# SAVE THE MIDWIVES

MAY '88

NO. 15

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## MIDWIFERY EDUCATION FOR THE FUTURE: A JOINT DECISION

STM is committed to the establishment of midwifery training that enables the midwife to practise competently as a practitioner in her own right - as the specialist of normal childbirth. This committment includes the principle that midwifery should empower women and is a service that must meet the needs of the women the profession targets.

Emphasis on birth as a medical event, the national shortage of midwives and the lack of adequate midwifery training have all contributed to undermining the very existance and status of the midwife in NZ.

There is ongoing debate as to whether a competent midwife requires a nursing pre-requisite, or whether a specialist midwifery training can adequately and more appropriately prepare the midwife for her role as the expert of normal pregnancy and childbirth.

The present system of midwifery education is wasteful of resources and not cost effective. Midwifery needs to be recognised as a profession in its own right.
Why train to be a nurse if you want to be a midwife?

A Direct Entry Specialist Midwifery Programme would have students highly motivated towards midwifery. In the UK it has been shown that there is a high retention rate within the profession following graduation from such a programme.
Direct Entry midwives are more likely to continue practising as midwives which is a vital characteristic in the effort to relieve the chronic nationwide shortage of midwives.

Women are increasingly demanding the services of midwives, as there is growing opposition to the use of the medical model in the care of pregnant and birthing women; and the associated use of high tech. procedures and medical intervention. The midwife has a responsibility to be active in her role as the womans advocate during the process of pregnancy, birthing and the postnatal period.

Simultaneously, increasing numbers of women are demanding an education programme to train as specialist midwives without requiring a nursing pre-requisite.

The Direct Entry Task Force created to work towards the establishment of a DE Course has received a $10,000 grant from the Roy McKenzie Foundation for the purpose of conducting a Feasibility Study and to explore a curriculum draft proposal that has appropriate cultural input. The successful culmination of this project relies on the joint input of professionals and community members and we would like to invite you all to respond to the enclosed questionaire. Judi Strid.

Aspects of Education

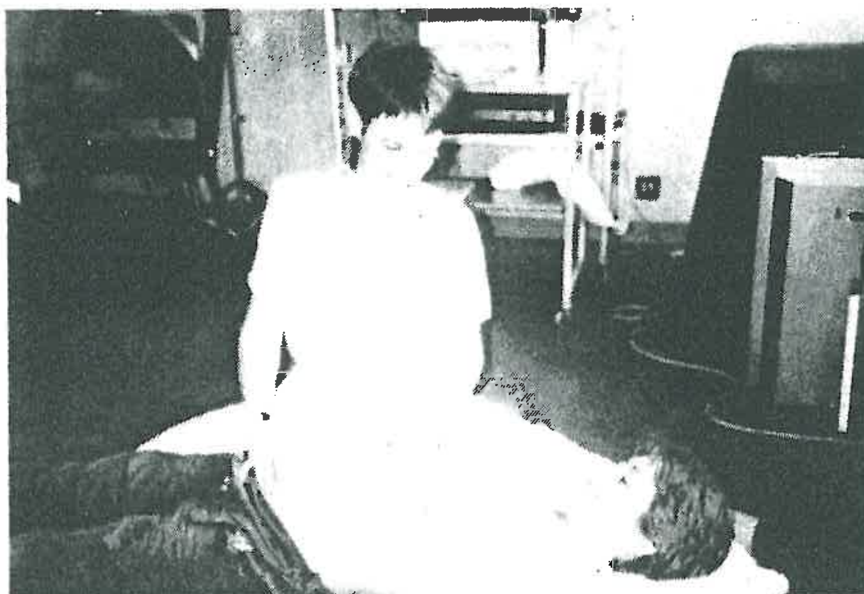
By Lorna Cowan, BA, RGN
*Student midwife*

