



JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, APRIL 1993





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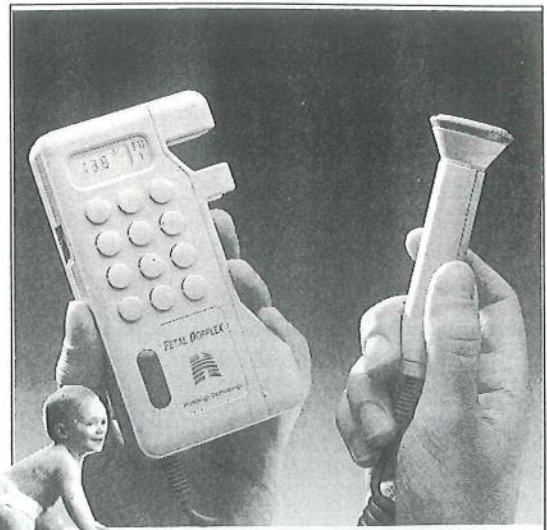
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Philosophy of the Journal:

- * Promote women's health issues as they relate to childbearing women and their families.
- * Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- * Provoke discussion of midwifery issues.

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Welcome to 1993. I hope you all had a good break over the summer and some of you managed to see some sun.

Two years on from the introduction of the Nurses Amendment Act, we still face many challenges in trying to provide a midwifery service which meets women's needs, and of which the midwifery profession can be proud.

The Maternity Benefit Tribunal was clearly a challenge from the medical profession responding to competition for increasing numbers of women are choosing the services of independent midwives. The New Zealand Medical Association put a case for a general increase in the maternity benefit but also argued that midwives should be on a separate schedule because their service was different to that of doctors – the doctors being more highly trained and able to deal with all the problems! The College argued that both midwives and doctors provide maternity service. The method of delivery of the service may be different but the outcomes should be the same. Therefore both midwives and doctors should be paid the same and from the same schedule. Karen Guilliland acted for the College and despite (or perhaps because of) her lack of legal training, she presented our case extremely well and cross examined like a pro! Indeed, all of the witnesses for the College were well prepared and impressive. The Tribunal finally finished deliberating towards the end of January this year and Simon Upton now has the report. We expect that he will have made a decision by the end of April. The financial cost of the Tribunal to the College has been enormous and we have been forced to ask for donations from practising midwives. The response from the South has been good but not as yet from the North Island. I urge you all to contribute. As a College we simply have no spare funds for massive unexpected exercises such as the Maternity Benefit Tribunal.

Karen and I have been meeting with the RHAs and have prepared a paper looking at the implications of the changes for midwives which you can read in this journal.

It is important that midwives put energy into working out how to provide midwifery services in the new environment. Talk to each other. Set up referral links with obstetricians. Do not be forced into linking up with general practitioners or underselling yourselves. Remember midwives can provide maternity care on their own responsibility and it is obstetricians we need when complications arise. A midwife is needed at every birth and therefore we

should be able to provide the fundamental structure of the maternity service.

I heard recently, the Chairperson of the Otago Crown Health Enterprise was promoting the notion of the 'supernurse' who is a specialist in everything. He was not in favour of the direct entry midwife as they couldn't work outside the maternity service! If this is to be the vision for the CHE it will be essential for midwives to demonstrate we can provide a viable maternity service outside the CHE structures. It is also essential that we protect the future of our profession by supporting our student midwives. They are our future.

One highlight for 1993 will be the production of the NZCOM *Handbook for Practice*. This booklet incorporates the Code of Ethics and Standards for practice and be valuable for all midwives in guiding and affirming their practice.

In May, Karen Guilliland and I, along with several other midwives from New Zealand will be attending the ICM Congress in Vancouver.

The College has put forward a remit to change the ICM Constitution to allow new midwifery associations joining ICM, to have consumer members. We have also put forward the following position statement:-

The Midwifery Partnership with Women

The ICM believes that midwifery is a profession which is based upon a partnership between women and midwives.

In keeping with this belief:

- (a) *The midwifery position should reflect the needs of women in society.*
- (b) *Women should be involved in the development and maintenance of the midwifery profession.*
- (c) *Midwifery associations should encourage women consumers to participate in the activities of their professional organisations.*

Rationale

Partnership is not the passive 'giving women a voice', it is developing and expanding a Midwifery profession together which is truly reflective of the needs of women in society. Joining forces with women succeeds in making the re-establishment of the Midwifery Model synonymous with reclaiming women's control over childbirth. Extending the Midwifery partnership to the professional organisation, development and maintenance of midwifery gives us a unique identity, social recognition and protects women's choices and self determination. A global acceptance of the partnership model could ensure the

survival of an independent Midwifery profession.

We are confident that the ICM Constitution does not allow the council to deny New Zealand's membership because of our consumer members and we informed the council of our reasons for this. We are keen, however, to encourage other midwifery associations to follow the New Zealand model.

It is this partnership with women that we must not lose sight of as we tackle the challenges of the health reforms and increase our strength and unity as a profession.

Good Luck. ■

Sally Pairman – President NZCOM

LETTERS TO THE EDITOR

Dear Editor,

In response to B. Pelvin's article "Current Ethical Considerations" in your December 1992 Journal, I must protest.

My interpretation of statements made by Simon Upton, the Regional Health Authorities, Health Professionals and Women's groups is that the availability of consumer choice is a backbone of health reforms.

How dare B. Pelvin presume to choose in which way midwifery should be practised for me, the consumer, by stating the continuity of care should be THE midwifery model.

She belittles the vast majority of her midwifery peers by damning fragmented care. Let's be honest, the ONLY continuity of care practised in New Zealand is within the Home Birth Movement and Independent Midwifery where women come home directly from the delivery unit. This is a small proportion of women. ALL other women are exposed to fragmented care and this care is given by most midwives!!!

I want an optimal outcome to my pregnancy, not necessarily a deep knowing relationship with a midwife, nor necessarily engaging a private medical consultant. Whatever my preference the important factor is that I may CHOOSE!!!

Make the scope of choices available to women consumer driven. If continuity of

Continued on Page 16 ...



A Half Day in the Life Of ...

Angela Kearney
Midwife

Currently working in Mozambique

“This is London..... Music, Music, Music, Ping, Ping, Ping..... It is 0300 hours, Greenwich Mean Time and this is the B.B.C.

Here is the news.....

I wake up to this sound from my radio and take a while to understand where I am and what I am doing listening to the radio at that hour. It is still dark, but already humid and there is one insistent mosquito buzzing around the pillow. I check the time on the alarm clock and indeed it is 5.00 a.m. Mozambique time. I have only a few minutes to get ready to leave the house.

Plug in the electric jug, check the fridge for bread – none – so I go for the next best thing – a bar of chocolate. Munch into that, make the coffee and then head off to throw a bucket of water over me, clean the teeth and finally dress, remembering that I should wear something that is comfortable and shoes that can walk miles.

Leaving the house by 5.10 a.m. the guard gives me a rather one eyed look wondering where I could be going in the dark and alone. I chirp a “Good Morning” and don’t let him into the story. He can wonder.

I’m off to do a visit to the small town of Murrua in the district of Ile, Zambezia Province. The work ahead of me is exciting and interesting and the sense of the ‘unknown’ is always fun. I’m especially interested in the role of the Traditional Birth Attendant within the society and hope to meet with some of these women in Murrua to talk with them, to learn a little of their customs, attitudes and practices to birth.

At a very quick pace I wander the streets of Quelimane, pass the hospital; there is some activity there and a couple of relatives of the sick are sweeping the sand to clean up for the new day. As I pass the area that has the cholera patients I think about the kind of work that is involved there and hope that the number of cases will reduce now the rains are nearly over.

Carolyn, the American anthropologist involved in studying the relationship between traditional medicine and the government health system calls out a very cheerful welcome in her usual effusive manner, and we join up to walk to the hotel to get our ride.

Waiting outside this large seven-storey hotel are two men. Dressed in navy blue shirts, shorts of denim, and runners, they greet us and curse the car which, as ever, is running late. They are pilots on contract up here from South Africa and want to get in five flights today.

The pick-up Toyota screeches around the corner and we all jump into the back and head out to the airport at a quick rate. Street activity is underway; there are people walking to their work places, a huge queue is forming outside one of the bakeries in town – yet again bread is in short supply – and then there are the stray, mangy dogs sniffing and rooting around in the smelly rubbish piles.

On the way to the airport we pass through two zones of fog. The pilots talk together; I guess that it is a bit of concern that they will not get away for a while, but once we get to the airport it looks like a clear day.

There on the tarmac stands the DC3 Dakota. It is painted red and white and is quite a magnificent-looking plane. The pilots begin their preflight check, running excess water out of the fuel tanks, checking the wings, the tail, the wheels, and other bits that I could not put a name or function to. There is a lot of discussion and laughter near the belly of the plane – I have an inkling of what this discussion is about – but I decide to stay clear in the meantime. Instead, I am eyeing up the chances of finding a place without people where I can pee. The cargo handlers are very quickly and efficiently loading sacks of maize and 20-litre tins of cooking oil. I head off to a spot between two containers, thinking no one knows where I am going and then I hear Carolyn yelling to me to hurry because the plane is ready to take off.

Climbing into the DC3 is easy and finding a place to sit also, because up the front of the plane are plenty of sacks of maize. I choose my place, make myself comfortable and then look around the plane. It was built in 1947 and so I wonder at the number of thousands of flights it has already done. Is it too old? Are all the bits still in working condition? Do the pilots know the hazards of flying here? The inside of the plane seems quite barren. Nothing on the walls, the windows are dirty, the door seems to be letting lots of light under and around the seals, one window flaps open. Let it be Ange, and relax and enjoy the flight. It's exactly 5.47 a.m. and all seems clear. We taxi to the end of the runway and without mucking around it is all engines on, full speed ahead and we are up in the air.

The noise is deafening and the shudders seem to shake my very bones. I know it is a flight of 55 minutes and so settle down with a book.

I am comfortable on the sacks but the cold begins to bite. It is such a different sensation to the usual heat and humidity of Quelimane. It is getting colder and I know we still have some feet to climb so I seek out a sarong in my day pack and wrap it around me.

