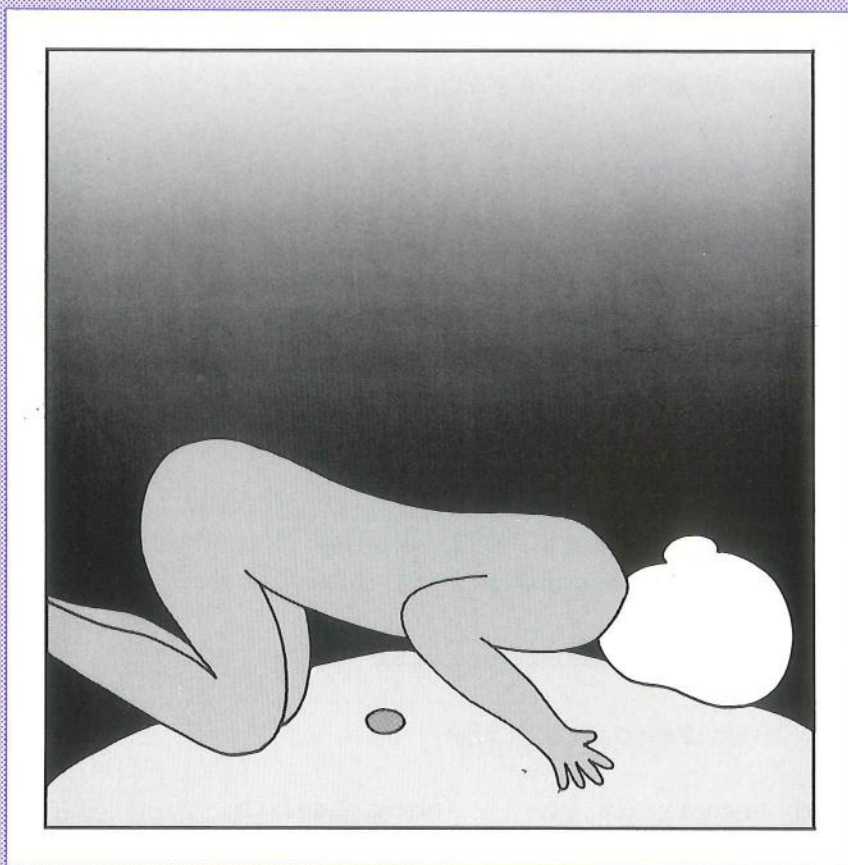




# JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, OCTOBER 1991







**NEW ZEALAND COLLEGE OF MIDWIVES  
CONFERENCE**

**14th 15th 16th AUGUST 1992  
WELLINGTON**

Research has shown that CONTINUITY of midwifery care results in a lower intervention rate and greater consumer satisfaction with birth experiences.

The 1990 Nurses Amendment Act acknowledges a woman's right to CHOOSE her care givers.

The CHALLENGE is developing a service that reflects:

Partnership with women.  
Knowledge that allows women real choice.  
Strength and unity within our profession.

**CALL FOR ABSTRACTS**

We welcome prospective participants to submit abstracts up to 250 words, for papers addressing the concepts of continuity, choice, and challenge in midwifery practice.

Typed abstracts and speaker profile required.

Closing date 28th February 1992.

Abstracts and enquiries to: Janet Lambie  
18 Fortification Road  
Wellington 6003  
New Zealand

Telephone 04 3887090  
Facsimile 04 3882887 IDD 64 4 3882887

# C O N T E N T S



ISSN 0114-7870  
No.5. October 1991

The New Zealand College of Midwives Journal is the official publication of the New Zealand College of Midwives. Single copies are \$4-00

**Editorial Collective**  
P.O. Box 249  
Palmerston North

Sue Fesché  
Sue Geard  
Helen Manoharan  
Heather Woodfield

**Special thanks to:**  
Liz Smythe (Auckland)

**National Advisor:**  
Karen Guilliland

**Published by:**  
The Dunmore Press  
P.O. Box 5115  
Palmerston North

**Cover design by:**  
Tauwira Taepa  
Helen Manoharan

**Contributions:**  
Original contributions such as reviews, forthcoming events, scholarly papers, research and articles of interest are welcomed. Artwork and photos will also be gratefully accepted. We can return originals. Articles should preferably be fewer than 2,000 words, and typed or neatly handwritten on one side of the paper. Articles must be signed by the author as being their own original work.

**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.

Letters and articles printed in this edition do not necessarily express the opinions of the Editorial Collective. They are the views and opinions of the authors.

Articles may be reprinted with the written permission of the Editorial Collective.

<b>Editorial</b>	<b>4</b>	Karen Guilliland
<b>Letters to the Editor</b>	<b>4</b>	
<b>A Consumer Viewpoint</b>	<b>5</b>	Judi Strid
<b>Midwifery Independence?</b>	<b>10</b>	Joan Donley
<b>Midwifery Education</b>	<b>11</b>	Jilleen Cole
<b>Midwifery Research Abstract</b>	<b>12</b>	Gillian E. Eyres
<b>Supporting the Supporters</b>	<b>15</b>	Bryony Hales
<b>Annual Report</b>	<b>17</b>	Karen Guilliland
<b>Antenatal Education - Why Childbirth Educators?</b>	<b>20</b>	Sharon Cole
<b>Coming Events</b>	<b>22</b>	
<b>Book Reviews</b>	<b>22</b>	



## EDITORIAL

### Budget Addendum



The Budget on the 30 July 1991 was a strong statement to New Zealand that this government believes it cannot sustain the Welfare State. The "user pays" principle has now been directed at both health and education sectors and many people are uncertain and apprehensive about the consequences.

The one area however where universal access has been retained is in maternity care. I believe the efforts of midwives and women's groups over the last few years to change the law and reinstate midwifery independence has raised politicians' awareness of the importance maternity care plays in the wellbeing of our society.

There is no hospital or outpatient charges for maternity clients and visits to the midwife or doctor remain free of charge to the woman under the Maternity Benefit. The Maternity Hospital Benefit of \$31.00 for each pregnant woman has been abolished

but this affected few people as it applied to private maternity care.

What will have a major affect on future maternity services however will be the devolution of the benefit from central government to regional health authorities. Managers are already voicing such anti-woman statements as "once I get control of that money you won't have all these choices". There is no recognition by many of these people that it is choice and control over one's own body and life processes that is a major factor in successful pregnancy and parenting. This new age of health managers and policy makers would appear to have little understanding of Primary Health and its social and environmental focus, which is why midwifery will continue to struggle for recognition as the most appropriate primary health care provider in normal pregnancy and childbirth.

We are now in an environment where competition and reward will dominate the health sector - this is not a climate which fosters consensus and negotiation or one which makes much allowance for individual differences or philosophies. Such a hostile environment highlights society's fear and ignorance of birth as a normal life process. Midwives and their profession

must be the stability which enables woman to believe in themselves and their ability to give birth.

Midwives in New Zealand over the last few years have demonstrated a remarkable increase in their own self esteem and belief in the importance of their work. Women with whom they have worked have been empowered to also build on their levels of confidence and this is the cycle we must promote and maintain. This belief in our ability to "affect the image women have of themselves, their abilities and worth" (Caroline Flint, Sensitive Midwifery, 1986), is the basis of our practice and over the next few years women will need all our strength and support if they are to conquer society's fear of childbirth.

Karen Guilliland

### Post Editorial

*The Editorial collective wishes to acknowledge the huge contribution Judy Hedwig made to the birth of this journal. A very time consuming effort with many frustrations. The editorial collective are the beneficiaries of that work.*

*Judy has resigned from the Journal so we wish her well in future ventures.*

## LETTERS TO THE EDITOR

### Spa Bath



Dear Editor,

In September 1989 a spa bath was fitted into the Delivery Suite at Wanganui Women's Unit. After two years of use, and many gallons of water later, we thought it was about time we evaluated the spa bath.

The use of warm water, i.e. bath/spa etc, as a form of comfort/pain relief for labouring women is in my opinion undervalued and very difficult to evaluate. One of the measurable ways to do this was, to see if the spa bath had affected the amount of narcotic analgesia used. The birth rate for Wanganui Women's Unit over the past three years has been fairly static at 960-1,000 births per year, with no change in the epidural anaesthetic rate.

From September 1988 - August 1990 we had a 5.6% reduction in the use of Pethidine.

From September 1990 - August 1991 we had a 15.5% reduction in the use of Pethidine.

As you can see, 'wow', in dollar terms - this is quite a saving. The effect of the use of the spa bath on women however, is subjective and very difficult to measure. I can only give you my opinion and my fellow Midwives' opinion that the spa bath has aided/comforted women in labour and has enabled them to make choices and stay in control of their birth experience.

Because of the great utilisation of the spa bath during labour, we of course, have had many deliveries in it with and without water! We now offer planned water births to selected clients. We hope to have a second spa bath fitted into our small unit in the near future.

Yours sincerely,

(L Young)

Charge Nurse on behalf of  
Wanganui/Taranaki Region of the New  
Zealand College of Midwives



Dear Editor,

I am interested in looking into the feasibility of collating NZ based midwifery research undertaken by NZ midwives, with the purpose of publishing an ongoing series of research books.

A precedent for this can be found in Robinson & Thomas (eds) (1991) Vol II, entitled *Midwives, Research and Childbirth*. London:

Chapman and Hall. This is the sec-

ond in an intended series which presents research of particular relevance to the care provided by midwives. In this book 12 contributors from throughout Great Britain have published their studies, based on the premise that midwives have the responsibility to ensure that their practice is research based.

It seems to me that those midwives with a special interest in research should have a forum to facilitate and promote 'research-mindedness' among colleagues, and that inclusion in an annual publication of NZ midwifery research would be something to aim for by midwifery researchers who want to disseminate their findings for the benefit of mothers and babies.

I would like to hear your opinions about such a project, and particularly from anyone who could assist in co-editing. I am sure it is possible to form an editorial/production unit from amongst NZ College of Midwives' members. It is expected that profits from such books would be donated to the NZ College of Midwives for a research fund available to assist midwife researchers.

