SAVE THE MIDWIVES

23

MAY 1990

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AUTONOMY: A MATTER OF PROCEDURAL TECHNICALITY??

For those of us who felt all was set and ready to go re. midwifery autonomy & that it was just a case of going through the due process; it was most alarming to hear that Opposition members under the guidance of Don McKinnon were directing their attentions to stopping the Bill from proceeding due to apparant procedural improprieties.

The subsequent alarm this generated throughout the country resulted literally in a barrage of telephone calls to Don McKinnon in particular. When I spoke to him by phone on the morning of the reading, he said he felt from all the phone calls he'd had, that he'd made an enemy of every midwife in NZ & would I pass on to midwives that in essence he supports the Bill. Rather worrying that he could be a Minister of Health!

As well as showing how effective phoning can be, it hopefully served to also alert politicians (and some in particular) that women and midwives are not impressed by political point scoring & delaying tactics at their expense. As McKinnon himself was actually a member of the select Committee I can't help wondering why he didn't use that particular forum to ensure the comments of organisations such as ACC were heard. Besides, there is nothing new about the issues he proclaims are new ones. Submissions & personal appearances before the Select Committee dealt with <u>all</u> the issues he expresses concern about.

I also can't help wondering about what is happening to the National Council of Women, as they have obviously neglected to represent the views of the majority of women in relation to birthing & midwifery issues. Perhaps this reflects the lack of input from younger women & the reluctance of the organisation to move with the times.

Save The Midwives was in the process of joining the NCW. This was put on hold when it was revealed that their submission on the Nurses Ammendment Bill viewed midwives in a way that is totally contrary to the aims & objectives of STM. It would be interesting to hear members views on this particular issue.

Smoking is an important women's issue that has particular implications for women who are pregnant and breastfeeding. In addition to the effects on babies, pregnant smokers are at greater risk of complications in pregnancy, & are more likely to have miscarriages, premature births & low birth weight babies. Passive smoking, or breathing in other people's smoke, also exposes women to health risks. Legislation is planned to end tobacco advertising & sponsorship (which targets young women in particular), & control smoking in public indoor spaces. However, the tobacco industry is a powerful force so it is going to take strong public support to ensure this legislation is adopted. See further on in this newsletter about what action you can take.

Judi Strid

Summary of the Ammendment Proceedings in the House

Judy Keall (Glenfield/Labour)

admitted the recommendations, from the Select Committee (SC) regarding the ammendment to the Nurses Ammendment Bill, to the House on May 29th. She asked that they be accepted without further ammendment.

She spoke about the aim of the ammendment allowing midwives to take sole responsibility where it is now stipulated that this must be taken by a Dr. She referred to the 99 submissions, of which 14 were actually heard in person over a period of more than 5 hours.

She explained that it was necessary to let midwives perform a range of related services such as routine diagnostic tests & referral to a specialist which requires ammendments to a number of Acts. The Select Committee recommended that these be drawn up for consideration by the whole house.

She outlined the views of the submissions which clearly stated the importance of birth choices for women, availability of options for rural women & confidence in the competence of midwives. She mentioned the knowledge & safety factor concerns expressed by the NZMA, O&G Society, various hospital boards & the National Council of Women. These did not oppose the principle of the Bill, but expressed concern about training & safety factors. Submissions from the Domiciliary Midwives Society, NZNA & College of Midwives showed that midwives were appropriately trained. Students are well prepared & ongoing midwifery training is proposed.

Judy Keall added that because of their past nursing training they are quite competent to do the job, & that when the SC had looked at qualifications in both NZ & overseas midwives (she stressed) <u>all</u> are nurse/midwives! The NZMA & O&G expressed concern about peer review, but midwifery groups showed that this was of a high standard. The COM & DMW Society reassured the committee that the accountability aspect was well looked after & the NZNA provides the external monitoring re. discipline.

Submissions showed that practical measures were needed to be taken to legalise & be identified in statute the prescribing & referral activities that midwives do anyway under standing orders. Access to Hospital & Diagnostic Sevices needs to include midwives and the Security Act & Medicines Act need changing re. pharmaceutical benefits and to allow the prescribing of (appropriate) drugs.

Responses from the House

Don McKinnon (Albany/National Deputy Leader & opposition spokesperson on Health)

stated that although the Opposition give clear support for the Bill he was critical of the chaos surrounding it. He described the record of midwives in NZ as clear & unequivocal & not questioned by anyone who had come before the Select Committee. However he had a great deal to say about how the original 2 clause Bill introduced in Dec'89 had been handled so badly it had now become a 24 clause Bill proposing ammendments to 6 Acts & 4 Regulations. He also questioned the competence of the Department of Health.

He stated the main issue was how the legislation was being dealt with in the House & that there was a need to rewrite the Bill, take it back to the Select Committee, call for further submissions & start proceedings all over again. He stated this action was necessary to preserve the integrity of the House & the Select Committee, & stated it made a mockery of parliamentary procedures & was wasting the time of the House! Along with some rude remarks to Judy Keall he stated he had never seen such a fiasco & debacle about what was technically a minor Bill, & quoted from the National Council of Women's (NCW) submission in defense of his arguments!

He was particularly concerned about the question of ACC, describing nurses cover as being left up in the air & that ACC makes no reference to midwives who want to be equal to GP's. He said this would mean midwives would have personal liability to NZ courts & that they warrant more than such a casual attitude. He was critical that ACC had not had the opportunity to give their view on this matter.

He was also concerned that groups such as the NZMA & O&G society were only given 24hours to comment on the changes & expressed the wish that for the sake of the midwives we get it right next time round. His wish to send it back to Select Committee & start the process all over again was presented to the Speaker of the House as an ammendment.

Helen Clark (Minister of Health/Labour Mt. Albert)

described the Bill as an important one which is welcomed & supported by many parents. She said it is a reasonable Bill & the Select Committee process exposed the need for further additions to the original ammendment. She attacked McKinnon for his niggly whinging comments that didn't focus on the real issue & warned that if he wanted to take on the women of NZ plus the many male parents who also support this action, it would be to his detriment.

The fact that all 99 submissions supported the Bill confirms the broad support for it & that every one supports greater choice. She stated that more women would choose home births, but even more important was that more would choose antenatal care under midwives which has not been possible with the present system.

She described birth as a normal healthy process for normal healthy women, & that this legislation will validate their choices. She emphasised that although this Bill deals only with the autonomy aspects of the Act it also must involve the stated changes to allow this to take place. She described the SC recommendations as very thorough in outlining what is needed. She concluded by reiterating the points that this will just legitimatise & officially recognise what midwives do anyway, & that their training already prepares them for such a comprehensive service to clients.

Katherine O'Regan (Waipa/National)

emphasised that National is not opposing the Bill, but she expressed her concern that although the Bill is only 12 lines long, it has a 24 clause ammendment which is an abuse of the House. She quoted from the Prime Ministers book "Unbridled Power" a passage relating to the desirability of proceedings being a sombre, solemn & deliberate business; & accused the Govt. of abusing the Select Committee procedure.

She described the concern of O&G's as being about what's best for midwives & that the caution suggested is not delaying, but making sure it is right for midwives first time round. She followed up the ACC argument adding that medical misadventure involving midwives wouldn't be covered by ACC. Nurses are covered alright but the patient receiving midwifery care is not. She wants to ensure that women are covered & knows that midwives want to be squeaky clean so they don't come into any disrepute. As the midwives say they're there for the mothers she knows they will support this move for caution.

She concluded by describing the Bill as an absolute shambles that needed to go back to the Select Committee & the Regulations Committee & that AHB's also needed to have input since some recommendations involved them as well.