The time drags on, I check my watch many times and right on 53 minutes from Quelimane I spot the grass airstrip in the distance. A quick descent and the motion of the plane changes, the noise alters and I see the grass rushing past the small windows. We are on the ground and quickly taxiing to a stop. I notice that Carolyn is already jumping out; we've hardly stopped moving, so I follow suit. Luckily I jump clear because within seconds the sacks come flying out behind me. The engines are still running, the pilots are anxiously watching out the side window of the cockpit and I am amazed at the speed and activity. Within five minutes the three tonnes of cargo is scattered in a hump outside the side door of the Dakota and the plane is on the way back to Quelimane again. It is a spot in the sky and I ponder on the chances of it breaking down and not getting back to pick us up. Oh, well, it's in the lap of the gods.

Carolyn has been to Murrua many times before and knows the town well and many of the people within the Government structures. She greets some old friends and then we head off to find the Administrator.

Murrua was a rich area that provided work and subsistence farming to a large population. But on the 11th November 1986 the 'bandidos armados' or rebels of the anti-government force took the town. They occupied it until the Frelimo government soldiers arrived on 12-6-90. During that time many people fled to the safety of other districts or the city of Quelimane,

many were captured by the bandits and were forced to work for them, and others were brutally murdered.

When Frelimo took the town last year the number of people living there was very small. Now in April 1991, as the assistance improves and the people feel safe on their land the population increases daily. It is estimated there are currently over 54,000 people in this area. It is physically beautiful, with a couple of large rock-faces and hills and large areas of cultivated land. Maize, cassava beans seem to grow well and near the river there are some small plots of rice.

The Administrator is not in town, nor his substitute so we ask for the assistance of a young man to take us to the hospital. The walk is interesting, over little streams, up and down well-trodden paths, people to greet on the way, the occasional child with a school book under its arm, mothers washing in the river, men sitting on rocks chatting together, and beautiful green crops all around. I guess it takes us 30 minutes to walk to the 'hospital'.

It is a red brick building that before the war was someone's home but all that was useful has been stolen. The corrugated iron roof has been stripped and now has been repaired in a very basic thatch. The walls are bare, the windows non-existent, and inside nothing, nothing, nothing. A man comes to greet us and tells us that he is the Agente Polivalente Elementar, i.e. the Community Health Worker. He wears a threadbare shirt, trousers held up with string and no shoes. He is currently in charge of health care for 54,000 people, as the nurse, who has one year's training, is in Quelimane trying to pick up some drugs and other necessary material. He explains to me that the 'hospital' is empty at that time of the morning as the health workers take everything out at night to their own homes to safeguard them in the event of an attack. He invites us to go with him to his home.

It is another 15 minutes walk along the path and when we get there it is to see the two young women who have been trained by the Mozambican Red Cross bending over a fire boiling up the instruments that will be used during the day. They greet me with much pleasure and explain that they had had three months training in the town of Ile, 80 kilometres away, and are local girls wanting to serve the people. I can see from their faces that they are very proud of their work and despite the difficulties they face because of lack of material, I know they are doing a decent job.

We meet the chief of the area and explain to him our reasons for the visit. I want to meet with the Traditional Birth Attendants (TBA) who up until now, in Murrua, have no formal training. This fits into the job I do as co-ordinator for the

training of TBA's in Zambezia. The Ministry of Health in Mozambique has a policy on training these women in basic hygiene and care of a mother giving birth and her newborn baby with the objective of reducing the very high infant mortality rate (375/1000 UNICEF data 1990).

It is estimated that 70% of births in Mozambique are outside hospital and in many rural areas of Zambezia Province this percentage rises to 90. In Murrua, at present there is no trained midwife nor a TBA who has any kind of formal training.

The role of the TBA in the community is vast and varied. She is often a traditional healer (curandeira) and has a great knowledge of local herbs and plants used in traditional medicine. She is always a highly respected person who has had children herself and is called on to assist mothers at the time of childbirth. They are with much experience, have many stories to tell and are always interesting to chat with.

We walk back along the same path. Carolyn goes off to meet with her traditional healers and I go to the World Vision Feeding Centre. It was set up in October last when the nutrition situation was desperate. Many hundreds of severely malnourished children have been treated and discharged from the Feeding Centre and as the general ration has improved and there is hope of a decent harvest the number of people admitted is reducing.

There are two large tents, spotlessly clean inside, grass mats on the floor and blankets at the foot of each mat. Outside in the sun and shade are huddled groups of mothers and children. At first sight it seems like they are all fairly healthy but on closer inspection I see that some of the children have Kwashiorkor, a severe state of malnutrition, where swelling occurs. I talk with the workers and see that all is under control. The kitchen is a hive of activity. Water boiling; oil, sugar and milk mixture being prepared. This is a recipe to make high energy milk which is given at regular intervals during both the day and night to malnourished children. The quantity required is calculated using the current weight of the child and the severity of the malnutrition. As the child improves the diet can be diversified to include fresh vegetables and more solid food such as maize and special high energy biscuits.

From there I continue on my way back to the hospital. By now the drugs and equipment are in place. There are old bits of material across the window spaces, the queue of people waiting to be attended is long, flies are buzzing, children are crying and old men are chatting away to each other. I have a look around and see that there is hardly anything there. Two syringes are used over and over again although the needle is changed for each patient. Aspirin, chloroquine (malaria), mer-

bendazole (worms), and iron. That's all!! I am amazed at the number of patients registered in the book. At least 120 per day and no properly trained health worker. No deliveries are carried out in 'hospital' as there are no facilities there.

Artimessa and Maria are two TBAs I talk with through an interpreter. They attend all the births in that area and do not have any help, support or material. We talk about the programme that Zambezia has for training at least 10 TBAs in each district in the next 12 months. Some courses have already begun and others are planned in the near future. The training courses are held in the district capital with the Maternal and Child Health Nurse doing most of the teaching and leading sessions to exchange ideas and learn from each other.

Marcia, the Maternal and Child Health Nurse of Ile will choose women who have the respect of the community and they will travel to Ile to participate in the three-week course funded by Save the Children Fund. They will then return to their villages with a Birth Kit and new knowledge. It is planned to do the first training course for Ile district with five TBAs in early May and at least one of the women from Mur-

rua will attend. Artimessa and Maria are excited by the prospect of this, and as we farewell each other it is with hope that we will meet again during the course.

I'm now a bit behind time and so need to walk at a very fast pace to the airstrip. I know that the pilots will not wait for anyone and that is incentive enough to get me cracking. I keep an eye on my watch as I need to be at the airstrip by 11.30 a.m. and as I struggle up the final slope at 11.28 a.m. I reach for the water bottle again to find it empty!!! I've drained it. No worries, Carolyn is only a minute behind and in true American style has, as well as iced water, a peanut butter and jam sandwich to offer me. We sit down in the shade of a huge tree to recount some of the happenings and within 60 seconds I hear the noise of a plane. It is the Dakota.

The routine is the same as the morning run, the cargo flies out the door, the engines do not stop, the dust blows into my eyes, I am even more dirty than I was three minutes previously, and that was pretty bad!!! I watch the final sacks being tossed out and climb up on them; using them as steps I rush up to the front of the plane. We are already on our way.

The plane increases speed and then

once it takes off it climbs very steeply virtually 'cork-screwing'.

Fifty-five minutes later we are in Quelimane. I jump out of the plane, hit the tarmac hard, scrape my knee, and breathe easily again. It is now that I go to investigate the underside of the plane. It was the topic of conversation earlier in the day and for a reason. There, at the level of the wing in the belly is the bullet hole, or rather two holes, the entrance and exit of a bullet that hit the plane the previous day. I knew about it but the odds were stacked against us to have a repeat. It had been hit five minutes outside of Murrua when the plane was low, so today we took off and climbed as quickly as possible to avoid any stray bullets. Flying is not a big risk ... it's only between 500 and 1,500 feet there's a problem.

By 1300 Carolyn and I are on the road from the airport to the city in the hot sun, a bit dehydrated, pretty tired and very, very dirty.

I say, "April the 5th, not a bad half-day. I think I'll write about it".



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Contracting for Midwifery Services under the Health Reforms

Karen Guilliland
Sally Pairman

The intent of the health reforms is to separate the funder (that is the government) from the provider (e.g. midwives). This process will commence on the 1st July where funding responsibility will be taken over by four Regional Health Authorities (RHAs). All of the money currently spent on health including the Maternity Benefit, AHB funding, pharmaceuticals benefit and General Medical Services Benefit (GMS) will be distributed to the RHAs on a population based funding mechanism.

The RHAs then buy the services needed by their communities from the providers.

The Maternity Services seem to be viewed separately by the RHAs when considering contracting. They do not automatically assume they will be part of the services offered by GPs. Based on discussions with the Southern RHA it appears they favour setting the price for total care per birth and are then, contrary to an initial interpretation, prepared to pay providers per birth. Competition will not be for contracts for payment but for clients. The RHA will not guarantee any provider a share of the market. It will be up to the provider to secure the number of clients they need to cover their costs.

RHAs will initially continue to pay according to the Maternity Benefit Schedule. However through 1993 they will be looking at various pilot schemes to assist in setting the price for a birth. That price will become the bench mark from which to negotiate contracts with all providers. In certain situations, some providers may be paid more than the standard bench mark because they have convinced RHAs of their higher costs

to provide access to their services e.g. rural midwifery services. Again, in the short term the RHA appears happy to have contracts with individual practitioners but our feeling is that in the long term there will be pressure for providers to group together.

We have identified several issues midwives need to consider before involving themselves in contractual arrangements.

1. METHODS OF PAYMENT

- (a) **Case Management** – i.e. the practitioner holds total payments and purchases all care required for a maternity service.

This requires establishing referral links with Obstetricians, Ultrasonographers, laboratories, pharmacies, Crown Health Enterprises (CHEs), paediatricians, anaesthetists, etc.

The case manager pays all other providers and takes the risk associated with an often unpredictable service. She must know the costs of her midwifery service and all her referral services before negotiating a price per case with the RHA. Profit and loss is determined by the swings and roundabouts associated with our unpredictable service.

