SAVE THE MIDWIVES

AUGUST '88 NO. 16

CONTENTS:

A SIGN OF THE TIMES:

Midwifery has entered into a momentous phase of positive change and unity which is looking good for the future of the profession and for the women and babies whose care is so inextricably bound up with the "health and wellbeing" of the midwifery profession. As Caroline Flint so accurately states -

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

Midwives in New Zealand now have a college which has been established to represent their professional interests as a profession in its own right; focusing on the issues that are of importance to midwives. This is a national organisation formed to support and promote the profession of midwifery and has been enthusiastically welcomed by midwives with a rapidly increasing membership. International comment is also very favourable.

Although not yet official, a pay increase has been granted to domiciliary midwives following the work of a paid negotiator Kelly Grovehills. Instead of a flat rate of $150 for labour and delivery as exists at present; the fee will change to $220 for the first 6 hours or part thereof, then $37.50 per hour after that. The official announcement will state when this is to take effect from, but this increase will enable more midwives to consider domiciliary practice as a realistic option.

The unfortunate case of complaints by a hospital midwife against a domiciliary midwife has both emphasised the need for more positive communication and understanding between midwives and the varying roles they perform; and exposed a couple of anomalies within the disciplinary procedure. It was revealed that the Nursing Council is not subject to either the terms of the Official Information Act, or enquiry by the Ombudsman; and that they are not required to notify the nurse or midwife that a complaint has been made until after investigations have already been conducted. Inevitably this resulted in the midwife concerned finding out second hand from unofficial sources. Changes are currently in process to rectify these problems.
For those of you who have followed and supported this case, you will be pleased to hear that the Nursing Council has dismissed the complaints and advised no further action.

Another positive development in the continuing struggle surrounding womens health issues is the recently released report by Judge Sylvia Cartwright following the Cervical Cancer Enquiry. Her recommendation for employment of patient advocates is a significant acknowledgement of the vulnerability of women within the health care system.

Judi Strid

MIDWIFERY WILL FLOURISH IF WE.....

- Recognise consumer needs
- Respond to society demands
- Act collectively to achieve change
- Support each other
- Encourage and respond to peer review
- Value midwifery as an essential service
- Take an active interest in our College Of Midwives
- Provide continuity of care and reclaim our role
- Update skills and knowledge base constantly
- Research and record our practise
- Take every opportunity to educate re. birth as a normal life process; and halt the interventionist trend towards childbirth.
- Change the Nurses Act.

Women and Midwives go forward together - Karen Guilliland

Giving Birth - How It Really Feels - Shelia Kitzinger

Despite various improvements that have resulted from pressure by women - a fundamental change in attitude is necessary. Women after all, are not "consumers". They are producers. They give birth to babies. The commercial model is an unsuitable one - We need instead to develop a model of care based on a sense of community of service to support the natural process of birth and respond to women's needs.

* Honey has been shown to be good for relieving diarrhoea in babies. A study involving more than 100 children admitted to hospital with gastro-enteritis found that honey could be used to rehydrate the children, its bacterial qualities helping to cure the condition. The recovery rate using honey was described as "dramatic" compared to that of the children given a conventional rehydration fluid. (Here's Health)

* Hazardous working conditions for pregnant women -
3 Manufacturers in the US silicon chip manufacturing industry have moved all pregnant women to other work because of hazards from 3 chemicals involved in the process.
One study found a 34% spontaneous abortion rate amongst women workers in so-called "clean areas". (Tomorrows World)

RESULTS OF THE PRELIMINARY DIRECT ENTRY MIDWIFERY QUESTIONNAIRE
(extract from paper - National Midwives Conference Aug'88)
Gillian White Eyres

Early in 1988 the Midwifery Task Force received a substantial grant from the McKenzie Trust Foundation to pursue a feasibility study and curriculum outline for a 3 year Direct Entry Midwifery Course. I was asked to undertake that study and formulate a curriculum.

SUMMARY OF RESPONSES: (preliminary study)

Total responses - 582

87% (506) were unhappy about midwifery training.

80% (465) believe that midwifery is separate from nursing.

94% (550) would like to see midwives recruited to meet special cultural needs

88% (512) agree that an autonomous midwifery profession is essential for a high standard of midwifery care.

96% (561) agree that midwives are essential in the preparation of positive parenting

82% (471) strongly urge the establishment of a 3yr Direct Entry Midwifery Course, to be available in accessible areas

56% (90/161) would apply for a DE course, if available.

54% (81/150) would have done a DE course had it been available (275 answered both sections of Q7)

152 participants declared themselves already to be midwives.

Reservations were concerned with cost-effectiveness, RN's wanted assurance that there would be a shortened course, some want to be nurses first.

Some respondents felt too old to undertake a new career but support a DE course. There was concern that DE's would not be as well qualified, which is, of course where the curriculum planning becomes a crucial aspect.

A few stated they were going to undertake midwifery training in another country. There was some reluctance to reply at this early stage of DE. development, and some felt that midwifery is a specialist part of nursing. The feeling that nursing/midwifery is too academic and should return to the hospitals, is still being voiced.

One suggestion was that the first 2yrs of nursing and midwifery are done together and the 3rd yr is separated out, a 4th being available to acquire a double certificate.
Some nurses did not realise that they wanted to become midwives until after their nursing training.

There was one comment that when a student nurse working with midwives, it was NOT a positive experience.
Some felt that promotion restrictions would be too constaining
There were 3 comments that the questionnaire was biased.

There were considerably more supportive comments than negative ones. Sadly many of the respondents against a DE course seemed to think the training would reflect ideas of 20-30 years ago.

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A DE midwifery course would express contemporary thought. Health principles are common to all the health professionals, nursing and midwifery included. There should be no need for antagonism between the two, as that would certainly be detrimental to NZ society, thus I appeal for sound, objective, exploration of the concept and not emotive outbursts.

While I am trying to engage the support of several Technical Institutes to set up a DE Midwifery Course under a clause which allows them to promote innovative courses' which meet the demand of the community, other members of the Midwifery Task Force and Midwives' Section have been working on the political scene and have suggested remits to prominent organisations for the AGM's. Marilyn Waring has been available as our consultant on protocol and parliamentary procedure. We have a lot of support.

Northland Polytechnic has already requested a written proposal for a Direct Entry Course and are at present considering what I have sent to them. I would like to interest others particularly where only basic nursing courses are offered and in areas of the country with the greater needs eg. Bay of Plenty, East Coast, Central NZ., and north, mid and south of the South Island.
Copies of my course proposal outline for initial discussion as sent to Northland are available.

I'd like to close by posing a question.
Subsection 3 of the Nurses Amendment Act 1983 states "Direct Entry Midwives (midwives without any nursing qualification) may be registered as midwives, but due to lack of nursing skills, may only practice midwifery in hospitals."

Is this an admission by Government that midwifery is separate from nursing?

DIRECT-ENTRY MIDWIVES PROVIDE POSITIVE BENEFITS FOR PATIENTS

Midwives at the turn of the century were midwives. That is to say, they had set their hearts on working in the field of pregnancy and childbirth, and their entire training was geared to that end.

Today, only 3 per cent of our midwives have received such specific training without first learning how to be a general nurse. Yet a direct-entry system of training for midwives presents several positive benefits.

The direct-entry midwife has not been trained to view pregnant women as sick and, since the majority of women in childbirth are indeed perfectly healthy, her attitude towards them is likely to be an appropriate and welcome one. She is also far more likely to stay longer in the job – it is, after all, exactly what she chose to do, whereas the varied career options open to a general nurse allow for a change of heart at any time.

This longer-term career outlook by the direct-entry midwife is particularly relevant today, since the trend towards care in the community is a trend in which midwives have a big part to play.

In addition to all these advantages the direct-entry midwife, while passing exactly the same examination as the midwife who is a trained nurse first, is cheaper to train: a registered general nurse will spend three years on her nurse education, followed by a further 18 months to qualify as a midwife. But the direct-entry midwife is qualified after a three-year training, as laid down by EC regulations, and UKCC rules.

In spite of all these benefits, Britain has only one centre for training direct-entry midwives, based at Derby City Hospital and producing just eight qualified midwives a year.

The person in charge of this unique scheme is Miss Marian Young, director of midwifery education for South Derbyshire health authority. Marian, as she prefers to be called, joined the scheme nearly 11 years ago, having worked previously in the Army, first as a midwifery sister and then as an obstetric teacher to student nurses.

The direct-entry system started in Derby 50 years ago but, until the implementation of the EC midwives directives in 1981, it was only a two-year course. When Marian joined the scheme, there was a considerable stigma attached to being a direct-entry midwife, promoted particularly by the trained nurses. And indeed, that stigma remains rife today.

Marian says: "I can understand why people might have thought them different in the old days – the two-year course certainly wasn't as good and the students did tend to be much more mature, and often didn't stay in service very long or get promoted once they had qualified."

But today, Marian's students all go on to get jobs and promotions, and their most common observation is that fellow nurses continue to put down direct-entry midwives while telling them: "But you're different".