My contact address is:

Gillian Eyres (White)  
Research Officer  
Dept of General Practice  
University of Auckland  
Tel: (09) 795-780 ext 6126



# A Consumer Viewpoint

Judi Strid

I WILL SPEAK OF SOME OF THE AREAS CONCERNING childbirth which I consider to be of particular concern to women at the present time and some of those which I have observed and learned from sharing experiences with women during my contact with the women's health movement over the past 15 years. Although there is need for a great deal of further change I wish to acknowledge the willingness of midwives as a group, to respect women's wishes and to respond to their needs. It is my belief that the effectiveness of a good midwife lies in her ability to learn from women, gaining an increase in insight and intuitive skills. So the optimum encounter is the two way one where each has something to share and something to learn. This provides the grounds for an empowering partnership.

However, we have taken some time to come this far to restore the rifts and to overcome the barriers which have often felt insurmountable.

## Initiating Some Action

Diminishing childbirth options for women and the increasing reliance on high tech equipment in NZ prompted an urgent need for mobilised action which was initiated by the founding of the Home Birth Association in 1978. This was a significant development, as together women and midwives increased community awareness and lobbied for changes that would curtail the steady decline in the existence of midwives.

It has also been the home birth movement that has made the most pressing challenges to the medical model approach to childbirth and it seems appropriate to look to birth at home as being the logical baseline on which to plan other maternity services. Significant factors that make birth

at home such a good baseline from which to start are:-

1. The woman has selected the place of birth and attendant herself
2. The woman has the opportunity to establish a rapport with her midwife and to make her needs well known
3. Emphasis is on nutrition and maintaining a healthy lifestyle
4. The birth is woman-centred
5. The birth takes place in familiar surroundings/the woman's space
6. The woman is with her family and others of her choosing
7. There is no haste or routine dictating the course of events
8. There is continuity of care from the antenatal period right through labour, the birth and including the post partum

In this situation the woman is in control. She cannot be so easily intimidated or taken advantage of when on her own turf where she is more likely to feel strong. The problem has been the limited numbers of midwives available to allow this option to be a possible choice for women in all areas. This has been compounded by the legal requirements and a general lack of confidence in the birth process.

In 1983 the Save The Midwives Association was formed by Auckland women to further highlight the plight of midwives and the subsequent affect on services for

women. This grew into a national network which has continued to disseminate information on midwifery training and the need to increase options for women through the provision of a greater pool of midwives.

## The Midwife as Advocate

As the advocate of the pregnant and birthing woman the midwife who acts as a resource rather than an authority can provide a much welcomed caring support without the threat of interference. The midwife who is not overwhelmed by fear of the birth process is a precious ally at a time when women are grappling with their own feelings of confusion about childbirth.

## Social Controls

As women within a patriarchal social structure we are all victims of conditioning, but in relatively recent times childbirth seems to have been particularly targeted for control by men. It is one of many aspects of women's lives that we are struggling to regain control over. The power struggle over who controls and who has responsibility for the birth remains unresolved. Midwifery is a feminist issue and women are increasingly demanding women to be their birth attendants, and they want to be in control of their own birth.

But for so many woman, being continually bombarded with overpowering propaganda from the medical profession has left them wondering about their own ability to give birth without the assistance of specialists and complex technological aids, many of which are still of an experimental nature, in so much that the long term effects of such practices are unknown.

Routine episiotomy clearly indicates a belief that the birth canal opening is not capable of stretching sufficiently to allow passage of the baby. Routine use of drugs such as oxytocin suggests that there is something lacking in women's bodies and the need for routine procedures such as rupturing membranes indicates that birth will not proceed without assistance. To support a lot of the intervention that women experience, you'd have to believe that women are of faulty design.

For many women, the only way to avoid the risk of interference and maintain control of their birth, is to opt for birth at home. This ensures them of control over who attends and how the birth takes place.

## NZCOM POSITION STATEMENT

### Infant Feeding

The NZCOM protects, promotes and supports breastfeeding.





They are also assured of continuity of care; a much valued maternity service component that seems sadly elusive for most women.

### Empowering and Affirming Women

Midwives can empower women by the expression of confidence in this normal process that women are so wonderfully equipped to deal with, and by acknowledging the uniqueness of each woman's experience. Obviously this will make a greater impact on restoring women's confidence where the midwife can provide sufficient continuity of care to establish a positive rapport and indeed develop a friendship and partnership with the woman she will share such intimate and precious moments with.

It is also important for women to know they have done well, and that even when there was an unexpected outcome, their efforts are acknowledged and given credit. Many women express feelings of guilt that maybe if they'd tried harder, or had done something different, the outcome would have been better. For many women it is important to be able to discuss the birth with someone who was with them at the time. This can be a critical part of the healing process for women who have felt traumatised by their birth experience.

### The Significance of Language

Language although arguably just a matter of semantics is also a powerful message sender. When those attending a birth, talk of delivering the baby, they actually may be usurping the woman's experience of giving birth and denying her a feeling of great momentous achievement. So she feels a failure. Women often describe birth as something that has been "done" to them. Describing the supporting role as delivering the woman or the baby can

detract from the women's own achievement and feeling of power for such a statement takes possession of the birth process. We need to give more thought to the language we use.

### The Trauma of Birth

The very real feeling of grief from being cheated and ripped off by the removal of control from women during birth is grossly underestimated and can linger on for many years. Women can recall very specific details about the birth of their babies many years after the event. Although experienced in different ways, the occasion of childbearing is a very deep, profound and intense one.

Shelia Kitzinger has described the similarity between the language used by rape survivors and women who have experienced traumatic birth. Both feel they have been robbed of control over their own body and are left torn and bleeding. They both suffer emotional damage, express feelings of having been tricked or cajoled and that they have been robbed of their sense of personal identity. Rape survivors say they were just a female body..... it could have been anyone, and women experiencing traumatic birth say they felt like just another case.

### Positive Preparation for Birth

More emphasis needs to be put on empowering women to be confident and assertive about expressing their needs. This is something that should be very much a part of the midwives' role. Empowering women to listen to their body and to be guided by it, rather than giving them instruction on how to deal with the various stages of labour and birth is of enormous value.

Birth is not a mechanised compartmentalized process that can be manipulated and predicted in this way. As a normal physiological process, pregnancy and birth has a natural flow of its own that is special to each woman.

Women can learn strategies to facilitate the release of tension and how to use support people effectively, but my feeling is that the main value of antenatal classes is the sharing and exchange between women. Women have amazing skills of sharing, networking and healing which help to strengthen the sense of knowing and wonder of it all. But, as Elizabeth Noble so aptly states, birth is not a shared reality - it is different for everyone. Each pregnancy also has its own unique rhythm and each woman will have different needs.

### Nutrition - The Issue That Really Counts

As well as assisting and enabling women to feel in control, another most significant

area that midwives can respond to in the antenatal period is in the provision of knowledge on nutrition and what constitutes a healthy diet. This promotes self help and most women are eager to learn what is best for them to eat during pregnancy and what they should avoid.

Many women express frustration at the confusing information and advice. Some encounter views that indicate such concern is showing an unhealthy preoccupation that is not to be encouraged and that they should just eat normally. This sort of comment can lead to a woman going through pregnancy on an inadequate diet which may affect the growth and health of her baby, as well as her own physical preparation for birthing and lactation.

Research has shown that poor nutrition can contribute to miscarriage, premature birth, low birthweight and even an affect on the child's developing brain if lack of sufficient nourishment persists into the later stages of pregnancy. It is essential that women are offered appropriate and accurate information to increase their awareness of the importance of nutrition and a balanced diet.

If pregnant women are in good health, feel good about themselves and have a strong support network, they are more likely to be able to assume responsibility for their birth and feel they have been in control of it.

### Drugs and Pain Relief

Women must be given accurate information in the antenatal period about ALL the risks associated with drugs administered during birth so they have been sufficiently well informed prior to the birth. It is not good enough to justify the provision of drugs because the woman is in pain and this must be fixed. Drugs are a dangerous alternative to the personal support and encouragement which will often best meet the women's need during the intensity of the labour.

If midwives are aware of staff shortages within the hospital, it is essential that women understand the implications of this before the birth so they have the option of seeking out an appropriate support person to take into hospital with them to ensure ongoing support.

More consideration needs to be given to other methods of pain relief where the woman feels it is a problem. For instance, there are women who never experienced a back rub for backache in labour, or thought to change position, or had access to the soothing affects of water. These are the kinds of alternatives that midwives can assist women to explore and check out before resorting to drug use. Alternatives such as acupressure and acupuncture should also be offered to the woman for consideration before drugs. There has been no



drug proven totally safe for use in pregnancy, or during labour and birth.

## Exposing the Myths

It is important to continue to expose the myths about women's bodies which include misinformation about birth; and the gaps and inaccuracy of medical knowledge. Medical literature about birth often varies considerably from what women experience. Fragmented care where the woman sees a multitude of health practitioners and care givers exposes her to the stress of varying and often conflicting information and advice.

## Midwifery and Obstetrics - Worlds Apart

Ann Oakley's observation that about 90% of obstetric procedures have no scientific validity to justify their use, particularly with regard to routine use, must serve to affirm midwives that their midwifery skills offer women the safest and most appropriate alternative care. It is of course in this argument that we have to be very clear about the distinction between midwifery and obstetrics, as problems inevitably arise when these two entirely different areas are viewed as one. It appears that some members of the medical profession who regard childbirth generally as a pathological event and potential catastrophe seem unable to make this distinction because they do not consider childbirth to be a normal natural process.

But the midwifery that best meets women's needs is not nursing and it is not obstetrics. Women-centered midwifery is a focus on a normal physiological process that can be achieved successfully by most women. True midwifery practice offers women caring and supportive expertise that exudes confidence in the woman's ability to give birth, along with the knowledge to recognise when assistance is required.

Midwifery is about normal pregnancy and normal birth - the situation for most women not subjected to interference and intervention. Obstetrics is about pathology, when something goes wrong and the process requires assistance. Obviously there still exists confusion and fear about what is within normal range, and it is here that the midwife as the expert on this aspect can provide the clarification and guidance that could protect women from wrongful diagnosis of abnormality.