The midwife as case manager is more likely to retain autonomy of practice as she manages the service that will be provided. The case management concept is similar to a global fee.

- (b) **Sub-contracting** – i.e. someone else is the case manager and you are contracted to provide midwifery care.

This care can range from total to part care. The sub-contracting arrangement will determine the amount of autonomy of practice a midwife will have.

It is this method of payment which holds the most pitfalls for the midwifery profession. It depends on the knowledge and philosophy of the midwife offering a service whether she risks losing her newly gained independence and once again becoming an obstetric nurse providing cover for a doctor. Midwives must think through carefully any sub-contracting arrangements with doctors or the gains made for midwives and choices for women will be lost.

Sub-contracting remains a viable option and indeed in small communities it may be the only option, but only if the midwife is clearly an independent practitioner responsible and accountable for her midwifery service i.e. working *with* the doctor and not *for* the doctor.

2. VARIATION ON CASE MANAGEMENT

Midwives may negotiate for normal pregnancy services rather than all serv-

ices e.g. domino, home birth services.

In this case whenever your client needed anything outside that which you could provide e.g. ultrasound, obstetric services, you would have to refer the woman for that service, much the same as today's situation. Referring on is different from buying in a service, however, in that influence over the service referred to, is minimal. This option may be a necessity where co-operation between doctors and midwives is minimal or where the only obstetric service available is through a CHE. In a co-operative, professional environment it could offer a good service for women equal to full case management.

While we see this option as the most common in the short term as RHAs roll over present services, it may change as providers start to group together to provide the total service and squeeze out individuals.

REGISTRATION OF CLIENTS; CHOICES FOR WOMEN

Inherent in the case management concept is the acceptance of client registration. RHAs see this as a way of preventing duplication of services. However we continue to be cautious about enrolment or registration of clients if it means women's choice of care giver is reduced. A major gap in the services now is information on choices available to women. In a competitive environment who will provide unbiased information to allow women to make those choices? This is not seen by the RHAs as their responsibility – the market philosophy says quality, choice and provider is dictated by the market, but this only works when there is a level starting point. Midwifery in New Zealand faces 60 years of women socialised into the medical model of birth. Advertising and media promotion was never a feature for doctors initiating a maternity service but seems inevitable for midwives in the new environment. The Health and Disabilities Bill further threatens women's choice by repealing the Social Security legislation which stipulated women had the right to choose their provider and place of birth. It is an ominous indicator that user pays may be the only provider of any choice in the future.

3. ACCESS CONTRACTS TO CHE FACILITIES

While the Commerce Act stipulates hospitals cannot use their position to deny access to providers, in reality some already do. They do it by demanding midwives meet rigid criteria set up by their Maternity Services Committees. In

some places throughout New Zealand these criteria take the form of extensive risk lists. While the College of Midwives is presently pursuing legal redress for these midwives under the Commerce Act we have concern that the new contracting arrangements may initially make the situation worse. In our opinion CHEs should not be able to deny access to any outside provider who is paying for the use of these facilities. The CHEs already face a decided advantage in that they inherit public maternity beds, maintaining current access agreements, which gives them control over outside providers with whom they are now in competition.

We have pointed this anomaly out to the health reformers. Midwives are reminded that the Commerce Act exists to prevent such monopoly. Do not accept obstruction to your clients accessing hospital beds. If you are a Registered Midwife you are entitled to an access agreement.

4. CONFLICTING ROLES AND RESPONSIBILITIES OF MULTIPLE PROVIDERS

The separation of funder and provider creates a potential contradiction between professional autonomy and responsibility and financial contractual arrangements. Because the case manager may buy the necessary services does she then have control over service delivery. If not then who does? In a situation of professional disagreement does the person paying dictate the decision? e.g. a midwife who is contracted to provide midwifery services to a doctor may disagree with a doctor who says a woman needs syntocinon augmentation. Is she forced to provide an unnecessary service, because the doctor is paying her?

What if the professional advice is not taken by the case manager? Who is responsible if the outcome is poor? The professional who knew it should be done but was not contracted to provide it or the case manager who neglected to buy the service? How will satisfactory standards of care be maintained under these conditions?

The present often heated debate throughout the maternity service is who is the primary practitioner? Who takes full responsibility? Whilst this is not resolved each professional group believes their care has a significant effect on the outcome. Each is prepared to take responsibility for their clinical judgments. What this new arrangement is in danger of doing is asking professionals to give away clinical judgement and carry out whatever service they have been paid for.

Whilst these examples are extreme the lessons of the last two years must be heeded. Competition has sometimes led to hostility between providers which in some cases has left women in a compromised position. Financial arrangements which increase hostility and remove clinical judgments can only make the situation worse.

RHAs and the professions need to acknowledge this potential for non professional behaviour. There is already evidence worldwide that if payment is attached to an intervention it increases that intervention and it is obvious that the method of payment has a significant impact on the standard of care. The current system is equally open to abuse e.g. midwives working for doctors who claim the benefit. These interventions often reflect the consequence of dependent midwifery practice. While over servicing can be a feature of the current system the new system has the potential to encourage under servicing.

Midwives considering contracts or sub-contracts for maternity services must carefully think all these issues through and try to come to some agreement with other providers including deciding each other's scope of practice before venturing into any new arrangement.

The RHAs appear to be taking a very broad interpretation of quality and are relying on the professions to provide quality assurance systems and performance indicators which protect the public. We view this trust in a competitive climate with a certain amount of cynicism. Our best quality controller is to involve the consumers as an integral part of any contractual arrangement. Midwives are urged to build connections with women's groups.

Points to Consider when Planning to Contract for Services

1. What services do you want to provide?
 - e.g.- total midwifery service and continuity of care?
 - postnatal care only?
 - how many births?
 - any limits of service?
2. How, when and where will you deliver these services?
 - e.g.- midwife only
 - shared care
 - in hospital or home
 - geographical area covered
 - collective contracts
 - compatible philosophy if grouping with other providers
3. What staff and resources do you require and under what sort of contract?

- e.g.- the resources, premises, equipment, software you have and/or need?
 - information systems
 - sub-contracts to home help, Lactation consultants, GPs
 - the method of payment for contract service?

4. What will the service cost to provide?
 - e.g.- cost of midwifery care
 - cost of referrals, investigations
 - administration costs
 - locum cover, insurances, equipment costs
5. How to ensure a quality service?
 - e.g.- meeting NZCOM Standards of Care
 - providing women's choice and satisfaction
 - providing continuity of philosophy and care
 - peer review, client evaluation and complaint mechanisms.
 - outcome statistics, documentation.

We are acutely aware hospital midwives are to face massive changes depending on the type of service the CHEs decide they will offer.

Some may only provide level 3 services and contract or leave normal services to outside providers. Some will contract for primary and secondary services and expect midwives on the staff to carry their own caseloads. Some will contract out their postnatal services and/or antenatal education. Most will reduce staff numbers and costs to increase their competitive or market edge. Many of these changes will offer midwives opportunities to expand their practice, but many will deny midwifery independence and continuity. Either way it is unlikely life will remain the same in the long term.

In addition to these disruptions competition itself brings disharmony. The health reforms will intensify the problems midwives and women have experienced in the years since the Nurses Amendment Act, as providers compete for clients.

The only chance women have of a cohesive maternity service and a strong midwifery profession - is if midwives are united in partnership with their women consumers. They must take an active part in the changes.

We must respect each other's practices and women's choices, value our differences and find compromises in difficult situations.

An understanding of the wider picture and its consequences is essential and midwives are urged to meet together and discuss each change they are faced with, in order to decide on the best direction for midwifery and the maternity service. ■

INNOVATIVE ORGANISATION

Elizabeth Tully

Sociologist

*(Karen Guilliland's responses
are in italics.)*

An important theme within contemporary sociological writing is the need for new ideas and approaches to the understanding of emerging forms of social organisation. This work challenges taken-for-granted perceptions about the organisation of social phenomena such as the family, economy and policy by revealing how complex and diverse the relations within these institutions are. Such an analysis focuses on the actual patterns or networks of social relations in which actors are located. It seeks to explain how creative, responsive people, who are both enabled and constrained by the contexts in which they are located, establish networks of relations which make new social forms possible.

This theoretical approach is therefore concerned with the way in which relationships between people shape their interests, strategies, resources and outcomes. I would like to draw on the idea of organisations as social constructions, whose structure reflects the nature/type of social relations from which they emerge, to explain the formation of the New Zealand College of Midwives. My objective was to examine the establishment of this professional organisation as a means of exploring how organisations are shaped. I spoke to Karen Guilliland, the inaugural president to hear her account of the process. To this account I have added some theoretical ideas about the development of professions.

The Process

The process began with the politicisation of the midwives who belonged to the Midwives' Section of the New Zealand Nurses' Association. With changes to the Nurses' Act in 1983 which allowed non-midwives/nurses to provide maternity care, there was a realisation that midwifery was not going to survive as an occupation unless midwives gained an independent, professional voice. The involvement of nurses in maternity care also highlighted the philosophical differences between those who believed that midwifery was separate to nursing and those who believed it was a branch of nursing. While not all midwives believed the former, an increasing number became dissatisfied with the latter.

The growing unrest within midwives' ranks was greeted with hostility by the Nurses' Association which argued that it could represent midwives' interests. Many of the nursing leaders held midwifery qualifications and therefore identified themselves as midwives. However, from the perspective of some midwives, these nurses were entrenched in the hierarchical, hospital-based medical model.

A midwifery conference in Auckland in 1988 provided the context for further developments in the professionalisation process. A paper entitled 'Midwives or Moas', given by the outspoken domiciliary midwife Joan Donley, was the catalyst for collective action.

It was decided to form a working party to form the New Zealand College of Midwives. The composition of this working party was crucial to the emerging College. It was a critical stage in the development process and midwives had to mobilise their resources in support of their collective goals.

It was totally in line with how we had been going that consumers would be represented in that working party. It wasn't even discussed – it was just assumed that the consumers would also be involved in the formation of the College. And so consumers and midwives were nominated for that group. They were charged with sorting out a constitution to bring back to the Midwives' Section.