They are indeed different from midwives at the turn of the century, but no different from nurse-midwives today. Their training, whilst obviously excluding such subjects as geriatrics and orthopaedics, is intended to equip them for every eventuality. They learn about diseases affecting child-bearing women, they gain medical and surgical experience and go to the gynaecological wards, they study paediatrics and they work in acute admissions to give them the knowledge to recognise conditions like a diabetic crisis, or a pulmonary embolism, which might affect pregnant women.

One of Marian's former direct-entry students, Sue Downe, still works at Derby City Hospital having qualified in November 1985. She gained a linguistics degree before deciding to become a midwife and was told about the Derby course when she applied to be a nurse and explained to the interviewers that midwifery was her goal.

Ms Downe, 28, agrees with Marian that the direct-entry midwife's view of her patient as healthy is a beneficial one. She also says: "I think we tend to have more faith in the process of childbirth. A lot of midwifery is intuition, and maybe we trust that more than the others."

Reproduced with permission from **NHS Management Bulletin**, July 1987, pp 4–5.

Direct Entry Midwifery

(From Homebirth Australia Newsletter #14 Spring '87)

CATHERINE WILLIS

In 1981 the National Midwives Association of Australia adopted the following definition of a midwife at their Annual General Meeting:

"A midwife is a person who is trained to practise midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognise the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor and carry out emergency measures in the absence of medical help. She may practise in hospitals, health units or domiciliary service. In any of these situations she has an important task in health education within the family and the community. In some countries her work extends into the fields of gynaecology, family planning and child care."

This definition outlines the skills and areas of service of a midwife and can therefore be regarded as the basic model upon which any midwifery education programme should be based. It is reasonable to assume that a comprehensive programme would prepare the student to perform the required skills and prepare a midwife to work in the areas outlined. A Direct Entry Midwifery (DEM) programme is one attempt to rationalise the education of a midwife with the accepted definition.

The proposal of a Direct Entry course for midwifery is based on the following basic principles:

* The parturient woman is the central person in the process of care;
* All women should have continuity of care whether they are low or high risk;
* Women should have the right and responsibility to choose whatever birthplace and attendants they believe will best suit their needs;
* Services provided by the midwife should be accountable to the consumer;
* The preparation of the midwife should be specifically to enable her to fulfil her practitioner's role as stated in the definition set out above;
* The criteria for selection and curriculum design must remain the responsibility of midwives.

Prerequisite - Selection Criteria

DEM recognises the difficulty inherent in changing orientation from therapeutic care to a promotion of health and wellness. The criteria for selection should take account of such factors as reasons for undertaking the course and motivation to practise in the profession of midwifery. In Willis' study the issue of prerequisites for a Direct Entry course was investigated but there was no consensus as to the appropriateness of either academic levels like the Higher School Certificate, or tertiary qualification. Rather than academic achievements, criteria that were considered as desirable in the selection of student midwives were: previous childbearing experience; a genuine desire to practise midwifery; a caring and empathetic nature; experience working with babies and mothers; motherhood; positive attitude to health, healing, birth and motherhood (Willis, in print).

If a DEM programme was implemented at a College where academic achievement was the traditional method of selection and it was considered appropriate to determine such a level, either the Higher School Certificate or equivalent result could be used, or the results of a specially designed entrance examination could be used.

There are arguments for imposing an age barrier on students. It is thought that an adolescent, newly graduated from high school would be unlikely to have the necessary life experiences or maturity to allow them to function effectively as midwifery students or to understand the process of birth that they are expected to study. It appears that there are three broad categories of women interested in a DEM programme:

* Women who want to be midwives but find the present method of training unacceptable;
* Women who are currently working as lay midwives and want a method to have their experience and knowledge assessed and recognised;
* Women who are working in other areas of the healthcare system (eg physiotherapists or childbirth educators) who are presently interested in extending their services to midwifery (Willis, in print).

In a recent study to establish if there was a need and a demand for a DEM course, interest was expressed by a number of women for such a course. In response to the question "If a 3-year full-time (or equivalent part-time) DEM course was established would you be interested in enrolling in the course?", the following results were obtained:

TABLE 1

Number of Respondents	Interest	Enrolling Now	Enrolling in Future
85	Fulltime	28	57
133	Parttime	56	77
96	Either (with credit)	42	54

Of the 14 respondents who indicated they were lay midwives, 11 expressed an interest in some form of DEM course (Willis, in print). The DEM course could accommodate lay midwives by providing an opportunity by which these midwives who have been previously practising midwifery unregistered can fulfil the necessary educational requirements and thus gain registration. The opportunity to recognise the skills and knowledge of this group of midwives will then be available. This is not possible under the present system.

Curriculum

The increase in information and skills, particularly in the area of birth technology has led midwives nationally and internationally to question the length and content of their courses.

In the United Kingdom training for postgraduate nurses in midwifery has been extended to 18 months to keep level with the standards of the rest of the EEC. In Europe the training of midwives is almost solely by 3-year DEM courses. In most of these courses there is no advanced standing given to those who already have nursing qualifications. To gain registration in the EEC, Australian registered midwives must undertake further training to gain equivalency in qualifications. Australian midwives must surely question the adequacy of their courses if they are not accepted internationally. The introduction of a DEM programme would address this problem.

A Direct Entry course in midwifery would be offered as a 3-year full-time programme incorporating skills and knowledge in the following areas: (a) Biological Sciences; (b) Social Sciences; (c) Behavioural Sciences; (d) Natural Healing; (e) Medical Science - Preventative Medicine; (f) Medical Science - Patho-physiology. The clinical training for the DEM course will incorporate the principles of continuity of care in the following situations: (a) hospitals; (b) birth centres; (c) community health units; (d) domiciliary service. The course will also have specific content to allow the development of the following skills in the individual: (a) Stress Management; (b) Communication Skills; (c) Counselling Skills; (d) Management Skills; (e) Assertiveness Training; (f) Research and Data Collection Skills.

Implementation of DEM

Implementation of a DEM programme could take several directions. One possibility is that a curriculum could be developed and the areas of midwifery training that overlap nursing training could be determined. A course could then be developed where an amount of time would be spent combined in a common course with nursing. This is a suggestion planned for midwifery education in the UK. Such an option it is argued would give the advantage of gaining credibility with institutions of higher education. It would give Direct Entrants an easy route into general nursing and nursing practitioners could still do a course in midwifery. It would give access to already existing resources in education. However such a programme does not risk confronting the issue of the relationship between nursing and midwifery and in fact would tie midwifery to nursing even more than it is already by preventing midwifery becoming a separately identifiable profession educationally.

A second option educationally is to develop a DEM programme independent of nursing. Such a programme would recognise that there are skills from many areas that contribute to skills needed for midwifery. It would have to establish its own academic credibility and deal with the issues of access to resources, career prospects, career retention and recruitment. However this course would clarify the issue of the relationship between nurisng and midwifery. It would be a statement of the independence of the profession and would set the direction for the future of midwifery.

In Australia it could reasonably be assumed that providing there was a common method of assessment of skills and knowledge, the routes by which students gain their theoretical knowledge and clinical experience could be varied. This is particularly relevant in a country where there is such varied distributions of populations and also varied demand for midwifery skills. Hospital-based programmes could continue to allow nurses the opportunity to train as midwives. Colleges of Advanced Education could develop midwifery programmes according to the local need and demand. This would include DEM programmes. An external studies programme could also be developed for the theoretical component of the course to allow women who would otherwise be excluded because of their geographic location or particular situation to participate.

It is also necessary to consider the possibility of varied training methods because there are so many lay midwives practising in Australia for whom a full-time 3-year course by Direct Entry is just as inaccessible as the present nurse/midwifery programmes are unacceptable.

Provided there was a general set of competencies which would characterise the level of performance required for registration - eg a satisfactory standard of theoretical knowledge, observation of a number of births, assistance at births and being responsible for a number of births - the standards of midwifery training could be monitored.

Cost of Direct Entry Midwifery

A comprehensive estimate of the cost of implementing DEM is not yet available. However the present system of educating midwives is wasteful of resources and inefficient in its ability to meet the demand for midwives with an estimated loss of 50% of new graduates (Barclay 1981). Such a system is not cost effective. The proposed DEM programme would have women highly motivated in the profession after graduating. Studies in England indicate a high retention rate within the profession of Direct Entrants. Changing the selection criteria alone would seem to make training more cost efficient than the system in use at the moment. Further, because graduates are highly motivated to practise they are more likely to stay as practising midwives and would contribute to solving the chronic shortage of midwives at present being experienced in maternity hospitals in Australia. This would offset whatever extra costs were incurred in a longer training period.

CATHERINE WILLIS

References

Barclay L (1981), "How is the midwife's training and practice defined in policies and regulations in Australia today?", Health Policy, Vol 5 1981, pp 111-132.

Willis C, in print.

