge will be gained only if the student chooses to specialise in those areas.

There is concern at the recent Education Department decision to only fund two experimental courses for Direct Entry education and to tie these courses to a Nursing Department. Was this decision made on purely financial grounds? What criteria were applied to meet midwifery and consumer need and were any Midwives involved in this decision? The consequences

of this decision means a reduction in opportunity for frank discussion. It sets up artificial competition between polytechnics to provide curricula under pressure.

It is important for Midwifery that some decision is made soon as to its educational future. It is unsatisfactory to continue with the ADN Midwifery option. Circumstances have overtaken the evaluation of Midwifery education presently underway and there will be few valid results from an evaluation process which has been fractionalised and lack lustre.

The difficulties faced by this evaluation parallels the difficulties this forum faces in addressing a national perspective. Despite a national or central evaluation agreed to between DOH and the Department of Education, all Midwifery courses at the polytechnics involved have changed in some way the conditions of evaluation thereby invalidating the results. National co-ordination will only ever be as good as each Polytechnic commitment to national goals.

The Nursing Council of New Zealand may in fact be the only regulating factor for Nursing and Midwifery and even then faces its own changes with the advent of the NZQA. If then Midwifery's only regulation is to be the Nursing Council, composition of Council and its Committees must be restructured to allow appropriate Midwifery representation.

*...it is no longer
appropriate for every
student nurse or doctor
to be at the birth.*

A further issue for Midwifery education will be the outcome of some Nurse educators push for degree status for Nursing. Whatever the decision it must be carefully and fully considered by practitioners and educationalists together. A reactionary response to the deregulation of education must be avoided. Individual polytechnics and a handful of nurses hold the future of nursing and Midwifery in their hands. They must consider the industrial climate in which they make decisions. A qualified nursing workforce is highly unlikely if the Employment Contracts Bill is passed. Creating a tiered nursing workforce or taking nursing education out of the average New Zealander's grasp may take qualified nurses further away from the bedside.

Midwifery is, of course, carried along with the decisions made by nursing. Midwives in general are uncomfortable about being under pressure to decide on degree

Continued on Page 15

A Framework for Midwifery Education

Report collated by
Sally Pairman

THE NURSING AND MIDWIFERY FORUM CALLED Vision 2000: Project 1991 took place in Auckland on March 14 and 15.

The intent of day one was to identify the issues facing education and day two was for developing strategies and a framework for nursing and midwifery education towards the year 2000.

Despite the title of the forum and the obvious intent to decide on the future of midwifery education as well as nursing, only three midwives were invited to speak during the forum. A small working group on Saturday 16th collated all the discussion from the forum and developed the framework and mechanisms.

Midwives did not go unnoticed however and it became increasingly clear that nursing was looking to midwifery for some guidance as to the direction they should take. Whilst there is clearly some individual resistance to the idea of nursing and midwifery being separate professions, this resistance is not active and opportunities to challenge were never picked up by nurses.

Over the two days it became obvious to midwives that the issues we face are different from those facing nursing. We are much further down the track of developing a framework for midwifery education because we have worked on and identified our basic premises. We know what midwifery is and we have a clear philosophy; we already have a College of Midwifery and a high public profile which presents a positive image; we have effective communication systems; we do not operate in a hierarchical structure, and we believe that 'a midwife is a midwife is a midwife'.

Nursing is realising that it needs to address these fundamental issues before it can move much further.

The suggestion from the NZCOM, presented at the forum, that a vehicle for collaboration and communication between midwifery and nursing would be to establish a Federation of Midwifery and Nursing was greeted positively. However as the intent of this federation would be to bring the professions together for discussion, nursing has first to decide what shape its professional organisation will actually take. There appeared to be marked discontent amongst nurses of the NZNA and its increased industrial role in recent years.

The forum provided a unique opportunity for midwives to discuss issues. On Thursday night we discovered that we came from all areas of New Zealand, from all areas of practice, including the midwifery tutors responsible for all our present midwifery courses, the BOM, our president and educator, and two consumer representatives.

It was heartening at that meeting to discuss the degree\diploma debate and to recognise how similar our thinking was.

By the end of the forum it was obvious that the task of the Saturday working group



was mammoth and was not going to be appropriate for midwifery. We agreed to meet on Saturday to develop a framework for midwifery education and discuss our issues.

A group of 20 women gave up their Saturday to do this work. An open invitation had been extended to all midwives and again the group was very representative.

We worked extremely well together and efficiently came up with the following framework for midwifery education. There are still issues which need to be discussed and these are outlined later.

The official forum working group invited us to present what we had achieved. They were impressed and agreed that it was inappropriate for them to address any midwifery issues. They would adopt our framework and expend their energies on developing one for nursing. This is no small victory.

The information which follows is initially the framework we have developed. This is followed by the issues we feel still need debate. We hope each chairperson will call an urgent meeting to discuss these issues and to bring the regional responses to the next national committee meeting. Individual members who wish are invited to comment in writing to the BOM before the meeting.

The time frame is short. All curricula for the three year midwifery courses must be with the New Zealand Qualifications Authority (NZQA) by 1st June and the polytechnics need clear guidance from the College on the issue of degrees as soon as possible.

Midwifery Education - A national framework

- 1 The New Zealand College of Midwives as the recognised professional body for midwives has a legitimate role in shaping midwifery education and practice in New Zealand.
- 2 The midwifery profession will honour the Principles of Partnership inherent in the Treaty of Waitangi in all aspects of midwifery.

Action

- The NZCOM, nationally and regionally, will begin dialogue with the New Zealand Council of Maori Nurses, the Maori Women's Welfare League and the Tangata Whenua.
- 3 Midwifery is a profession in its own right

Implications

- Midwives regulate their own education

- Midwives regulate their own disciplinary procedures
- Midwives evaluate and assess practice
- Midwives speak for the profession nationally and internationally
- Midwives define their own body of knowledge
- Midwives set their own Standards of Practice

4 The long term aim of the New Zealand College of Midwives is the establishment of a separate Midwifery Council.

5 In the interim the NZCOM requires:

- a) equal representation on the Nursing Council of New Zealand, including equal representation on all associated committees.
- b) the appointment of midwifery advisors to the Department of Health and Area Health Boards.

6 In relation to disciplinary matters, the NZCOM supports a mechanism which involves significant consumer representation in all disciplinary processes, with recognition of midwives as the appropriate persons to make professional comment. It is recommended that the structure of the Independent/Domiciliary Midwives Standards Review Committees could serve as a model.

7 The New Zealand College of Midwives recognises midwifery as an independent profession and all educational programmes must reflect this belief.

8 The New Zealand College of Midwives recognises a three-year broad-based midwifery education as the most appropriate form of preparation for entry into midwifery practice.

Implications

- Entry into these courses will be by individual assessment with recognition of prior experience and learning.
- Until the Midwifery Council of New Zealand is established, the midwifery advisors to the Nursing Council of New Zealand will be the Council's representatives to the New Zealand Qualifications Authority on midwifery education.

9 The New Zealand College of Midwives believes that it is an unreasonable interpretation of the Nurses' Amendment Act 1990 to restrict the number of courses and prohibit the ongoing intake of students.

The purpose of evaluation of courses should be to refine the programme, not to decide the necessity for the course.

Implication

- The NZCOM will initiate discussion with the Ministries of Education and Health on midwifery education.

10 All midwifery curricula will be presented to the NZCOM for endorsement.

Implication

- The NZCOM will establish an Education Committee to facilitate this process and to undertake an education advisory role. It is recognised that the role of the committee may change with the establishment of the Midwifery Council of New Zealand.