As well as writing a constitution, the working party spearheaded a concerted effort by midwives to forge networks with women's groups. Both midwives and consumer representatives discussed midwifery philosophy with various groups including Maternity Action Alliance, the Home Birth Association and Save the Midwife. Guilliland regards the combined effort that went into the writing of the College's philosophy and standards as a crucial part of the process.

I have been involved in nursing for 25 years – in a political way and as a teacher of nurses and midwives – and I have never known standards to be written and to be used in the way that the midwives and women wrote them. They actually came out of a collective philosophy whereas the standards of nursing were, I think, an academic exercise.

As well as providing a philosophical framework for the emerging College, the discussions about midwifery philosophy helped midwives construct an independent professional identity. As this identity was based on their partnership with women, it had feminist overtones which some of the more conservative midwives had difficulty accepting.

One of the concerns that was raised during the discussions about midwifery philosophy was that there was no mention of the fetus or the baby. The midwifery philosophy is that you are woman-centred, not baby-centred. In talking that through over a two year period people came to recognise that this was what made us, as midwives, different. It is not that we do not think that the baby is important, it is that we never separate the baby from the mother. There are not two 'patients' – there is one – it is the woman and she has a baby.

I think that the process of talking the philosophy through made some midwives realise that this wasn't a radical concept.

When you say woman-centred a lot of midwives are threatened by the language used. But we kept saying not to be frightened by feminism – feminism is just a social theory – midwifery has aspects of that theory. I would just say that we are trying to redress the balance and give women equity, access and choices.

The Context

In analysing how and why the Midwives' College took the particular shape that it did it is necessary to consider the social and historical context in which the formation process took place. As this assignment argues, organisational outcomes are not called forth in an automatic and unconditional way. They emerge from the alternatives that the social and historical context makes possible. In the case of the College, the activities of the women's health movement in the 1980s contributed significantly to changing political attitudes towards the provision of maternity care. Midwives' and consumers' challenges to the medical profession's monopolistic and technologically-driven approach to obstetrics met with a favourable response from policy makers who were endeavouring to make health services more competitive, flexible and cost-effective.

Not only did midwives have consumer support for their traditional, woman-focused approach to birthing, but they also had a powerful political ally in the then Minister of Health, Helen Clark. Clark was concerned about the status of women's occupations generally and was particularly sympathetic to the plight of midwives. She was instrumental in bringing about the Nurses' Amendment Act in 1990 which

gave midwives the right to practise independently of the medical profession. As Clark was part of a government which aimed at increasing competitiveness by deregulating health services, she could mount a strong argument against the monopoly of registered medical practitioners over the supervision of childbirth.

The Cartwright Report fuelled a growing disillusionment with the medical profession, the inquiry led to consumers gaining a greater say in the provision of health services by various means including patient advocates in hospitals and consumer representation on medical committees.

The Outcome

The New Zealand College of Midwives officially opened in April 1990. It gave midwives a new professional and political identity; one constructed in alliance with the consumers for whom they provided a service, rather than their nursing colleagues. By setting up their own organisation midwives created the opportunity to articulate their claim to professional autonomy in both the public and the political arenas. And, by involving consumers at a national, regional and community level of College activity, they demonstrated their commitment to working in partnership with women. In joining forces with consumers they succeeded in making the re-establishment of the midwifery tradition synonymous with reclaiming women's control over the birth process. At the first national conference following the formation of the College, Guilliland said:

The formation of the College legitimises our profession; it gives us, midwife and consumer alike, a focus, a place to cement ideas, to formulate plans for innovative practice, and allows us to promote the maternity service women want and deserve. It distinguishes us as a separate entity to nursing and, make no mistake, that will be the only way midwifery survives as a profession in its own right.

Two years on this professional-consumer alliance is proving to be a successful, if somewhat controversial, organisational form. While there are midwives throughout the country who will not join the College because of the consumer involvement, those midwives who do belong have supported equal membership rights for lay members.

When we started we needed to restrict consumers' voting rights because midwives really panicked about being taken over by consumer groups. As there were only three consumers on the 10-member national committee this seemed very unlikely. However, it was a sort of

evolutionary thing. People needed their own time to come to a full understanding of what consumer involvement means. Two years down the track we have taken this restriction out of the constitution so that consumers have full membership rights and can vote on everything. There was no opposition to this move at all – and yet when we first talked about it there were enraged midwives up and down the country. There are still area midwives who won't join the College because of the consumers in it. But I think there is less and less of that feeling.

From Guilliland's perspective, as a politically active health professional, the professional-consumer partnership makes for a very productive relationship. Apart from the fact that it is tangible evidence of the midwifery philosophy, it also ensures that midwives do not become professionally introverted.

If you really do believe that midwifery is a partnership then there is never an issue as to whether you are a woman or a midwife on a committee. In fact, it is the most successful way of working that I have ever been involved in as a health professional. I've been on the Nursing Council and I know that the way we work is infinitely easier than the way the nurses are working. You get so self-consumed and so self-absorbed within a profession that you lose sight of what it is that you have a profession about. The women are much kinder on us than we are on each other – that balances a lot of the punitive, obsessive stuff that oppressed groups get into. The women say 'hang on a minute – aren't you being a bit tough on yourselves – you don't have to always punish yourselves'. That amounts to permission from the women to move on – and that is very important.

The other thing is that the women do not give up on issues which are important to them like, for instance, breastfeeding. The reason that we have really persevered with breastfeeding is that we have had consumer involvement from La Leche League at a national and a regional level and they've kept us on our toes. When midwives have been frustrated and found it difficult to get complimentary bottles removed the consumer says 'you just have to'. 'We'll go back to league, and write a letter, and we'll do this and we'll do that.' And there's a feeling that we're not by ourselves – there is a whole consumer network out there that is supporting us and gives us energy.

Opposition to consumer involvement is not limited to the more conservative midwives in New Zealand. The College faces the possibility of being expelled from

the International Confederation of Midwives over the issue. The concern is that lay membership of the professional organisation destabilises the profession and takes status away from midwives.

I find it fascinating that it is thought that to let women join a professional group of midwives takes status away from midwives; our whole philosophy is that our status is in the women – that is the only status we have. Internationally midwives want the sort of status that joining the boys gives them – lawyer, doctor, accountant status. What we are saying is a feminist argument really – you don't join the boys, you stand up in your own right, make yourself have status through what you are and who you are.

We do not believe that the I.C.M. is constitutionally able to deny our membership, but it may be, that is what some may want to try. I believe it would be a remarkably anti woman stance if the I.C.M. expelled a group of midwives because they had women in their College! Until international midwifery accepts the partnership model I don't think midwifery's profile and status (in the western world at least) will progress, because that is the only thing that makes us different from a medical model.

Discussion

In concluding, I will briefly outline some relevant ideas on the social organisation of professions from the theoretical model developed by Abbott (1988). Of particular interest to this discussion is how the organisation of a profession relates to its claims for jurisdictional authority over certain work. I will then make some observations on how and why the Midwives College came to take the form that it did. It should be recognised, however, that this is not a definitive account of the formation of the New Zealand College of Midwives. It is one attempt to relate some contemporary sociological ideas on the emergence of new forms of social organisation to an actual example.

According to Abbott's system model of professions, professional groups are bound to particular sets of tasks by jurisdictional ties which are neither absolute nor permanent. At various times these ties are created, abolished or reshaped through the process of interprofessional competition. Thus jurisdictional claims furnish the impetus and the pattern to organisational developments (1988: 2). While professions vary in the type and extent of their jurisdictional claims, every profession aims for a 'heartland' of work over which it has complete, legally established control. Abbott says:

In order for professions to have control over certain work, they must gain jurisdiction over it. It is not enough for a profession to simply perform skilled acts and justify them cognitively, it must claim publically-recognised rights such as monopoly of practice, control of professional training and rights of self-discipline. These jurisdictional claims are staked in various social arenas including the public media, the legal system and the workplace. Of concern is the idea that the successfulness of such claims is affected by the social organisation of the profession.

This idea of professions competing for social/cultural legitimation of their jurisdictional claims over work highlights an important aspect of the alliance between midwives and consumers in the College. In a challenging and innovative way, midwives have collapsed the boundary that normally exists between the professional with her/his expertise and the lay client/consumer. Rather than basing their claims for professional recognition on superior knowledge and skills, midwives argue that their professional status is derived from their partnership with women. Hence, while they are competing within the system of professions, which Abbott describes, they are doing so on a different basis – a basis which challenges some of the taken-for-granted rules of professional conduct.

In terms of interprofessional competition, the alliance with consumers has advantages for midwives in that it helps to secure access to work in the competitive maternity marketplace. As independent birthing practitioners, midwives would have to compete with doctors (both general practitioners and obstetricians) for clients. Given the medical profession's dominance over the provision of maternity care, midwives face considerable professional opposition to their jurisdictional claims over the management of normal childbirth. In this competitive interprofessional situation midwives' jurisdictional claims would be given greater authority by the social/public support that comes from their partnership with consumers.

Another significant aspect of the alliance with consumers is that it enables midwives to construct a professional identity radically different from that of nurses. Having finally extracted themselves from beneath the umbrella of the medically-oriented nursing profession, midwives need to clarify in the public mind just how and why they are different to nurses. Basically they need to promote their woman-centred, social birthing philosophy. By making the relationship with their clients/con-

sumers explicit in their professional organisation, midwives demonstrate both their commitment to women and their difference from the medical profession.

While there are advantages for midwives in being in a formal partnership with women, there are also disadvantages. As suggested in the introduction, people often find themselves enabled and constrained by the contexts they are in. While the unorthodox professional arrangement enables College midwives to engage in a productive relationship with consumer members, it constrains their relationship with colleagues who are opposed to lay membership and it may be constraining in terms of professional recognition from their international colleagues and other health professionals.