Birth does not conform to time slots yet women are so often required to produce some form of action within specified and pre-determined time sequences. Midwives can protect women from this unnecessary stress (if all is well) by challenging their colleagues and associates who think this way, and by advocating a more relaxed attitude to the time that some women need

to give birth. I often wonder how many women who are "fixed up and sorted out" due to failure to progress, in fact just needed more time.

## Alternatives to Medical Intervention

Women are increasingly looking to midwives for guidance on alternatives to medical intervention. It is of enormous value often accompanied by relief for a woman to hear her midwife suggest alternatives to such interventions as episiotomy, ultrasound to diagnose pregnancy, amniocentesis for determining fetal lung maturity, or the use of drugs and membrane rupture to induce labour.

Women may feel uncomfortable about a suggested procedure but feel intimidated by the urging of her care givers for it to be carried out. Women say they fear some form of reprisal and that their care will be directly affected if they are not a good patient. This fear of punitive action is very strong in institutional settings where the woman as a patient is infantilised and encouraged to conform to a well established routine. Overt questioning is frowned upon and considered to indicate a morbid interest in the goings on. Sometimes women who question procedures are seen to be uncooperative and ungrateful by displaying what is seen as a distrust of medical expertise.

Medical technology should have no place at most births since the overwhelming majority are normal. Embarking on a technological cascade of intervention alters the experience of birth to a dehumanising and traumatic one. Surely it must also force the midwife into practising obstetric nursing. We need to be mindful of what should be avoided to allow the natural process of birth to unfold without interference.

## Mother and Baby as One

The view of regarding the fetus as a patient in its own right quite apart from the mother, is a very disturbing trend which is of great concern to women. This view allows obstetricians and paediatricians in particular to take on the role of the advocate of the fetus suggesting a conflict of interest between mother and fetus. As well as being inappropriate, it undermines and removes



the role of the mother as the natural advocate for her baby

Extremes of this situation are being enacted in the US where mothers are legally required to have caesarean sections because a specialist who has taken on the role of fetal advocate determines that this is best for the fetus, irrespective of the mother's views and feelings. Enforced caesareans have taken place without adequate evidence that this was an essential life-saving procedure; purely on the advice and authority of a specialist.

However, once the baby has been "safely" extracted, the specialists lost interest. Their job is done and now it is over to the mother, who has probably lost all confidence, is intimidated, feels angry, cheated and abused. She may also be confused and disorientated by her situation. Although the example given is an extreme one, the feelings expressed are experienced and described by women who feel they were denied control of their labour and birth. What sort of preparation for mothering and positive parenting is this?

In comparison, a women-centered approach views mother and fetus as one and that the needs of each meets the needs of the other. In this situation responsibility and decision making falls naturally to the mother.

## Informed Consent

Women can be coerced and manipulated into consenting to intervention because they are told it is in their best interests and in particular the best interests of the baby. Sometimes the woman is unaware that procedures have been initiated without any form of consultation at all - particularly procedures which are viewed as being of a routine nature and therefore carried out automatically.

Pregnant and birthing women are in a very vulnerable situation - often in a strange place, dealing with people they may not know or have had little contact with. They frequently describe feeling apprehensive and powerless, or reassure themselves with the thought that someone will look after them as they are in the hands of experts and those who know best. They may also not be wearing their own clothes, in a state of undress or possibly in an intimately embarrassing position. In this situation it is difficult to be assertive and hard to focus on the right questions to ask. This may be exacerbated by pressure to agree, due to the apparent haste in the need for action.

## Routine Procedures - A Risky Business

Medical procedures used purely for routine measures rather than an indicated need may contribute to changing a normal pregnancy/birth into a high risk area.



Physician created complications are noted for their tendency to set in motion increased rates of interference and their associated risk factors.

Midwives can ensure that women understand the situation and that they have received the appropriate information on which to make an informed decision. They can also check that women are informed as to who will be attending them (where applicable) and that women are aware of the status and level of experience of their care giver. Staff in teaching hospitals often assume that there is implied consent to participate in teaching purely on the basis of the woman being present in the hospital.

### Autonomy

The recent legislative change restoring autonomous practice to midwives brings the opportunity for much needed change in the provision of maternity services. Midwives are now able to offer care and support to women and their families unhindered by the need to reassure doctors that all is well, or without having to protect women from over anxious doctors and their often unnecessary technological equipment. We realise that this period of transition as women adjust to the change and try out the options, also applies to midwives who need time to explore how the change will work for them. Recognition of this process of transformation will hopefully help facilitate a feeling of mutual support, tolerance and trust between women and midwives.

This change means midwives can now work collaboratively with other health carers without having to hand women over. The issue of continuity is a priority one for women, even where pathology occurs and specialist consultation becomes necessary, the midwife should remain the primary caregiver. After all, the GP operates in this fashion, referring to a specialist for the purpose required whilst retaining the role as primary caregiver.

### Direct Entry

Many women feel drawn to midwifery following their own birthing experiences. Most have no wish to be nurses and usually have no interest in nursing at all. Some women do take up nursing as a means to get into midwifery, some have gone overseas to undertake direct entry training elsewhere, whereas others compromise by

becoming supporters at births, childbirth educators or lay midwives. This is both wasteful of an enthusiastic resource of mature committed potential midwives, and immensely frustrating to women who feel so passionately drawn to midwifery.

It is important that midwives overcome their differences about the present and past variations in training. Instead of focusing on pecking orders and on whose training is superior, there needs to be an acknowledgement of the number of women keen to train as midwives directly, without having to get there via nursing. Those of us working in this area would value input on how this is most effectively achieved rather than whether it is feasible or in sufficient demand. I believe these aspects have been resolved, and we now need to move on to activating DEM in a way that prepares student midwives for competent knowledgeable and confident practice.

Although I don't wish to speak on behalf of any other culture, it is important to note that Maori and Pacific Island women have expressed great interest in DEM. The present system disadvantages these women and certainly doesn't offer them an equitable opportunity to enter the midwifery profession so they can be available to attend women of their own culture.

### A Partnership with Consumers

Consumer support can be a powerful force but such a force is only mobilised by those who are prepared to serve the interests of the consumer rather than the profession concerned. Such a partnership offers a greater likelihood of mutual satisfaction and is more likely to generate willing feedback which helps to ensure the service is on target. Midwives must make it their business to listen to women. Women centred childbirth focuses on:

- The woman as the central figure
- Making available options that meet women's needs as determined by women
- Respecting and supporting women's choices
- Continuity of care
- A system of accountability that listens to and acknowledges women's experiences
- Involving women in partnership with the planning, alteration and implementation of all maternity services
- Making women feel special and of value

### Consumer Representation

The NZ College of Midwives made history with its inclusion of consumers at the executive level thus giving the official seal to its commitment to partnership between women and midwives.

I wish to strongly endorse the need for a consumer representative (in any situation) to be both a consumer/user of health services, and someone who is actively involved in community based work on health issues (in this case women's health) with links and connections to consumer groups. As a representative, they are more likely to be effective if they actually represent and reflect the views and perspectives of consumer/community groups. Their link to a community group/s also includes accountability to that group, which a lay representative working in isolation does not have.

It is inappropriate that those holding medical power, or operating as health professionals and service providers be consumer representatives.

A consumer representative is part of an established consumer health group who comes with a mandate from the community, having gone through a process of selection with the community for the position. The selection of a consumer representative needs to be initiated by the group to whom the representative is accountable. It is not appropriate that service providers or care givers make this choice.

Consumer participation will strengthen the position of women enabling them to be strong partners with midwives. In this position they can provide comment on areas that work well for women, and those that are in need of change, so the necessary action can together be effectively implemented.

### Women Need Midwives and Midwives Need Women

As Caroline Flint beautifully describes, the relationship between women and midwives. Midwives and women are intertwined, whatever affects women affects midwives and vice versa - we are interrelated and interwoven. When midwives are strong, women are able to labour safely and without interference. When midwives are weak, women's bodies are taken over and the birth process is interfered with often to the detriment of women.

Women and midwives must be strong. We need each other. ■

## NZCOM POSITION STATEMENT Staffing in Maternity Units

The NZCOM believes that women in maternity units should be cared for by midwives.



# The Healthcare Professional's guide to Lambskin Bedding for Babies...

BOWRON  
**Babycare**

Exhaustive laboratory and clinical tests have proven BABYCARE'S safety and benefits.

## THE FACTS:

☆ Babycare is used by over a million babies worldwide

**A Cambridge University child care and development group project on very low birthweight babies nursed on lambswool found:**

☆ Low birthweight babies made significant weight gains when nursed on lambskins

☆ Babies on lambskins settled more quickly and cried less

☆ Parent-Baby bonding was enhanced

**Babycare Lambskins-tested and passed:**

☆ United States Flammable Fabrics Act

☆ United States Federal Hazardous Substances Act requirements for rigid and pliable solids



PURE NEW WOOL

**Sanitized**



For your **FREE** 'Lambskin Bedding for Babies' information pack, phone Auckland 09 415-8390, Christchurch 03 3842-609 or post the coupon below.

**PLEASE** send me my **FREE** lambskin information pack to:

Name:.....

Address:.....

.....

.....

Please post coupon to:

Marketing Department  
G L Bowron & Co Ltd  
P O Box 19-544  
Christchurch

GLB036



# Midwifery Independence?



Photo: Jane Scotts

Joan Donley, O.B.E.

**T**HE PASSAGE OF THE NURSES AMENDMENT Act in August 1990, giving N.Z. midwives independence in practice as well as principle, was a great victory!

However, it didn't just "happen". It was part of a protracted struggle over many years as women resisted the medical model of childbirth, of the politicisation and eventual unity of midwives culminating in the formation of the College, of the reclamation of the training of midwives as independent practitioners, of learning lobbying skills, and finally of having a visionary Minister of Health who clearly understood the issues.