11 The New Zealand College of Midwives recognises that the understanding and mutual need between women and midwives is the strength and base of the profession.

Implications

- Midwives will continue to work with consumers at every level of decision making regarding midwifery matters.
- The NZCOM has a commitment to maintaining a high public profile and promoting a positive image.
- The NZCOM recruitment policy will reflect the changing needs of the community within a cultural context.

12 The New Zealand College of Midwives believes that the clinical experience available to midwifery students must encompass continuity of care and independent midwifery practice.

13 The New Zealand College of Midwives believes that women have the right to decide where they will birth and have the right to continuity of care from the midwife of their choice.

14 As midwives are the only primary health care givers who can provide continuity of care during the child-bearing cycle, midwifery students must have priority of access to clinical experience.

Implications

- There is an urgent need for collaboration and review of clinical experience of all students currently placed in maternity settings.
- The NZCOM will convene such meetings, initially at a national level.

15 The Nurses' Amendment Act 1990 demands a re-evaluation of the role of nurses in maternity care. Education offered to nursing students must reflect the independent role of midwives. The NZCOM acknowledges that nurses must have an understanding of childbirth within the family social

model. However, the traditional placement of nursing students in maternity areas is no longer appropriate.

Implications

- The Comprehensive and Enrolled Nursing programmes need to be re-structured to reflect the place of childbirth within this family social model rather than the traditional obstetric nurse model.
 - The NZCOM will begin dialogue with nursing and nurse educators on this issue.
- 16 The New Zealand College of Midwives values the contribution midwives make to students gaining clinical experience and will explore ways to acknowledge this.
- 17 In order for communication and collaboration between nurses and midwives to be effective and to enhance the Principles of Partnership, the New Zealand College of Midwives recommends the establishment of the New Zealand Federation of Midwives and Nurses.

Areas for Discussion

1. Degree/Diploma

The Education Amendment Act 1990 makes it possible for polytechnics to apply to NZQA for approval to run courses which will award a degree.

In at least three polytechnics, nursing is moving to the provision of three-year, broad-based courses leading to registration where students will be awarded a degree in nursing.

The previous concept of completing a three-year diploma in nursing and then going on to do a basic degree in nursing is no longer the only means of achieving degree status.

Those nurses who graduate from the degree courses will have a degree at the end of three years. Because these courses must recognise prior learning and experience and give credit for these to meet NZQA requirements (the new accreditation body for ALL courses in New Zealand), some people may achieve registration and degree status in less time than this.

Nurses currently in practice will have the opportunity to seek credit for their knowledge and experience and complete a specified number of papers to also gain a degree in nursing. This will be individually assessed.

Nurses with degrees will have the opportunity to go on to do an honours degree, a master degree or a PhD.

Nursing intends to have three-year diploma courses in nursing continuing at the same time but believes that the graduate from a degree course is different and will have greater ability to think critically and creatively, to undertake research and to generate

nursing's body of knowledge. They do not think that all nurses want or need a degree. It has been suggested that the clinical career pathway needs to change to reflect the new environment.

What about Midwifery? Should the three-year broad-based midwifery courses currently being developed around the country award the graduate a degree or a diploma? All graduates will be registered midwives if they meet the Nursing Council requirements for registration.

The Pros

- the present graduates from the separate midwifery courses are largely operating at a degree level already. (Three-year course graduates will be at least as skilled and educated.)
- the practice of midwifery has changed since 1990 amendment and midwives in independent practice are operating at a high level.
- other health professionals of equal status have degrees e.g. doctors, physiotherapists. May improve equity.
- midwives may disadvantage themselves in the long-term if nursing goes to degree and midwifery doesn't.
- public credibility may increase with degree status (already high but may influence women's choice of independent midwife).
- more cost effective to develop courses which can share some teaching with nursing.
- more equitable with nurses also doing a three-year course.
- mature applicants (over 20) will be entitled to open entry, therefore, not disadvantaged.
- may be more appropriate education for future midwifery leaders and midwives who will do research and generate and develop midwifery's body of knowledge.



The Cons

- may distance midwifery from consumer.
- could be detrimental to public perception of a midwife (e.g. too academic).

- may deter mature women and those from other cultures from applying.
- resistance from midwives in practice.
- will it improve care for women?
- does our status come from qualification or from consumer?
- does midwifery need research or a written body of knowledge?
- words like Bachelor, Masters, Doctorate are inappropriate for midwifery.
- New Zealanders generally are not academically qualified and perception of what degree level is may be incorrect.

Some discussion

In Auckland we debated these issues but did not have time to reach conclusions. It was felt important for all midwives and consumers to have input into the final decisions.

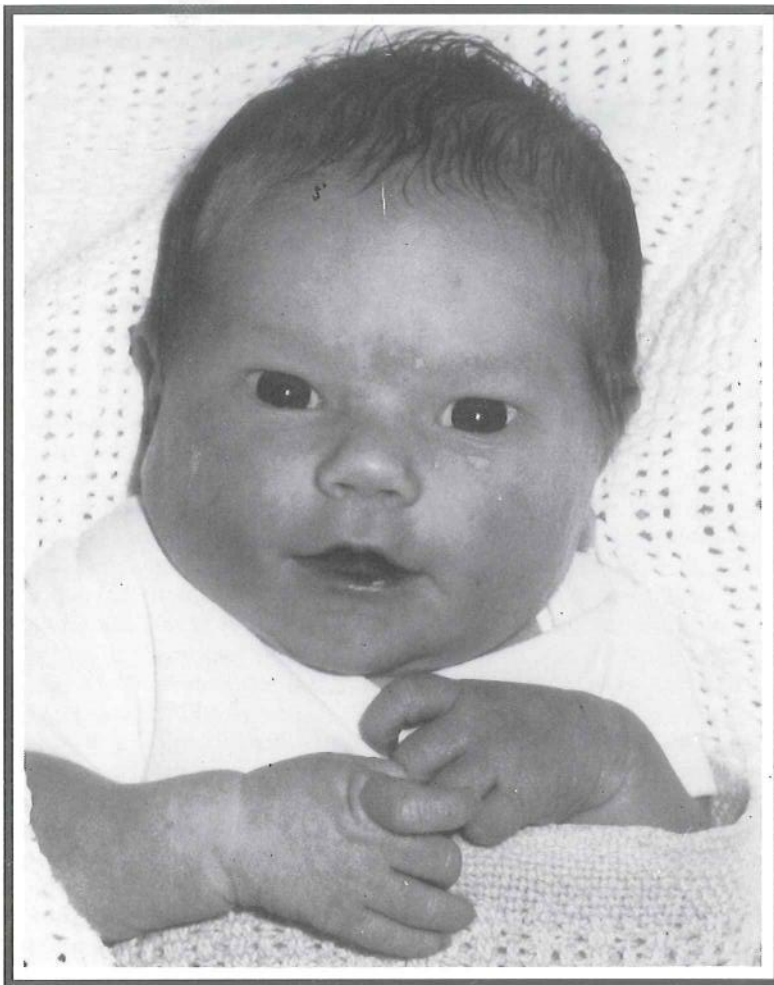
Whatever outcome we thought it was important to have consistency throughout New Zealand and not to develop two levels of midwife from these new courses. We recognised that 'degree' would become the basic level qualification and that experience and ongoing learning comes after this and must be valued highly. Midwifery practice is considered more important than qualification. Midwives in practice will have the opportunity to undertake some further study to also obtain a degree if they wished. (May improve opportunities for present DE midwives).