Jenny Kirk (Birkenhead/Labour)

described the Opposition as being out of step with NZ women & parents, quibbling over a minor technical matter, as all the issues had been discussed at Select committee. She declared it was time to lay at rest the view that this was somehow endangering the lives of women & babies, as nothing could be further from the truth.

She stated this will enhance the outcome & offer choices to low risk women. Opposition had come mainly from the med.prof. whereas support had come from midwives, nurses and parents. She quoted from the submission sent in from the Wairarapa Parents Centre who have been running antenatal classes for 13 years and support the ammendment. The quote related to the need to rectify the ridiculous & costly duplication of services, commenting that the change in legislation will be met with the approval of parents involved in childbirth.

She said the safety factor issue, the concerns of the medical profession, issues concerning access to drugs, blood & urine testing, insurance/ACC, referral plus training were all discussed & investigated very thoroughly & have been covered in the supplementary audit. She described the evaluation & assessment aspects of midwifery training & that midwives often know more than the Drs. She referred to the exemplars & quoted one which described an undiagnosed breech birth with a good outcome where the midwife talked the anxious Dr through the correct procedure.

Murray McCully (East Coast Bays/National)

stated that the Opposition do support the principle of the Bill which indicates confidence in NZ midwives & supports choice for women, stating that this was not an issue. The issue is how the Bill should procede through the House & if parties with an interest should be denied an opportunity for a say.

He repeated the concerns about how a simple Bill had emerged in a more complicated form & expressed concern that the Misuse of Drugs Act should not be ammended lightly. He described this Act as a very important one & that mistakes in this area are important ones that shouldn't be made.

He also had plenty to say about comments made in the PM's book "Unbridled Power" which he informed the House were available at 25cents in bargin bins throughout the countrys bookshops! He expressed surprise that the Minister of Health & the Prime Minister should overlook these lofty words & supported McKinnons ammendment so other groups could also have their say.

Voting

The House then voted on whether to support McKinnons ammendment for the Bill to return to Select Committee. 29 supported him & 43 were against, so the Bill procedes to the second reading.

REPORT OF THE SOCIAL SERVICES COMMITTEE ON THE NURSES AMENDMENT BILL

NEW ZEALAND HOUSE OF REPRESENTATIVES 1990

COMMITTEE CONSIDERATION OF THE BILL

Background

The Nurses Amendment Bill is a two clause bill amending the Nurses Act 1977.

Clause 1 relates to the Short Title.

Clause 2 amends subsections (1) and (2) of section 54 of the principal Act which creates offences relating to obstetric nursing. The effect of the amendment is to permit a registered midwife to take sole responsibility for the care of a patient throughout pregnancy, childbirth and the post-natal period where currently that responsibility may be exercised only by a medical practitioner.

Following the introduction of the bill the committee advertised publicly for submissions, setting a closing date of 9 February 1990. 99 submissions were received, 12 of which requested a personal appearance before the committee.

Issues raised in submissions

Submissions fell into two categories: those supporting the bill and indicating brief reasons for that support, and those supporting the principle of autonomy for midwives but raising specific concerns.

General Issues

Submissions stating general support for the bill made the following points:

- The amendment will open up birth choices for women.
- Midwives have the competence to care for women both pre- and post-natally, to recognise the need for referral should the pregnancy deviate from the norm, and to deal with emergencies.
- The amendment will simplify maternal and health care. Many procedures at present carried out by medical practitioners could be performed by midwives.
- Midwives offer continuity of care and a professional, relaxed and supportive service.
- Birth is a natural process. Current law encourages over use of medical intervention and makes it too technical.
- The amendment will advantage rural women who do not have the same access to health care as other women.
- The amendment would relieve the burden on hospital resources where normal pregnancies are concerned, and help channel resources to areas of greater need, to high risk areas and to post-natal care.
- Women during pregnancy and childbirth are vulnerable. Some doctors tend to create a less than harmonious atmosphere.

Specific Issues

a. Knowledge and Safety in Practice

The issue of whether midwives are competent to recognise complications that may arise during pregnancy and childbirth was raised in a number of submissions.

The principal concern in the submission of the Royal New Zealand College of Obstetricians and Gynaecologists was that passage of the bill should not lead to a reduction in standards of care; there should be adequate provision for assessment of the underlying health of the woman, provision for laboratory tests and interpretation of their results, treatment of existing disease, and competent use of medication. The College, the New Zealand Medical Association, and the Nelson Area Health

Board argued that the current training of midwives is not sufficient to permit the proposed change to legislation and maintain standards of safety, even if that training is preceded by a 4 year general nursing course. The concept of autonomy for midwives in itself was not opposed by the College, providing these concerns are met. The question of whether claims against the Accident Compensation Corporation are possible in the case of medical misadventure involving the practice of midwives was also raised.

The manner in which the Royal New Zealand College of Obstetricians and Gynaecologists saw existing standards of care and autonomy for midwives being best applied was within the context of a team approach. This would involve an initial assessment being made by a medical practitioner, with subsequent modification of future management if the assessment proves normal. This view was supported by the New Zealand Medical Association, the Nelson and Wanganui Area Health Boards and the National Council of Women. The Nelson Area Health Board and the New Zealand Medical Association cited the United Kingdom practice of "flying squads" as an example of the team concept.

The National Council of Women, although supporting the principle of greater autonomy for midwives, was anxious that the amendment not be seen as a cost cutting measure that would eventually limit rather than expand choices for women, and might lead to a decrease in standards of care.

The view that midwives lack sufficient training to recognise possible complications was refuted by the New Zealand College of Midwives, the Domiciliary Midwives' Society and the New Zealand Nurses' Association.

The committee was informed that the reality is that maternity care in New Zealand is almost exclusively undertaken by midwives to the extent that they are often in the position of instructing house-surgeons in aspects of care. Where unexpected problems do arise, a midwife is competent either to deal with the problem or refer the woman to a general practitioner or an obstetrician.

The New Zealand College of Midwives further stated that assessment constitutes a major part of midwifery education and that the relationship built up between midwife and client often enables an assessment more accurate than would be made by a general practitioner. Assessment is enhanced by the ability of a midwife to spend time with a client and gain a thorough understanding of socio-cultural and other influences on underlying health. The New Zealand College of Midwives stressed that midwives have no wish to take on the role of doctors, and that it is quite appropriate to refer a woman to a general practitioner, or to an obstetrician as do many general practitioners, should problems arise.

In the case of medical misadventure, the committee was assured by its departmental advisers that patients should be able to claim compensation in case of personal injury resulting from an accident caused by a midwife. Midwives who are members of the New Zealand Nurses' Association are covered by personal indemnity insurance which is designed to meet the costs of any civil or statutory liability that a nurse/midwife may incur in the practice of his/her profession.

The committee is aware that the issues of knowledge and safety in practice are closely related to training of midwives and their accountability both to their peers and to their clients. The issue of accountability is discussed below. The committee is satisfied that the New Zealand College of Midwives has the capacity to set appropriate standards of training to permit registration as a midwife and to ensure that no diminution of standards of safety occurs.

The committee addressed the issue of who is competent to be a registered midwife for the purposes of this bill. The committee was advised that the term "registered midwife" covers those registered midwives currently practising in New Zealand whose training is sufficient to meet the criteria for registration by the Nursing Council of New Zealand and would include:

a registered general and obstetric nurse or a registered comprehensive nurse with a post-graduate midwifery course;

or an overseas trained midwife who has been granted registration by the Council and who is likely to have a broad based midwifery education.

The committee also recognises that these standards are more appropriately incorporated in guidelines than in legislation.

The committee recommends no amendment in relation to knowledge and safety in practice.

b. Accountability.

A number of submissions stressed the need for enhanced accountability should the bill proceed. This issue was addressed by the Royal New Zealand College of Obstetricians and Gynaecologists, the New Zealand Medical Association, the New Zealand College of Midwives, the New Zealand Nurses' Association, and the Domiciliary Midwives' Society in oral evidence.