FOR MIDWIVES THERE ARE GOOD REASONS TO EMPHASISE THE DIFFERENCES BETWEEN THE TWO PROFESSIONS

NURSING TIMES FEBRUARY 25, 1987

Nursing and midwifery look set to part company. The partnership by which the vast majority of midwives first qualify as nurses is likely to loosen over the next 10 to 15 years. In the long term, most midwives will not be nurses.

Last week's announcement that the department of health will fund more direct entry coures for midwifery coincided with the publication of a report from the Royal College of Midwives on the future role and education of the midwife in the UK[1]. The RCM not only argues for separate training, it also omits any reference to nursing as a route towards qualification. Indeed, in a document that is rather longer on advocacy than analysis, there is just one mention of nursing and that was only included to point out differences between it and midwifery.

This enthusiasm on the part of midwives to distance themselves from nursing may seem distasteful to some nurses. After all, every one of the working group that produced the RCM report is a nurse as well as a midwife. Yet this route to becoming a midwife is neither applauded nor condemned; instead it is ignored as if it does not exist and has no future.

Yet for midwives there are good reasons to emphasise the differences between the two professions. In recent weeks it has become all too apparent that the midwife's right to practise is under threat. Some unit policies have set out specific clinical responses which, in effect, undermine the midwife's ability to exercise her clinical judgement. Given the onward march of technology and the medicalisation of childbirth which has already threatened their independence, it is hardly surprising that midwives are anxious to define professional boundaries and distance themselves from nurses and doctors alike. The last thing they want is to become obstetric nurses in the American mould, and who can blame them?

However, it is ironic that nursing and midwifery should drift apart at a time when nursing reformers are emphasising just those qualities that midwives say are so essential to their work. Nurse education is planning to place more emphasis on health, to become more holistic and place greater importance on the nurse as an autonomous and accountable practitioner.

But the departure of midwifery may not be all bad news for nursing — presumably nurses will continue to have the opportunity to undertake post-basic courses in midwifery and enrich both professions as a result.

The abandonment by the UKCC of the experimental midwifery branch in its final Project 2000 proposals[2] may also allow for some questioning of the health model of care.

If we are honest, then we should admit that the demands on nursing skills will continue to come from the sick, who must remain the profession's top priority. NT

REFERENCES

[1]Royal College of Midwives. *The Role and Education of the Future Midwife in the United Kingdom.* London: Royal College of Midwives, 1987.

[2]United Kingdom Central Council for Nursing, Midwifery and Health Visitors. *Project 2000. A new preparation for practice.* London: UKCC, 1986.

World Infant Mortality Rates from the *1987 World Population Data Sheet*

Deaths in the first year of life per 1000 live births

1.	Japan	5.5
2.	Iceland	5.7
3.	Finland	6.5
4.	Sweden	6.8
5.	Switzerland	6.9
6.	Hong Kong	7.5
7.-8.	Canada	7.9
7.-8.	Denmark	7.9
9.	Netherlands	8.0
10.	France	8.1
11.	Norway	8.3
12.-13.	Ireland	8.9
12.-13.	Taiwan	8.9
14.	Luxembourg	9.0
15.	Singapore	9.3
16.-17.	Belgium	9.4
16.-17.	United Kingdom	9.4
18.	West Germany	9.5
19.	East Germany	9.6
20.	Australia	9.0
21.-22.	Antigua and Barbuda	10.0
21.-22.	Netherlands Antilles	10.0
23.-24.	Spain	10.5
23.-24.	United States	10.5
25.	New Zealand	10.8
26.	Italy	10.9
27.	Austria	11.2
28.-31.	Brunei	12.0
28.-31.	Cyprus	12.0
28.-31.	Macao	12.0
28.-31.	Reunion	12.0
32.	Israel	12.3

DATES TO REMEMBER

EMPOWERING TO TRANSFORM - August 31 - September 4 1988
The 3rd National Ecumenical Feminist Women's Conference in ChCh - Enquiries: G. Cherry,PO Box 29-194, Christchurch

WOMEN'S MENTAL HEALTH GATHERING - 25-27 Nov'88
To be held in Auckland at Nga Tapuwae College in Mangere. Creche, wide range of food, marae, good access and facilities for disabled women.
Enquiries: Mental Health Foundation,PO Box 37-438,Parnell,Auck.

NATIONAL CONFERENCE OF CHILDBIRTH EDUCATORS - Nov 24-27 1988
Melbourne, Australia

TOUR OF NZ BY MICHEL ODENT - Dec 9-15 1988
Auckland, Tauranga, Wellington and Dunedin.
Enquiries: Childbirth Education Network, PO Box 7042, Tauranga
Pauline Scott (075)79109 or Anna Hedley (075)440272.

9th INTERNATIONAL CONGRESS OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY, Amsterdam, The Netherlands 28-31 May 1989
The main theme of the congress will be "Psychological, emotional and emancipatory aspects of women's health care."
Enquiries: Congress Secretariat, c/- QLT Convention Services, Keizersgracht 792, 1017 EC Amsterdam, The Netherlands.

NETWORKS:

CHILDBIRTH EDUCATION NETWORK
PO Box 7042, Tauranga -$15 annual sub. for quarterly newsletter

HOMEBIRTH ASSOCIATION
PO Box 7093, Auckland -$5,$10,$15 annual sub.for newsletter

IMMUNISATION AWARENESS SOCIETY
B.Heritage,3 Martin Ave,Mt Albert,Auck.-
$15 annual sub.for membership and newsletter

NZ WOMEN'S HEALTH NETWORK
PO Box 2312, Tauranga for newsletter

MATERNITY ACTION
Lynda Williams, 16 McEntee Rd,Waitakere,Auckland
(Also NZ contact for ICEA)

CHILDBIRTH EDUCATORS ASSOCIATION OTAGO
Jenny Drew, 102 Cannington Rd.,Dunedin

FERTILITY ACTION
PO Box 46148, Herne Bay, Auckland.

WORDS FROM THE PAST:

1962 -
(extract from letter to the editor of the Journal commenting on an American plan to implement a system of paraobstetric personnel which is seen by this author to be a close parallel to the NZ situation)

".....another difficulty with the nurse-midwife system is that it requires a large number of deliveries for nurse training. Obstetric nursing, including 5 normal deliveries, is now an obligatory part of the general nursing curriculum in NZ (decided on by the Nurses and Midwives Board without consultation with the medical profession), and takes so many deliveries for nurses that on occasions the training of students and interns is compromised.....:.

The physicians, preferably a body such as the American College of Obstetricians & Gynecologists will need to maintain strict, almost ruthless, control over nurse-midwife training or the same problems may tend to arise. Not only theoretical instruction, but practical work and actual patient care will require close supervision. Rigorous control of all aspects of the training will gain the physicians a valuable group of assistants; if physician control is not complete from the outset of such a scheme its originators may well receive (and merit) the execrations of future obstetricians.

G.H. Green, M.B., M.R.C.O.G.
Associate Professor, University of Auckland
Graduate School of Obstetrics & Gynecology.

Choices for childbirth

"Birth — Whose Responsibility?" was the theme of the recent annual conference of the **Home Birth Association** attended by Ministry staff.

Having a baby in our society has become a medical event. Even in the majority of normal births doctors, not women, control labour, and the use of high technology machines and intervention is common. This is called the medical model of birth.

Increasing numbers of women are choosing to give birth naturally and at home, assisted by midwives. This was, after all, common practice until a few decades ago.

Barriers to homebirth and the autonomy of midwives include the legal requirement that a doctor be present at birth, the opposition of many doctors to homebirth, inadequate midwifery education, poor pay levels and pressure of work for midwives. Domiciliary midwives have become an endangered species, according to the Home Birth Association.

The Association's aims include promoting homebirth and natural birth, raising the status and conditions of domiciliary midwives, and ensuring the survival of midwifery as a profession.

Midwifery education was a major concern of the conference. Recent changes to nursing education have meant that midwifery study will soon be largely removed from the Advanced Diploma of Nursing to become a post-basic course of its own. Midwives, however, argue that their profession is entirely separate from nursing, and that women should be able to train as midwives without going through comprehensive nurses' training first. The Home Birth Association will continue to lobby for a 3-year, direct-entry training course for midwives.

The issues surrounding homebirth and the role of midwives were covered by Jennie Nichol of the Health Department in her keynote address to the conference, **A Choice of Birthing** (copies are available from the Women, Children and Family Programme, Department of Health, PO Box 5013, Wellington). Women interested in this topic should also read Joan Donley's excellent book **Save the Midwives** (New Women's Press, 1986). For information about homebirth, contact the Association at PO Box 9130, Wellington.

From Ministry of Womens Affairs Newsletter:

NATIONAL MIDWIVES SECTION BI -YEARLY CONFERENCE 1988:

THEME: Midwifery - The Key To Safe Motherhood

KEYNOTE SPEAKER: CAROLINE FLINT.....on
Control In Childbirth and the Importance to Women

The events surrounding childbirth are of supreme importance to women. Birth is a life changing experience that a woman never forgets. They can recall each experience in blow by blow moments. She emphasised the importance of Ann Oakleys research "Transition to Motherhood" which showed that women feel victorious when in control; or like victims when birth is "done" to them.....and are then subsequently more likely to develop postnatal depression.
Birth is not just a 24 hour event, but of supreme importance in the womans life. It is important she experience a feeling of rightness.