The Nursing Council requirements for midwifery state that clinical experience will be no less than 50% (1500 hours) and up to 60% in a three-year course. Therefore the clinical experience will be the same in both types of course.

Our main concern was that whatever the title of the course, midwives must define the product (midwife graduate) and control what is in the course. Midwifery must not distance itself from its powerbase - the consumer.

There are undoubtedly aspects we haven't covered. The question to be asked is:

- Do we want the new three-year midwifery courses to award a degree or a diploma along with midwifery registration?
- 2. One other aspect we wanted discussion on was how the midwifery profession could acknowledge to midwives the value it places on their contribution to midwifery student experience. Any ideas?
- 3. What kinds of post basic qualifications do midwives want available to them? ■



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Jesse's Birth

Rosemary Penwarden

FOR THREE WEEKS NOW I HAVE BEEN TRYING to tell myself "Don't get excited, these are pre-labour contractions, not the real thing, not yet, not yet..." And this morning I wake feeling different.

"I feel different today Tim, maybe you'll get a baby for Father's day." But on the outside, in the practical part of me that has been battling futilely these weeks to stop my excitement, I think "Oh yes, I've said that before".

"Oh yes, you've said that before", says Tim.

Perhaps I may even be imagining the 'show' that I find this morning, it is so slight, hardly a speck. Could it really be what I've been waiting to see? Do I ignore it or begin to get excited...again?

More contractions, mild though, and as I move through the morning they come and go quite without my attention, quite erratically. Then the morning is over and I hardly noticed it, so within myself am I this day, tuned in, feeling and believing the feeling by now, the difference. I visit friends up the road, march up the hill with an energy my body seemed to have forgotten weeks back as this child inside became heavier, riper, hungrier. I breathe in the icy air and tingle all over, all through, the aliveness I can almost not contain and I feel my body at its ripest most alive point, about to burst.

Back home, about lunchtime, I am still effervescing with energy. I look at Tim who is doubtful that today is the day, not wanting to believe me yet.

"Let's make love", I suggest as a huge wave of warmth sweeps between us. But

contractions are becoming stronger now and I consider the practicality of the idea and bake cookies instead and make soup. By the time the dishes are over I am stopping every five minutes to lean over the bench and breathe, deep and low, into my abdomen, into my uterus. I phone Sally, the midwife, she will be here in an hour, and I begin to get ready between contractions - which by now really are different - longer and harder and their strength is startling at first until I find my flow within and work with them, ride with them.

"Baby, you are on your way this time." I sense inside that he is startled too, but then he quiets and works with this energy, like me. And I soothe him silently inside me.

We have a mattress on the floor, clean sheets, towels, plastic, old sheets, cushions and pillows. Soft things too to wrap a baby in - that tiny woollen singlet, those tiny soft baby clothes that my eyes and fingers have touched, caressed quickly and lovingly these last weeks. All is ready as my body flows now strong and hard on waves of power. We are taken over, this baby and I, by the force of birth and all we can do is ride with it when it sweeps upon us. My breathing is fast and deep. My woman's body moves to the rhythm and flow for which it was created. I lean forward over the pillows and I am working, working within myself, totally concentrated. Between contractions I look about me just enough to be sure that all I need is here with me. Tim, close by and touching me rubbing my back, I want him close. Soft music and within the music the

sound of running water and birds help me to be here by their earthiness, for now is the time of my life when I am joined with the earth. Performing the birth miracle, the act of creation. I am the earth Mother opening my being to a new life.

Sally is close too, encouraging me with her touch and her presence and I feel safe here in my home, safe and in control, free to answer this force within me. Arani, four, is playing in the other corner of the room with her dolls, my friend Bhadra with her. She comforts me too at times and I feel her four-year-old concern and love and it soothes me. I know she is safe too. I know inside it is good that she can share these moments of her brother's birth.

Now the pain sweeps me up suddenly and strongly with each contraction. It is all I can do to stay with it and breathe. I feel on the edge of falling, of not being able to hold on any longer to the thread of peace within me. Then it ebbs again and I have a moment to recover before the next rush of pain. My pelvis, lower back, my whole abdomen feels forced, dragged open in tidal waves of energy. I know nothing of time, I know nothing but this overwhelming force, and the hands on me touching me keeping me from falling over the edge.

There is a sudden rush of warmth and relief as waters gush down and out of me from within my womb. The waters my baby has bathed and moved in all these months, where his life began. My inner, life-giving ocean, and now I am open, birth is close.

I bury my face in the pillows, clench my teeth around a wet cloth, try somehow to endure or escape this frightening pain. And then I sense a change and know baby's head is close, it is time to push. I need help to move though my body knows what to do and I squat, Tim holding me from behind, waiting for what is to come.

There is stillness now and quiet, all waiting and anticipating. Arani's dolls forgotten, she is sitting on Bhadra's lap watching. I feel the presence of the great spirit of birth surrounding and engulfing us all. It is a new energy which takes over now and causes me to push - as if my body is pushing without me. I watch in the mirror in front of us and can see the top of his head emerging. With my fingers I can feel it, soft wet and warm. This huge downward energy is like a great emptying of myself. I let out a long low moan from somewhere deep within, so deep it feels and sounds to have come from below me, from inside the earth, from my own beginnings. Slowly, slowly my body is stretching open and even through the stinging stretching pain, I watch his head appear in the mirror, as if from another's body, in awe and amazement. A round, bluish, perfect head, then it turns slowly and with more downward energy my son, guided by careful hands, slithers out and flops gently to the floor. ■



Photo: Jane Scotts

It's Still Women & Midwives in Partnership

Joan Donley, O.B.E.

AFTER THE HEADY DAYS OF THE NURSES' Amendment Act, the present climate is depressing, to say the least. But, despite the doom and gloom promoted by the 'targeting' of universal benefits, further restructuring of health and education services and the Employment Contracts Bill, the performance of our midwives at Vision 2000 augers well for the future.

Although in the minority at a Forum 'to develop a national framework for nursing and midwifery education...', midwives were brilliant, they really had it together! They were articulate, politically aware and made valuable contributions to the proceedings and workshops. And finally, in developing the midwifery 'Vision' based on midwifery as a profession in its own right, they made another stride towards control of midwifery destiny.

The development of the midwifery Vision was democratically open to all midwives and consumers prepared to come back on Saturday morning. In three hours we had a comprehensive document which was presented to the official 'invited' framework group.

What is the secret of the dynamic progress of midwives? I see it as the direct result of our partnership with women.

I recently had a letter from the UK Association for Improvement in Maternity Services (AIMS) which says that the latest fight there is over changes in midwifery training which will place it under the control of nursing. The writer, Beverley Beach, wants to know "how New Zealanders provoked the women into supporting change, because we are only going to get through if we get women mobilised, and any advice would be more than welcome".

Our strength lies with our partnership with women. We are going to need it even more in the struggles ahead of us, as the Task Force 'unshackles' our health care system and strews the 'shackles' around for the private entrepreneurs to pick up.

In the health sector we are facing market force concepts like the 'funder/provider split', the end of the universal maternity benefit which instead will be 'targeted' to selected groups with those excluded going private or without.

In the industrial sector, the Employment Contracts Bill will do away with established awards and collective bargaining, setting worker against worker. As an example, back in October 1989, Ruth Richardson advised Canterbury Area Health Board it should "generate efficiencies" by employing part-time workers to get around paying penal rates to nursing staff (NZ Doctor).