The principal focus of the submission of the Royal New Zealand College of Obstetricians and Gynaecologists was the maintenance of standards and the necessity for appropriate training and peer review.

The committee was interested to hear that this issue is being addressed in the development of a peer review concept by the New Zealand College of Midwives and the Domiciliary Midwives' Society. Standards for Midwifery Practice, Service and Education are being used by individual midwives and midwifery tutors as well as area health boards as a basis for the specific standards of their maternity services. Ongoing midwifery training is being promoted, and the Domiciliary Midwives' Society has set up a pilot scheme to monitor midwifery standards in domiciliary care. The New Zealand College of Midwives is working to extend this monitoring system into area health board services.

A number of other submissions addressed the issue of monitoring and review, linking annual review to a licence to practise. Monitoring and review were also addressed by the Nelson and Northland Area Health Boards which saw a need for an amalgamated system of monitoring in the obstetric field. The New Zealand Medical Association suggested that any review team should include patient representation to ensure accountability to the consumer.

The New Zealand Nurses' Association informed the committee that the Labour Relations Act defines employer responsibility where a midwife is employed by an area health board. An external monitoring mechanism is provided by the Nursing Council which is the disciplinary body for nurses and midwives where the safety of the general public is concerned.

As with training issues, the committee agreed with the suggestion of the New Zealand College of Midwives that monitoring issues are a professional matter, more appropriately incorporated in guidelines than in statute. However, the committee indicated its interest in the development of these standards for accountability, and their incorporation in guidelines.

The committee has no amendments to recommend in relation to accountability.

c. Access to medicines, laboratory tests and benefits.

The written submissions of the New Zealand Nurses' Association, the Auckland Domiciliary Midwives, the New Zealand College of Midwives (Auckland and Canterbury—West Coast branches), Waikato Area Health Board, Nelson Area Health Board, Canterbury Area Health Board, and National Council of Women all drew the committee's attention to the need for midwives to be able to prescribe the range of medicines commonly used in pregnancy and childbirth, within certain parameters. Submissions also requested that midwives be able to call for a range of routine diagnostic laboratory tests such as blood and urine tests, cervical smears and swabs. To make this possible, midwives would require access to the same range of benefits as is currently available to medical practitioners carrying out maternity work.

During the hearing of oral evidence these points were reinforced by the New Zealand College of Midwives, the Domiciliary Midwives' Society and the Royal New Zealand College of Obstetricians and Gynaecologists (subject to adequate training). The committee was informed that in practice, de facto prescribing by midwives already occurs. This varies in manner, from signed prescription forms being left in maternity units and ante-natal clinics to midwives having an annual supply of medicines supplied through a general practitioner or a local hospital. Midwives informed the committee that no matter how medicines are supplied at present, they do carry medicines and are happy to assume responsibility for their use.

The committee recognises that for midwives to provide comprehensive services and to ensure the safety of mother and child, midwives would need access to the range of routine diagnostic laboratory tests and medicines commonly used in pregnancy and childbirth, and to be able to claim for the associated social security benefits. Following the hearing of evidence correspondence and discussions occurred between the committee's departmental advisers and representatives of the Royal New Zealand College of Obstetricians and Gynaecologists, the Royal New Zealand College of General Practitioners, the Domiciliary Midwives' Society and the New Zealand College of Midwives on the medicines and laboratory tests thought necessary for low risk childbirth.

Consideration was given to whether there should be any restriction on the amount of pethidine that a midwife should be permitted to administer. However, the committee was satisfied that statutory regulation is impracticable, and that adequate controls can be best left in the hands of the Nursing Council of New Zealand.

The committee therefore recommends that the following Acts and regulations be amended:

Nurses Act 1977—to provide for complaints against registered midwives or allegations of professional misconduct in relation to the Social Security Act 1964 to be investigated by the Nursing Council.

Social Security Act 1964—to Part II of this Act to allow registered midwives to claim maternity benefits, pharmaceutical benefits, other benefits relating to buildings and equipment, allowances and expenses, and grants in relation to services provided; to claim payments and refunds normally claimed by medical practitioners in respect of maternity care.

Medicines Act 1981—to refer to a registered midwife as a prescriber of medicines; to allow registered midwives to have possession of prescription medicines; to enable the Minister to prohibit prescribing, as in the case of medical practitioners; to enable the Medical Officer of Health to prohibit a registered midwife from supplying a prescription or restricted medicine to an addict, and to include registered midwives in regulations made under this Act.

Misuse of Drugs Act 1975—to allow registered midwives to prescribe the controlled drug pethidine, and to amend the disciplinary provisions for contravention of the Act to include registered midwives.

Social Security (Laboratory Diagnostic Services) Regulations 1981—to permit registered midwives to order a range of laboratory diagnostic tests as specified in the regulations, and for the Department of Health to make payments of fees for the services ordered.

Social Security (Pharmaceutical Benefits) Regulations 1965—to allow registered midwives to sign for their own pharmaceutical supply order, and to include registered midwives in the penalty provisions where medicines have been prescribed excessively.

Misuse of Drugs Regulations 1977—to allow registered midwives to prescribe the controlled drug pethidine to patients under their care, for maternity use only.

Medicines Regulations 1984—to provide for conditions under which a registered midwife may prescribe medicines.

d. Access to hospital services.

A number of submissions focused on the importance of appropriate back-up services and the need for midwives to have access to hospitals and referral services on the same basis as medical practitioners. This was supported in oral submissions by the New Zealand College of Midwives, the New Zealand Medical Association, the Nelson Area Health Board and the National Council of Women. The submission of the New Zealand Medical Association sought the availability of these services in the context of a team approach to maternity care, whereas the emphasis of other submissions was that referrals should be able to take place without the requirement to use a medical practitioner as a "gate-keeper".

The need for midwives to keep records and be able to notify births was also raised in this context.

The committee agrees that, in order to ensure the safety of mother and child, it is necessary for midwives to be able to refer women to hospital or to specialist advice should a pregnancy deviate from the norm. The committee is also aware that midwives would require access to patients referred to hospital on the same basis as doctors referring maternity patients. This would require amendment to the Area Health Boards Act 1983 In order for a midwife to be able to maintain records and register births, amendment to the Obstetric Regulations 1986 is required.

The committee therefore recommends the following amendments to:

Area Health Boards Act 1983—to allow area health boards to enter into agreements with registered midwives as to the conditions on which patients in a hospital maternity ward or maternity annex are treated. This access would be on the same terms as medical practitioners are currently accorded.

Obstetric Regulations 1986—to provide for a registered midwife to be able to notify septic conditions to the Medical Officer of Health and to notify births and maintain records.

Conclusions

In making its recommendations the committee recognises the need for training to be appropriate to retain existing standards of safety and care and so that any deviation from the norm can be detected. The committee is also aware of the need for adequate monitoring and review systems to be set in place. These issues received the unanimous support of the witnesses appearing before the committee.

During the hearings of evidence on the bill it became clear to the committee that, for registered midwives to provide comprehensive services and to ensure the safety of mother and child, it would be necessary to permit midwives to perform the range of related services referred to in submissions. This includes: administration of medicines commonly used in low risk pregnancy and childbirth; the ability for midwives to call for routine diagnostic laboratory tests and to claim for the associated social security benefits; and ability to transfer patients to an obstetrician or to a hospital if necessary.

Summary of recommendations

The committee has carefully considered the bill and has resolved to recommend that it be reported to the House without amendment.

In recommending that the bill be reported without amendment the committee is aware that the amendments that it wishes to see incorporated are not within the scope of the bill as introduced. **The committee therefore recommends that amendments to the following Acts be drawn up by means of a supplementary order paper for consideration by the Committee of the whole House:**

Nurses Act 1977—to provide for complaints against registered midwives or allegations of professional misconduct in relation to the Social Security Act 1964 to be investigated by the Nursing Council.