It is evident from this account of the formation of the Midwives College that the social networks in which midwives were embedded played a crucial part in shaping the structure of their professional organisation. In mobilising their resources for collective action, midwives recognised that their relationship with women, both as individuals and as members of consumer organisations, was a vital aspect of their professional existence. In the social and political context of the late 1980s, when consumer activism brought results, this relationship provided a useful foundation for an emerging professional organisation. An organisation which clearly shows how creative human actors establish networks of relations which make new social forms possible.

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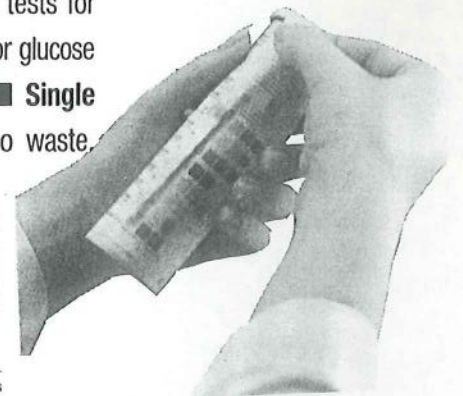


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old new one
she is to us a gift

Te Koha

Te Koha

Janna Russo

2pm, Friday 6th September 1991, a feeling from deep within, intuitively I knew my time of growing and carrying Te Koha within my body was drawing to an end. Instinct told me that I had felt my first contraction.

Excitement welled within, I had been waiting to meet her for nine months. As my first experience with childbirth 15 years ago had been a 'far from joyous' occasion, I tentatively awaited the arriving of Te Koha. At that time a 16-year-old, I prayed that the act of birthing would be kinder to me at 31.

Today, as I write, Te Koha is 11 weeks old. I have but a scattered recollection which will come together and form a story I'm sure.

To start with, my biggest fear was the fact that I was likely to shit during birthing. In front of others? What a shrink. I wondered whether there was any way I could prevent such an unsightly event. Needless to say I did a lot of praying for emotional maturity. I had been told that the only thing that would prevent me from having a magnificent experience would be my own fear. I stuck with that and got brave with the prospect of shitting myself. After all, what can she expect? Birthing is the greatest natural 'opening' and 'letting go' known to humankind.

Well anyway, she was coming. All day I got about in my nightie, the short cotton number with the frilly shoulder straps and bright polka dots. I even ventured out to do some shopping hoping that no one would recognise its 'nightdress' appearance. Too bad ... I didn't care what anyone thought... Te Koha was coming and I was comfortable.

It was not surprising given my cultural background – mother Maori, father Italian – that I started craving raw mussels and salami 24 hours into my labour. These two foods I've adored since childhood so it was kinda symbolic of security. And I must add not just any kind of salami, it had to be just right. So off Nicho and I trots to the Deli counter to investigate salami. I wonder if any heads turned to gaze at that polka dot nightie. My contractions were approximately 10 minutes apart. So every so often I'd lean on Nicho's shoulder and 'fire breathe' through a pain. I still remember the excited and proud gleam in Nicho's eyes as he advised shop attendants that "this is my partner Janna ... we're going to have a baby today ... she's in labour!" Much to their delight and fascination. Well me... I just wanted to cut a track and explore the exquisite taste of raw mussels and salami on French bread.

Now, by the time the word was out and the 'aunties' started gathering. Mmm 'the aunties'. Four women that I love very much. Four women whose voices were very familiar to babe through the wall of her home, my puku (stomach). Four women whom I felt privileged to have at my side during my journey. Aunties (alphabetical order so as not to offend) Charlotte, Jenny, Mary and Rhonda. Mmmm, words just couldn't describe the magic of their presence.

And Nicho throughout ... as close to me and babe as ... a whisper. Safe in the knowledge that all I had to do was reach out my hand and feel the gentle and reassuring squeeze of his hand in mine. For your presence Nicho ... ka nui taku aroha. Anyway back to business. Te Koha was a coming and there would be no stopping her.

I'd made one phone call to Julie, I think at approximately 7 pm on Friday night. Well, by 8 pmish on Saturday night I had had enough of this labour

business. By this time I was down on my knees fire breathing every six or so minutes, I'd read horror stories about women's cervixes dilating only 1-2 cms after hours of labour and I thought that must have been for me as well. I couldn't bear it any longer, I was tired and I wanted to know the news, good or bad. Julie sounded surprised that I was still labouring, she had assumed that the contractions had ceased the previous eve. I said "nope, I've been in labour for 30 hours and I'm tired". So Julie being Julie (on a scale of 1-10, Julie is 15 in my books) arrived equipment in hand in approximately 20 minutes.

To cut a long story short, sure she was a coming, although that babe was a coming real slow. I was 6cms dilated and our waters hadn't even broke yet. Needless to say, I wonder if she could crochet with those long plastic thingies that look alot like crochet hooks?

GUSH! Now I know why a *big* pile of towels is recommended. Beautiful warm water from within. That's when the birthing smells started for me. It was all on. It wasn't long before everyone in the room disappeared during contractions. Physically they were still there, Nicho, Julie and the four aunties, although to tell the truth, they could all have been doing handstands during my contractions and I wouldn't have known. For at those times I visited a place deep within myself where all that existed were me, Te Koha and God (God being the Universal Energy of Love).

Oh, by the way, by this time the candles had been lit and it was totally candlelit affair. Soft and calm on our spirits.

I had previously had all these ideas of where and how I would give birth, in the bath, squatting, kneeling. I'd thought "women rise from the hospital gurney and have their babies where they choose". Being a gentle feminist I never thought I'd have a baby the way that I did. Guess how? Lying on the bed on my left side. Yes, I tried other ways but that was where I was most comfortable. And believe me COMFORT COUNTS!

Our 'precious cargo' finally made her entrance into this world at 12.15 a.m. on Sunday the 8th September. "Haere mai Te Koha ki te ao marama. Welcome Te Koha, into the world of light."

As soon as she was placed on my chest, only seconds after she was born, umbilical cord still intact, the previous 34 hours and 15 minutes seemed all worthwhile. I'd do it all again with pleasure.

After two knots and then with sharp scissors, Nicho had the honour of severing Te Koha's umbilical cord. She had well and truly entered this world. From now on in, our bond would be connected via intuition and instinct.

And that my dear friends was only the beginning I'd like to extend my special thanks to Julie, whose presence and subsequent home visits provided for me the drive to contact and celebrate my own courage and strength. As a mother, I acknowledge and celebrate my own magnificence. I bore and grew those children, my body embracing and nourishing new life. And to you mothers out there e wahine toa ... e wahine ataahua. You are all beautiful strong women.

I'd like to finish by sharing something that was gifted to Te Koha from her godmother Steph (fondly known as Sam). It's taken from the prophet. It goes like this:

And a woman who held a babe against her bosom said, 'Speak to us of Children.'

And he said: Your children are not your children.

They are the sons and daughters of Life's longing for itself.

They come through you but not from you.

And though they are with you, yet they belong not to you.

You may give them your love but not your thoughts for they have their own thoughts.

You may house their bodies but not their souls, for their souls dwell in the house of tomorrow, which you cannot visit, not even in your dreams.

You may strive to be like them, but seek not to make them like you. For life goes not backwards nor carries with yesterday.

You are the bows from which your children as living arrows are sent forth.

It's been really enriching for me to put this story to paper. I hope these words from my heart reach your heart.

Ka kite (see you).

P.S. Te Koha in Maori means The Gift.



Letters to the Editor (Continued)

care is consumer driven, please produce the supporting research. ■

M. Henderson
Consumer/Midwife
Auckland

Impressed

Dear Editor,
I am a midwife working in a Birth Centre in Sydney, Australia.

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Yours sincerely,
Jenni Andrews
Sydney



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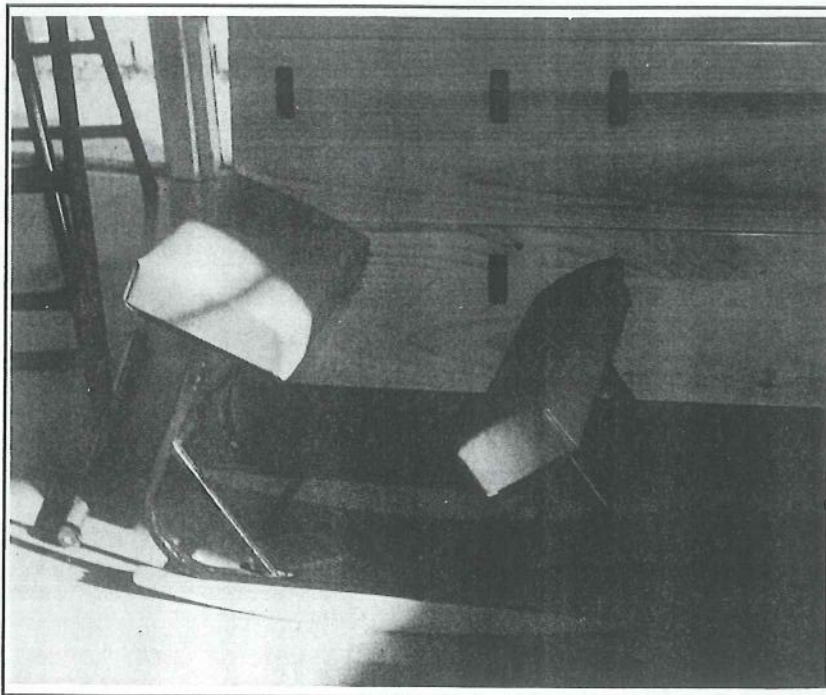
Fridays 8.00 am - 3.00 pm

I have used this rocker for my clients for several years. It is of great value in coaxing unborn babies into the most suitable position for an easy birth.

If first-time mothers will use it at meal times and when watching television, from 34-36 weeks of pregnancy, and other mothers from 39 weeks, they will definitely increase their chances of an on-time, short-as-possible labour and reduce the risk of post maturity, induction, forceps and caesarian section. It has a totally non-invasive action, so is safe for all mothers to use.

Jean Sutton (Midwife)

Independent Consultant for Normal Birth



The frame of the rocker is in black, with the padding and rockers being a smokey blue colour. The price is \$191.25 GST inclusive. (Freight to your city/town is extra.)