Richardson was merely expressing National's policy which is that "welfare is a reward for not performing" a statement made by her and Simon Upton three years ago (NZ Herald, 6.3.91). That was prior to the 'fiscal crisis' which Ros Noonan claims has been a "godsend" for National giving it a rationale for promoting "the Treasury-Business Roundtable ideological fanaticism" (Dominion Sunday Times, 24.3.91).

In giving the Task Force the Gibbs' Report as one of its reference documents, National is proving it is not "gutless", a charge Gibbs publicly levelled at Caygill when he did not implement the Gibbs' recommendations (NZ Medical Jnl, 27.7.88).

The College has to seriously consider what these proposed changes will make to maternity services. The 'targeted' group will be expected to pay for 'free' care by being compliant clinical material; obstetricians will be lobbying to target the benefit to level 2 & 3 maternity services, i.e. medicalised childbirth will be subsidised while the low risk (midwifery material) will pay. This has already been proposed in Auckland - it's not a nightmare.

The funder/provider split will turnover to area health boards (or whatever they become) the administration of the targeted maternity (and GMS) benefit. Who gets paid, and for what, could then depend on the priorities of the individual board and the political pressure that can be brought to bear.

As well as monitoring board meetings and decisions and responding quickly, all MPs should be lobbied and fully informed of the issues. There are a few mavericks in the National Party, but also, most of the new members are not well informed on the issues. Joy McLaughlan (Hutt) speaking at Vision 2000 did not know what the Maternity Benefit is.

College members need to:

- * Get clued up on relevant issues;
- * Lobby all MPs;
- * Monitor/lobby your area health board;
- * Maintain/consolidate unity with women.

As I have said before, speaking in trade union terms, women own all the raw (clinical) material and control the means of (re)production, and that is a position of power. ■

Antenatal Education - Whose Purposes Does it Serve?

Andrea Gilkison

TEACHING IS AN INTEGRAL PART OF A MIDWIFE'S practice, and as a midwife I have always believed that the midwife is the best health professional to provide antenatal education. I have looked on in despair as yet another area of midwifery practice has been gradually eroded, with physiotherapists and childbirth educators 'taking over' what was once the domain of the midwife.

However, taking a closer look at the way that politics, society and institutions control women both as consumers of a health system, and as health care workers, has led me to a more in-depth examination of what women learn from antenatal classes, who controls these classes, and the place of the midwife as childbirth educator.

Institutional Control

Antenatal education in New Zealand generally refers to a series of antenatal classes for pregnant women and their partners to learn about fetal development, maternal health during pregnancy, to prepare for childbirth and to learn parenting skills. These classes are usually run by maternity units. They are often large classes, held in late pregnancy. They may be taught by midwives, childbirth educators or physiotherapists. They are normally held in the hospital environment and aim to prepare couples for the kind of birth they can expect in a New Zealand hospital.

It is significant that classes are usually held in the maternity unit where the woman will give birth. The institution which offers the classes has a high level of control over them; deciding for whom the classes will be provided, what should be taught, who should teach it, and the nature of the evaluation. These days decisions are made with cost-effectiveness uppermost in the administrator's mind.

Rising costs have led to permanent changes to all parts of health care organisations. Antenatal classes which were once provided as a free service by hospitals are now often charged for. Consumer-based childbirth education such as 'Parents' Centre' have always had to charge their clients. This aspect raises the issues of availability and equity - crucial issues if one believes that antenatal education makes a positive difference to the woman's experience of childbirth and parenting. The current interest in efficient, cost-effective health services is in direct conflict with values of health promotion, availability and equity.

Levin (1978:170) suggests that 'patient education is becoming an attractive interest in terms of its income-producing potential and, even more significant, its potential for bending patient behaviour to accommodate the needs of the system'. This latter point is particularly poignant in the area of antenatal education. Much of the material covered in classes aims to 'prepare' women for childbirth in that particular institution.

In other words, admission procedures will be 'described', technological devices and possible interventions will be 'explained', women will be told what to 'expect' from various staff members, how they will feel at certain stages of labour and what will be *done* to help them. Women are encouraged to ask questions about the procedures, and offered 'choices' within certain boundaries, but to question the status quo or to challenge the system is definitely not a part of most antenatal classes. Preparation for childbirth then, could be analogous with shaping a woman's behaviour to accommodate the requirements of the institution.

Societal Control

The values and beliefs of society also affect antenatal education. The affect of these values is all-pervasive, as Guntrip (cited in Salmon, 1969:10) suggests:

Every phase of education, whether incidental or planned, depends on the judgement of society as to what is good or bad, what is true or false, what is ugly or beautiful, what is of value, what is worthless in human affairs.

Redmond (1978:1365) suggests that 'a curriculum has a conceptual/philosophic framework that links it to societal goals and that provides it with some identity and accountability to the public'. True, but who decides what the 'societal goals' are, and are they the same for all people within a society? I would suggest that a curriculum for childbirth education is indeed linked to societal goals, and those goals are determined by the dominant culture. For example, the belief that women are ignorant about their bodies and their pregnancies, and obstetricians are the experts in women's health underlie most antenatal education curricula. Are these goals necessarily congruent with the values and beliefs of pregnant women, and does this fit with what women want from childbirth education?

A national study by Jacoby (1988) in England asked 1500 women what their main sources of information and advice were at various stages antenatally, during labour and delivery and postnatally, and how helpful this had been. The researchers found that although nearly 75 per cent of first time mothers attended antenatal classes, only 6 per cent mentioned them as the most helpful source of information. Informal sources such as mother, husband, relatives, friends, neighbours and other mothers were considered most helpful by 43 per cent of the women, whereas professional sources were felt to be helpful by only 24 per cent. These findings indicate a gross discrepancy between women's needs in antenatal preparation and societal and institutional goals.

Antenatal classes tend to include infor-

mation on how to use existing maternity services, emphasising assisting women to make a 'good' adjustment to hospital. These "how to use the system" components of patient education...reflect the expectation of the patient's adapting to the system' (Levin, 1978:172). Few classes encourage awareness of the hazards of obstetric care, or of how to change the system to conform to *women's* needs and preferences.



Antenatal education generally focuses on the individual woman's personal health behaviour and activities such as diet, exercise and lifestyle over which women can supposedly exercise personal control. If we consider the part the environment and society plays in women's experience of pregnancy and childbirth, it may be necessary to consider skills that bring about social change as well as reduce personal risk (Levin, 1978).

Political Control

Politics is a dirty word to many of us, and I have heard many midwives say that they do not engage in politics. Yet without realising it, we all do, and as client educators we are caught up in the politics of antenatal education.

Politics is defined here as relations of power between legislators, administrators, health professionals and consumers. Aroskar (1987:268) suggests that 'power is probably a pervasive feature of all ideas about what characterises politics', and goes on to say 'political and ethical dimensions are inherent in relationships at all system levels, most obviously in policy development'. By its very definition, power and therefore politics are inextricably locked to a given set of (probably unacknowledged) value-assumptions which predetermine the range of its application. Midwives are as much a part of this power relationship as legislators and administrators are. We are governed by the power that others have over us, and in turn wield power over those subordinate to ourselves. As such, midwives are engaging in politics in their everyday practice.