Social Security Act 1964—to Part II of this Act to allow registered midwives to claim maternity benefits, pharmaceutical benefits, other benefits relating to buildings and equipment, allowances and expenses, and grants in relation to services provided; to claim payments and refunds normally claimed by medical practitioners in respect of maternity care.

Misuse of Drugs Act 1975—to allow registered midwives to prescribe the controlled drug pethidine, and to amend the disciplinary provisions for contravention of the Act to include registered midwives.

Medicines Act 1981—to refer to a registered midwife as a prescriber of medicines; to allow registered midwives to have possession of prescription medicines; to enable the Minister to prohibit prescribing, as in the case of medical practitioners; to enable the Medical Officer of Health to prohibit a registered midwife from supplying a prescription or restricted medicine to an addict, and to include registered midwives in regulations made under this Act.

Area Health Boards Act 1983—to allow area health boards to enter into agreements with registered midwives as to the conditions on which patients in a hospital maternity ward or maternity annex are treated. This access would be on the same terms as medical practitioners are currently accorded.

The committee further recommends the amendment of a number of regulations, to come into force on the same day as the commencement date of the bill. These are as follows:

Social Security (Laboratory Diagnostic Services) Regulations 1981—to permit registered midwives to order a range of laboratory diagnostic tests as specified in the regulations, and for the Department of Health to make payments of fees for the services ordered.

Social Security (Pharmaceutical Benefits) Regulations 1965—to allow registered midwives to sign for their own pharmaceutical supply order, and to include registered midwives in the penalty provisions where medicines have been prescribed excessively.

Misuse of Drugs Regulations 1977—to allow registered midwives to prescribe the controlled drug pethidine to patients under their care, for maternity use only.

Obstetric Regulations 1986—to provide for a registered midwife to be able to notify septic conditions to the Medical Officer of Health and to notify births and maintain records.

Medicines Regulations 1984—to provide for conditions under which a registered midwife may prescribe medicines.

DIRECT ENTRY TO MIDWIFERY

SUMMARY OF RESPONSES TO

DIRECT ENTRY TO MIDWIFERY

DISCUSSION DOCUMENT & DRAFT CURRICULUM PRPOSAL

This document was released in February 1990 to facilitate discussion & input into the establishment of Direct Entry Midwifery Training in NZ; & with regard to the Draft curriculum, to invite comment on a proposal from Carrington Polytechnic.

The document was presented by the Save the Midwives Direct Entry Midwifery Task Force, in conjunction with Carrington Polytechnic School of Health Studies, and with the official endorsement of the NZ College of Midwives.

We would like to acknowledge once again the funding assistance from the McKenzie Foundation which has made this possible.

Comments from those who participated in our 1988 DEM survey revealed considerable confusion & misinformation over what people thought DEM training actually consisted of. This obvious need for information about DEM was a challenge to us & it was our hope that this educative aspect would be addressed in the discussion document.

One area of confusion which needs clarifying is the use of the term specialist midwife. This was not intended as an official term, but as a statement of clarification that the course is one of midwifery only with no professional pre-requisite.

Comments are still welcomed regarding issues concerning DEM & curriculum details, & can be sent to:

Jilleen Cole
School of Health Studies
Private Bag, Mount Albert,
Auckland 3
ph.(09) 894 180

It is also advisable for anyone interested in participating in the DEM course to contact Carrington to ensure their name is on the list of potential applicants.

DISTRIBUTION OF THE DOCUMENT:
(In numbers per document)

Copies of the Document were available free of charge

STM members	- 300	women & midwives
	14	delivery suites
	20	home birth groups
	15	parents centres
	25	other organisations
	20	overseas contacts

Sent to groups, organisations, individuals at their request - 163

General Distribution (inclu. at seminars, conferences etc.) - 132

Sent to key people & groups recommended as being an important initial contact for Maori & Pacific Island input. - 63

Sent to other groups recommended as having a possible interest - 17

Sent to Technical Institutes - 10

Sent to additional overseas contacts - 47

TOTAL - 826 (distributed directly by DEM Taskforce)

Many groups also photocopied & distributed the document for their members, or advertised its availability. All 691 people who responded to the 1988 DEM questionnaire were sent a summary of the questionnaire which also informed them about the discussion document & advising them on how to obtain a copy if interested.

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OVERSEAS RESPONSES TO THE DISCUSSION DOCUMENT
(some are extracts)

* We were interested & pleased to receive a copy of your discussion paper on Direct Entry to Midwifery. The Taskforce is to be congratulated on the enthusiasm & drive with which it is tackling the issue of Direct Entry. I hope that your search for opinion & comment on your questions & proposals is fruitful. I wish the NZ midwives success in pursuing every means to ensure that the profession continues & flourishes in the future.
- General Secretary Royal College of Midwives Trust, UK

* I am most impressed with your Direct Entry to Midwifery Syllabus. I think you are entirely on the right lines. I agree that the length of the course should be 3yrs with half of that made up with theory and half of that made up with practice.

I am pleased that you base the course on a philosophy of health & that you are encouraging your DE student midwives to be responsible, thinking, challenging, questioning people. I am most impressed with the physical skills you have included & at the end of this training programme your midwives will be able to hold their head high wherever they practise throughout the world.
- Caroline Flint
Consultant Midwife, Independent Midwife, UK

* With my best wishes for all your efforts
- Anne Thompson Co-Author of the UK 1988
Direct Entry: A Preparation for Midwifery Practice

* Congratulations to you all on acknowledging the changing needs of pregnant & labouring women. I want to endorse your comments about the present shortage of midwives & the poor retention rate following training. It is a clear indication that there is a need for change & the DEM program is a wonderful opportunity for it. It would be wonderful if the course gets off the ground next year. Here in Australia we are not that far yet, but we are working towards it. I wish you all the very best.
- Henny Ligtermoet, Childbirth Educator, Founder of the Australian Homebirth Movement, Australia

* This is all very exciting. Many congratulations to you all. I have worked through the document very carefully & have a number of suggestions to make, some focussing on minor matters & others on important issues..... (detailed submission enclosed)
- Shelia Kitzinger
Author, Anthropologist & Childbirth Activist

* I am very excited at your progress & extremely pleased that you seem to be winning. Your programme seems to be excellent.
- Soo Downe, UK Direct Entry Midwife Researcher & Activist

SUBMISSIONS

Total of written submissions - 30 (received by May 15th)
Total of oral contacts - 23 (these were verbal contacts made specifically to endorse the document)

Of the 30 written submissions - 12 were individual women *
8 of above want to do DEM

1 was from a Polytechnic

4 were from midwife groups

5 were from midwives *
1 mw is DE trained
1 mw is opposed to DE
2 are lay mws

7 from overseas †

1 from NZ Parents Centre

1 from NZNA/Auckland

* woman & mw joint submission

A SELECTION OF COMMENTS

* There should be a DE training centre in at least each of the main centres.

* Use Maori model of health rather than crisis/adaptation frame work.

* I support DEM students being trained alongside other health professionals (HP) as there will come a time when they will need to work together anyway.

* Nursing training must be kept separate from mwfry training.

* It is not appropriate for tutors to be teaching both DE & separate courses for reg.nurses. DE mustn't be seen as a nursing course. Tutors in charge of the nursing course should not direct what goes on in a DE course. DE course should be under the control of a group of parties, incl. mws, consumers, interested reps.from minority groups, tutors, & students.

* Important to site DEM where already a viable mwfry course as could act as umbrella for a new course, share resources, foster inter-professional relationships & opportunities for shared learning.