If you would like to find out more about the Maternity Rocker please ring (07) 849-3606 and ask to speak to Barry Wilson or Kirsten Hosking.

The Hamilton Workshops and Training Centre (Inc.) is a non-profit organisation which works in partnership with people with disabilities.

One of our sections is a metalwork and wirework division. Our workers work in teams and are supervised to ensure strict quality control. The Society prides itself on producing high quality products.

Placenta

A User's Guide

Kim Wheeler

Midwife

What's the big deal about your placenta? Well, your baby's placenta is as important to your baby's growth and development as your baby's genetic make-up.

Instead of saying 'You are what you eat,' maybe we'll all be saying in the future 'you are what your placenta makes you'.

In this guide I would like to introduce you to some of the interesting things about the placenta, its range of functions, and to a 'user's guide' of terms you might hear about the placenta.

The Third Stage of Labour - the End First

Soon after your baby is born, the third stage of labour begins. This is where the placenta is born. This stage is generally accompanied by some bleeding, until the muscles in the uterus clamp down and stop the flow of blood. The bleeding continues for several days but should only be about as heavy as a period.

Most placenta are round in shape and look and feel pretty solid. Some people think their placenta looks like liver but there are a lot of differences, outside and in. At this time, you'll be able to see the side that acted as an exchange area for the food that your baby gets from your blood. This side or the 'maternal' side, is very red and bloody, and lumpy looking. The lumps are formed by many tiny clumps of blood vessels that carry the babies blood to the 'exchange barrier'. This barrier is formed by the cells of the placenta and is where the nutrients from the mother's blood cross the placenta into the baby's blood.

The other side is smooth and has lots of big visible blood vessels. This side is the side closest to the baby. The smooth shiny covering which is usually white, is continuous with the membranes that keep the baby

in the liquor, amniotic fluid or waters.

You'll also see the cord. The cord has three blood vessels which carry blood from the placenta to the baby and back again. The cord is attached to your baby's umbilicus.

Before Implantation - Back to the Newly Fertilised Egg

At the time of implantation, which usually occurs around 3-4 days following fertilisation, the fertilised ovum (called a zygote at this stage) is 'free-living'.

"You are what you eat", maybe we'll all be saying in the future "you are what your placenta makes you".

As the zygote floats down the fallopian tube to the uterus it divides many times producing a solid mass of cells within the original outer layer of the ovum.

The zygote is now called the morula. The morula is covered with a sticky protein layer which means that it can stick to the wall of the uterus.

A space filled with liquid develops in the centre of the cells of the morula when it has adhered to the wall of the uterus. The morula is then called the 'blastocyst'.

Inside the blastocyst is a little clump of cells called the inner cell mass, these become your baby. A layer of cells one layer

thick covers the blastocyst and these are the first cells of the placenta - the trophoblast. The cells of the trophoblast that end up closest to the blood vessels that nourish will become the placenta. At this stage the protein layer outside of the trophoblast breaks down, its job of helping the morula stick to the wall of the uterus is finished. The process of implantation starts.

Implantation

Implantation begins when the protein coating of the morula breaks down and the cells of the blastocyst from the blastocyst stage begin to grow into the tissues of the mother's uterus. The first placental cells, which are already producing hormones, can also produce enzymes that break down the cement like proteins found between the cells of the endometrium or the lining of the uterus. The placenta stops breaking down this cement when it comes into close contact with the blood vessels that feed the tissues of the uterus.

At this point small pools of the mother's blood are formed around the tiny blood vessels of the placenta. The small blood vessels in the area of the placenta get taken over by the placenta. The pressure of the blood coming into the lakes forces the blood that is already there out of the lake back into the uterus. In that way the blood is always being changed for the fresh blood ready to feed the baby. Your blood and the baby's blood never mix and nutrients cross through the cells of the placenta by several paths.

Food for the Baby

The placenta does most of its growing and spreading in the uterus in the first 10 weeks of pregnancy and is fully mature at the



end of the first trimester of pregnancy (from this time until the birth, the baby is called a foetus).

There are several steps for nutrients to get into the placenta that are in close contact with the mother's blood.

The nutrients must then move through these cells to the membrane on the other side of the cell into the baby's blood which is circulating in the placenta.

The baby needs all the nutrients that we do to stay healthy. These are vitamins, amino acids—which are the building blocks of proteins, carbohydrates like glucose, minerals, and fatty acids that make fats and oils.

The baby makes its own stored by assembling them from the fatty acids from the blood. Fats can be used for energy generation throughout pregnancy. Storage of fats by the baby takes place mainly in the last few weeks of the pregnancy.

The type of fat that makes cell membranes, is transported in large quantities initially. This is so there are sufficient amounts of liquid for the huge number of cell divisions occurring as the baby grows. Each time a cell divides it needs enough liquid to create a whole new membrane, or coating for the daughter cell.

Also transferred by the placenta to the baby are immunoglobulins, proteins that keep the baby free from diseases when it is born. These all come from the mother's blood. The placenta and the baby probably work together to make sure the baby and the placenta get what both need at different times during pregnancy.

The Paths that the Food Takes

Because the baby's and the mother's blood never mix there is a 'sieving' effect for nutrients in the places where the placenta sits in the mother's blood. There are several ways that nutrients get into the placenta and then into the baby.

The simplest process is diffusion. This can occur where there is more of a particular nutrient on one side of a cell membrane than the other nutrient will move across to balance up the each side of the membrane. Some experiments have shown that the placenta is able to adjust this process. This gives a steady flow of nutrients to the baby by moving the nutrient quickly to the baby so there is always less on the baby's side of the placenta but often a lot of the nutrient in the baby's circulation.

Oxygen in your blood is an example of a small molecule which diffuses quickly across the placenta to the baby. Similarly carbon dioxide produced by the baby dif-

fuses quickly back into the blood from the placenta.

A steady supply of oxygen to the baby is very important for the baby's development.

Placenta from women who smoke are generally smaller and 'gritty' to touch. The gritty feeling may mean the placenta is less efficient and may make the baby smaller than normal at birth.

Women who smoke during their pregnancy may limit the amount of oxygen crossing the placenta as well as exposing the baby to chemicals like nicotine that are in the blood. Smoking appears to have fairly identifiable effects on the placenta. Placenta from women who smoke are generally smaller and 'gritty' to touch. The gritty feeling may mean the placenta is less efficient and may make the baby smaller than normal at birth. The baby is small because it is undernourished. Some women who smoke don't have smaller babies and this may be due to some compensatory mechanism in the placenta.

Ethanol or alcohol, is another small molecule that diffuses easily across the placenta. Drinking alcohol is not recommended during pregnancy. Although the placenta may not be affected directly, ethanol diffuses straight through to the baby. Persistent use of alcohol during pregnancy can have devastating effects on the baby's mental development. One or two glasses of wine a night is 'excessive' in pregnancy.

Some nutrients diffuse across the placental 'cells' by 'facilitated diffusion'. This process is where a particular protein binds to the nutrient and carries it across the cell membranes. Examples of nutrients transported in this way are glucose and iron. If all the proteins that carry iron or glucose are being 'used' then the extra amounts of nutrients will not cross from the mother's blood into the placenta.

Another way that the baby gets essential nutrients is by a process called active

transport where nutrients are pumped across the placental cells. This uses energy from the cell but does not depend on the amount of the nutrient or the number of protein 'carriers' available. That energy is recouped by the placenta. The placenta gets energy from glucose and oxygen in the mother's blood and some glucose may even be transported back from the baby for use by the placenta. Just as there are proteins that transport glucose from the mother's blood across the placenta so there have been proteins identified that carry glucose back to the placenta.

The placenta produces lactate from the glucose in the mother's blood. Lactate can be converted back to glucose by the baby. Lactate and fructose, which is another sugar, are transferred by the placenta to the baby. The baby may use these molecules to store energy but may also convert these molecules to glucose to produce energy.

The recycling function between the baby and the placenta as seen with the sugars has been shown in experiments with some of the amino acids and who knows how often this may happen with other nutrients.

The Placenta Towards the End of Pregnancy

As the baby grows it begins to run out of room in the uterus around the time of the delivery date. At this time the placenta begins to become less efficient at passing nutrients and changing the environment inside the uterus to the baby's needs.

The aging of the placenta probably has something to do with the cells not being able to divide and grow and this may be programmed into the placental genes.

So here we are back where the story began at the third stage of labour! I hope you have a good look at your magnificent placenta. It really is a remarkable organ.

Note

I wrote this to present some of the most recent research findings in an understandable form for anyone interested in families. I feel this is a sadly neglected subject. I am a practising midwife and am researching the human term placenta at a PhD level.



Advertising Feature

Baby Care Products

Philip Melville
Pharmacist

A new born baby is a delicate unprotected being, open and trusting both emotionally and physically. When a mother perceives this sensitivity she looks for gentle, quality products to care for the baby. Weleda's range of Baby Care products was developed out of such perceptions and feelings.

Such an approach encompasses the whole child. The emotional life is helped by developing a strong, secure relationship with the parents through, for example, massage, frequent cuddles and breast-feeding. The baby's senses and nervous system are supported by protection from harsh light, sound and colours, and through play with simple toys from natural materials. General physical health can be looked after from many aspects, from diet and exercise to simple measures like using woollen soakers.

Weleda preparations are developed from an overall approach to life, which acknowledges the spiritual and emotional side of our nature as well as the accompanying physiological processes. The remedies attempt to harmonise bodily functions without placing unnecessary demands on the developing metabolism and immune system.

General childhood illnesses are not regarded as meaningless events but rather as a necessary part of the development process. Caring and nursing techniques are used which recognise and support the developing bodily functions of the child. Care is taken not to suppress symptoms unless such a step is necessary because the child's own systems are not coping.

An example of this can be seen in the way childhood fevers are managed. The most effective action which a child's organism can take to overcome an infection is to react with fever. All metabolic processes are speeded up and the increased body temperature is itself an environment discouraging the growth of bacteria and viruses. The treatment will vary from child to child, however, generally speaking, at the very early stages Weleda Erysidoron (Apis 3x/Belladonna 3x - a pharmacy only product) would be administered together with hot non-stimulating drinks to relax peripheral circulation and so encourage perspiration, and the patient would be kept warm.