Illustrations of power-wielding in antenatal education are abundant. Presently there are no commonly accepted outcome standards for antenatal education. The most clearly stated desire is for compliance with the medical regimen in order to achieve a "healthy mother and baby". Often, knowl-

edge is meted out according to what the midwife believes the woman needs to know in order to justify what will be done to her, with the goal of 'intelligent compliance which allows and requires patient decision making within parameters' (Redman, 1978:1363). If this is so, can antenatal education as we know it, be said to be in the woman's best interests?

The form that antenatal classes take, and their content, has become so much a part of the ideology of maternity hospitals that no-one questions their validity. Levin (1978:171) notes that:

patient educators can use the same approach that the physician would in planning therapy: diagnose the needs, decide on acceptable outcomes, select a method appropriate to the patient's conditions, administer the educational treatment and observe results. Implicit in this approach is the professional's responsibility to help the patient achieve optimal compliance with professionally prescribed health care.

If a midwife were to question her part in ensuring optimal compliance, structures exist to ensure that her employment is jeopardised. I have known midwives to be made redundant, or to give up their job because they questioned their part in perpetuating the values of the institution.

Ethics, Choice and Control

Choice is an important issue for childbearing women, and choice is very much a part of ethics - so, we need a quick look at the ethics of midwifery in antenatal education. Up until now, midwives have had little choice or control over the working environment, so it must be assumed that consumers have even less. As health professionals we must take responsibility for controlling and limiting our clients' choices.

Buckenham and McGrath (1983) suggest that two assumptions basic to control are 'That the health professional has superior knowledge', and 'has an ethical commitment to act in the patient's best interests'. With antenatal education we have come to take these two assumptions for

If a midwife were to question her part in ensuring optimal compliance, structures exist to ensure that her employment is jeopardised.

granted, yet they need to be questioned because they relate to the ethical issues of control and choice. 'Autonomy is a dominant value in the literature of nursing.... If we ignore a person's values or replace them with our own, we risk undermining their sense of worth and meaning' (Leff, 1986:375).

Midwives (along with doctors and nurses) are convinced that they are the best authorities on what clients should learn. A good example of this is the information given regarding the use of ecobolic drugs during the third stage of labour. Midwives have been taught that the routine use of these drugs has greatly lowered the incidence of postpartum haemorrhage, so as part of our antenatal education, we tell mothers that they can expect to be given an injection just as their baby is being born. We tell her what will happen, and why.

This demonstrates both elements of control: 'superior knowledge', and acting in the 'patient's best interests'. If a midwife were to question that practice, suggest to women that this drug is not always needed, that midwife could well be reprimanded, or even dismissed. Yet from an ethical standpoint, that midwife has offered that woman a choice, given her the control which is what women say they want.

Issues of choice, compliance and cooperation have been raised in this discussion of the political, social and institutional control over antenatal education. To quote from Paulo Friere, 'Education is never neutral, it either oppresses or liberates'. From this analysis it would seem that most antenatal education probably fits into the category of oppression rather than liberation!

So where to from here? As midwives, I believe it is our responsibility to release our control over women, to stop perpetuating the culture of society and institutions, and to listen to what women want for their

*'Education is never neutral,
it either oppresses
or liberates'.*

antenatal care. This is not an easy thing to do; we have been socialised into believing that we are the experts, that we should decide what is necessary for women to know about pregnancy and childbirth. It takes a great deal of trust in women to be able to stand back and say; "What do you want to know? How can I help you to find out?" This is to let women decide, to go their own way, to see them eventually reach a point where they can truly be said to have made an informed decision. This approach is consistent with humanistic theories of learning.

If a humanistic approach was used as a basis for antenatal classes, the group would identify their own learning objectives, topics they would like covered and how they would like them covered. The midwife would create a warm, caring environment conducive to group discussion and sharing of feelings. She would facilitate the group, act as a resource person and pay special attention to the feelings and emotions being discussed. Evaluation of learning would be undertaken by group members according to their own objectives.

Using this analysis it appears that most antenatal education programmes in New



Zealand are under institutional control, which means that women learn what the institution wants them to know, that society has its own firmly held assumptions related to women, pregnancy and childbirth which are passed on through antenatal education. And most importantly, power over women as providers and consumers of health care is clearly evident.

It is my belief that it is women, the consumers in this case, who should have the control, make their own choices, and that childbirth education should meet their needs. This poses a challenge for midwifery. Can we release our power, and let women determine the midwife's place in childbirth education?

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(Midwifery Education continued from page 6)

status. We need broader discussion and consideration to reach a decision that is right for Midwifery - a forced decision is not a desirable way to plan future Midwifery needs.

In summary the course of action the New Zealand College of Midwives would like to see taken is as follows:

- * Advanced Diploma of Nursing Midwifery option be discontinued as of December 1991.
- * Continue support for separate mid-

wifery courses for R/Ns in the transitional phase towards integration into Direct Entry courses.

- * Ensure evaluation of Direct Entry Programmes is completed and long term Direct Entry courses established.
- * Re-evaluate the clinical requirements for education of all health professionals in maternity care.
- * The appointment of midwifery advisors to Nursing Council and Department of Health.

- * Establishment of a structure which provides for ongoing discussion with all Nursing and Midwifery groups on preparation for practice.

At this stage in New Zealand, women have identified their needs. Midwives are taking up the challenge, legislation has facilitated change, and we ask for nursing support to follow through with our vision. ■

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"A Midwife's Gift - Love, Skill and Knowledge"

*The Theme for the International
Confederation of Midwives
22nd International Conference*

Beverley Crombie

KOBE IS A SMALL CITY IN JAPANESE TERMS, bordered by the calm inland sea of Osaka Bay and the Rokko mountain range behind. It is a hard city to get lost in, as long as one remained above ground that is, and didn't venture into the vast subterranean shopping centre which connects the four rail stations.

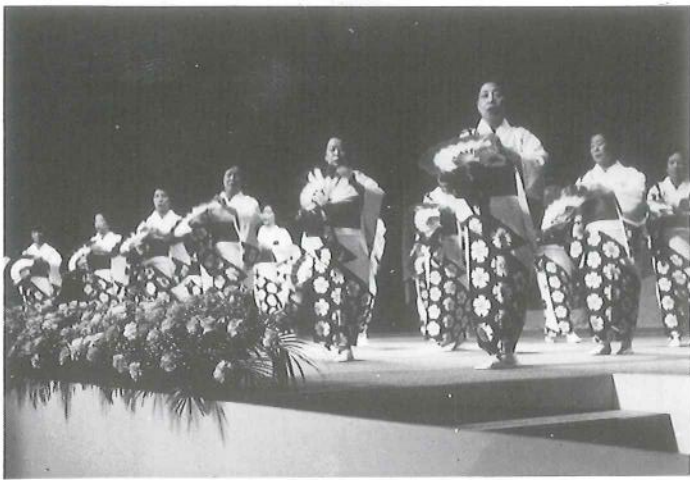
With minimal available land, the Japanese had not only tunnelled underneath, but had built an island in the harbour and were in the process of constructing another. Port Island as the first is called was the venue for the 22nd International Congress of the International Confederation of Midwives.

This island has many conference centres, exhibition halls, and a monstrous World Hall resembling a slater-bug. On site also is a luxury hotel, the Portopia - where some delegates stayed, a shopping centre, hospital and many apartment buildings for the 'better off' Kobe residents. To reach the island one took the Portliner, an overhead rail system, which followed a circular route as boring as the Farmers bus. A computer drives the train and a recorded commentary by a nice lady, who told us in American English where to get off (literally). However Hotel Portopia ran a free courtesy bus every half hour for hotel residents. So in Kiwi style this became our commuter system. Walking through the elegant hotel was as close as we got to being residents.