Now, a year down the track, how many midwives are actually practising independently? Most of the midwives known as "domiciliary midwives" (DMs) are doing so. Although this number is small and growing only slowly, they are recognised as a threat to obstetric control of childbirth. Therefore, a number of tactics are being used in an attempt to undermine midwifery independence. The medical/hospital interests have co-opted the basic tenets of independent midwifery e.g. "continuity of care" and "options" in childbirth, in order to market birthing centres and DOMINO births.

While DOMINO births are an acceptable middle ground which has to be traversed during this transition period while both women and midwives overcome their 50-year conditioning that childbirth is a medical crisis, it should be recognised as such, as an interim process, as a short term "option".

In the long term it furthers neither a woman's control over her birth experience, nor midwifery independence. Birth in hospital, regardless of how inconspicuous the controls appear to be, is still birth under medical control. As Joy Bickley

points out to nurses, they do not have total control over their work as they don't control resources. Neither do they have any control over government or Area Health Board policies which affect their workplace. (NZNJ, Aug 1991, p15)

Even in the short term some midwives are already finding there are "unintended consequences". In a Discussion Paper presented at NZCOMI meeting, 3 August, Marion Lovell & Carey Virtue point out that provision for either doctor or midwife, or both has resulted in:

1. An incentive for the provision of continued dual funding and escalating cost of childbirth;
2. Doctors continuing their role as "gatekeeper" and controlling access to alternative midwifery services (by directing women to midwives in their own practices);
3. Fragmentation, which the law was designed to reduce, continues to exist. By failing to provide a complete service, midwives are able to concentrate on the more lucrative aspects of midwifery (laboured birth). The responsibility for the care remains with the doctor, thus retaining the obstetric approach to childbirth.

"If we, as a professional group, want to maintain our credibility and demonstrate that midwives make a difference, then we must promote midwifery that reduces intervention, sees birth as a normal event and is cost effective." They recommend that there should be a recognition of the purpose of the law change; and that future discussions on funding should recognise the differences between midwife only care and dual funded care.

Any legislation which changes the status

quo will result in a vigorous reaction from those whose power and income is threatened - and this is no exception! The present reaction is two-pronged: Minister of Health, Simon Upton is being bombarded with stories of midwives' incompetence, while DOMINO births are being promoted as the "safe option". (In the 1930s women were lured into having babies in hospital in the interests of "safety" and on the promise of "painless childbirth" e.g. "twilight sleep"; today it's "safe options" and epidurals).

These issues are not new. A 1980 Auckland Homebirth Newsletter comments on Bonham's suggestion that if DMs were under the supervision of Hospital Boards (rather than the Department of Health), they would not only be better paid, they would also be able to work in the birthing centres (BCs) then being mooted. The Newsletter mentions how the independent Parents Centre's physiotherapists were colonised by being "sucked into the system" and that in USA where BCs proliferated, the women selected for these would have been eligible for home birth, yet there was 20-25% transfer rate with a 9% c/section rate after transfer. The comment was that 'BCs attached to big hospitals are subject to the pressures and procedures of the hospitals (all the gear is there, after all, monitors, drugs, etc) and are not a "home away from home".'

There are basically only two "options": birth in hospital which is birth under medical control regardless of how covert, OR birth at home where women are in control supported by midwives who are independent. In fact, the only place where midwives are independent is in the community or in a free-standing midwifery B.C.



# Midwifery Education without Nursing as Prerequisite

Jilleen Cole

**F**OR A NUMBER OF YEARS, WHICH INCLUDED the passing of the Nurses Act in 1977 entry to midwifery without nursing as a prerequisite has not been possible. Midwifery has been viewed as an extension of nursing, and for many nurses the additional qualification was needed to advance their career. Since the early 1970s, until recently, the number of midwives registering in New Zealand had diminished. Many of the midwives presently in practice have been educated and registered outside New Zealand.

Since early in the 1980s there has been a steadily growing opposition by women to the medicalisation of childbirth in New Zealand which has followed trends in the United Kingdom and the United States of America. There has also been a growing demand for greater choice in childbirth related health care. Women's choice is often a higher profile midwifery care. As well as the demand for a greater midwifery focus, there has been an increasing number of women seeking an education to practice midwifery which does not have nursing as a prerequisite. Although attempts have been made to address the problem of providing an adequate education and meeting service needs, all education to prepare midwives has been based upon the premise that midwifery is a specialism of nursing.

During the past few years, midwives recognising the danger of losing their separate midwifery identity, have become more cohesive as a body, formed a professional organisation and have become increasingly vocal in their assertion that midwifery and nursing are separate professions. Midwifery is not a specialism of nursing. Midwifery and nursing are different and should be viewed as separate professions. Midwifery shares some common knowledge and skills with nursing as it does with other health related





professions, but it has its own quite distinct body of knowledge and research which should determine its status as a separate profession. This concept should not cause conflict between nursing and midwifery. As health related professions nursing and midwifery should be able to progress side by side, with interaction, and sharing as appropriate but recognising and respecting both the differences and the uniqueness of each. This recognition and respect is vitally important.

It is from the belief that midwifery and nursing are different professions that direct entry to midwifery has evolved. Midwifery education needs to be broadly based, women centred and wellness orientated. Midwifery education without nursing as a prerequisite as it is today is an entirely new concept for New Zealand. It is not the old revisited and it does not arise out of the nursing profession. It is a direct response to women's needs.

It must develop out of consultation and collaboration with all those involved - educators, students, women, the tangata whenua and should acknowledge and practice the principles of biculturalism inherent in te tiriti o Waitangi. The very fragmented path which was formerly followed by those who became midwives without first becoming nurses may have met the need of 20 or 30 years ago but would certainly not meet today's need for high quality education for practice.

For midwifery education to meet the needs of women, of midwifery students and the midwifery profession, there needs to be the "vision" which Professor Norma Chick writes of in her paper presented at the Nursing and Midwifery Forum in Auckland, April 1991. There needs to be a real commitment by the providers of midwifery education to the development of midwifery as a separate profession and without a nursing base. Midwifery may develop side by side with nursing but not within it. Nurses may choose to become educated as midwives and their shared knowledge will

assist the transition to their new profession. However, it could be that some aspects of their nursing education may hinder the development of their midwifery knowledge. Teachers of midwifery students must have a fundamental belief in what they are doing and may need to assist teachers of shared resources, to rethink - to look at their attitudes and beliefs about midwifery and nursing. Midwifery students need to learn with teachers who share the "vision". Teachers who facilitate learning for both midwives and nurses need to respect the differences between the professions and acknowledge the knowledge, skills and attitudes which are neither one nor the other but belong to both as caring health professionals.

Midwives need education as well as practice. They need the opportunity to develop as creative, thinking individuals and to learn on all levels - practical, conceptual, emotional, imaginal and spiritual with all being equally important. Their education needs to be firmly rooted in research and students enabled to become self directed, self determining professionals. Education should promote creativity and innovation and should enable the beginning practitioner to practice with knowledge, intuition and skill but without fear.

Midwifery practice needs to affirm and celebrate the individuality of *all* women. It must meet the needs of all the women of New Zealand and must empower and

affirm their ability to give birth happily and free from fear. Women who have such care will become strong and secure and be an influential force within the health system and society - a bicultural society.

Sometimes birthing is abnormally difficult - sometimes there is underlying illness. Medical and obstetric care will always be necessary for some women and should be freely available when needed. Referral to appropriate services is an integral part of a midwife's role. To meet all these needs there must be collaboration, co-operation, real sharing and trust between education institutions, service providers and consumers. The difficulties in obtaining appropriate practice learning in a system where students are supernumerary are acknowledged. Practice learning requirements need to be examined in relation to the needs rather than in relation to what seems to be available. There are many ways of being creative and innovative in providing a high quality learning environment and these should be explored together.

It would seem that we have a materialistic entrepreneurial, often fear driven climate in many of the education institutions and in parts of the health sector. If caring is one of the tenets of both midwifery and nursing practice, the education of their professional practitioners should reflect that caring. It should be neither elitist nor competitive and should be provided in a form which is a response to consumer need - both Maori and Pakeha. It should be situated in areas which demonstrate that need and the caring should be evident in all professional relationships. We should strive together to meet the needs of our communities in the most appropriate way, sharing our knowledge and resources, the power and the rewards, in an atmosphere of friendship and love.

"There is one thing stronger than all the armies of the world and that is an idea whose time has come".

Victor Hugo.



## NZCOM POSITION STATEMENT Ultrasound

Recognising that pregnancy and childbirth are part of a woman's normal life experience, the NZCOM rejects the routine use of ultrasound technology including cardiotochography.



# Towards Autonomy- An Examination of Midwifery Education in New Zealand

Gillian E. Eyres (White)

**A** THESIS SUBMITTED IN PARTIAL FULFILMENT of the requirement for the degree of Master of Arts in Education. University of Auckland. 1990

## Abstract

An examination was conducted, over the period of one academic year to obtain information about student midwife's beliefs, expectations, and aspirations, concerning becoming autonomous, independent, midwife practitioners. Concurrently, an exploration was made of the five midwifery curricula available in New Zealand (1990), and discussions were held with the various tutors responsible for each course. The study was both quantitative and qualitative. The sample was not randomly selected, the target population being all full-time student midwives enrolled in a midwifery course in New Zealand in 1990.

The Nurses' Amendment Act was passed in August 1990, midway through this study. The Act enabled either a midwife or a medical practitioner to take responsibility for the care of a woman throughout pregnancy, childbirth and the postnatal period. During its passage through the New Zealand House of Representatives there were ninety-nine submissions, many supporting the intent of the Act, albeit with reservations. Those reservations were addressed in this thesis.

The results of this study showed that, in anticipation of the Act, there was a consensus of opinion among student midwives that midwives should be independent practitioners with the primary focus being on mothers and babies. However, one third felt unsure about their own capabilities to practise independently upon graduation. There was also some disagreement regarding what were consid-

ered to be specific midwifery functions. Although the students were not clear about the issue of whether midwifery should be a separate profession from nursing, a strong professional midwifery identity had developed by the end of the student's respective courses. The main concern of both students and tutors was related to gaining quality clinical experience.