* Whoever is in control of DEM course must accept totally the philosophy behind DE training.

* DEM's must spend time equally with dmw's & level 1 hospital mws to be throughly immersed in normal practice.

* I will go to great lengths to begin the training I have always wanted to do.

* Very wasteful to have to do 3yr nursing course when I want to be a mw, not a nurse.

* Everyone should do the whole course (even nurses).No credits.

* Credits could be gained by oral examination with experienced midwives being the examiners.

* Committment to completing the course & working in mwfry is an essential criteria for all applicants.

* There is no place in any stage of pregnancy, childbirth or postnatal care for someone who has a negative attitude.

* All prospective students should have the same considerations.

* Quote from Truth or Dare by Starhawk..."The dominnant culture presents it's own style & values as the norm & other cultures are seen as deviant, quaint, backward or less valuable & so we are all diminished".

* Preference should be given to applicants of minority groups, this is showing sensitivity for the oppressed culture.

* Distance Learning theory could be done by correspondence with tutor workshops several times a year.

* Scholarships & grants must be available to students experiencing financial hardship unless you want the course to be available only to well-off people.

* Rectal examinations are not relevant to modern midwifery & should not be included in the curriculum.

* Concept of DEM needs marketing to ensure public & other HP understanding & acceptance.

* Should be moving towards DEM being the only mwfry course.

* Concern about getting suitable tutors to teach some modules ie. doubt whether there are many who could adequately & in sufficient depth, teach the module on professional identity.

* Course content needs constant appraisal so tutors & trainees are up to date in their knowledge but are also self critical & continuously developing their self awareness & their skills.

* Course is too front end rather than whole of life.

† Comments have also just been received from:-
-Midwifery Task Force of British Columbia
-British Columbia School of Midwifery
-English National Board
-UK Central Council for Nursing, Midwifery & Health Visiting
-Tutors from Derby, UK

What Is Necessary for DEM Training?

1. Support high quality preparation - 6
2. Communication skills very important - 3
3. Competence in any field of midwifery practice - 1
4. Able to differentiate between normal & abnormal - 4
5. Must know variations of normal - 3
6. Must be immersed in normal mwfry practice - 4
7. Ability to help restore & maintain normality - 2
8. Able to provide quality assurance to client - 3
9. Dislike term specialist mw. A mw is a mw. - 3
10. Encourage keen perception & clear observation - 1
11. Apprenticeship to experienced midwife - 3
12. Needs ability to assess,research & analytical skills- 2
13. Access to appropriate hosp. & domiciliary experience- 1
14. Assess O/S training & seek assistance from O/S mws - 1
15. Two-way learning between women & mws - 5

Does Midwifery Share Knowledge with other Professions?

1. Support stated concepts shared - 2
2. Support shared knowledge teaching alongside other HP- 6
3. Wellness aspect is shared in common with nursing - 1
4. Pathophysiology & communication skills in common - 4
5. Support sound backing in nursing - 1
6. Support sharing of new entrant nursing students basic skills introduction block (ie.BP,pulse etc) - 1
7. Support core yr for mw,nurses,O/T,physio,medicine - 1
8. Support sharing of natural healing methods - 3
9. Support shared comprehensive counselling skills - 2
10. Support sharing with childbirth educators training - 1
11. Keep nursing training separate from DE training - 3
12. Support sharing same subjects for cost effectiveness- 3
13. Must be student centred & health learning if shared - 1
14. Support sharing in area of psychological needs - 1
15. Oppose sharing of knowledge with other HP - 1
16. Share core subjects ie.A&P,chemistry,sociology, cultural awareness,study skills etc. - 1

Criteria of Admission for Course Applicants

1. Maturity & outlook = consideration academic ability - 9
2. Maturity & outlook more appropriate than a.ability - 5
3. Support age requirement & maturity preference - 4
4. No age requirement necessary - 7
5. Not sure about whether age requirement appropriate - 1
6. Personal cb experience important consideration - 7
7. Personal cb exper. may be a value but not for select- 9
8. Positive attitude to preg,birth & parenting required- 13
9. #8 not required as course should develop these - 1
10. Support preference to minority group applicants - 8
11. Don't support preference to minority groups - 1
12. Cultural considerations part of selection process - 2
13. Support all students meeting basic academic criteria- 2
14. Applicants to show recent ability to study - 2
15. Committment to completing course essential - 2
16. Committment to working in mwfry field essential - 2

Options for Siting DE Courses

1. OK if tutors teach both DE & sep. course - 5
2. Support tutors teaching one or the other/not both - 5
3. Support DE & separate courses in same place - 3
4. Support DE & separate courses at different places - 3
5. Competition & resentment between courses unlikely - 2
6. Oppose hospital based siting of DE course - 2
7. Need to address competition - communication skills - 3
8. Need to address competition - drop ADN/mwfry - 1
9. Re.competition-teach feminist understanding of power- 2
10. Boost mws self-esteem to reduce compet. & resentment- 1
11. Support wider geographical spread of courses - 1

Clinical Experience

1. No less than half DE training to be clinical - 5
2. At least 2/3rds clinical & 1/3 theoretical - 2
3. At least ½ clinical exper.to be in domiciliary field- 2
4. 1/3 to be full continuity own client load
5. Must focus on NORMAL - 9
6. Support draft proposal components - 1
7. Focus on continuity of care - 3
8. Support apprenticeship to experienced mw - 5
9. Strong focus on practical experience - 3
10. Practical to include all levels of mwfry experience- 3
11. Focus on mothers needs, comfort & safety - 1
12. Support quality rather than quantity - 2

Credit for Previous Experience & Education

1. Support use of a credit system - 7
2. Oppose credits. Everyone to do whole course - 1
3. Support use of portfolio to show experience - 1
4. Need for identifiable competency - 1
5. Difficult to judge & assess experience - 1
6. Support oral exam. conducted by experienced mws - 1
7. Support topic specific examinations/tests - 1

Distance Learning

1. Support & want Distance Learning as part of DEM - 13
2. Support audiovisual,computer,satellite development - 2
3. Support flexible time frame (part-time) - 6
4. Needs proper quality supervision - 6
5. Support correspondence with study blocks at base ctr- 4
6. In conjunction with apprenticeship - 5
7. Support University type modules for flexibility - 4
8. Support opportunity to study modules of choice - 3

What The Law Allows For

1. Being addressed in Review of Nurses Act - 1
2. Support change so DEM can do home births - 3
3. Support training centre in all main centres - 1
4. Support professional autonomy - 1

Biculturalism, The Treaty of Waitangi & the Maori Perspective of Health

1. Support selection preference/allocation for Maori - 5
2. Support Maori language option in course - 3
3. Oppose Maori language provisions in course - 1
4. Too expensive to include M.language in course - 1
5. Support involvement of Tangata Whenua - 7
6. Special needs of Maori to be considered - 8
7. Maori to be treated same as everyone else - 2
8. Include Maori perspective in course - 6
9. Same tertiary bursary to apply for all students - 1
10. Better financial funding for M. women in need - 1
11. Support major input of M.people in setting up course - 3
12. Support bicultural approach in course - 3

The Perspective of Other Ethnic Groups

1. Treat same as everyone else - 1
2. Support examinations to be in 1st language - 1
3. Ask each group to identify special needs - 2
4. Support selection/allocation preference for training - 2
5. Consult re. input for setting up course - 2

The Polynesian/Pacific Island Perspective

1. Give selection preference/special allocation of #'s - 6
2. Support examinations to be in 1st language - 3
3. Consult with PI people re. course content - 4
4. Treat same as everyone else - 2
5. Special needs of PI students to be considered - 5
6. Financial assistance for PI students in need - 1
7. Support credit system for "trained" PI mws - 2
8. Include PI perspective in course - 2
9. PI people to have major input into setting up course - 3

Funding & Scholarships

1. Tertiary bursary same as for other students - 4
2. Specific grants for hardship & accomodation - 7
3. Grant amount to vary for need - 2
4. All grants to be the same for all students - 3
5. Govt. should pay - 1
6. Ministry of Women's Affairs or Lotto should pay - 1
7. Special trust fund to support mwfry education - 1
8. Reallocation of badly utilised health service money - 1
9. Important concern for women with children - 5
10. Course structure in modules to allow part-time - 4
11. Community sponsorship for those with committment to return & practise mwfry in that community - 1

OVERVIEW

Generally the submissions were enthusiastic & supportive about the content of the Discussion Document. Most supported the document in principle, commenting on areas of particular interest to them. Some suggested additions, changes, priority areas & issues of concern.