The Conference began with the opening ceremony on Sunday 7th October. There were 6,000 enrolments from 43 nations. To find the World Hall was simply a matter of following women of all skin colours, shapes, and ages into this huge building, assisted along the way by much smiling, bowed greetings from traffic wardens, door people and Japanese student midwives who worked tirelessly, and were patiently smiling throughout the conference.

We were processed through name badging, receiving pocket sized transistor translators, the large proceedings book, and the conference committee presented us with a commodious black and tan bag containing Japanese gifts - calculator, enamel brooch/pendant, chopsticks (hashi), scarf, handkerchief, towel and other handmade ornaments. All 12 New Zealanders present gathered together under the NZ flag for photographs.

The opening ceremony commenced with many introductions, the parading and presentation of flags from representative nations, and the President's address. President Sumiko Maehara spoke on "A Midwives Gift - Love, Skill and Knowledge". The theme for the conference was adapted from Margaret Miles' statement that good midwifery requires head, heart and hands. Maehara defined skill (or hands) "as evolving when a human being initiates a certain method among many potential methods



Opening ceremony.



Midwives from New Zealand.



World Hall, Kobe international centre.



Bev Crombie and Joan Donley.

Photographer Glenda Stimpson

for accomplishing a particular end, skills can exist in more than one form.

To help a mother through her delivery the midwife needs not only the skill to evaluate the process of delivery but also the skill to evaluate the mother herself. "Knowledge (or head) she said is the forerunner of skills, but skills have to be applied before knowledge attains universality and validity.

To illustrate love she chose the quote of Japanese novelist Kurala Hyakuzo who said "Pure love is the desire to improve the life of others". What better statement could be applied to the practice of midwifery?

Further welcoming speeches were made by male dignitaries including the Mayor of Kobe, an obstetrician; the representative of the prefecture Hyogo; and finally the Princess (now Empress) Mikasanomiya. The opening ceremony ended with dancing displays, drinks and social intercourse.

Themes for the morning plenary sessions held on the next four days were:

- * midwifery practice in the world
- * midwives and bioethics

- * midwives and technology
- * midwifery education and research.

On the Monday Barbara Kwast from WHO challenged us all with her opening statement "the right to enjoy successful pregnancy and childbirth and to regulate fertility safely is denied to millions of women today. The magnitude of maternal mortality and morbidity is witness to this social injustice. The WHO estimates that at least half a million pregnancy-related deaths occur each year. Most of the women who die are poor and live in remote areas or in city slums. Their deaths are accorded little importance and fail to enter registers." She also said that maternal mortality has many facets - social, political, educational and managerial as well as clinical. The reduction of maternal mortality requires vision, interpreting our times and finding solutions.

Juaka Kamara described the problems of West Africa in her paper "West African Midwives In Operations Research To Reduce Maternal Mortality In Rural Communities". In March 1988 12 midwives had attended the Operation Research workshop

initiated by the Safe Motherhood Initiative. They examined health facilities, quality of care in tertiary hospitals and socio-cultural factors affecting women e.g. a woman cannot leave a compound without her husband's permission. They recognised that midwives trained in 'western ways' had a negative effect on the community and untrained TBA's can be a threat to women's lives. They saw that problems of regions should be addressed according to the needs of that region. Programmes have since been set up to improve knowledge and perception of obstetric complications. Mobile midwifery service and transportation availability have also been established.

F. Foord in her paper titled "Mobile Midwifery Service In Rural West Africa", said that since 1982 Health Centres have been set up in the West Kiang district. Every village with a population over 400 has a TBA and VHW (village health worker). This service has considerably lowered maternal mortality - however it is apparent that midwives are still needed for early detection of problems. Since 1989 two midwives and a community health nurse have

visited 21 villages twice monthly. In the first six months 278 women were enrolled in antenatal care and there were no maternal deaths in that period.

Holliday Tyson spoke on "A Retrospective Descriptive Study of 1,001 Toronto Homebirths". There are 48 midwives in Ontario, and the group is about to be legalised. Because of debates on the safety of homebirths 26 midwives in Toronto were contacted and birth records from January 1983 to July 1988 scrutinised. Statistics of the 1,001 births included following obstetrical outcome; 83.5% were delivered at home with no complications with the remainder being transferred either ante or postnatally. Of the multiparous women delivered at home 93% achieved normal vaginal births either at home or hospital and 3.5% LSC's. There were two neonatal deaths from asphyxia (one baby born at home and one in hospital after transfer in latent labour). 60% of multiples had intact perineums.

Margaret Peters, from Melbourne presented a global view of women and childbirth in "The Business of Childbirth". She makes us face the 'real world', by sharing from her vast experience in the third world and comparing this to our every day life. For example she states that childbirth has traditionally been labelled as the 'business of women'. But if this is so, why are so many women disadvantaged in a business they own? She said the problems were illiteracy, with the 'girl in the family' being disadvantaged. Male dominance is such that women risk their lives if their husband is absent or does not agree to help being sought. The lack of recognition of the work of women as primary care givers and also subsistence farmers and manufacturers of goods which are sold or exchanged to ensure the family is fed. It is generally acknowledged that women grow about half of the world's food and work longer hours than men. Margaret challenged us to look at the situations when personal economic imperatives cloud the professional judgement of any health care provider and in this the poorly paid can be more vulnerable. Job security does not always mean an adequate income is assured for some of our colleagues. Finally the inferior status ascribed to those who attend others in childbirth is not easily overcome. If we do not reassess this little will be achieved, for we have only improved maternal outcomes where the ratio of nurses and midwives to doctors is high and the general education of the women enabled them to increase their share holding in the business of childbirth.

An hour and a half for lunch was neces-

sary to queue for bento boxes (lunch), toilets, the special commemorative stamps (which kept running out) and to chat with women from every corner of the world. Five to 10 minutes open air walk was welcome to find the building where the afternoon sessions were held. Temperatures and humidity were quite high 24-26°C.

It was with much pride that the Kiwis heard Joan Donley present her paper "Midwives Dilemma" at the plenary session of the second day. Many midwives from other countries envied our new-found autonomy, as Joan astutely spoke about the dimensions of our dilemma.

Caroline Flint, the English Independent midwife and author of "Sensitive Midwifery" gave a thought provoking paper entitled "The Importance of Control For Woman". She stated that as most women have control in their own homes, this is where they should have their babies, as privacy and familiarity enhances self-confidence.

Nicky Leap from London pursued a similar theme in her paper, "The Less We Do, The More We Give". Amongst other discussions she pointed out the "put down" words we use in midwifery - "failure to progress", "failure to breast feed", "confinement", calling women "girls or ladies", "allowing". Nicky said that we need to build a new profession centred around, and responding to the needs of child bearing. She went on to say that if we listen to women and take our cues from them and develop flexible ways of working, then we will be able to empower women to build confidence in themselves - even when circumstances are far from ideal. We need to master the "mistressly" art of doing nothing.

Thursday's 'speech of the day' was by Lisa Paine from Baltimore USA on "Midwifery Education and Research in the Future". She first quoted from Eleanor Roosevelt, 1884 who said "no one can make you feel inferior without your consent". Lisa then went on to say that a good midwife must keep learning each day of her life, should speak freely and serve the poor with the same affection as the rest and must continue to search for perfection. We are to "forget what the book says. This is how you stop a haemorrhage before it begins." Remain humble, remain sensitive.