Each of the five midwifery curricula compared favourably to each other and were designed for, and capable of, producing midwives prepared for independent practice.

It was concluded that there was a need for a conceptual model of midwifery to be developed, and the study resulted in a set of recommendations for the future education and practise of midwifery in New Zealand. ■



*"Gillian is a Registered Direct Entry Midwife, holds the Midwifery Tutor's Diploma, a Bachelor of Education, Master of Arts (1st class Hons), Diploma in Social Sciences (Psychology), and Certificate in Adult Education. Academic qualifications have all been gained while working fulltime either in clinical practice (including domiciliary midwifery), or as a midwifery tutor. Gillian would like to convey the thought that Direct Entry midwives CAN and DO contribute effectively to the profession of midwifery and the care of mothers and babies."*

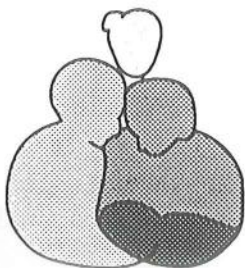


# Nurture III Electric Breast Pump



*"The Nurture III Breast Pump is by far the best small pump available today."*  
-Kathleen Huggins, R.N., M.S., author of THE NURSING MOTHER'S COMPANION

- The safe and effective method for expressing mothers' milk
- Adjustable suction control
- Capable of double pumping
- Compact, portable design
- Built to be reliable and economical
- One-year guarantee
- Electrical operation makes pumping easier and faster than manual pumps or hand expression
- Ideal for working mothers



## *Breastfeeding Naturally*

Kath Ryan  
Lactation Consultant  
(03) 465-7365

"Bimblmie" • 8 Scotia Street  
Waikouaiti • Otago  
New Zealand



# Supporting the Supporters

Bryony Hales

**T**HERE HAS BEEN MUCH CHANGE IN THE practice of midwifery in recent times. A strong motivation for this has come from listening to the needs and wishes of women. We have heard that women are wanting to choose their companions to be with them through the birth, whether they be the baby's father, her mother, a close woman friend, or a group of family and friends.

Jean talks about the importance of having this choice in birth: "I am really, really, really pleased you are here, Gareth. It makes all the difference in the world, you holding me - you have no idea" and later, "It sounds corny to go on about it but to have that person who you know best in the world to hang on to, to listen to, to remind you of practical things". (McKenna, 1988, p126, 129).

In her introduction to *Birth Reborn*, Sheila Kitzinger writes: "Fathers are now encouraged to share in childbirth, but our society has made a mockery of the loving, passionate participation a man can feel when he is fully involved in the drama of birth, not just a 'vogueur' at delivery. The person a woman has chosen to be with her may be warmly welcomed only as long as he or she stays out of the way, does not question routine procedures, and goes out whenever asked to. My five daughters were born at home, and I still cannot help being a little surprised when women, delighted with their experience in hospital birth rooms, say "...and they allowed me to...", "they let my husband..." (Odent 1984, pxvii).

A Midwife's actions and behaviour can be crucial in enabling a woman to choose, by welcoming her supporters, and ensuring that they can share positively in the birth process.

Now let us look beyond the experience of birth itself. Who can say how important this welcome could be, in promoting the bonding of a baby with both her parents, her future family and friends? Studies have shown that a child's presence at her sibling's birth can decrease future rivalry, reduce resentment towards the mother and the new baby, and reduce fears and misconception about birth. (Olds, London and Ladewig, 1980). Many adults, too, carry fears and misconceptions. A warm positive birth experience would promote belief in birth as a natural part of life's process.

The following discussion outlines the steps a midwife can take to support the supporters, during a normal pregnancy and birth.

## Process of Support

Building support for the supporters is a process which mirrors that of building the relationship with birthing woman - antenatally, during the labour and birth and post-natally. It also follows the pattern of assessment, setting goals, carrying out planned activities and evaluating achievement.

## Antenatal - assess

The first questions are: Who does the woman want to be at her labour and birth, and what roles does she want this person to play? While, for example, she may want her mother there too as a guiding, reassuring supporter, she may want more intimate, emotional support from her partner, and may have particular requests such as, that the father cut the umbilical cord, or be able to bath the baby immediately follow-

ing the birth. These questions can be clarified by discussing a birth plan with the woman and her supporters. Key wishes can be identified, and hoped for wishes that are not so important, can be changed if the birth does not go as planned.

Assessment also includes finding out about her supporters' previous experience of birth, and how much knowledge they have, or will need, to play a role.

In particular, children who are to be present may need their own special support person, someone whose sole responsibility is attending to their needs. (Olds *et al* 1980). It is important that this person be known to the child(ren), be flexible, comfortable with and knowledgeable about the birth process so they can explain what is happening as the child(ren) require.

## Educate

Following the assessment of the supporters' knowledge, antenatal education is often carried out in classes, covering the progress through pregnancy, birth and the changes occurring with new parenthood.

If supporters have had previous negative birth experiences, these can hinder the relationship between them and the woman, and affect her expectations. Fears, contradictory experiences and expectations held by supporters may be best discussed separately with the midwife, in order not to undermine the woman's confidence, and enable such fears to be openly and honestly voiced.

Similarly, children may need a separate session shortly before the labour, explaining, for example, that labour is hard work, and that their mother will need to concentrate, that she may make unusual sounds, that labour is usually painful, but that women's bodies are made in a special way to cope with birth, and that birth will be a "wet" time. (Old's *et al*, 1980).

## During the birth - assess

Moore (1983) provides one framework for assessing the interaction between a labouring woman and her birth supporters. A first question is whether the number of people present is tiring to the woman or reducing her ability to cope. Observations that Moore suggests a midwife makes are: the amount of physical contact; the amount and quality of verbal interaction; and the effectiveness of this support.

A woman's reaction during labour to contact with others will vary. Claire, quoted in *Birth* comments: "He annoyed me at first because he tried to chat and I didn't want to talk. I was thinking of sending him out. When he was rubbing my back he was half killing me, but when he was just sitting there it was fine. I was glad he was there, but I didn't want him hassling me". (McKenna 1988 p64).





Odent has observed that "It is the intuitive sense that enables a midwife to "feel out" whether people present during labour are playing positive or negative roles... I think of one incident, when a woman couldn't seem to get beyond eight centimetres' dilation, when her husband left the room for a short time to rest, their baby was born. Though this woman had told us she wanted her husband present, her body was saying the reverse... Men sometimes find it hard to observe, accept, and understand a woman's instinctive behaviour during childbirth. Instead, they often try to keep her from slipping out of a rational, self-controlled state". (1984, p43).

The midwife's role is to assess the needs of the woman in labour, which may be expressed in many different ways. At the same time, although the primary focus remains with the woman, a midwife who is truly supporting her choice will also assess the needs of her supporter. There may simply be a need for explanation, encouragement and direction, or perhaps the midwife may have to intercede on behalf of the woman.

### Explain

The actual experience of labour and birth can differ almost unrecognisably from the norm described to a woman and her support crew. While the principle focus for explanation and reassurance must be the woman herself, her supporters will be listening too. Their understanding is particularly important if any of them are to be involved in decision making about the birth. Clear explanations will help supporters know where to be and what to do, especially in cases of intervention; for example, the insertion of epidural anaesthesia.

### Allow, Encourage, Provide

If the midwife assesses that the support being given is effective, then her role is simply to provide the environment for that support to take place in.

This may be just allowing<sup>1</sup> labour and the interactions to go ahead with as little involvement from her as is necessary, or perhaps giving verbal encouragement to everyone.

Accounts of labour reveal the importance of these interactions between a woman and her companion, which range from quiet eye contact, or light touch, to inventive and fun activities. As John tells in *Birth* (McKenna 1988 p 15) "I suddenly remembered that we had this mineral water spray which would be quite cooling, as well as using the sponge. It's quite fun to

have the chance to spray someone in the face and have them enjoy it".

At times, both woman and supporters may feel lost about further ways to last through the labour or relieve pain, or perhaps intervention may be needed to help labour progress. At this part the midwife may have to suggest, for example, a change in position, a walk, a bath or shower, or more intimate activity such as nipple stimulation. Privacy may be one of the most important things a midwife can provide!

While the midwife and the supporters are busy attending to the woman in labour, the wellbeing of the support crew can be overlooked. It may need the midwife to suggest and allow the others present to take a break, have a drink, or have a stretch.

### Intercede

When the interaction is assessed to be unhelpful to the woman, the midwife will have to intercede on the woman's behalf. This may be as little as encouraging the supporters to use positive expressions towards the woman, or may require asking someone to leave until the situation can be improved.

During the labour, the midwife acts as a role model for the support team, focusing her energy on the woman and the birth, without distracting conversation or activities.

Perhaps one difficult aspect for supporters is knowing when to be quiet. The midwife can direct them into less active, gentle support measures such as contact touch, or breathing through contractions with the woman, or encourage someone to take a break if their interaction is proving to be a distraction.

### Reassure

Along with explanations comes reassurance. The support team will need to be told, on the basis of the midwife's observation, that they are doing a good job, and that the midwife is noting their progress as well, just as the labouring woman needs positive expressions of encouragement so too will her companion. Positive reassurance, positive suggestions and directions will help build their confidence and useful participation.

### After the birth - acknowledge

When the immediacy of the birth is over and the mother and the baby settled, perhaps days, perhaps only hours later, time can be made to talk over the birth, to reaffirm the experience, and to answer

questions. Feelings of guilt, or fear, that may have arisen if everything didn't go according to plan, can be discussed.

The midwife has been working as a member of a team - now is the time to acknowledge the others' role in the birth, whether this is a general thank you, or specific comments about particular moments.

Feedback from the support crew will help the midwife plan her care for future births, and hopefully provide her with positive response to her skills.

### Supporting the Supporters

In building a relationship with a woman's chosen birth companions and enabling those supporters to become truly involved in the labour and birth, a midwife is achieving several goals.

She is giving effect to a woman's choice of birth plan. She is providing an environment in which a wider group of people can experience birth in a positive, confident, non-fearful way. She is hopefully giving impetus to a set of warm, supportive relationships for the mother and the new baby.