Most submissions did not address every issue highlighted in Part 1 & only some commented specifically on the draft proposal. Where support is registered for something, this does not necessary mean to the exclusion of other options. Two submissions opposed the concept of DE but commented on aspects of the document.

Concern was expressed at the lack of Maori input at Taskforce level & the need to ensure input into DEM courses by the Tangata Whenua, Pacific Island groups & other minority groups. Lay midwives expressed concern that the professionalisation of midwifery has become the over-riding issue with a power play-off between midwives, GP's and Obstetricians, & that the curriculum needed to be more grassroots to interest them.

Emphasis on quality clinical experience with a paramount focus on NORMAL & continuity case load care came through loud & clear, plus the need to incorporate alternative healing methods.

Apprenticeship was suggested as a positive aspect relating to a number of the areas for consideration by many submissions, particularly in relation to distance learning & clinical experience in ones own community.

Modular structure of the course (ie Univ.courses) was recommended for providing greater flexibility. This was noted as being beneficial for distance learning, those who could only do it part-time, those who were financially disadvantaged & for a credit system to operate.

Funding was a frequently expressed concern as was the need to make the course available to as many interested women as possible. We even had an enquiry about Australian women being able to do the course.

Oral submissions came from women desperately keen to do DEM training who are delighted it is finally going to happen; and from midwives who see DEM as an appropriate & long overdue move much needed by the profession.

The overwhelming message was one of enthusiasm, support & that we are on the right track.

DATES TO REMEMBER

* **WORLD SMOKEFREE DAY** - 31st May

* **UNIVERSITY MARAE MONTHLY HUI** - One Sat.per mth till November
Te Ao Pakeha, The Pakeha World: A Maori Perspective
Contact - Auckland Continuing Education Office ph. 737 831

* **WORLD ENVIRONMENT DAY** - June 5th
Created by the UN Environment Programme where Governments & organisations are asked to undertake activities to reaffirm concern for the preservation of the environment.

* **FERTILITY ACTION COURSES ON WOMEN'S HEALTH ISSUES** - Auckland
Course 1 commences 7 June (6 Thursday evenings)
Course 2 commences 19 July (6 Thursday evenings)
$100 for 1 course or $180 for both - Educ.College,Epsom Ave.
Contact: Fertility Action,PO Box 46148,Herne Bay (09)780 357

* **INTERPLAY BETWEEN THE COMMUNITY & PROFESSIONS IN DETERMINING & POLICING ETHICAL CODES SEMINAR** - June 18th 7.30pm-9pm
Auckland University Hall, 22 Princess Street, Auckland

* **NZ O&G SOCIETY ANNUAL SCIENTIFIC MEETING** - June 23 Wgtn.
Enquiries - Secretariat,Postgraduate Office,PO Box 7343,Wgtn

* **MEDICAL TREATMENT & INFORMED CONSENT SEMINAR** - June 25th
Auck.University Hall, 22 Princess Street. 7.30pm-9pm

* **ICEA 1990 INTERNATIONAL CONVENTION** - Aug 3-5 Chicago, USA
Theme: Midwifery Keynote Speaker: Marsden Wagner
Enquiries: PO Box 20048, Minneapolis, Minnesota 55420, USA

* **AUCKLAND WOMEN'S HEALTH COUNCIL CONFERENCE** - August 5th
"Cartwright & Beyond-The Shape of Women's Health in the 90's"
ATI Akoraga Campas,Northcote,Auckland - Waged $40 Unwaged $25
Enquiries AWHC, 10 Carlton Gore Road, Grafton, Auckland.

* **NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE** - Aug 17-20 1990
Knox College - Dunedin (AGM on the Friday night)
Enquiries: Conference Cmttee. NZ College of Mws, Otago Region
PO Box 6243, Dunedin North. (Calling for abstracts/ideas)

* **IMMUNE SYSTEM - GATEWAY TO HEALTH CONFERENCE** September 7,8,9
War Memorial Hall, Marine Parade, Napier. $99 registration
Enquiries: Hawkes Bay Polytechnic, Private Bag, Taradale

* **HEALTHY CITIES WEEK 1990** - September 24-29

* **WOMEN & SURGERY** - Melbourne University, Australia Sept 27-29
Aim: To raise/discuss issues of women & surgery to highlight women's experience & concerns; expose problems experienced by women,influence directions taken within the healthcare system and promote change in attitudes, planning and practice.
Enquiries: 318 Little Bourke St,Melbourne,Victoria 3000,Aust.

* **INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS:** October 8-12 1990 Kobe, Japan
Theme: " A Midwife's Gift - Love, Knowledge and Skill "
Enquiries: ICM International Congress, Nursing Association International Relations, 8-2, 5-Chrome Jingumae,Shibuya,Tokyo (or to NZCOM Board of Management, PO Box 21106, Christchurch)
Deadline on abstracts - Jan 31st 1990

* **EARTH FIRST EXPO** - Avondale Racecourse and Showgrounds Oct 18-22 1990. Contact: PO Box 8371, Symonds St. Auckland
To celebrate the spirit of co-operation between the different cultures which now make up the NZ community in the search for better ways of co-existing with each other & the natural environment on which we ultimately depend.

* **HEALTH PROMOTION FORUM 1st ANNUAL CONFERENCE** - Oct 24,25,26
Lincoln Function Centre, Lincoln Road, West Auckland
Enquiries HPF, Dept. of Community Health, Med.School, Auck.

* **FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES:** 14-17 November 1990 - Massey University, Palmerston North
Theme: Women as Health Providers Within a Context of Culture, Society & Health Policy.
Enquiries: Dept. of Nursing Studies, Massey University, PN.

* **AUSTRALIAN COLLEGE OF MIDWIVES 7th BIENNIAL CONFERENCE-** Perth 16-18 September 1991 Theme: " Birthdays, Birthways "

* **2ND INTERNATIONAL HOMEBIRTH CONFERENCE** - 1992 Sydney
Enquiries & Input: Jane Thompson,12 Thornton St.Fairlight,NSW

UPDATE ON DIRECT ENTRY MIDWIFERY IN THE UK

Jilleen Cole spoke to the Auckland Region of the College of Midwives on May 23rd about her recent 3 months study leave trip to the UK to investigate DE midwifery training.

Jilleen is a member of the Direct Entry Midwifery Taskforce and a Tutor at Carrington Polytechnic. She wrote the draft curriculum proposal which is presented in the Save The Midwives Direct Entry Midwifery Discussion Document & is actively involved in the setting up of a DE course at Carrington to commence next year.

She explained that her interest dated back to when she was 18 years old and set out specifically to be a midwife. She did the 18 mths maternity training, discovered lots of unanswered questions and was treated like a second class citizen next to those who were general trained. She then went on to do her general training and then midwifery - a very long way to become a midwife. Most of her clinical practice has been as a midwife, and she feels strongly that any course must satisfy the needs of someone wanting to learn, not just for the qualification at the end.