Womens bodies are beautifully designed for childbirth and their vaginas are beautifully designed for childbirth. It is fabulous the way they are made - so clever and amazing.

Only midwives can change the enviroment for childbirth although many of them feel impotent. Childbearing women are very vulnerable particularly if they are lying down, with no knickers on and wearing someone elses clothes. Imagine everyone in the House of Parliament debating flat on their back with no knickers on and in someone elses clothes. It is ridiculous to expect anyone in this position to assert themselves.

A midwifery skill to overcome this sort of problem is to buy time. Wearing clothes helps to do this. For example, a woman finding it getting tough wants an epidural - but first she must go to the loo (takes ½hr), then she has to take her clothes off and by the time she mucks around with her clothes, she feels ready to push. If her clothes have been removed upon arrival that is an hour lost straight away.

Women are too vulnerable to change things when they are in labour so the role of the midwife is a vital one. She doesn't agree that doctors hold all the power as 75% of doctors are actually bluffing. For example, they claim theirs is a scientifically based profession - but will often have no evidence to support their practice - so it is important to present the evidence....they must go along with you. Doctors are also not around all of the time - they generally just flash in for the birth and this is the midwifes strength. The midwife is always there. When the doctor orders for the membranes to be ruptured; this is carried out by the midwife. So the midwife can state " I feel this is unethical because evidence shows that routine rupture of membranes is dangerous". (Caroline actually carries around an indexed folder with all the references she needs to produce quickly for such occasions).

Midwives are a committed profession and have the interest to change how childbirth is organised. Midwives also need help and support from women as they are also interested and committed, but only midwives can make this a high profile issue.

A very effective way of keeping a high profile is to write; and to write prolifically.

Everyone present at the conference had to promise that EVERY WEDNESDAY they would write something - a letter to an MP, the editor of a newspaper/magazine, or an article for a journal or newsletter etc., or to document what they are involved with in an effort to share their knowledge and experience with other midwives. Such action could produce 15,000 letters in a year which offers great potential for change. Writing a letter every Wednesday about the need to change the legislation will constitute an ongoing pressure. This is midwives responsibility - to write and inform. Caroline describes herself as an ordinary midwife with a big mouth and not even a wonderful writer - just very prolific as she writes all the time.

Another effective thing to do, is to every day tell 1 person about midwifery. This increases community awareness and helps promote the role of the midwife.

Choice -
Childbirth must be judged form a baseline of normality. This is more likely to happen with a homebirth where the woman gets to know her midwife and everything is conducted in her own surroundings. She eats what she wants, chooses her own position, the people present and takes ultimate responsibility. It is her pregnancy, her labour, her midwife, her room etc. This can also be done in a labour ward where an area can become the womans territory, but there must be a bolt on the door so no-one enters without her consent.

Control and choice are integral parts of our lives and without them we are diminished and lessened. Women need to feel empowered to become mothers as the motherhood role is a very important one. A woman has to be supremely self confident to be a mother. The birth and early days of preparation for mothering need to both prepare and empower women.

Know your midwife?
We have devised a system for pregnant and birthing women to see as many different people as possible. The number of health professionals that women come in contact with during this time is phenomenal and distressing. For instance at the change of a duty the day staff come on to find a labouring woman going up the wall and wonder what the night staff have done. But she was OK before.....its the change of face that did it! Under such circumstances, it is a credit to human ingenuity to give birth normally whilst having to relate to all this.
Women all over the world face this every day.

We have divorced ourselves from central processes which is fine for some situations - but not for childbirth; yet this is what is happening to women. Women are being destroyed not empowered; and midwives are also being destroyed as their practice is disempowered. The beauty of the profession is the committment and the excellent quality of care - but it is fragmented. Midwives are in a no win situation, and they don't learn so easily either. It is easier to learn if you see a woman the whole way through. You then have a total picture of labour, birth and all other relevant factors. You can pick up more so it is easier and more effective to practise in this way. Only midwives are in a position to do something about this.

Studies to show what happens when midwives look after women - Runner/Strong 1969 (American College of Nurse/Midwives) at the John Hopkins University conducted a randomised control trial using 3,975 women.

Group 1 - under care of doctors
Group 2 - under care of nurse/midwives

Results
- greater number of antenatal visits to midwives
- women in midwives care had higher % of larger babies! (now being examined to see if traditional midwifery skill does actually grow bigger babies)
- midwives gave more analgesia but in smaller doses
- shorter 2nd stage & total length of labour (midwives)
- 58% operative deliveries by physicians
- 90% normal delivery with the midwives.

Conclusion
Midwives are very very good at looking after women, and women under midwifery care do better and get better care.

What Choice - What Position In Labour; Caroline Flint

Midwives are in a key position to implement change, but must work with women to do this. Women hold the purse strings, are better with the media and are more numerous. All midwives should belong to all the organisations concerned with childbirth and babies. The paramount role of the midwife is a quiet and peaceful one - to be there and to be with women.

She suggested midwives look at the reasons why women are denied control of the situation, and also what hampers midwives from truly practising as midwives. It is important to read as much as possible, and to listen to women very carefully.

1. Medical guidelines of acceptable behaviour in childbirth.
2. Childbirth as a pathological event & not a normal process (doubt own ability to "perform")
3. Routine procedures without consultation with women.
4. Discouraged from questioning procedures.
5. Health professionals presented as the experts who know best (intimidating and reduces confidence).

Further studies - Showing superior outcome with midwives

1. "Improving outcome of pregnancy by using midwives" - Doris Haire 1981 North Central Bronx Hosp.- Journal of Nurse/Midwifery - 88% normal births, 2.3% instumental, 9% C-section (25% national average).
4.2% per 1,000 perinatal mortality of babies over 1000g

2. Effectiveness of certified nurse/midwives - American Journal Ob. & Gyn. 1972 - University of Mississippi/Medical Centre Group looked after by midwives - more antenatal visits, 9.1% forceps (Drs - 29.5%), 82.6% normal deliveries (Drs - 62.1%).

3. 1983-85 St.Georges Hospital in Tooting "Know Your Midwife Scheme" involving 250 women over 2 years and a team of 4 midwives. A significant difference was the amount of time women had to wait in the antenatal clinic and that they were able to discuss anxieties etc. so client satisfaction was high.
Results - length of labour longer but ½ the epidurals which represented a cot saving of £12,000. Less antenatal admission which represented a cost saving of £25,000. Women on the scheme were less likely to be induced and found it easier being a mother.

4. 1982 British Journal of O & G showed the symphosis pubis to be much softer/flexible during childbirth, and that the pelvic diameter increased by 29% if the women was upright. It is bizzare to lie women down, and also restricts the blood supply. Let women choose their own position. Many rotate their hips which is important in helping to open up the pelvis.

PARENTAL LEAVE ACT:
The working Women's Resource Centre- 159 Great North Road, Auck Ph.762156 notes a disturbing trend that women are losing their jobs for being pregnant - despite the Act which gives women protection against this happening.
200 women a month in Auckland alone are comming to the centre because they have lost their job for being pregnant.
Midwives must help by informing women of their rights.
Aim to make the conditions of the Parental Leave Act as well known as holiday/sick leave; plus changing the attitude that pregnant women are unacceptable in frontline work dealing with the public. Include this information in antenatal classes.
Entitlements - Pregnant women are entitled to 10 extra days of unpaid sick leave for preg.related things ie. morning sickness, to attend the antenatal clinics, consultation with midwives etc Up to 1 year unpaid parental leave which can start 6 weeks before the birth. This time can be shared between the couple and how they divide it is up to them. This also applies to adoptive parents. An important provision is that whoever is on maternity leave still retains normal employee status. They are entitled to redundancy agreements; they must have their same job back and can only be replaced with a temporary appointment. Must apply for parental leave 3 mths before due date.

NEWS

● Caroline Flint . . . New Zealanders may be labouring in vain.

"Oooh," **Caroline Flint** is wont to say, "you've got nice big feet!" And if she ever says it to you, hesitate a moment before kicking her back. It's not your feet she is really interested in. It's just that good, big feet indicate a good, strong pelvis — and Caroline Flint can't help herself: she always looks at women in relation to their pelvis. Pelvises are her business.

Flint is a very enthusiastic midwife and, as the author of two books and many articles, the instigator of important midwifery studies, and as a zealous public campaigner for midwifery and midwives, this British woman is something of a hero to her colleagues.

Here for the recent national conference of midwives, Flint has been much struck by New Zealand women.

"New Zealand women are beautiful," she says. "You're tall, well nourished, get lots of lovely sunshine and you all have lovely big feet.

"Everything I've seen so far indicates you should be able to labour successfully and without interference."

Imagine her horror, then, to find that one in five New Zealand woman give birth by caesarean section.

"It doesn't tally," she says. What it does add up to is what she calls "the appalling state of childbirth in New Zealand."