# Training for Midwifery in the 1980s

## Impressions of a student midwife.

## Improving the training of student midwives may be one way of safeguarding the future of the profession.

According to the Code of Practice[1] accepted by the International Federation of Gynaecologists and Obstetricians the midwife should be able to carry out the following duties subsequent to her midwifery training:
'She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.'
During my training in a large London teaching hospital I have found that most midwives give fragmented care and rarely fully undertake any of the above responsibilities.
In the community the midwives' role has been taken over by General Practitioners or Health Visitors. In consultant units the majority of midwives' work has been eroded by obstetricians: directly or indirectly by unit policies.
The increased use of technology in these units can also undermine, rather than enhance, the skills of the midwife.
I would suggest that this insidious diminution of the midwives role results in parturient women receiving unsatisfactory care and could eventually eradicate midwives as described in the definition above.
It would appear that the 80's are a time when the midwifery profession must look for ways to safeguard its future. Improving the training of student midwives may be one way of doing this and certain aspects of the training can be considered.



## Selection of candidates

The majority of student midwives come from a background of general nursing. Robinson (1986)[2] found that only 16.2 per cent of newly qualified midwives in her study were 'intending to make a career in midwifery' before undertaking their 18-months training. This increased to only 24 per cent after qualifying although 85 per cent of the sample expressed some intention to practice.
Many student midwives remain orientated towards general nursing and 43.2 per cent gave 'I find more job satisfaction in general nursing' as their reason for not making a career in midwifery in Robinson's study. This can have a detrimental effect on their practice as midwives, and can result in some midwives feeling happiest when looking after ill women, such as abnormal cases and post-caesarian section women.
If the midwifery profession is to survive it needs to promote midwifery training as the beginning of a separate career and not as a post-basic course to general nursing.
Midwives require a different approach to general nurses: being able to establish a relationship with a healthy woman; giving education and advice without undermining the woman's independence; being



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able to wait patiently during labour and to be able to act on, and be responsible for, her own decision making are some examples.
There are problems with recruiting midwives from the nursing sector particularly as a reference from the candidate's present nursing officer is often required. If we accept the fact that different qualities are beneficial to a midwife than a nurse, it may follow that nurses wanting to be midwives are dissatisfied with their present work. In which case the long waiting lists for places at midwifery training schools, sometimes as much as two years, may be very off-putting.
By this time these women may have left nursing, or may be seen as 'bad' nurses due to their frustration or outspokenness making references difficult. Even interviewing candidates may not distinguish those really wanting to practice as midwives rather than enhance their nursing career, as preparation for interviews is commonplace and this includes reasons for wanting to make a career in midwifery.
The Report of the Commission of Nurse Education[3] supported the concept of Direct Entry Programmes for midwifery training. However, these appear to remain neglected. If more courses were available the profession could attract women who intended to fulfill the accepted role of a midwife. These women may have more appropriate attitudes to parturient women as they have not looked after ill patients, which often results in a disease orientated approach.

## Academic aspects

Midwives have had their own body of knowledge throughout history. During this last century the knowledge of the midwife has greatly increased with the enormous development of obstetrics, and other related sciences such as microbiology, embryology, pharmacology and the use of technology.
The syllabus and training of midwives has reflected these changes and the requirements are detailed in the Handbook of Midwives Rules[4]. However, the way in which the course is presented can vary enormously between different tutors and training institutions.
I feel that the emphasis appears to be on rote learning of a large amount of information, often with a bias towards the obstetric viewpoint. If midwives want to be seen as professionals in their own right they should clarify their own particular body of knowledge which should be research based where possible.
Research into human behaviour, feelings and reactions is notoriously difficult and is often inconclusive, however, it may provide some basis for midwifery practice. Many midwives appear frightened or dismissive of research, which is a pity because the profession would certainly be much stronger if all midwives had a working knowledge of it.
On the whole, lectures from doctors, whether paediatricians, obstetricians, genito-urinary specialists or psychiatrists, were based on theories and research. However, midwifery practice was often stated and justified because 'It's the way we do it here' – especially at ward level. Perhaps having a project on a certain topic as a compulsory part of the training would at least ensure that student midwives became familiar with research techniques and make full use of library facilities. A discussion of this work could form part of the final oral examination.
Class discussions formed a valuable part of my learning experience and may also promote more articulate midwives. This is important if a beneficial relationship between obstetricians and midwife is to develop.
I feel that the midwifery training could be broader based encompassing some phychology, social sciences, philosophies which concern women and childbirth and holistic approaches to medicine. The final midwifery examination papers would need to include questions of a more discussive nature in addition to those at present which are orientated towards midwifery procedures. This may result in the Advanced Diploma in Midwifery becoming obsolete.