Often such steps are sufficient to control the fever. Only if the fever continues to rise uncontrolled is it necessary to resort to antipyretics.

The active ingredients in Weleda preparations are, in the main, effective time-proven plant substances. *Calendula officinalis* is a plant which is a key ingredient in Weleda's external Baby Care products. *Calendula* has a long history of usage and is well documented as a vulnerary, however its wider medical properties are still being researched and are much debated.

Numerous constituents have been isolated from *Calendula* extracts (including saponins, triterpene alcohols, sterols, flavonoids, carotenoids, an essential oil and bitter principals), and we do know such facts as that the saponins have anti-bacterial, anti-fungal and anti-inflammatory properties. However, despite comprehensive phytochemical investigations into the constituents, as yet, no specific active principal has been identified in relation to the anti-microbial or wound healing properties of the plant. It is therefore only through the 'co-operation' of various plant constituents present in the extract from the whole herb that the final therapeutic effect can be achieved.

Other herbs such as *Echinacea* have undisputed and stronger properties than *Calendula*, and should be used on infected wounds. The great virtue of *Calendula*, however, is its extremely good skin tolerance, making it ideal for use on minor infections and irritations of a baby's sensitive skin.

Chamomile, like *Calendula*, is a member of the *Compositae* or daisy family and is used in both internal and external products. Chamomile is an important ingredient in both the colic and teething powders. Research has isolated both alcohol and water soluble active ingredients. Of the former category the principal constituents of the essential oil, bisabolol and an azulene, chamazulene, have been the subject of much research. They have been shown to have a pronounced anti-inflammatory action, to such a degree that synthetic copies are now available. The aqueous extract of Chamomile contains other active compounds including many flowers, such as apigenin, which have demonstrated a powerful spasmolytic activity. As with *Calendula*, Chamomile flowers contain a wide array of constituents, yet again the therapeutic action can only be explained by the whole - not the parts. Like *Calendula*, the whole plant is well tolerated, making it an ideal anti-inflammatory and anti-spasmolytic for preparations such as teething and colic powders.

The bases of Weleda creams and ointments are quite unique, containing substances which can easily be assimilated and do not stress bodily functions. A typical Weleda medicinal cream base is made from cold pressed almond and sesame oils, beeswax and lecithin to which oil and water/alcohol plant extracts are added.

Weleda baby teething and colic powders are non-alcohol triturations and are amongst the most popular in the Baby Care products.

'Natural' products are currently fashionable and in much demand. 'Natural' is in itself a very ambiguous term with the uninformed consumer commonly regarding natural as being synonymous with safe and effective, which is, of course, not necessarily true. ■

A Study of Student Midwives' Beliefs, Expectations and Aspirations

Gillian White

Midwife

Table 1
Number of Full-time Students Available and Consenting to Take Part

School	Number Available	Number Consenting
Auckland	37	21
Waikato	10	6
Wellington	12	12
Christchurch	6	6
Southland (1989-90)	10	7
(1990-91)	15	15
TOTAL	90	67

The Initial Response Rate = 74.4%

The subsets of students (excluding Southland), responding to

- questionnaire 2 = 78%
- questionnaire 3 = 55.5%

Table 2
Age (in Years) of Respondents

School	Range	Mean	No.
Auckland	24-48	33.3	21
Waikato	28-36	31.3	6
Wellington	25-40	30.0	12
Christchurch	28-47	37.5	6
Southland (1989-90)	24-48	30.1	7
(1990-91)	24-42	29.9	15
ALL	24-48	33.5	67

Table 3
Sex of Respondents

Female	Male	Total
66	1	67

During 1990, the year of passage of the Amendment to the Nurses' Act 1977, a comparative study was made of current midwifery education in New Zealand, and of student midwives expectations of their ability to practise as autonomous, professional midwives (White, 1991).

All student midwives undertaking a full-time midwifery course within the five New Zealand Polytechnics were invited to participate. They were sent a series of three self administered questionnaires (precourse, midpoint, and end of course). Because the Southern Region (Southland), had a different academic year, only the first questionnaire was given to students completing the course (1989-90), and students commencing (1990-91). This provided a unique sample and results were analysed separately.

Concurrently a visit was made to all Polytechnics offering midwifery courses. Tutors were interviewed using a set of predetermined questions adapted from two models of curriculum evaluation by Stake (1983) and Stufflebeam (in Clark *et al.*, 1983).

Table 1 shows the number of full-time midwifery students actually available and those consenting to take part.

Background data

Tables 2 & 3 show the age and sex of respondents.

80% of students had more than one general educational qualification with 58% having University Entrance and one student having a degree. 78% of students had attended a secondary school and/or polytechnic; 15% had attended university or were undertaking university papers.

Only 7% of students were not in work related to nursing prior to the course (3% of those being unemployed).

There were no Pacific Island, or Asian students enrolled in the sample. 85% were European (57/67); 3% were Maori (2/67), and one student indicated that she was both Maori and European.

Early Discharge

Diana Brice

Teacher – Early Childhood Education

The effects of early discharge from hospital on the attachment and nurturing processes of mothers and their babies.

Following overseas trends, the concept of shorter stays in hospital after childbirth (early discharge) has become the subject of study as to its popularity, workability, advantages and disadvantages.

Kilgour (1990) defines early discharge as a planned event, occurring from six hours after normal childbirth.

Overseas studies reveal that the advantages of planned early discharge far outweigh the disadvantages but to date, very little local research has been done. Summarising Kilgour's literature, family involvement in early discharge programmes received many advantages. For example, bonding and attachment had less negative intervention during the early hours of life. As a result of any separation, mothers and babies begin to have different responses to each other which can have both short and long term effects on their subsequent relationship (Klaus and Kennel, 1976).

Therefore it is important the aim of any programme is to ensure there is as little intervention as possible. Other benefits of early discharge include improved lactation, closer bonds within the family, less sibling rivalry, less disruption to family life and a mother who is much more confident, independent and motivated.

The system of planned early discharge from hospitals in New Zealand has been brought about by recent changes in government policy. It has been in place in the surveyed area for approximately one year. A small scale study was carried out in 1991 to assess the effects of early discharge on:

- the well-being of the family
- the effects on the mother/child relationship
- and breastfeeding.

This involved interviews with the charge midwife of the maternity ward, the community midwife and a leader of the local La Leche group. Seven mothers, representing a total of 18 births, were also interviewed to assess the consumer view.

The charge midwife stated that their early discharge system was cost effective, practical and working. Women need to be informed in early pregnancy that early discharge is expected except under medical or exceptional circumstances. Women, should be encouraged towards independence by being positively informed and by preparing a support network.

The community midwife indicated that early discharge was working well although parental expectations could lead to some problems. Mothers from the lower socio-economic group, particularly, gained from the early discharge scheme, as they were assisted through the antenatal programme on a higher scale than other groups. Many of their partners were also free during the day to attend classes and clinical visits, hence enhancing their involvement. Mothers from the higher socio-economic groups who tended to be working were less involved in this system, often because of a lack of time. However, all who were motivated and keen to learn about mothering achieved good levels of mothering skills and breastfed longer. Although all mothers were encouraged to have active births, the amount of information and motivation actually determined this.

Midwives are playing a greater role in antenatal care, the birth and postnatal care. They are becoming increasingly important to mothers and their families. Most mothers interviewed expressed a preference for midwifery care and preferred a minimum amount of medical assistance from doctors, although they valued their medical expertise.

The La Leche leader stated early discharge was good for mothering and particularly good for breastfeeding. Good bonding and attachment generally resulted if early discharge was the decision of the mother with adequate home support. However, all too often mothers are ill-informed about breastfeeding and not well prepared. Many mothers appear to be relying on a high degree of medical management and La Leche have noticed a decline in counselling and membership of their organisation.

It is vital that mothers are motivated and informed so the early discharge scheme can work successfully.

There have been many changes in hospital procedures over past years and many women are experiencing fewer problems encountered under earlier and more rigid systems. This is particularly noticeable where women have had a midwifery only birth, and developed a rap-

port with the midwife. They often stated they were able to experience pregnancy and birth with more choice, knowledge and confidence.

I interviewed a number of mothers who represented a cross section of cultural and socio-economic groups, with ages ranging from the mid-20s to mid-30s. The ages of their children ranged from five months to nine years. Mothers interviewed expressed a clear preference for the planned early discharge system but most were unsure how the system worked in its present form. Advantages expressed were:

- high success rate with breastfeeding
- better management
- more continuity in the home.

The crucial period proved to be the first two days at home following early discharge where 75% of women surveyed experienced a period of physical and psychological adjustment which included feelings of inadequacy and helplessness. However, each mother had received assistance for her problems but only after actively seeking such assistance. She usually contacted the agency with which she felt the most comfortable, e.g. midwife, family, plunket or family doctor. Partners were listed as the main support providing there was good communication and understanding. Partner involvement in the antenatal period was stated to be very beneficial.

A crucial factor to a successful system is the planning stage. This can be carried out locally by comprehensive antenatal classes, for mothers can attend alone or with their partners. Here there is an opportunity to become informed about antenatal care, birth and the care of the mother and baby. The transient nature of the population studied reflected the lack of family support networks. The quality of antenatal classes was another point of dissention as this had varied considerably over the years. Mothers with successive births tended to avoid these. All mothers wanted personal choice and shorter stays in hospital as opposed to previous longer stays and professional intervention.

The system of early discharge is still in its infancy so teething problems may occur. Mothers need to be encouraged earlier to be better informed of the choices offered and they need to establish a support network of family and professionals. The problems of lack of motivation and understanding of the early discharge system and the necessity of being informed at an early stage has largely been unrecognised by the mothers and the authorities. Finally, as the scheme develops it is encouraging to note that a lot of effort is being made to ensure its continuity and success.

References

- Kilgour, R. (1990), *Early Discharge After Childbirth*, Wellington: Department of Health.
Klaus and Kennell (1976), *Maternal and Infant Bonding*, St Louis: C.V. Mosby.