She believes that the modern approach to childbirth with its underlying theory that "giving birth is very dangerous" engenders fear in labouring women, making labour difficult and setting off the chain reaction of interference and medication that can include caesarean section.

Caesarean births involve major abdominal surgery — a fact easy to overlook as the operation is performed so often.

It usually takes a woman a year to recover fully from a caesarean, Flint says, and this is made worse because the operation occurs at the beginning of a busy, stressful motherhood.

Far better, she believes, is the midwives' traditional approach that childbirth is normal and natural and that all most women need is encouragement and support. Given that support and patience, she believes 85 per cent of women can give birth naturally.

NZ HERALD 18-8-88

Lay People May Do Smear Test

HERALD 11-8-88

People outside the medical profession are likely to be recruited to do smear tests as part of a national cervical cancer screening programme.

The Health Department is looking into introducing a screening programme as recommended by the Cartwright inquiry.

The chief health officer of the department, Dr Karen Poutasi, said in Wellington yesterday that a number of women wanted to be able to have the smears taken by lay people.

"I think there is definitely going to have to be that option."

She said it would take only a short time to train lay people in how to take the smears, which would be followed up if there were any signs of cervical cancer.

One option, being asked for by Maori women, was for marae-based testing.

Dr Poutasi said the department had found some women felt more comfortable having the tests done by lay workers, while others wanted the smears done by doctors or nurses.

Her comments follow statements by Phillida Bunkle, one of the authors of the *Metro* magazine article which sparked the inquiry.

She said there was no reason women should not be given the training to carry out the tests. She said it did not make sense for women to pay $25 a time for doctors to do it.

Details of the anti-cancer screening programme will be released early next month.

The chairman of the Medical Council, Dr Stewart Alexander, a Wellington pathologist, said yesterday that an automated system of reading routine cervical smear tests would be essential if a national cervical cancer screening programme was introduced.

HERALD 15-8-88

Sir,—Is Mr John Banks aware that there is a move to charge $25 for the antenatal classes provided at National Women's Hospital?

Since he feels that these should be compulsory, would he be prepared to subsidise disadvantaged parents so they can attend these classes?

Other hospital and area health boards are also considering a "user pays" approach to antenatal education.

Because of this the recent national midwives' conference in Auckland passed a resolution urging hospital and area health boards to continue to provide free antenatal education . . .

Joan Donley.
Mt Albert.

Need to return to midwives

Sir, — Your editorial on "golden oldies" (June 11) warmed the cockles of my heart and also spurred me on to react to a May 12 article highlighting the alarming increase in unwarranted medical intervention in the birth processes. It also mentioned Dr Wendy Savage's suggestion to enlist "grannypower" in an effort to restore midwives to their rightful place as women's main birth attendants.

I am a grandmother, and in earlier years worked as a domiciliary midwife in German-occupied Holland during World War II. Conditions in 1944-45 were such that practically all intervention (such as cesarian and forceps) was too hazardous even in the few cases where it was obstetrically indicated.

Food was rationed at 450 calories a person a day; rubber gloves, soap, disinfectant and all bandaging material had run out completely; the authorities had cut off all electricity and gas supplies, which ruled out sterilisation of instruments etc; coal and oil for heating and lighting were similarly unobtainable.

Most drugs had been requisitioned, though some could still be bought on the black market at exorbitant prices. Only women with massive infections and a temperature over 40 degrees were supplied with one aspirin tablet per 24 hours. Many mothers-to-be lived in fear for their husbands as those men who had not been carried off to work in Germany were hiding from the authorities or worked in the resistance.

So one dealt with emaciated women, beset by fears, prone to infections and often hypothermic because of lack of heating in an unusually cold winter. Meticulously kept statistics for that period show a rise in morbidity and mortality, due not to hasty or incompetent obstetric management but to circumstances not normally met with in obstetric practice.

As midwives were powerless to relieve these shortages and fears, they had to rely on patience, compassion and perseverance to assist, encourage, cajole and humour their clients, and in the majority of cases brought labour to a successful end.

The above suggests that with adequate assistance most women can give birth at home and without intervention by war-like instruments such as needles, knives and forceps. Since time immemorial women have always done so: on sampans, in igloos, mudhuts or wherever.

I also subscribe to the view that women are ideal birth-attendants: most men are not and by no means all women are.

If we genuinely wish to return to normality in the birth process we need more, competent midwives, intensively trained over a period of at least two years by talented domiciliary midwives now working in the field.

It will be time and effort well spent.

(Mrs) E. ODINOT
Eastbourne

DOMINION 28·6·88

Much More Than Unfortunate

"... all cases should be passed to the care of Professor Green whose conscience is clear and who should accept responsibility for whatever happens."
NZ HERALD 6·8·88

Those words, from the minutes of a meeting of senior medical staff of National Women's Hospital, Auckland, on June 20, 1966, launched a course of treatment which continued for 20 years until it was exposed in a non-medical magazine as an "unfortunate experiment." In the light now of the findings of the consequent inquiry the title seems an understatement.

The inquiry has recorded a disturbing toll of failures arising from the 1966 decision to withhold orthodox surgical treatment from young women with a sometimes pre-cancerous condition of the genital tract. Judge Cartwright has found a failure to note the rising incidence of invasive cancer among patients included in the trial, and even a failure to stop the trial and revert to normal treatment when cogent evidence of the risk began to emerge. The reluctance evidently arose from respect for "clinical freedom" ahead of patients' safety.

Her inquiry began amid so much official hand-wringing about the need to restore public confidence that it was in danger of becoming another symptom of the very instinct that permitted patients to be used, largely unwittingly the judge has found, in medical research. The instincts of the profession for too long have been to comfort rather than inform the patient, to demand uncritical trust and to keep professional disagreements and uncertainties very close to its chest.

Judge Cartwright's hard-hitting report has dealt a blow to those attitudes, especially the last. She has found doctors' inclination to police themselves grossly deficient. Not only did the hospital authorities approve unconventional treatment, "in an attempt to prove," she says, "a theory that lacked scientific validity," but despite expressions of concern from several doctors over 20 years they failed to review Dr Green's methods and failed to enforce elementary ethical standards of patient consent. Her words are forceful:

"The fact that the women did not know they were on trial, were not informed that their treatment was not conventional and received little detail of the nature of their condition were grave omissions. The responsibility extends to all those who, having approved the trial, knew or ought to have known of its mounting consequences and its design faults and allowed it to continue."

No wonder, therefore, the judge is moved to recommend that a third party, a "patient advocate," be inserted into the hospital relationship. And no wonder she suggests that such an advocate have a voice in clinical ethics and patient information.

The deficiencies exposed in National Women's and its supervising authorities are almost certainly not isolated to those institutions. The whole profession should take the Cartwright report to heart. The judge predicts the rise of more assertive patients who will seek and expect to receive adequate information. Her findings will hasten that trend. They blow a useful hole in medical mystique.

LETTERS:

Dear Editor,

The Wanganui Area Health Board has 6 rural hospitals, plus a base Obstetric Unit. Several years ago, it was suggested by clients coming from the rural areas to the base obstetric unit, theat further information be available to them. Recently, each rural hospital maternity unit, was presented with a video of the Base Obstetric Unit. This video has been very well used by clients, who may have to come to Wanganui to have their infants, and return back to the rural area for postpartum care. The clients have expressed much appreciation in being able to see what the Wanganui Obstetric Unit looks like, and all the amenities it has. This is one way of bridging the gap between rural hospitals and base obstetric units.

Thankyou for Save The Midwives magazine which I do enjoy reading. I wish to draw your attention to the article on Area Health Boards pg. 19/20, as the map does not show the Wanganui Area Health Board which was the second such Board to be established in NZ - 1.10.85. One of the strengths of the area Health Board, is the Area Health Watch Committees. These committees have been set up in Wanganui city and all the rural areas, and I am pleased to say these committees ran, and are still running "well women's' clinics, and free cervical smear clinics for the women in our region. The Area Health Watch Committees are comprised of many consumers, and are excellent avenues for the voices of women to be heard.

Ailsa Stewart - Assistant Principal Nurse/Wanganui Hospital.

To the Editor

I viewed with alarm the lack of knowledge of midwifery issues by the Whangarei National Council of Women, and the way a retired nurse decided how it should be treated. Worse still; the National Council of Women's dismissal of a number of remits. I wonder why midwifery training should be treated with distance, as was the registration of stillbirths, definition of pornography and the availability of childcare etc.
Why have the women of NZ sat idly by and allowed doctors, nurses and politicians play havoc with the St Helens midwifery training schools which were once a fixture in every NZ city. My sincere advice to all midwives who believe in the mothers right of choice, is to band together with the Home Birth Association and elect a midwife to be a delegate to the NCW. It would be helpful if she has the knowledge of what a St Helens midwifery training was, and how the Karitane Hospitals and midwives assisted the mothers as they worked together for the welfare of the mothers and children. Motherhood is one profession in which we will never have any opposition from men.