A paper on continuing professional education stated that midwives must be given the opportunity and accept the challenge of being responsible for their own CPE and relating it to their practice. Attendance at an approved refresher course every

five years is no longer sufficient to keep midwives up-to-date in England.

Another thought provoking paper came from Norma Naisbitt of England who spoke on "The Pursuit of Competence". This described the changes which have occurred in midwifery education. For example obstetricians were concerned that they no longer acted as examiners and they felt this was a great loss to midwifery. It is essential that at the completion of the course the midwife is a competent practitioner.

"Midwifery Care Wards - A Model For The Future". Sheila Drayton from Cardiff opened with this statement "in order to empower women to achieve a positive experience in childbirth, they must be able to develop a trusting relationship with their midwife. Therefore hospital maternity care should be arranged in a way that avoids moving from ward to ward and changing carers."

Sheila explained that in this ward the midwife who delivers the mother becomes her primary midwife. During the first year the midwives had to gain confidence in their ability to provide total maternity care. So far surveys have demonstrated increased client satisfaction and significantly improved job satisfaction for midwives.

On Thursday evening the Japanese midwives put on a Japan Night for everybody. Meal tickets gave access to beer, noodles, barbecued corn, tempura, and other unidentifiable Japanese food. Everybody received 'lucky dips' of wooden clogs, yukata (kimono), and there was much dressing up. Dancers, and drummers finally culminating in a very long conga line that weaved in and out of stalls. It was a lovely evening with much socialising.

Friday morning, when we went back to the World Hall for the last time, we were told that five million women were permanently handicapped as a result of childbirth, half a million women die each year in childbirth, 99% of whom were from developing countries. The International Confederation of Midwives has input into the World Health Organisation - we must advance education to spread midwifery care and promote the midwife as a key worker. There is also a need to review the training of midwives - midwifery education programmes must be separate from nursing. The practising midwife must be able to evaluate her practice.

We dispersed at midday. Six thousand professional, caring persons had gathered together bound by a practice linked to the existence of human beings, - such potential power, such responsibility! ■



Lactation Consultancy in New Zealand

Kath Ryan

BPharm PMS IBCLC

Why Lactation Consultants?

The promotion of breastfeeding is a success story with breastfeeding numbers generally continuing to rise until they reached a plateau in the early 1980s.¹ Along with the increase in the number of women initiating lactation goes an increase in both the number experiencing difficulties and the complexity of the nature of those problems. The percentage of women who start out breastfeeding is good but, alas, the statistics show a rapid fall off in the breastfeed rate in the first three months.

Clearly, these women are not receiving the support they require when problems arise. Many of them discontinue lactation because of a lack of information at a crucial time. Generally, standard advice is all that is required, but increasingly more skill is needed in diagnosis of problems and management of the mother and baby.

Women are feeding their babies under new and difficult circumstances. Take for example, mothers with diabetes, AIDS, or phenylketonuria, and those undertaking paid employment outside the home. Babies born very prematurely, who previously would not have survived, are now doing so and those with neurological impairment or physical handicap require specialised help to initiate, establish and maintain breastfeeding. We are beginning to realise that there are very few situations in which

breastfeeding is not possible, given the right support and information at the right time.

The same problems have been experienced overseas where lay and professional people began to fill the gap in services. In 1982 La Leche League International (LLLI) recognised a need for appropriate standards for such lactation advisors and began developing guidelines for this field.

Lactation Consultant Certification Examination

The International Board of Lactation Consultant Examiners (IBLCE) was formed in 1985. This international board is an independent body which administers the certification examination and recertification programme for Lactation Consultants.

The Board established an examination which meets the requirements of the National Commission for Health Certifying Agencies in the United States of America. First held in July 1985, the examination has become annual with candidates throughout the world and translations available in Spanish and German.

The first New Zealander to sit the examination was Rachel Walker of Christchurch in 1986. The examination was available in New Zealand for the first time in 1990 with eight candidates sitting in Christchurch.

Certification is effective for five years

during which time Lactation Consultants must participate in continuing education programmes. After five years proof of continuing education must be provided or the examination taken again. After ten years recertification is by re-examination only.

The topics covered by the examination in which the candidates must show proficiency include anatomy, physiology/endocrinology, nutrition/biochemistry, immunology, pathology, pharmacology/toxicology, behavioural science (psychology, sociology and anthropology), interpretation of research, ethical/legal considerations and technology in so far as they relate to the mother, baby and family.

Preparation for the examination is the candidate's responsibility. Several institutions in the US offer courses of study either by attendance or correspondence. Most candidates organise their own preparation study from recommended reading material and texts. Massey University offers a one year extramural course in Human Lactation which may be useful preparation for the examination.

What is a Lactation Consultant?

Australian experience shows that the majority of candidates are midwives or lactation nurses, lay breastfeeding counsellors, doctors and the equivalent of Plunket Nurses. Most have a tertiary qualification and all have considerable experience in lactation management.

The IBLCE provides the following competency statement which best describes what is required of a Lactation Consultant in general terms.

"The International Board Certified Lactation Consultant will:

1. Possess the skills, knowledge, and attitudes to competently provide comprehensive consultation and education in routine and special circumstance lactation.
2. Integrate additional knowledge from the following disciplines in providing care for breastfeeding families: Maternal and Infant Anatomy and Physiology, Immunology, Endocrinology, Biochemistry, Infant Growth and Development, Psychology, Sociology, Anthropology, Nutrition, Pharmacology, and Toxicology.
3. Utilise knowledge of personality, family, and group theory when providing breastfeeding support.
4. Integrate cultural, psychosocial, nutritional, and pharmacological aspects of breastfeeding in lactation consultation practice.
5. Utilise appropriate communication skills in interaction with clients and health care providers.
6. Maintain a collaborative, supportive relationship with clients, emphasising individualised family care,

client autonomy, and informed decision making.

7. Serve as a client advocate.
8. Utilise adult learning principles when providing educational experiences for clients, health care providers, and the community.
9. Intercept current research findings to determine appropriateness for application to practice.
10. Make appropriate referrals to other health care providers.
11. Maintain and enhance knowledge and skills with appropriate regular continuing education.¹²

In New Zealand a Lactation Consultant can be expected to fill many niches; in a hospital situation as the resident expert on lactation, she will work with mothers both antenatally and postnatally and after discharge, in the home. Typically, her objectives might be to:

- assess the infant at the breast
- help mothers with problems
- improve the overall experience of breastfeeding
- extend the duration of breastfeeding
- ensure accuracy and consistency of advice given to the breastfeeding mother.

She will also work with midwifery and maternity staff in a teaching capacity offering education courses whereby staff may regularly update their knowledge. Where the hospital is associated with a teaching establishment the Lactation Consultant will offer clinical teaching opportunities for medical and nursing students.

Jones and West³ showed that the presence of a lactation nurse "significantly extended the duration of breastfeeding" by the mothers whom she supported. They also demonstrated an increase in interest and general awareness by hospital staff in the breastfeeding mothers, which led to a general improvement in breastfeeding management.

The ideal situation would be the eventual establishment of a Breastfeeding Clinic in conjunction with the hospital. This requires the co-operation of many disciplines such as paediatrics, midwifery, obstetrics and gynaecology, dietetics, social work and, of course, maternity and lactation services.

As well as all of the above services such a clinic would provide a telephone consultation service to breastfeeding mothers and health professionals. Clinic appointments made as a routine for all mothers and babies discharged from the maternity ward, by referral from health professionals such as general practitioners, Plunket or District Nurses and social workers, by lay breastfeeding counsellors or by personal request.