Do you have what it takes to deliver?

Midwives

If you're a practising midwife, we know you have.

And, when you come to Southland, we'll do some delivering as well.

You'll have the chance to use your skills in a country which offers professional challenges along with a very civilised pace of life.

We'll introduce you to the friendly team at Southland Hospital, Kew, and to the progressive attitudes of our Board. You'll love the relaxed lifestyle in the area, the opportunities for outdoor recreation and leisure, the cheap housing available and the fact that you can live in the country and work in the city.... need we say more.

Southland Hospital, Kew, is the base hospital for Southland in the South Island. Along with other small hospitals in the area it services a population of 110,000 people. Like other NZ Hospitals, Southland, Kew, provides free obstetric services such as ante-natal, post-natal and delivery suites.

The Hospital is staffed by a friendly team. And just to show you how highly we value our staff, we were the first Board in NZ to promote "Professional Excellence" - a system used to develop each individual's personal and professional growth, resulting in nurses being totally responsible for running wards. Our salaries are also performance-based.

Living in Southland, you'll find your lifestyle definitely changes for the better. You'll be close to lakes, mountains and rivers, with plenty of opportunity for outdoor activities such as skiing, fishing, sailing and tramping.

So if you're a practising midwife with experience, and can be registered in New Zealand, come and join us in Southland.

To find out more, write to: Mary Bunting, Surgical and Family Health Administration Officer, Southland Hospital, Invercargill. Phone (03) 218-1949, fax (03) 214-5789 for further information. Please quote vacancy no. 16/314.

Temporary and permanent accommodation is available. We even provide holiday accommodation!

SAHB Southland Area Health Board

Anne Kollis

Midwife

A solo mother of two, I had worked as a Registered Nurse until my children had left home to undertake tertiary studies. Now it was my turn to start studying again. I had always dreamed of becoming a midwife but found this very difficult to do in New Zealand.

Having completed all the necessary application forms and waited and waited, I finally proceeded to Melbourne to undertake midwifery studies.

Before too long, I graduated from Royal Women's Hospital with my much-treasured ticket in November 1989 – my 50th birthday present to myself!!

Full of pride and eager to practise, I returned to New Zealand and started work as a midwife. I was literally dying to work in a delivery suite, an area I enjoyed, felt comfortable in and had received good clinical grades.

However, of course, I had to take pecking order! So I commenced work on a busy postnatal ward and attempted to settle in. If only they had allowed us to use roller skates! The corridors were so long and the running up and down carrying necessary equipment certainly took its toll on my poor feet! I soon discovered that a trolley loaded with linen, nappies, cotton balls, lotions, thermometers, peri-pads and sphygmomanometer, plus sample tubes of Bepanthen cream etc., did the trick, much to the Charge Midwife's dismay, as it cluttered the corridor!

Bepanthen cream? – I frowned, and thought I could remember using that stuff on a geriatric women's ward as a student nurse, to help counteract urine scalding around peri-vulval areas, so what was it doing here, and for what use?

I enquired, and to my amazement discovered the samples were donated by Roche Pharmaceutical Products, Australia, for the women to use on their nipples and areola to help prevent cracking, promote healing and keep the area soft.

My mind ticked over and I thought of the 25% lanolin base and the controversy over pesticides. Yes, I remembered from my studies, the National Health and Research Council of Australia, following investigations by its working party in 1987, concluded the maximum possible exposure to breastfed babies whose mothers were using a lanolin-based ointment was well below the 'no-effect' level identified in laboratory experiments, so this did not concern me so much, but what of the preservative – Benzalkonium Chloride – used in this product?

I decided to continue with my work and just observe for a couple of weeks or so. I saw that staff were giving a tube of Bepanthen Cream to each woman as necessary, with instructions to smear a little

on after showering and after feeding baby. One woman had bought her own tube and was very liberally smearing it over her nipples and areola following each feeding.

I dared to comment on this action, explaining my concerns about possible toxicity of the preservative within Bepanthen and that it would be advisable to use the cream sparingly. I also suggested she taste the cream as she expected her baby to feed from her nipples smeared with the product.

Well as 'chit-chat' happens, this woman discussed the topic with another nurse, who in turn reported it to the Charge Midwife. The whole issue resulted in me being verbally chastised. I then discussed the matter with the hospital pharmacist and Quality Control Nurse, who wrote to Roche, Australia to obtain a report on this product. I had certainly made a point and caused a ripple!

Some weeks later, I received a copy of the report and correspondence from Roche which emphasised lanolin based products, being well below the 'no-effect' level of pesticides. Also identified in the laboratory was Benzalkonium Chloride, the ingredient I had aired my concerns about. Not satisfied, I decided to pursue the matter further.

A few hours of research later, both in the medical and university libraries, I came up with enough evidence to substantiate my concerns.

Strong points of concern were:-

1. *Toxicity rating of Benzalkonium Chloride employed at use concentrations 0.1% as a germicide and sanitiser (mice and rats) may be 3 to 4. The mammalian toxicology of Quarterly Ammonium Germicides is not well ascribed.*
2. *Concentrated Aqueous Solutions of Quarterly Ammonium compounds are primary skin irritants and concentrations as low as 0.1% to 0.5% as in Bepanthen are irritating to conjunctiva and mucous membranes (babies mouths?!).*
3. *A curare like paralysis of skeletal muscles and severe central nervous depression sometimes preceded by excitement and convulsions, has also been noted in poisoned animals.*
4. *When taken by mouth these products cause nausea and vomiting and strong solutions may cause oesophageal damage and necrosis.*

Currently working in
the USA

Conclusion

Although the concentrations of Benzalkonium Chloride (05%) in Bepanthen Cream is ascribed to be so low that it is not very harmful to a human, it is, in fact, a toxic product, and could be harmful if sufficient is digested. My concern is, women and midwives who do not understand the use and effects of the cream, are in fact offering a potentially toxic product to a baby several times a day to ingest, thus increasing the systemic toxicity level.

It not only tastes foul (have you tried some?), but has a tendency to make the nipple area 'boggy'. Recent research has indicated that the taste and smell of natural colostrum from the woman's breast containing protective antibodies, lysosomes and lipids, acts as a natural protection lubricant and healer. The smell and taste of colostrum also helps entice the baby to suckle at the breast, initiate lactation and assist in the establishment of breastfeeding.

Why then offer a potentially toxic, foul tasting product to an innocent baby to ingest?

Jan Pana Cards

Jan Pana is the sole La Leche League Leader in the Solomon Islands and is involved in exciting projects there:-

- producing radio programmes and advertisements regarding breastfeeding
- taking sessions for nurses and mothers in hospitals and clinics
- writing a national breastfeeding policy and WHO Code of legislation
- producing breastfeeding pamphlets and posters

Dunedin North La Leche League sells cards designed by Jan (cover illustration) and most of the profit goes to provide her with essential resources for her projects.

The cards are available in packs of 10, 5 of each design, with 10 envelopes.

Cost: \$6 per pack

\$50 for 10 packs (postage included)

Send order with payment to:

Dunedin North La Leche League

Tui Bevin

129 Signal Hill Road

Dunedin

Ph. (03) 4738 677

New Zealand College of Midwives

Membership Form

B.O.M.
P.O. Box 21-106
Christchurch

Regional Information

Name _____
Address _____
Telephone Home _____ Work _____
Place of Work _____

Subscription Enables:

- * A Professional Midwifery Organisation
- * Establishment of an office and a National Midwifery Centre
- * Employment of a Co-ordinator for the College
- * Professional Indemnity Insurance

Type of Membership

Full Member (Registered Midwife Full or Part-time)	\$155.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	\$50.00
Associate Member (with Indemnity Insurance)	\$155.00
Associate and Affiliated Member (Other groups e.g. Parent Centre, La Leche League, etc, and other interested individuals)	\$30.00

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 _____ Are You: [Delete One]

New	
Renewal	
Change	

NZNA Member: YES/NO
NZNU Member: YES/NO
Claiming on Maternity Benefit Schedule: YES/NO

Type of Membership

Full
 / \

 / \

 Waged

 Unwaged
Associate with Indemnity
Associate Affiliate

Place of Work _____

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

Northland
ROSE RAE
P.O. Box 4219, Kamo
Whangarei

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

Waikato/Bay of Plenty
VIOLET STOCK
c/- Tauranga Maternity Annex
Tauranga

Eastern/Central Districts
ANDREA GILKISON
43 Rangitane Street
Palmerston North

Wanganui/Taranaki
AILSAS STEWART
Women's Unit, Base Hospital
Wanganui

Wellington
VIV McENNES
P.O. Box 9600
Wellington

Nelson
BRONWEN PELVIN
P.O. Box 672
Nelson

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

Otago
JO WALLIS
P.O. Box 6243
Dunedin North

Southland
JO MAWDSLEY
P.O. Box 31, Wakatipu
Queenstown

WELEDA

Baby Care Preparations

have been working effectively for over 60 years.

The WELEDA Baby Care Range is formulated from biodynamic plant extracts, first quality plant oils, unadulterated natural essential oils and waxes to provide effective and natural protection, while still allowing the skin to breathe.

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 recognizes 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.

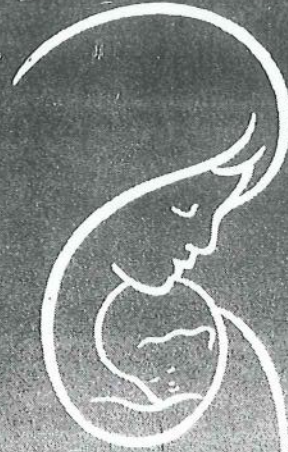
Calendula, the original Marigold, has been widely acknowledged as a healing plant: herbalists call it a vulnerary. Research shows the Calendula plant to possess marked anti-inflammatory and antiseptic properties. The mild and soothing qualities of Calendula, make it WELEDA's perfect choice as the basis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

A practical booklet entitled "WELEDA Remedies for Mother & Child" is available for Health Professionals.

For your free copy write to:

Dept MJ, WELEDA (NZ) Ltd,
PO Box 8132, Havelock North.

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!