## Clinical aspects

The English National Board lays down detailed guidelines of the extensive experience a student midwife must gain during her training. The clinical aspect of the student midwives training is very important and again varies greatly between training institutions depending on the type of experience they can offer in their area. The development of my clinical skills resulted primarily from working on an individual basis with experienced midwives, particularly in the community.
Unfortunately there does exist a complaint amongst many student midwives that their previous nursing experience, where it is applicable to midwifery, is often berated: I call it the 'Can you take a blood pressure' syndrome? This is demoralising and may contribute to the fear of taking full responsibility for a woman's care upon qualifying.
Clinical experience is often fragmentary with post-natal care one week and labour ward the next. This can result in student midwives feeling confident in skills related to specific areas such as ante-natal abdominal examinations or care of the mother during labour, and this was reflected in Robinsons study in 1976.
The overall view of a woman in the context of her family and own environment in pregnancy, labour and puerperium can only be seen with home confinements. In Robinsons study this was the one area where the majority of newly qualified midwives lacked confidence with 60 per cent responding that they felt 'less than adequately prepared' to care for mothers during a home confinement. Some student midwives have no experience of a home confinement and perhaps this should be a compulsory part of training.
As the clinical skills of the midwife are so important I would suggest that the satisfactory continuous assessment of student midwives clinical work should be a statutory requirement before registration.

## The future

In the future I hope that the training will be broader-based and be seen more as an education than a training. Perhaps even a degree in midwifery may be possible in the same way that we have a degree in nursing now.
A holistic approach towards parturient women is more satisfying for the midwife and her clients. Various moves are being made towards this with the introduction of consultant teams (where a group of midwives work under one particular consultant) in some units.
Research is being done into the concept of midwives teams which holds exciting possibilities for the future particularly if they could be incorporated into the midwifery training.
Ultimately I hope that midwives will be able to fulfill as much as possible the definition given at the beginning of the article.

***References***
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*2. Robinson, S., (1986). The 18-month training: What difference has it made?* Midwives Chronicle *Feb. '86 22-28.*
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*4. United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1980). Handbook of Midwives Rules 22-23. UKCC London.*
***Acknowledgement***
*I would like to thank Diane Sharples for constructive criticism on the proof of this article. (Submitted April 1986.)*



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## DATES TO REMEMBER

NATIONAL HOMEBIRTH CONFERENCE, New Zealand - 13-15 May'88
Hosted by the Wellington HB Assoc. PO Box 9130, Wellington.
The theme of the conference is "Birth - Whose Responsibility?"

NATIONAL HOMEBIRTH CONFERENCE, Hobart, Australia- 27-29 May'88
For enquiries write to Homebirth 88, GPO Box 528F, Hobart TAS 7001, Australia.

INTERNATIONAL CHILDBIRTH EDUCATION ASSOCIATION (ICEA) CONVENTION, Honolulu, USA - 15-17 July'88
Enquiries contact NZ rep. Lynda Williams, 16 McEntee Road, RD. Waitakere, West Auckland.

INTERNATIONAL CONFERENCE ON HUMAN LACTATION, Australia
14-19 August'88 in Melbourne and hosted by the Nursing Mothers' Association of Australia. Further information from -
NMAA, Conference Secretariat, PO Box 231, Nunawading, VIC 3131 Australia.