All these are part of a midwife's responsibility, where she maintains a focus towards the birthing woman. As Caroline Flint explains (1986) "The partner and the midwife are really there for the same thing - to be with the woman during her childbirth and to support and cherish her. Perhaps the midwife also needs to cherish the partner as well". ■

1. People receiving care from a health professional often look to that care giver for guidelines on what is appropriate and permissible behaviour. I use the word 'allow' deliberately, not to imply that the midwife retains control, but to mean 'create space for' and 'give permission/support for'.

### Bibliography

- Flint, C. *Sensitive Midwifery* London. Heinemann 1986.
- Kitzinger S. *Pregnancy and Childbirth* Sydney. Doubleday 1982.
- McKenna, N D *Birth* London. Bloomsbury 1988.
- Moore, M *Realities in Childbearing* Philadelphia W B Saunders Company 1983
- Odent, M *Birth Reborn* (British ed) London. Souvenir Press, 1984.
- Olds, S London, M and Ladewig P *Maternal - New born Nursing (2nd ed)* California. Addison Wesley Publishing Co 1980.



# New Zealand College of Midwives (INC) Annual Report

Karen Guilliland

---

THE YEAR STARTED IN DUNEDIN WITH THE National Conference and Keynote Speaker, Marsden Wagner. The theme, "Women in Partnership", and the friendly, relaxed atmosphere ensured a very successful conference. Dr Wagner's support of Midwifery, as the profession internationally recognised as the experts on normal pregnancy and birth, came at a very politically expedient time. His lecture tour preceding conference had been enthusiastically received by women and midwives and well covered by the media. His statements on New Zealand's high intervention rates still reverberate around the obstetric world and debate is ongoing. We hope this increased awareness of the need for accountability for one's practice has positive repercussions and New Zealand women can look forward to safer and more satisfying birth outcomes as a result.

Helen Clark, then Minister of Health, raised Midwives to their feet when she promised independence and support for Direct Entry Midwifery. She was given a standing ovation and made an Honorary Member of the College.

Sure to her word, two days later on the 22nd August, the Nurses Amendment bill passed through Parliament and became law. It was one of the few Acts passed where both parties were supportive and positive about the appropriateness of the legislation reinstating Midwifery Independence from the medical profession. The work of hundreds of women/midwives who were instrumental in bringing this to the legislative chamber must be acknowledged and recorded. It was a remarkable and inspiring effort which is recognised throughout the Midwifery world as a coup for women's power!

The rest of this year's work has mostly been dealing with implications of the Amendment Act.

The Department of Health Workforce Development Unit funded our proposal for an Educator to co-ordinate workshops, lectures and seminars on the changes and implications of the Act. I was employed by the College in February as the Educator and have spent the last five months travelling around New Zealand speaking to Midwives, Area Health Boards, GPs, obstetricians, nurses and consumers about the role of the midwife. It has been a character building experience! We have a lot of work to do before there is real understanding about our philosophy and practice amongst non midwives. However the overwhelming support and thirst for knowledge on the part of midwives has been a highlight and bodes very well for our future.

## Contracts

As with any new innovation there have been a number of problems. Midwives'



ability to gain contracts with Area Health Boards giving them access to hospital beds and Board facilities have varied throughout New Zealand. The main problem can be clearly isolated as the inability of those in charge of obstetric/maternity services to believe that a midwife can practice in her own right. Whatever other barriers were put up all were initiated by this disbelief. Disappointedly some of those people are nurse managers and I wonder when this oppressive group behaviour will dissipate. The same Boards who had for years willingly and without qualification given contracts to doctors were suddenly voicing concern for safety, the inference being that medicine could be taken on trust but not midwifery.

Other Boards however, took the law change as a golden opportunity to implement a quality assurance component to their contracts for all practitioners. These Boards impress with their consultative and educative approach. At the time of writing and one year after the law change most midwives throughout New Zealand who require a contract are able to obtain one. The major exception is Auckland (NZ's largest Board) where no midwife has been granted a contract despite months of negotiations. Resistance and hostility to Midwifery autonomy has distressed both Midwives and the women in their care. Canterbury (the biggest employer in the South Island) has also been slow in granting contracts. Consequently many choosing midwifery care have been denied their choice of practitioner. There are now approximately 108 midwives with contracts throughout New Zealand and this number is increasing.

There are many more practising in the community however who do not require a contract, bringing the number of independent practitioners to approximately 200.

### Maternity Benefits

Benefits are the second most problematical area since the Act.

It would be fair to say that money, and the fact that midwives are receiving it on an equal basis with doctors, has been the biggest bone of contention between mater-

nity care providers. Rumours and conjecture about midwives "blowing out" the Maternity Benefit have been rife and without foundation. We have endeavoured to encourage the Department of Health to facilitate tripartite discussion between itself, the College and the New Zealand Medical Association in order to resolve the situation, but this has not yet happened.

Meanwhile the College is distributing a questionnaire on claiming practices by midwives and collating claims to provide an information base for future negotiations. We have contracted the Nurses Union to do much of the legal work necessary. Trish Mullins has been invaluable with her legal and industrial acumen.

### Midwifery Education

It has been a slow process to establish Direct Entry Midwifery courses but we are hopeful that they will be a reality for 1992. There has been no formal communication from the Department of Health over Direct Entry to either Nursing Council or Polytechnics and as a consequence there are still uncertainties about the number of courses to be funded and where they will be sited. Educators involved support the College stance that there should be no stipulation on numbers. If Polytechnics can fund a course from within existing resources they should be able to do so e.g. reduced numbers in another full-time course.

Five Polytechnics submitted curriculums to the Nursing Council for approval, four diploma and one degree programme. Midwives need to debate further their support or otherwise for the type of course they wish midwifery students to take. However, Polytechnics are autonomous and decide their own directions, so we may have little input into the final decision.

Every curriculum also needs the approval of the New Zealand Qualifications Authority, who also need not necessarily agree with the direction we wish to take in midwifery education. Women continue to apply and enquire about Direct Entry programmes reinforcing the need for such a course despite resistance still from some

nurses in management.

Refresher courses are now well established at most centres. Midwives report very favourably over the availability of courses and workshops and hundreds of midwives have attended throughout New Zealand.



### Publications

The Breastfeeding Handbook for midwives has undergone extensive consultation over the last months and Handbook Committee (Marcia Annandale, Lynda Bailey, Gail Warwick and Chrissy Fellows) plan to have it ready for publication very soon. There has been a very favourable response from midwives and community groups involved in breastfeeding, which endorses the incredible research and commitment given to the project by the Committee. Our congratulations and gratitude go to the team.

The Journal, under the hard working leadership of Helen Manoharangoes from strength to strength. She now has a Palmerston North Editorial Collective to help her - Sue Fesché, Heather Woodfield, and Sue Geard. To take on such a commitment as the Journal requires extreme dedication on the part of these women and that it is all done on a voluntary basis shows their devotion to midwifery and its future.

The newsletter collated by Beryl Davies, another volunteer midwife whose "spare" time is consumed by midwifery matters, is sent to every member approximately six weekly. It keeps us in touch and updated on national happenings. It is distributed by the Board of Management - spare them a thought every six weeks as they fold and label 1,100 newsletters!

### International Events

Twelve midwives attended the International Confederation of Midwives Conference in Japan last October. New Zealand was well represented as an entity in Midwifery circles. Joan Donley was a plenary session speaker, a great honour for us and as she spoke to the 6,000 strong conference there were some very proud New Zealand midwives listening to her.

## NZCOM POSITION STATEMENT

### Immunization

The NZCOM believes that immunization is inappropriate in the first six weeks of a baby's life unless specific risk factors are present.



Adele Birkbeck, a well known Auckland midwife, presented her breastfeeding paper at the session I was moderating. Both of us were a little nervous but Adele did well and I managed to co-ordinate the different languages and introductions without mishaps! Presenting my paper to the 1,000 Midwives in the previous session however was extremely nerve wracking. It is such a privilege to be among such long admired midwives I wanted to make sure they all understood just how historic were the midwives achievements in New Zealand.

We were one of eight countries chosen from conference by the "Japanese Journal for Midwives" to be interviewed on our country's midwifery status. I see that as recognition of New Zealand as having been a model for change that is worthy of recording. A major issue for New Zealand at the pre conference congress was the status of our consumer members of the College. Following discussions, Jacqui Anderson and myself, as delegates, proposed that New Zealand present a paper at the next conference on consumer membership. My grateful thanks to the College for the opportunity to attend.

### Funding

Workforce development funding was granted to the College also for the production of a leaflet encouraging a bicultural midwifery profession. As a result the College has invited the New Zealand Council of Maori Nurses to nominate a representative and Whanau to the National Committee.

We are delighted to welcome Mina Timu Timu, a midwife from New Plymouth as their representative. Mina has offered to co-ordinate the brochure to encourage Maori women to become midwives.

Further funding was granted for a research proposal to develop midwifery services and education. Natalie Allen's proposal was accepted and she is presently working on a questionnaire.

### Nursing Council

As the Ministerial Midwife appointee to Council, I have attended numerous meetings in this capacity. I am also on the Education Advisory Committee and so have been very involved in the Direct Entry Curriculums. It has been a highly educative and interesting involvement but it is vital that we have more representation. I am presently the only midwife on Council. The Council is aware of this and has been very supportive and consulted the College on most matters pertaining to midwifery.

Marion Lovell, Christine Smith, Chris Hannah, Beryl Davies, Jeanie Douche, Maureen Laws, Liz Smythe and Sally Pairman have all acted on a consultancy basis on a variety of issues pertaining to registration, education and exam setting. A major undertaking for me was the rewriting of the Standards for Midwifery Registration recently passed by Council.

The Board of Management and myself have taken advantage of the trips to Wellington for Nursing Council meetings to meet in the evenings. I would like to thank and acknowledge the hard work of these women who need to meet every week in order to deal with the daily workings of the College. They took over at a time of great change and believe me when everything is new, it creates great stress on those expected to organise the changes. We are a different organisation than when we started and have ahead of us a number of decisions relating to our functioning. The Board of Management has carried us through to this point and I thank them on your behalf.