Derby no longer has a DE course. They have had no new intakes for the past 2 years & have not been granted approval to run more at this stage.

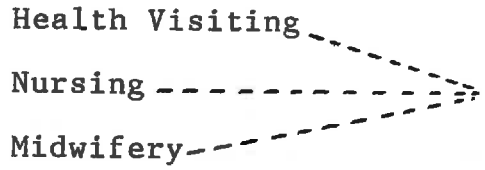
Dorset & Oxford are the only 2 DE courses presently operating. However, approval to offer DE has been sought & gained by 7 other regions. 3 of these will begin Sept/Oct - the beginning of the academic year and will operate from educational establishments.

Dorset offers a 3 year Midwifery Diploma Course & will be offering a 3 year DEM degree course (which is shorter than Oxford) in September, as it has just been approved. They will offer
- 18 months midwifery for nurses
- 3 year DE Midwifery Diploma
- 3 year DE Midwifery Degree

Oxford offers the following BSC Honours Degree Courses
- 4 year DE Midwifery
- 4 year Nursing (general)
- 4 year Pediatric
- 4 year Psychiatric
- 4 year Mental Handicap

All courses are run separately, although modules in common are run side by side.

Birmingham will be offering a DE Diploma starting in September which Jilleen felt looked very promising. It has a sound midwifery background and has developed out of the College of Midwifery rather than from a Polytechnic. The College has a strong link with the University. Funding is a joint arrangement between the Univ.& Health Authority. The planned course has a very positive & real midwifery/maternity feel about it, & Birmingham was acknowledged as being well known historically for its contribution to midwifery.



All legislation, councils etc. are specific to each & this makes things much easier for everyone.

Overall Impressions

Jillen felt she couldn't understand why we weren't already doing it! She acknowledged the skills & parts in common that midwifery has along with other health professions, such as caring & nurturing, but that midwifery is very separate from other health professions including nursing.

In the UK nurses wanting to be midwives could do an 18mth course, but there was now no midwifery course for already qualified nurses in Oxford. However, most places will have DE midwifery & midwifery for nurses running along side each other. It is acknowledged that courses for nurses will have to continue for some time, but there is already talk of having a credit system for nurses who want to go on to do midwifery. Undergraduate courses for both midwives & nurses are seen as the training of the future.

Criteria for Entry

Same as for nursing courses which takes students straight from school with 5xO levels & a couple of A levels. There is lots of competition as the demand is high. The Oxford Degree course has 16 students of which half are school leavers age 17/18 yrs, and the other half are mature students. Criteria is basically done only on academic requirement & interview. Dorset wanted more mature students, but is not permitted to stop school leavers from taking part. A balance of ages is wanted. The process for application is via a central clearing house which sends out information on the courses.

Reasons for chosing Midwifery

Except for 1 student who had had a birth experience with her mother, the school leavers chose to be midwives because they wanted a job that involved caring & nuturing but didn't like the blood & guts of nursing!

The mature students chose specifically to be midwives because of their previous contact with childbirth, some of them had a personal experience of childbirth as well. They all felt that they balanced each other very well & felt very much as one group

How the Courses Operate

Polytechnics - Degree
- Diploma

Colleges of Nursing & Midwifery have an affiliation to the Education Authority (ie. Polytech) & the Area Health Authority which pays a minimum salary of £4,000 to Polytech. students. Those on degree courses receive an ordinary bursary. However the system is presently undergoing changes so this may change.

All courses are evaluated during the course & at the end. Jilleen did speak with some midwives & nurses who were students at an open university (like Massey) but as this is just new the success of integrating into the system is not yet known.

There is no consumer input into midwifery education at all. It is all done by educators & Health Authority Management. Jilleen feels that consumer involvement is crucial.

All one Midwife

Whatever the course, there will be one midwife only & the clinical requirements of all courses will be standardised to meet EEC regulations. (This is obviously an issue for us to consider as well). There is one qualification only as a midwife is a midwife, but there will be a difference in promotion & job opportunities. However, whatever the route, equal competency is expected.

Preparation of staff responsible for clinical practice is seen as very important in the UK.

Refresher Courses
are compulsory for 1 week every 5yrs with an increasing amount of time up to 3mths for time spent out of midwifery.

Holland

In Holland she spoke to midwifery students in Amsterdam. Here the midwifery course is 3years whether you have previous nursing training or not. Nursing & Midwifery are seen as entirely different professions, where a credit system for nurses is not appropriate & there is just 1 midwifery course.

New Zealand College of Midwives

National Conference - Women in Partnership

August 17 to 20, 1990, Knox College, Dunedin

Keynote Speaker

Dr Marsden Wagner

Regional Officer for Maternal and Child Health, WHO

Programme

Friday 17		Annual General Meeting (evening)
Saturday 18	*Consumerism*	Opening Ceremony, Cocktail Party (evening)
Sunday 19	*Midwifery*	Conference Dinner (evening)
Monday 20	*Feminism*	Closing Ceremony

Conference proceedings will be published after the Conference and be available for purchase from the College in November 1990.

Enquiries should be directed to: Conference Committee,
New Zealand College of Midwives,
Otago Region,
P.O. Box 6243,
DUNEDIN NORTH

MANAWATU HOME BIRTH ASSOC. INC.
P.O. Box 733
Palmerston North

HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP

ADDITIONAL HOME BIRTH MIDWIFE REQUIRED

we are looking for one more domiciliary midwife to join our enthusiastic team to help cope with the demand.

From September onwards we are left with one midwife working.

The Manawatu Home Birth Association is active and well established and is willing to assist the new midwife in any way possible.

For further information write to the above address or phone Carol (063) 85226

HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP

Women & Smoking

Women-Specific Health Effects

Not only do women suffer the same smoking-related health problems as men, but smoking also represents an additional health threat to women. Smokers on oral contraceptives are at increased risk from heart attack and stroke, and are more prone to pill failure (becoming pregnant).[6] Women who smoke are two to five times more likely than non-smokers to get cervical cancer. Women smokers also reach menopause two to three years earlier than non-smoking women, with consequent increased risk of osteoporosis (early menopause from any cause accelerates the bone-thinning process).[7] Women who smoke are at greater risk of complication during pregnancy and are more likely to have miscarriages, premature births, and low birth weight babies.[8]

The risk of most of these smoking-related effects is highest for those who began smoking in their teen years.

Principles for Action

Current campaigns are not reaching all women, and we need to ensure that women are included in future plans. Any action or policy should be underpinned by the following principles:

- The benefits of non-smoking must be valued for women themselves, not just because they bear children.
- A priority for policy action is to end the commercial exploitation of an addictive and lethal substance.
- The social and political context of women's lives must be acknowledged. Health education material which does not take account of the circumstances of women's lives is unlikely to be effective.
- Women, and particularly Maori women and young women, must be involved at all levels of action, from developing legislation to providing support for women who want to stop smoking.
- Maori women must be enabled to develop their own smoke-free strategies.
- Women, and particularly Maori women and young women, should be visible equally with men in any anti-smoking publicity material.

  This should include showing non-smoking female role-models and women heroes who are prepared to make a public stand against smoking.
- Women should be encouraged to explore other ways of coping with stress and role-conflicts at the time of giving up smoking.
- Myths about dependence and women finding it harder to quit smoking than men should be discouraged because the belief that you can do it is a vital factor in being able to stop.

Health Effects of Passive Smoking

The link between smoke inhaled from other people's cigarettes and such diseases as lung cancer and heart disease is now well established. The only issue is the numbers and kinds of illnesses which are affected by such passive smoking. Current estimates are that about 273 non-smokers die each year from breathing other people's smoke.

8. The Home Birth Groups of Aotearoa call on all Area Health Boards to provide funds for paid home help to support women choosing home births & planned early discharge from hospital.