Irismary Bradford Smith - Retired Domiciliary Midwife.

Save The Midwives

I am writing on behalf of my husband and myself to register our support for homebirth and proper payment for domiciliary midwives. We have just lost ours in Dunedin because she can't afford it anymore, and due to the complete lack of a trained support system.
Our third daughter was born at home and I only wish we'd known of it as a viable option when we had the other two.

Anne Stevens - Dunedin

BITS & PIECES:

* Chinese develop male contraceptive ring -
Chinese researchers at Binzhou Medical College, Shandong, have developed a male metal contraceptive ring. The ring holds the sperm duct tightly to stem the flow of sperm. Clinical experiments have apparantly shown that it is 100% effective with no side effects
(China Population Newsletter Vol 4, no 3 June 1987)

* A new male birth control method -
A Chinese doctor has been experimenting with a new method of male birth control claimed to be 99% effective. The simple technique involves blocking the spermatic duct by injecting it with elastic polyurethane. The method, unlike vasectomy, is easily reversible and has vasectomy, is easily reversible and has been tested on 10,000 patients so far with a 99% success rate and no reported side effects. The Chinese Xinhua News Agency reported that a panel of experts from the World Health Organisation has approved of the new method, calling it simple and safe, although it did not report whether the WHO has approved of the new method or officially endorsed the procedure. (UPI, Beijing, China Oct'87)

* Drugs in labour & birth -
There are no dumb questions when it comes to asking about drug safety. All regional anesthetics reach the fetal circulation and brain within seconds or minutes of administration to the mother. As late as the 1970's many obstetricians thought the placenta was a barrier between the maternal and fetal circulations. British investigators have noted that the use of oxytocin to induce labour increases the incidence of jaundice in the newborn. (Doris Haire)

* Breastfeeding -
A study of childrearing advice between 1550-1900 showed that up to 1650 weaning was recommended at 2 years; between 1650-1725 21 months was the average recommended weaning age but nursing of older children was only dispproved of after they reached 4 years. Between 1750-1850 the recommended weaning age dropped to 10-13 months but nursing until 2 yrs was still common and not subject to disapproval. (LLL)

Is There Sex After Childbirth?

This article, by Teresa Pitman, is reprinted from *Healthsharing*, a Canadian women's health quarterly

"I thought I was prepared for birth – we went to prenatal classes – but in the end I found myself laying flat on my back on the delivery table, my feet in stirrups, no feeling from the waist down, and my baby being pulled out with forceps. I had a huge episiotomy and it felt like a horse had kicked me between the legs. Sex? I didn't even want to think about it.

"For the next baby I did a lot more preparation, found a new doctor and knew exactly what I wanted. I gave birth to my baby without medication or intervention, nursed right away and was back home in four hours. No episiotomy, just a little tear that needed no stitches. I felt so good, I was ready to make love the next day."

A woman's sexuality is rarely static. It is affected by all the physical and emotional changes she experiences, so that sometimes her libido (level of sexual desire) is high, and other times it is low. Pregnancy is an obvious time of dramatic physical and emotional change, but giving birth doesn't make everything go "back to normal".

The postpartum period (just after the baby is born) will be different for every woman, just as labour and delivery are. Having a caesarian section, an episiotomy, a forceps delivery or other forms of intervention can affect the mother's sexual feelings. The place of birth – hospital or home – and the relationship with the doctor or midwife attending the birth can also be important. A woman who has given birth with minimal intervention will usually have less physical trauma and is more likely to have positive feelings about her body and her sexuality afterwards.

Many women, however, find the months after giving birth a difficult time sexually. They may experience physical discomfort or pain, or may simply find themselves disinterested in sex. As one new mother said, "I felt like a switch had been turned off." She was afraid that it would never be turned on again. These problems seem even worse because there is little information available about how childbirth and breastfeeding affect women's sexuality.

Maria's experience was typical: her doctor advised abstaining for six weeks and being sure to use contraceptives afterwards. She didn't even know what she was supposed to be abstaining from: oral sex? intercourse? masturbation? According to Dr Joyce Barrett, a family practice physi-

cian who frequently speaks on sexuality, this standard advice often leads to fears that sexual activity "too soon" after the birth will cause serious physical damage. Barrett advises her own patients to follow their own inclinations and express themselves sexually in whatever ways appeal to them and feel comfortable.

One of the most common physical results of giving birth in hospital, and one that is frequently related to sexual problems, is an episiotomy. This is an incision in the perineal tissue at the bottom of the vagina that is stitched together again after the birth of the baby. A recent study by the Canadian Institute for Child Health found that in half the hospitals surveyed, more than 75 per cent of mothers received episiotomies during delivery. The percentage tends to be higher for first-term mothers, because they generally experience a longer pushing stage and the vaginal tissues stretch more slowly. Episiotomies are often done to speed up the birth, even though research shows no benefit from shortening the pushing stage when the baby is not in distress. Women who give birth with midwives in attendance are much less likely to be given episiotomies.

Any episiotomy, whether cut straight back or off to the side, can cause problems during sexual activity. The same is true to a lesser extent of accidental tears which may happen during the birth but which usually heal more easily than episiotomies. During arousal, the vulva and vagina normally become engorged with blood. This swelling pulls on the episiotomy stitches and can cause considerable pain, even if the incision is healing well. Any kind of sexual stimulation can cause genital swelling – stroking breasts and sucking nipples, touching the clitoris with tongue, fingers or penis, licking or stroking the inner thighs. There doesn't need to be any contact with the vulva or penetration of the vagina for discomfort to be felt.

After a few months, the scar tissue at the episiotomy site often becomes less sensitive to the swelling of the surrounding tissues. However, many women find this area feels numb and completely unresponsive to any stimulation. One woman described it as "a gap in sensation". Other women experience a burning feeling when the area is touched with some pressure, even when the episiotomy is apparently healed. This can be quite painful during repeated movements of vaginal penetration. Some positions put less pressure on scar tissue; it often helps for the mother and her sexual partner to look at the episiotomy, noticing exactly where it is and what kind of touching causes discomfort. Oral sex and stimulation of the clitoral area with fingers or a vibrator may avoid the sensitive scar tissue. If an episiotomy causes a long-term persistent pain, a woman should insist on medical attention.

For many women breast stimulation is an important part of sexual activity. During the postpartum period, however, the breasts take on a new function: providing

I felt like a switch had been turned off. I was afraid it would never be turned on again.

food for the baby. According to Masters and Johnson these changes affect sexual responsiveness. Even when a woman does not breastfeed and lactation is suppressed, the breasts are generally less sensitive to stimulation for about six months after the baby's birth.

A breastfeeding woman may experience sexual excitement as her infant suckles. Her uterus will contract rhythmically as she nurses, just as it does during orgasm, and the baby's strong sucking may be quite stimulating. Some women are horrified and guilty about these feelings, and may react by weaning the baby or by redirecting these sexual feelings into their adult relationships. Such feelings are common and normal, though, and women should seek to accept them as a fringe benefit of breastfeeding.

A baby's suckling is very strong and a nursing mother's sexual partner may be surprised at how vigorous the sucking or rubbing of the nipples needs to be before the mother responds. Breasts may be so tender and engorged during the early weeks of breastfeeding that touching them is more painful than pleasurable. When sexually aroused, a woman may feel the tingling sensation that indicates her milk is "letting down". During orgasm, milk may drip or squirt from her breasts.

Some women and their partners like this, and find the larger, firmer breasts and even the leaking milk very erotic. In other situations, a mother's sexual partner will feel that "her breasts belong to the baby now." Some sexual partners dislike the sweet taste of breast milk and the messiness of unexpected leaking. It may help to know that leaking decreases as breastfeeding becomes better established, and usually stops altogether by three or four months.

Another important part of sexual arousal that is affected by childbirth is

I felt so good I was ready to make love the next day.

vaginal lubrication. Normally, as a woman becomes excited, lubricating fluid coats the walls of her vagina. This happens during the postpartum period as well, but it usually takes much longer, requires more stimulation and less lubrication is produced. Women who are not breastfeeding generally find this response returns to normal within about three months.

Breastfeeding, however, suppresses the ovarian hormones, which can mean that decreased sexual response and lubrication may continue for a long time. A vaginal lubricant (such as saliva or K-Y jelly) may be useful in this situation.

As a result of these hormonal changes, many women find they have little or no sexual desire. Sometimes this improves once the baby is about six months old, starts on solid food and is nursing less. For other women, this disinterest in sex may last through the entire time of lactation, perhaps even longer.

This lack of libido can be very frightening to a woman who has previously enjoyed her sexuality. Mary, for example, had five babies in ten years, and breastfed them all until the next pregnancy became obvious. During that entire time period she experienced very little sexual desire, and began to feel that she would never experience it again. She was relieved and delighted to discover, after her youngest daughter was weaned, that she was once again interested and responsive.

A major physical factor affecting postpartum sexuality is fatigue. New babies are exhausting. The mother may simply have little energy left for sexual activity – she'd rather take a nap.