### Summary

This annual report has been my most difficult to write because it reflects a period of great change for midwives. In previous years, our energies have been directed towards achieving recognition as a profession in our own right. We joined forces with the consumer and worked together consistently for years in order to change the law reinstating our professional role.

This achieved, regions now grapple with the changes the law has brought, midwives are in danger of losing the unity and cohesiveness that won their independence for them.

Real life intrudes on most midwives as they try to fit in all the demands that this period of massive change brings. The unifying philosophy of "a midwife is a midwife" and a "a midwife is where a baby is born" is tested as once again individual rather than collective needs are highlighted in the change to become independent.

It is important that the terms independent, domino, domiciliary, hospital, district and community when attached to the word midwife do not become a way of dividing midwives from each other.

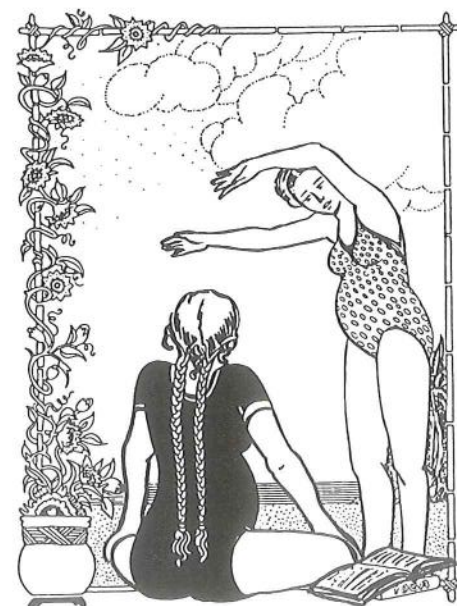
We must recognise and acknowledge that this is a time of transition from one style of practice to another and that there will be differences of opinion on how we deal with change. If we continue to accept that wherever a woman chooses to have her baby she is also entitled to the midwifery care of her choosing we must find ways to accommodate those choices.

In a time where there is marked hostility from the medical profession towards midwifery it is vital that we keep our vision and philosophy alive. It is my belief that if we found the effort to change the law daunting, it fades to nothing when faced with the onslaught of a very threatened medical profession. It must be noted however that many individual medical practitioners have shown their support for women's choices and are working with midwives in a variety of ways throughout New Zealand.

Many general practitioners and Area Health Boards have adapted to the changes positively and women in those areas have benefited from a comprehensive maternity service. However, others have not and there is evidence that real barriers to women's choices in childbirth exist in a number of regions. The method of obstruction is to *attack* the integrity of the midwifery profession. In a medicalised society like New Zealand it is not difficult to reactivate the fear of childbirth that dominated the last two decades. We must be strong and dedicated to our philosophy if women are to be able to continue their support. We can only do this if we support each other.

The next year should not only be a reflection on what we have achieved but a time for planning our future direction. We will have to adopt our "old" patterns and structures to facilitate unity and consultation. I believe we need to review the operational structure of the College along with its role and responsibilities in order to respond effectively to the challenges we now face.

1990 was the year of the midwife - let's look forward to our decade.





# Antenatal Education- Why childbirth Educators?

Sharon Cole

IN THE LAST JOURNAL, ANDREA GILKISON posed the question 'Antenatal Education - Whose Purposes Does It Serve?' While lamenting the erosion of another traditional area of midwifery practice, Gilkison illustrates how midwives have abrogated that responsibility by perpetuating institutional control over women, through the antenatal education that is offered in the hospital setting.

This admission by Gilkison is precisely the reason that a Parents Centres New Zealand's, Childbirth Educators' course has emerged. Kitzinger (1977:3) explains that antenatal teaching is a new profession, demanding new and varied skills and while a midwife's knowledge of body mechanics and her experience of conducting labours are important, they are not sufficient to make a good antenatal teacher.

The midwife aspiring to be a teacher needs further study and practice, and needs a much greater knowledge of the psychological and social factors that are intertwined with the physiological factors in the experience of childbearing. This greater valuing of the social and psychological factors is unlikely to occur within the hospital setting where physiological factors predominate. This is because power and prestige in medicine are linked to the scientific and technological approach that characterises the biomedical model of health.

Until the mid 1980s, antenatal education in New Zealand was conservative and varied little. It followed the medical model of childbirth and it was largely taught by members of the health professions who had received the 'medical seal of approval'. Classes were large, women were talked at and were completely indoctrinated into the medical model - childbirth was inherently dangerous, it could only be termed normal in retrospect and it encouraged women to put themselves completely into the hands of their doctors.

*You decide when to see your doctor and let him confirm the fact of your pregnancy. From then onwards, you are going to have to answer a lot of questions and be the subject of a lot of examinations. Never worry your head about these - they are necessary, they are in the interests of your baby and yourself, and none of them will ever harm you.*

Family Doctor Publications, 1977  
(Oakley, 1980:10)

Given the strong concern of second wave feminists with health issues, it was inevitable that women would challenge the philosophy of the medicalisation of childbirth and thus question the appropriateness of available antenatal classes. Women were reading the works of Shelia Kitzinger and Ann Oakley and many recognised



that birth had been hijacked by the medical profession. There was questioning of the widespread belief that birth was inherently dangerous so that routine hospitalisation and intervention were necessary to ensure the safety of mother and baby.

1984 saw the timely visits by two women who are very influential internationally in the field of childbirth education. Diony Young from the International Childbirth Education Association and Janet Balaskas, founder of the Active Birth Movement alerted many to the insidious process of medicalisation of childbirth. Women were reminded that birth is a normal event in a woman's life process and that every woman brings innate knowledge to birth. "It is to the woman that birth belongs, not the doctor, midwife or hospital". While perinatal morbidity and mortality outcomes are important, so too is the personal satisfaction of the woman. She has the right to make choices about her pregnancy, labour and birth and she has the right to be supported in those choices.

As women sought out options in their desire to reclaim birth, it became clear that traditional antenatal classes were inadequate. In order to challenge the power relationships that dominate birth, there needed to be a reassessment of class size and structure, of the teaching techniques and of the content of antenatal classes. Overseas, women were being trained in the specialised field of antenatal education and through such organisations as the International Childbirth Education Association, the National Childbirth Trust and Associates in Childbirth Education. A new professional was emerging - the childbirth educator.

At the Parents Centres' national conference in 1988, those who were taking Parents Centre antenatal classes got together to take stock of the situation and look to future directions. There was concern about the different teaching approaches and standards of education being taught in classes in the auspices of PCNZ. Some physiotherapists had updated their knowledge and were including stretching exercises and breathing relaxation in their classes but many were not. In any case, the supply of physiotherapists was drying up as many were returning to work in difficult financial times. Many of the speakers espoused

the medical model of birth and advocated the routine use of obstetric technology. A number of educators lacked any qualifications in the health field.

The women present decided to set up an independent New Zealand Childbirth Educators course and include within it, parts of the Australian Associates in Childbirth Education course. The first intake of 20 students took place in early 1990 and every intake since then has been fully subscribed.

The objectives of the PCNZ Childbirth Educators Course are:-

1. To provide trainees with a sound knowledge base regarding the anatomy, physiology, psychology and sociology of pregnancy, childbirth (in all its variations) and the early parenting period.
2. To help trainees develop group leadership and communication skills, and a wide range of techniques and evaluation methods for teaching adults.
3. To help trainees realise their role as childbirth educators:
  - supporting and nurturing pregnant women and their families.
  - providing resources which will encourage expectant parents to make informed decisions about options available during pregnancy, labour and post-partum.
4. To obtain a recognised qualification in childbirth education - the PCNZ Childbirth Education Diploma.

The philosophy of the course is one that centres on wellness and health promotion. It is an enabling philosophy, seeking to empower women by giving them the knowledge and skills to make informed decisions about their pregnancy and birth. Emphasis is given to placing the woman in the middle of the health care circle. Birth belongs to her, not her care givers and each birth is unique to that woman. Birth is not merely a physical event - the emotional, social, spiritual, mental and cultural aspects assume as much importance as the physical aspects.

The Childbirth Educator needs many skills and much knowledge:-

1. A background in, and constantly up-

dated knowledge of the philosophy and current trends in preparation for childbirth, both globally and locally.

2. A practical and theoretical knowledge of the physiology and psychology of pregnancy, labour, postpartum and neonatal care.
3. Responsibilities to oneself, one's profession, the parents and the rest of the health care circle.
4. Skills in group leadership which builds confidence in the participants.
5. Skills in communication and facilitation.
6. The ability to support parents and help them support themselves.
7. Coping strategies for the childbearing and early parenting years.
8. Skills in working with other educators in preparation for parenthood courses.
9. A knowledge of adult learning and teaching.
10. A knowledge and understanding of different cultural approaches to childbirth.
11. An ability to liaise with others involved in allied fields.

Having established the course and seeing it running successfully, PCNZ recognises that there is still much to be accomplished. One of our major objections to traditional antenatal classes is that little cognisance is taken of the needs of women. There is little thought given to the principles of childbirth education and consequently objectives of specific programmes are vague. Because these objectives are vague, and indeed there may be little agreement as to what they are precisely, there is almost no monitoring or evaluation of the programmes. No one knows if they are meeting the needs of women because no one bothers to ask women what they really need.

While childbirth educators in training must have stated aims, and objectives are monitored and evaluated to ensure these aims and objectives are achieved, some centres within PCNZ still offer the traditional classes taken by health professionals who know much about physiology and obstetric technology but little about the principles of childbirth education. PCNZ

Continued on Page 22

## NZCOM POSITION STATEMENT

### Endorsement and Advertising of Products

It is not the policy of the NZCOM to endorse any commercial products.

Sponsorship or advertising which contravenes the objectives of the NZCOM is not acceptable. The NZCOM upholds the WHO International Code of Marketing of Breast Milk Substitutes.



would like to establish standards of practice and a system of accreditation for childbirth educators so that all Parents Centres' antenatal classes are high quality and empowering.