9. The Home Birth Groups of Aotearoa oppose the transfer of domiciliary midwives to the supervision of secondary care services, ie. hospital managers of maternity services, with in Area Health Boards. Domiciliary midwives are primary health care workers & should remain under the supervision of the primary health care division of Area Health Boards. Any change to the conditions of employment without consultation without the Domiciliary Midwives society contravenes their contract.

Move away from technical births praised

Northern Advocate 11.5.90

Women's Affairs Minister Margaret Shields today welcomed the move away from technical births to women controlling the situation.

Mrs Shields was speaking at the national home birth conference, being held in Whangarei this weekend.

While people should not forget that technology played an important part of saving the lives of many women and childern, it should not interfere in the right of women to enjoy the birth and to make it a natural experience, she said.

The world had gone mad over technology in the 1960s, and birth procedures like inductions, episiotomies and epidurals became common.

A Dunedin study in 1980 found that 75% of women giving birth at their time received episiotomies. It had got to the stage where birth without a doctor present was seen to be dangerous, and this view was enshrined in law by the 1977 Nurses Act, which made it illegal for a midwife to attend a birth without a doctor, she said.

The history of birthing procedures challenged the validity the medicalisation, she said. Women always helped each other with births.

The midwife or "wise woman" was the key in a female controlled reproductive care system in Europe until the end of the 17th Century.

"Her part in the birthing process was described as 'catching babies'. That is precisely what she did. The labouring woman sat on a birthing stool and her baby was caught by the midwife. After the birth female friends were feasted at a 'groaning party'. Those friends then took over the women's household and childcare duties for a 'lying in' period."

The breakdown of the system was largely due to the development of the barber-surgeon's guild in the 12th and 13th Centuries. Surgeons took over as birth attendants not because they were better but because they had power.

The guild was given jurisdiction to prosecute those practising in their territory who did not hold a university licence or guild membership.

"That included all midwives — women of course, were barred from university and the guilds. Even outright violence was used to stop midwives attending births. Midwives were the main victims of the witch-hunts.

They were accused of copulating with the devil, devouring newborn babies and horror of horrors — rendering men impotent."

The major thing in the barber-surgeons' favour was that they controlled the use of forceps, she said. Midwives were not allowed to use this new piece of equipment, which they had actually invented, by using two spoons to dislodge impacted babies.

"Other techniques that many of us never question resulted from medical men taking over as birth attendants. Many were introduced for the convenience of the practitioner. The lithotomy position (lying flat on your back) was introduced so that the surgeon would not strain his back during delivery. "The move to hospitals as birthing venues was both so that doctors didn't have to travel to see patients and even more importantly to provide a pool of cases on which to train medical students."

Home-birth babies less likely to die, says report

Dominion 15.5.90

SYDNEY

BABIES are almost twice as likely to die during or soon after a hospital delivery than a home-birth, according to a report published yesterday.

The perinatal mortality rate for homebirths is 5.9 per 1000 births, compared with a national rate of 10.7.

The first comprehensive national report on homebirths also says such births are significantly less likely to involve medical or surgical intervention than hospital deliveries.

The analysis of 3400 home-births planned between 1985 and 1987 was conducted by the Sydney University based National Perinatal Statistics Unit, and will be debated at a national homebirth conference in Adelaide this weekend.

It founds that the caesarian rate for homebirths was 2.2 per cent — about one-eighth of the national rate. Almost 5 per cent of homebirths involve an episiotomy, compared with hospital rates which range from 30 to 80 per cent.

And 90 per cent of women giving birth at home do not use medical methods of pain relief.

The report also found that in roughly one-in-seven planned homebirths, the mother or baby needed to be transferred to hospital either during or after labour.

As well, about three-quarters of homebirth midwives supervise fewer than 20 such births every year.

Homebirth Australia national co-ordinator Hilda Bastian, who co-authored the report, said it showed homebirth was becoming a real choice for Australian women. — NZPA-AAP

HEALTH PROMOTION FORUM

HEALTH PROMOTION FORUM
DEPARTMENT OF COMMUNITY HEALTH
UNIVERSITY OF AUCKLAND
PRIVATE BAG
AUCKLAND

The Health Promotion Forum has just published its first Directory of Health Promotion Organisations, in response to the need for a national networking resource with a focus on health promotion.

It provides regional listings of organisations and special projects, an outline of the Ottawa Charter, a health continuum, and maps of Tribal areas and Area Health Board regions.

We believe this directory is extremely valuable in enabling us to work together on the New Zealand Health Goals.

The Health Promotion Forum also maintains a National Health Promotion Database Register from which this Directory originates.

An information form for entering further data is attached at the back of the Directory.

Updated versions of the Directory will be released regularly, and we appreciate information which will assist us to maximise the usefulness of this resource. Please let us know of changes of address, new organisations and any information in the directory that is not accurate.

FERTILITY ACTION COURSES

These courses are designed for all women with an interest in the politics of women's health.

In each evening session there will be time for discussion after the speaker's presentation. The sessions run on Thursday evenings, 7.30 - 9.00 or 9.30 from 7 June - 23 August. Topics covered will be:

- Introduction to Women's Health *Sandra Coney*
- The Unfortunate Experiment *Linda Williams, Sue Neal and Cheryl Hamilton*
- Hormone Replacement Therapy *Ruth Bonita*
- Informed Consent *Jan Crosthwaite*
- Hysterectomy *Lynne Giddings, Sandra Coney, Lyn Potter*
- Breast Cancer *Betsy Marshall and Barbara Holt*
- Pacific Island Women's Health *Moera Douthett and Lita Folaiki*
- A National Cervical Cancer Screening Programme – is it possible? *Betsy Marshall and Ruth Bonita*
- Women and Alcohol *Sally Casswell*
- Women and Tobacco *Deirdre Kent*
- New Birth Technologies *Pat Rosier*
- The Reconstructed Female *Sandra Coney*

The cost is $100 for one course of six sessions, and $180 for two courses. Courses will be held in the Special Education Rooms, Auckland College of Education, Epsom Avenue. Contact (09) 780 357.

new zealand family planning association (inc)
Auckland Education Unit
214 Karangahape Rd Auckland 1 N.Z. Ph. (09) 796-182 Fax (09) 798-242

INTRODUCTION TO FAMILY PLANNING - A COURSE FOR NURSES AND OTHER HEALTH PROFESSIONALS

COURSE OUTLINE

This is a basic introductory course for registered nurses who wish to increase their knowledge in the field of Family Planning.

During a four day course participants will be exposed to a variety of issues relating to contraception.

All aspects and methods of contraception will be discussed so that the participants will have a greater understanding of the physiological and social factors involved in the provision of contraception.

Pre-pregnancy planning, infertility, cultural aspects, age related factors and the promotion of health will all be discussed within the context of birth control in New Zealand.

Topics that will be covered during the course -

* Sexuality
* Adolescent needs
* Cultural contraceptive factors
* Pre-pregnancy planning
* Early pregnancy
* Fertility Awareness
* Barrier Methods
* Intrauterine Contraceptive Devices
* Hormonal Contraception
* Post Coital Contraception
* Sterilisation
* Termination of pregnancy
* Cervical cytology
* Sexually transmitted diseases
* Menopause
* Psychosexual aspects of counselling

Four courses will be offered in 1990.
All are from Tuesday to Friday inclusive -

June 12th - 15th
July 31st - August 3rd
October 16th - 19th

COST: $220.00

OBSERVATIONAL CLINIC SESSIONS

These sessions are provided for the observation of the practical application of the theoretical, physiological and social aspects of contraception and family planning.

They are offered in conjunction with the Introduction to Family Planning Courses; to nurses currently working in relevant situations; or to students of nursing courses.

They will consist of 2-3 sessions observed in a local clinic over a short period of time.

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