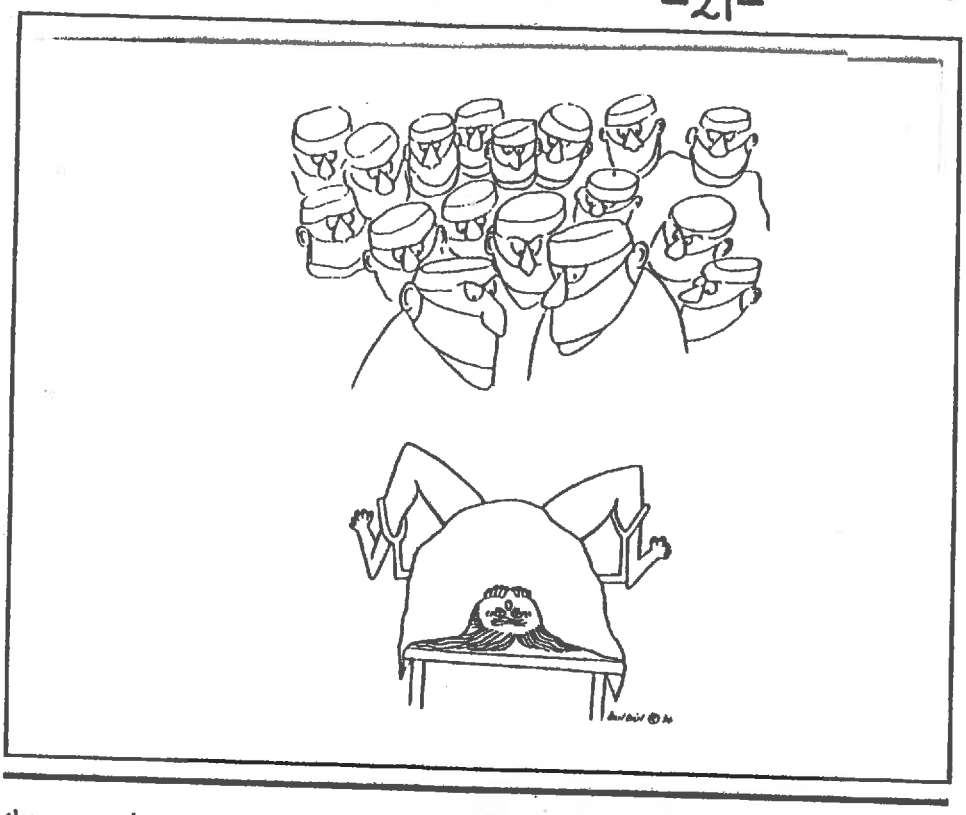
Constant tiredness is probably inevitable with a baby, but some mothers find it helps to have a nap whenever the baby sleeps, or to have someone else take the baby (even for an hour or so) while the mother rests. Bringing the baby into the mother's bed at night, so that she doesn't have to get up for night feedings, can help as well.

Sheila Kitzinger, author of *The Experience of Childbirth*, describes giving birth as a psychosexual event in a woman's life. The experience causes not only the physical changes described above, but emotional changes that can effect physical responses.

Heather, for example, had expected a natural, unmedicated birth. Instead, her daughter was delivered by an emergency caesarian section after a long and frightening labour. "I felt like my body had failed me," she says. "It didn't work properly. I wasn't normal. And all those feelings carried over into my sex life."

A vaginal birth can also be traumatic. Sandy was given a large episiotomy and her baby was delivered by forceps while an anaesthetist held the gas mask over her face. "It was like being raped," she says. "For a long time afterwards any touching in that area seemed like a violation. I just wanted to protect my body."

Some women find that talking about



these experiences helps them to come to terms with the anger and resentment they may feel about their births. It helps to connect with others who have been through similar situations and to share reactions and suggestions.

Even a woman who is pleased with her birth experience often feels dis-satisfied with her body during the postpartum period. Her breasts will be larger, may be marked with blue veins, sagging a little or a lot, and the nipples will be darker. Her belly will be soft and flabby and possibly striped with stretch marks. She may have a caesarian scar or extra weight gained during the pregnancy. Many women find it hard to see themselves as sexually attractive when they compare the body in the mirror to the thin, unblemished young woman in the magazine on the dresser.

The extra weight and lax muscles can improve with time and exercise. But stretch marks and scars are permanent, although both will fade to a lesser or greater degree gradually. It can take time for a mother to accept her new body. Her partner may also find it difficult to adjust to the changes, and so communicating about feelings is very important.

Despite the exhaustion and stress of motherhood, some women find themselves completely absorbed by the baby. Gabrielle, who had been married for several years, wished during the early months of her baby's life that her husband "would just go away. He had done his part, I didn't need him anymore. All I wanted was my baby."

Some women are surprised by the intensity of their feelings for the baby and their desire to focus entirely on the mother-infant relationship for a period of time, but in some cultures a period of isolation for mother and baby of six to 12 weeks is expected. During this time mother and infant are cared for by others, and the mother doesn't put energy into any other relationships. A Canadian woman from the Mediterranean island of Malta described how, as a teenager, she was sent to do the housework and cooking for a relative who had just given birth. Years later, when she had her own child, a young cousin came to so the same for her; she was able to rest and concentrate entirely on her newborn. This total absorption in the baby usually decreases as the baby grows older and less dependent.

Women who give their babies a lot of nurturing – carrying them in their arms or in a baby carrier much of the time, feeding them on demand, sleeping next to them – may find they are "touched out" by the end of the day. They don't want any more physical contact or any more demands made on their bodies. Sex becomes "one more thing I have to do before I can go to sleep."

Sometimes it only takes a short break, a chance to reclaim her body as her own, a walk around the block, a meal in a restaurant, or a long soak in a hot bath, for a woman feeling this way to find her interest in sex returning. This situation also improves as the in-arms-baby who nurses all the time becomes a more independent toddler.

Even women involved in long-term relationships that have been based on an assumption of equality may find that the balance of power shifts after the birth of a baby. The mother may discover that she is expected to do a larger share of the housework during her maternity leave (or if she decides not to return to work) because "she's home all day, anyway." This implies that mothering and caring for the baby is somehow an insignificant contribution and not real work. The overburdened mother is likely to resent the unfairness of the situation.

Even in lesbian relationships the baby may be seen as primarily the mother's responsibility, and she becomes the one who must make all the arrangements for babysitting, daycare, doctor's appointments and anything else that the baby requires and that the family can afford. A relationship which leaves one parent free to go to work or out with friends in the evening while the other must find, evaluate and transport to day care, take time off for doctor's appointments and worry about the scheduling and suitability of these arrangements is clearly unfair. Life changes after a baby, and both partners need to adjust and contribute.

If resentment builds up in this area, the mother may find she is less sexually responsive to her partner. A mother who is disinterested in sex may also feel resentment if her partner pressures her for sex. On the other hand, a woman can feel hurt if her partner makes no attempts to initiate touching or sexual activites, being afraid she is no longer attractive. Talking, both before the baby arrives, and afterwards when problems develop, is the key to preventing serious damage to the relationship. Both the mother and her partner need to express their feelings, concerns and fears to each other as they experience them.

The single mother faces an even more difficult situation. The baby is totally her responsibility and her financial status may mean she has few options. All her energy may go into meeting the baby's needs, with little left over for her own. When Anne, a single mother, met a new sexual partner, she said, "it was like being a virgin all over again. I'd ignored my sexuality for so long (I just didn't have time to think about it!) that I wasn't sure I could remember how to do it."

Another common experience after giving birth is postpartum depression. More than 50 per cent of mothers will have a brief episode of so-called baby blues, but one in ten will suffer from real depression. One common symptom of depression is loss of interest in sex. Unfortunately, many women with postpartum depression never seek help and may suffer alone for months. Talking with supportive friends or other new mothers can help lessen the isolation; sometimes professional counselling helps.

The changes in sexual response during the postpartum period are real. It isn't all in your head. Sexual changes are normal, although every woman's experience will be different. Some women find it takes years for desire to return. Other women find that it returns quite quickly.

Sexual desire and responsiveness will ebb and flow throughout a woman's lifetime. The postpartum period is often a time when sexual energy seems to be redirected into mothering, but that energy has not disappeared forever. It will be there again as the sequence of pregnancy, birth and lactation is complete. ■

MIDWIVES OR MOAS? Joan Donley

(presented at National Midwives Conference - August 88)

It is almost ten years since the last midwifery students graduated from St Helens. During that time, more and more midwives have become aware of the wide gulf that exists between what we think we are or should be and what we acyually are, that is the difference between our fantasy and the reality. For instance:

- We claim midwifery is a profession in its own right;
- The Departments of Health & Education and the NZNA claim midwifery is a post graduate course of nursing;
- We refer to ourselves as 'midwives' and are classified as such on a midwifery register;
- Legally we are defined as 'nurses', and there is a move to do away with the midwifery register and place us under one comprehensive register;
- We subscribe to the ICM/WHO definition of a midwife as an independent practitioner;
- Since 1971 we have been required to work under medical super vision, ie. we are obstetric nurses.