Where health professionals are running the classes, their training will need to be assessed and their inadequacies addressed. Presently there is a lack of integration in philosophy and practice between childbirth education programmes and the management of labour and delivery - many health professionals lack knowledge of the principles of childbirth education. They also lack knowledge of the accepted principles of adult education and teach in large classes with formal seating arrangements using a lecture style of delivery. PCNZ hopes that as more childbirth educators are trained, there will be sufficient teachers to offer small classes where the emphasis will be a participatory style of learning.

PCNZ is presently seeking formal recognition of the Diploma in Childbirth Education from the Qualifications Authority. This means there will be an acceptance of the validity of the Diploma and of the standards of education offered by the qualified childbirth educators. There needs to be ongoing liaison with the professional bodies representing midwives and physiotherapists to keep them informed of developments and new directions in childbirth education. Within its own organisation, PCNZ has much re-educating of its own members to do so that they are aware that there are alternative models of childbirth to the medical one and so that they are committed to the empowering of women.

There also need to be a demystifying of childbirth so women can accept that the knowledge and skills that surround childbirth are not the exclusive preserve of the medical profession. Modern childbirth education aims to bring the woman back to the centre of the health care circle. It also seeks to build on her existing knowledge and skills to rekindle her faith in her ability to give birth. It highlights the importance of the emotional, social and mental as well as the physical aspects of pregnancy and birth. Finally, it aims to empower women by enhancing their knowledge, skills and self awareness so that they have true freedom of choice based on informed consent.

Sharon Cole  
National Co-president  
Parents Centres New Zealand

## References

- Kitzinger, S. *Education and Counselling for Childbirth*, Bailliere Tinnall. London. 1977.  
Oakley, A. *Women confined*. Martin Robertson Uk. 1980.

## COMING EVENTS

**A Workshop on the Maintenance of Breastfeeding**  
4-5 November 1991  
Quality Inn  
Palmerston North

### Enquiries:

DDS Mackenzie, Workshop on Breastfeeding, Dept. of Animal Science, Massey University, PN.

**International Confederation of Midwives 23rd International Congress:**  
9-14 May 1993, Vancouver, British Columbia, Canada

**Second National Midwifery Forum - Issues in Midwifery Practice Today:**  
1-2 November, 1991 Continuing Education Unit, Department of Nursing, La Trobe University.  
**Contact:**  
Ms Liz Pittman, Coordinator Continuing Education Unit, Department of Nursing, La Trobe University, St Helliers St, Abbotsford, Victoria 3067, Australia.

## Second International Homebirth Conference:

Sydney, Australia. 4-7 October, 1992 Reclaiming our Heritage, Creating our future.

### Contact:

Conference Secretariat, GPO Box 2609, Sydney, NSW 2001, Australia. Tel: (02) 241 1478, (02) 247 6940. Fax: (02) 251 3552.

**25th Anniversary of the Hutt Hospital Obstetric and Gynaecological Dept:** Celebrated on Friday 18th and Saturday 19th October, 1991 at Hutt Hospital. It will be held combining with the N.Z.C.O.M. and the Wgtn. Dv. of the New Zealand Obstetrical and Gynaecological Society.

### Exciting Programme

### For details contact:

Miss Julie Foley and Mr Peter Mellor  
Obstetric Unit  
Hutt Hospital  
LOWER HUTT

## Manawatu - Horowhenua Obstetric & Gynaecological Society:

Obstetric & Gynaecological Study Day 1991. Thursday 7 November, 1991. 10.30 - 17.00, Programme, 18.00 Dinner.

### Venue:

The Coachman, Fitzherbert Ave, Palmerston North.

### Contact:

Dr Tim Crowe (Secretary), P O Box 545, Palmerston North. Phone: 3569-061. Fax: 3581-836

## BOOK REVIEWS

**The New Zealand Pregnancy Book**  
*Dr Sue Pullon with Becky Bliss*  
Published by Bridget Williams Books,  
New Zealand, May 1991.  
ISBN NO. 0 908912 03X.  
\$39.95

This new publication is an extremely comprehensive, well designed guide of the latest approaches to pregnancy and to childbirth. Five women share their intense experiences of pregnancy and delivery with accompanying illustrations and photographs.

The New Zealand Pregnancy Book makes information available and accessible (interspersed with short quotes from a variety of people) including:-

- Home versus hospital
- The changing role of midwives
- 'Medical Control' of childbirth
- Options for care and delivery, describing the situation as it is now, and the choices available within the existing system
- Coping with other commitments at work and home
- Concluding with a very full practical, convenient glossary of medical terms and an appendix of useful organisations within New Zealand

Sue Pullon, is a mother of three children, a general practitioner with postgraduate qualifications in obstetrics and gynaecology, who currently lives in Nelson.

Becky Bliss, is a designer and illustrator, and former art director at the Department of Health.

With its continuity, variety, flexibility and supportiveness, the 'The New Zealand Pregnancy Book' is highly recommended as a unique and indispensable resource for all parents-to-be, midwives, doctors and all people associated with childbirth.

Helen Manoharan

## Labour Ward Manual

*Liu, D.T.Y., MPhil (Bio Eng), FRCOG.*  
*Fairweather, D.V.I, M.D., FRCOG*  
Published by Butterworth-Heinemann, United Kingdom, 1st edition. 2nd edition 1991.  
ISBN No. 0750610964  
Recommended Retail Price: \$76.00

This is an excellent text both for education and reference in obstetric units dealing with high technology and complicated pregnancy and labour.

Comprising 22 chapters, it is well laid out, concise and easy to read. Headings are highlighted and main points "boxed" for attention. Layout is such that the book looks spacious with good diagrams throughout and supportive photographs. Information is descriptive and step by step guidelines are given for some instances eg: repair of episiotomy.

In such a changing environment, some drugs and methods may be superseded; generally this book is well suited to New Zealand obstetrics.

The authors (both obstetricians) make a challenging comment at the end of the first chapter.....

"Labour is a reminder of Nature's insistence on survival of the fittest. The role of the obstetric team should be to allow what is physiological to continue, but to intervene where appropriate to counter nature's indiscretions".

Sue Fesché  
Palmerston North





**New Zealand College of Midwives  
Membership Form**

**B.O.M.  
P.O. Box 7063  
Wellington**

**Regional Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Place of Work \_\_\_\_\_

**Type of Membership**

Full Member (Registered Midwife Full or Part Time)	<b>\$74.00</b>
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	<b>\$37.00</b>
Associate Member (Other interested individual)	<b>\$74.00</b>
Associate Member (Unwaged interested individual)	<b>\$37.00</b>
Affiliated Member (Other Groups e.g. Parent Centre, La Leche League, etc)	<b>\$37.00</b>

**Method of Payment**

Please tick your choice of payment method.

- Subscription payable to College Treasurer (Please enclose cheque or money order)
- Deduction from Salary (Please arrange with your pay office)

**National Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Date of birth \_\_\_\_\_ NZNA MEMBER: YES/NO [Delete One]

**Type of Membership**

Full  $\left\{ \begin{array}{l} \text{Waged } \square \\ \text{Unwaged } \square \end{array} \right.$       Associate  $\left\{ \begin{array}{l} \text{Waged } \square \\ \text{Unwaged } \square \end{array} \right.$       Affiliate

Place of Work \_\_\_\_\_

*Please return completed form (together with money if applicable) to the National Committee member for your area.*

*Northland*  
LYNLEY McFARLAND  
16 Russel Road  
Whangarei

*Auckland*  
GLENDA STIMPSON  
P.O. Box 24-403  
Royal Oak, Auckland

*Waikato/Bay of Plenty*  
KITTY FLANNERY  
12 East Street  
Hamilton

*Eastern/Central Districts*  
JULIE KINLOCH  
76 Charles Street  
Westshore, Napier

*Wanganui/Taranaki*  
AILSA STEWART  
Women's Unit  
Base Hospital, Wanganui

*Wellington*  
MARION LOVELL  
P.O. Box 9600  
Wellington

*Nelson*  
BRONWEN PELVIN  
P.O. Box 672  
Nelson

*Canterbury/West Coast*  
JULIE HASSON  
P.O. Box 21-106  
Christchurch

*Otago*  
JO WALLIS  
P.O. Box 6243  
Dunedin North

*Southland*  
LESLEY WATSON  
390 Dee Street  
Invercargill



# WELEDA

## Baby Care Preparations

have been working effectively for over 60 years.

The same care mothers exercise in selecting the best possible foods for their baby's nutrition, is taken by WELEDA in the manufacture of the WELEDA Baby Care Preparations, which are absorbed and act through the baby's skin.

Calendula, the original Marigold, has been widely acknowledged as a healing plant: herbalists call it a vulnerary. Research shows the Calendula plant to possess marked anti-inflammatory and antiseptic properties. The mild and soothing qualities of Calendula make it WELEDA's perfect choice as the basis of the WELEDA Baby Care Range.

Unlike the majority of baby products marketed today, WELEDA Baby Preparations are entirely natural. No synthetic preservatives, no colouring materials and no petroleum derivatives, such as paraffin, are used. Such substances are foreign to the human skin (especially the delicate skin of a baby), and hinder the elimination and absorption processes occurring through the skin.

WELEDA recognises our bodies as living organisms and treats them accordingly with preparations from the living kingdoms of nature. This principle is basic to all WELEDA products, whether for internal or external use.

*A useful booklet entitled "WELEDA Remedies for Mother & Child" is now available from WELEDA. Available from your WELEDA Stockist for only \$1.00 or send \$1.60 to WELEDA.*

### Weleda Baby Care Products



gentle and effective

made entirely from  
fine natural ingredients

Nappy Rash Cream

Calendula Baby Oil

Calendula Baby Cream

Calendula Baby Powder

and other products

Available from selected Pharmacies  
and Health Food Stores

or from

FREEPOST NO. 125

WELEDA (NZ) LTD

HAVELOCK NORTH

TELEPHONE (06) 877-7394

**WELEDA BABY PRODUCTS ARE BABY FRIENDLY**

**Let your baby discover why!**