The clinic provides an important teaching opportunity whereby students can become familiar with the normal physiological function of lactation, while also acquiring knowledge of the problems which may occur, their diagnosis and treatment. Overseas experience has shown the clinic to be a worthwhile adjunct to hospital services.

The number of mothers breastfeeding past the very early days is increased substantially when such a clinic is available.⁴

Another niche in which Lactation Consultants may be found is that of research. There is an increasing awareness of the importance of sound research into the physiology and management of lactation.

Private practice, either alone or in conjunction with a medical centre or general practitioner, is one other area in which a Lactation Consultant may be found. Here she will be responsible for antenatal instruction in breastfeeding preparation, postnatal assistance and counselling. She may offer a telephone counselling service from her own home as well as visit the mother in her home.

Finally, the Lactation Consultant will be involved in community education, by being available to speak to special interest groups both professional and lay, the Lactation Consultant will endeavour to raise the level of general knowledge regarding breastfeeding. It is important that the Lactation Consultant maintain close contact with breastfeeding support groups, such as La Leche League, in order to ensure the free exchange of services and information.

In summary then, a Lactation Consultant is a person certified by the IBLCE, who uses the title IBCLC (International Board Certified Lactation Consultant) and has specialised knowledge and skills in breastfeeding. She will be employed in positions within a hospital, a breastfeeding clinic, teaching, research or private practice.

When to Contact a Lactation Consultant

Besides helping with routine antenatal preparation for and postnatal initiation of breastfeeding the Lactation Consultant is able to provide specialised skills in more difficult situations. She will work with these families and their health care providers to develop a plan which will enable them to achieve their breastfeeding goals.

Early referral to a Lactation Consultant will benefit families who require special breastfeeding assistance. It is appropriate to involve a Lactation Consultant in the following more complex situations:

- * Mother is anxious about breastfeeding, particularly if previous experiences were not positive
- * Mother is returning to work and wishes to continue breastfeeding
- * Mother has flat or inverted nipples

- * Mother has unrelieved pathologic engorgement
- * Mother has persistently sore, cracked, bleeding or blistered nipples
- * Mother has recurrent mastitis
- * Mother has actual or perceived low milk supply
- * Infant has not latched-on and displayed audible swallowing by 24 hours of age
- * Infant has difficulty breastfeeding
 - latch-on and swallowing not consistent
 - feedings last longer than one hour
 - appears hungry after feeding
- * Infant has inadequate output - fewer than 3 bowel motions or 6 urinations in 24 hours
- * Infant has inadequate weight gain or has not regained birth weight by 2 weeks of age
- * Infant displays signs of suck/nipple confusion - accepts bottle but not breast
- * Special circumstances - prematurity, multiples, congenital anomalies, neurological impairment, maternal illness, separation of mother and baby
- * Relactation, Induced Lactation (adoptive nursing)
- * Family requiring times-intensive support and assistance.

Where to From Here?

We are indeed fortunate in the 1990s to be able to witness the birth of a new profession. Whether or not Lactation Consultancy thrives in its infancy depends on allied professions, the community and the consultants themselves.

It is likely that acceptance by employers and colleagues of Lactation Consultancy as a specialist area will be conditional upon performance. Lactation Consultants will need to prove their worth by being competent, professional and ethical in their clinical and teaching practice. To do this though, they must be given the opportunity to share their skills without having to overcome suspicion and hostility. Health authorities will need to recognise the qualification as well as the specialised skill and knowledge of Lactation Consultants.

In turn, Lactation Consultants must take advantage of opportunities for continuing education and ensure that suitable training programmes are established for new entrants into the profession. It is important to form a professional body to oversee educational requirements and to monitor standards of competency. Currently there are three options:

- to belong to the International Lactation Consultant's Association (ILCA)

Continued on Page 22

(Lactation Consultancy continued from page 21)

- to belong to the Australian Lactation Consultants' Association (ALCA) or to form a New Zealand branch of ALCA
- to establish a New Zealand Lactation Consultants' Association, affiliated to ILCA.

Having provided an explanation of why and how Lactation Consultancy came into being as well as having described where Lactation Consultants are likely to be employed this article outlines their duties and responsibilities for the future. It also calls for their acceptance by other health professionals.

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3. Jones, D.A., West, R.R. Effect of a Lactation Nurse on the Success of Breastfeeding: A Randomised Controlled Trial. J. Epidem & Comm Health 1986 40:45-49.
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Rachel Walker, Christchurch IBLCE Operations Administrator Assistant reports eight NZ candidates have recently completed the certification (IBCLC):

Marcia Annandale

- Area Co-ordinator of Professional Liaison for La Leche League NZ and a consumer representative for LLLNZ on the NZCOM.

Chrissy Fallow

- Principal Midwife of Lincoln Maternity Hospital.

Barbara Hamilton

- Postnatal Charge Midwife Manager - National Womens Auckland.

Aldwyn Black and Valene Rossiter

- Both postnatal Charge Midwives of Waikato's Women's Hospital.

Elizabeth Norton

- Co-ordinator of Professional Liaison for LLLNZ - Waikato.

Marie Bedford

- La Leche Leader - Waikato.

Sue Novak

- A neonatal nurse at Taranaki Base Hospital. ■

COMING EVENTS

International Confederation of Midwives Research Conference 1992

The organising committee has decided to cancel the Research Conference which was to have taken place at Koningshof Veldhoven in the Netherlands from 13-15th March 1992.

1991 Travelling Nurse Scholar

The 1991 NERF travelling scholar will be Ginette Rodger, from Edmonton, Canada. Ginette was the Executive Director of the Canadian Nurses' Association (from 1981-1989), but is at present in full time study at the University of Alberta completing her PhD in Nursing Studies.

The theme for this series of seminars is 'Empowering nurses in the midst of change'. To be held in Auckland, New Plymouth, Palmerston North, Napier, Wellington, Christchurch and Invercargill. There is a possibility of a short side trip to Whangarei.

Ginette's visit will start in Wellington on June 3rd and finish on June 29th.

NZCOM AGM

2nd August 1991

6.00 pm

Staff Resource Room, School of Nursing and Health Education, Wellington Polytechnic.

All welcome - if you wish to have billeted accommodation - contact Beryl Davies (04) 887-403.

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The International Board of Lactation Consultant Examiners, Inc
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for

Lactation Consultants
Examination Date - 22 July 1991
Examination site - Auckland or Hamilton

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Write to RACHEL WALKER,
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BOOK REVIEW

Birth Without Doctors

Jacqueline Vincent-Priya

Published by Earthscan Publications Ltd,
London, 1991

\$35.00

This book is based on Jacqueline's experiences over several years of travel throughout Malaysia, Thailand and Indonesia. It describes the lives of childbearing women, traditional birthing practices and the daily life patterns in various village communities.

Jacqueline questions and records traditional midwives (bidans) in their different villages and countries, trying to understand a society with totally different values. It is easy to find yourself being totally absorbed into the daily lives of the women, their social organisation, practices and beliefs surrounding childbearing.

This book provides a valuable insight into childbearing in different cultures and provides a wealth of information about Malaysian, Thai and Indonesian customs where 'barefoot' midwifery is the norm. It sports a wide selection of photographs and a full glossary of terms and their meanings that have been used.

I would recommend this book to all those interested in cultural aspects of childbearing, as it would be a valuable, worthwhile addition to any midwifery/childbirth book collection.

Helen Manoharan

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