Obviously, if we are going to bring reality into line with our ideas of what we should be, then we are going to have to make some very difficult decisions at this conference. No longer can we just discuss the issues. If we fail to grasp the opportunity presented at this conference to determine our future, then I suggest that we select several of our best specimens so that in due course they can be embalmed and placed in the museum alongside the other extinct species, the moa.

There has probably never been a better time in recent history in which to seize the initiative in determining the role and status of the NZ midwife. Not only is the whole country in a chaotic state of 'market led' restructuring and therefore very conscious of cost effectiveness - and midwives are cost effective, women, the consumers and our natural allies are rebelling against the medicalisation of childbirth.

However, it's not going to be easy to reclaim midwifery as an independent profession to meet the needs of women as they define those needs. It means changes in our own ideas and practises as well as fighting to regain our lost territory. Such a mighty battle requires a plan of action that is based on a realistic analysis of the historical, political and social conditions. This is known as a 'strategy' ie. a plan to change something.

The strategy I am proposing is that we form our own independent professional organisation which is the primary step in speaking for ourselves. This idea is not new, it has been in the wind for several years.

One of the stumbling blocks has been our historical dependence on the NZNA which itself began as a professional association, and our present reliance on NZNA to negotiate our industrial conditions. The recent labour legislation has limited our industrial options and thus made our choices easier. I will deal with that one later. First, I want to discuss the other impasse - our relatively recent conditioning in perceiving ourselves as nurses.

Ever since Eve ate that apple midwifery has been distinct from nursing. While nursing and midwifery are 2 branches of the same strong tree of caring, midwifery grew out of the age-old covenant between women, while nursing developed from caring for the sick and wounded in convents, on the battlefield, in poor houses and finally in hospitals under the dominance of doctors. Despite the fact that birth has become more medicalised under medical dominance and nursing is developing a more holistic approach to illness, that does not change either the historical roots nor the basic concepts between caring for people who are ill and supporting well women to do what their bodies were designed to do.

In fact, it is the medicalisation of childbirth that has blurred the differences between nursing and midwifery. Hospital based, medicalised childbirth has led to the conversion of the midwife into a sophisticated obstetric nurse and placed midwifery firmly under nursing/medical dominance. This same development has led nursing to expand its parameters to engulf the midwife's role, not only in NZ but throughout the Western world.

In NZ this was officially stated in the 1981 NZNA Policy Statement on Maternal & Infant Nursing, the very title of which is significant! This document was prepared in haste when it was feared that domiciliary midwifery could get beyond the NZNA medical control. Its stated purpose was to reinforce the role of the nurse in the area of maternal and infant health in line with the changes in nursing education. Even while saying that 'midwives are the backbone of maternal and child health nursing services in NZ' (p9) it firmly classified midwifery as 'nursing services', defined the midwife as a nurse and midwifery as a post-basic nursing qualification. It therefore set the philosophical base for the Nurses Amendment Act, 1983

It stated 'there is failure to agree on the most basic question, "Who is a Midwife?"' (p19) then went on to urge nurses 'to strive for recognition as a powerful professional group advocating changes and innovations in the delivery of maternal and infant care.' (p20) To facilitate the final devolution of the midwife, it proposed the 'family health nurse' who is primarily a generalist with specialist qualifications such as community health nursing or midwifery (p13) based on the premises that -

(i) the origins of health care are within the family
(ii) the nurse is the professional most suited to nurture the health potential of this group. (p6)

This was a blatant take-over bid which went unnoticed at the time as midwives looked for ways to control the mavericks in their midst - the domiciliary midwives. The bid was legalised in the Nurses Amendment Act 1983 which reinforced the role of the obstetric nurse permitting her and several others to carry out maternity care under medical supervision.

The Act did have one good aspect - it roused midwives from their long slumber and politicised them very quickly! Since then midwives together have worked for and gained NZNA endorse ment for the WHO/ICM definition of a midwife (1985), have prepared midwifery Standards of Practice, Service and Education; have gained a separate midwifery education to start next year, and with consumer support have forced revision of the 1981 NZNA Policy Statement, an excellent document which will hopefully be endorsed by NZNA Conference next month.

While these are impressive gains, it is important to realise that those who hold power do not give it away. Under pressure they do make short-term accomodation to diffuse opposition, especially if they are in a weak position. As yet the NZNA have not clarified their position on the role of this family health nurse in maternity care. So while there has been a slight shift to accomodate the noisy midwives, we still have to contend with the bureaucratic mind-set of many NZNA executive members, polytech HODs and departmental advisors, all supported by the politically powerful powerful medical profession.

At present the NZNA represent us on the Board of Health. Since one of the basic functions of any organisation is to protect the interests of its members, how can NZNA represent the interests of nurses and midwives when we are contending for the same territory? This is called 'a conflict of interests'. It would be politically naive, if not downright stupid for us to believe that NZNA could represent our interests. In fact, the Minister of Health, David Caygill noted when reviewing documents that the midwives have different views on their education and role than that of the Nurses Association. (Letter to Norma Campbell 14.1.88).

If we want legislative changes in order to reclaim our autonomy and our territory we will have to fight for these. That's what wars are about - territory, trade, power. The first step in any struggle is to be able to speak for ourselves, and we can only do that through our own professional organisation.
How can we say midwifery is a profession in its own right, then depend on some other body to speak for us? Further, while this body defines us it is questionable if we are a profession. While a profession is defined as an occupation requiring an education, according to the NZNA Policy Statement on Nursing in

NZ 1976, only midwives who have taken a post-basic nursing education (nurse practitioners) can qualify as professionals. This questions the professional status of many of us, and it ties us more firmly to nursing.

While I have some reservations about the elitism of professionalism, that is the accepted power base from which we must operate to regain our independence. So long as we remember that our survival rests with satisfied consumers, 'professionalism' shouldn't corrupt us. Caygill has said, that in view of our problems and the shortage of midwives, he can't understand why we haven't formed our own organisation before this. He also stated that should midwives form such an association he would be forced to address that body on midwifery issues rather than the NZNA (Interview with Karen Guililand 28.11.87).

This would certainly be a step in the right direction. However, the Minister is only a figurehead. He still has to run the power blockade in his own department, which is a bureaucracy. A bureaucracy is defined as a concentration of power exercised by administrators. In this case, these are the nurse advisors whose concepts of what a midwife is are defined by NZNA policy statements and their own nursing backgrounds. The most powerful nurse advisor to the Minister of Health is Sally Shaw, who is not a midwife. She is a RGON with a BA & MPH and is adamant that a midwife is a nurse. While 2 of the nurse advisors have a midwifery certificate, they were not nominated by us to represent our interests.

In fact, we have no process through which we can directly influence departmental decision making and this was clearly evident in the recent decision to continue the midwifery option within the ADN as well as initiating the 3 year pilot separate midwifery course. We definitely need our own representatives on the Board of Health and the only hope we have of achieving this is through our own organisation.

So what are we waiting for? Conditions were never more propitious: we are united, more politically aware, more women-centered in our practice, have more consumer support and are even displaying some tendencies towards sisterhood. Our opposition are all in the process of restructuring which is subjecting them to changing roles and uncertainty. The Department of Health is under pressure from Treasury, from Maoris, from consumers and from midwives. And, as mentioned earlier, the recent labour legislation has made our decisions easier. We can only form a professional organisation.

Since we are already covered by an award, we are now prohibited from forming our own industrial negotiating body, regardless of how many members we have, or may have in the future. (1988 Labour Relations Act, Part 1V). In fact, until 31 March 1989, NZNA has unchangeable and exclusive coverage of midwives under

the State Sector Act. After that date, whether we like it or not, we are up for grabs on the industrial front. Then, we can remain under the restructured NZNA when we finally find out what that will be, but it appears that Sections will have to reorganise. Or we can liaise with NZNU, or PSA, or the Hotel & Hospital Workers, or Childcare Workers or ATTI (Assoc. Teachers in Technical Institutes), or any other union interested in representing our industrial interests.

In order 'to overcome the legal problems that the new Labour laws have created for special interest groups' the NZNU has proposed a Federation of all unions representing nurses, and this is yet another option.

In a recent paper (July 1988) the National Midwives Section assessed the situation and suggested 2 options if we formed our own professional association. These are:

(a) We can forgo industrial representation. Under NZNA member ship rules, midwives are already negotiated for under the title 'nurse', ie. we get industrial representation by default as do nurses who do not belong to NZNA/NZNU. We take the stance that it is more important to keep choices for women in childbirth and retain the status of the midwife as defined by WHO. We form an association whose primary aim is to promote midwifery in order to survive as a profession. The membership fee would be high in order to meet this committment on a national level and all funds are for this purpose. The assoc. would be the voice for midwives;

(b) We accept the (a) hypothesis but as individuals we choose to belong to NZNA (or other suitable union) for industrial representation, and to the Midwives Assoc. for our professional needs. This committment would also be expensive.

In view of all these factors I am proposing that today we make history and officially form our own

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