NATIONAL MIDWIVES CONFERENCE, Auckland - 5-7 Aug'88
To be held at the Auckland Trotting Club.
Caroline Flint - who set up the Association of Radical Midwives in Britain and author of "Sensitive Midwifery" will be the main guest speaker. She will speak on
Friday - Midwifery - The Vision: Education- Where, when & how.
Saturday- Importance of Choice. Alternative positions of Labour
Sunday - Homebirth
Time will be left for discussion and copies of papers will be available.

WOMENS STUDIES ASSOCIATION CONFERENCE, Nelson - 19-21 Aug'88
This conference is concentrating on nursing and midwifery this year, and is asking for workshops and papers. Information can be obtained from Lynn Milne, Nursing Dept.,Akaranga Campas, ATI., Auckland.

9th INTERNATIONAL CONGRESS OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY, Amsterdam, The Netherlands 28-31 May'89
The main theme of the congress will be " Psychological, emotional and emancipatory aspects of women's health care."
Congress Secretariat, c/- QLT Convention Services, Keizersgracht 792, 1017 EC Amsterdam, The Netherlands.

MATERNAL & NEONATAL CARE CONGRESS, Belgium - 12-15 Sept'89
Prof. J.J. Amy, Dept. of Gynacology, Andrology & Obstetrics, Academisch Ziekenhuis, Vrije Universiteit Brussel, Laarbeeklaan 101, B-1090 Brussels, Belgium.

INTERNATIONAL CONFEDERATION OF MIDWIVES 22nd INTERNATIONAL CONGRESS, Kobe, Japan 8-12 October 1990
Contact ICM 22nd International Congress, c/- Japanese Nursing Association International Relations, 8-2, 5-chome Jingumae, Shibuya-ku, Tokyo, Japan.

# INTERNATIONAL HOME BIRTH CONFERENCE WORKSHOP: OCT'87

## MIDWIVES FORUM ON HOME BIRTH

Rahima Baldwin - author of "Special Delivery" & "Pregnant Feelings", takes classes specifically to prepare HB couples for HB but has mixed classes to share what HB couples have with hosp. couples. She sees the role of the MW to increase awareness and teach women of their choices.
Communication is important and the woman must be able to centre on herself. Women must be orientated to assert themselves about what they want and to have the knowledge to deal with situations such as precipitate labour etc.
There is a need for mws to understand the energy of birthing, and to avoid putting pressure on the woman to perform.
They must also be skilled in supporting the woman in dealing with the unexpected and a feeling of failure - ie. preparing for HB and ending up with c-section.
Her classes teach focusing on the baby and she uses a rebirthing type of exercise to assist this process. Her classes are consumer orientated with an emphasis on confidence and enthusiasm and she warns against mws giving a message of "you can't do it without me".

Beatrijs Smulders - spoke on midwifery in Holland and the position of the Dutch Midwife in Dutch Obstetric care and the importance of post-natal care.
Midwifery training is of a very high standard and much sought after - Of 500 applicants each year, only 24 are accepted between the 3 midwifery schools in the whole of Holland.
Right from the start, there is a clear division between normal childbirth and pathology and in the school there is a corridor between where these areas are dealt with so this concept is clear. If any problem occurs on the normal side, the case is transfered across the corridor to the other side. Student midwives do an apprenticeship in a private practice and part of their training is on how to operate a midwifery practice. She herself bought a practise from a retiring midwife for df.40,000 (approx. $NZ35,000).
96% of women book for HB, 4% for hosp. birth but they encourage women to leave their choice until the end of the pregnancy.
They see women for 15 prenatal visits on average - and if any problem arises they will refer the woman to an OB. for 1 consultant appt. The woman then returns to the mw who makes the ultimate decision as to whether to continue care or transfer to OB. They have a good working relationship with O&G.
Women have a lot of confidence in the birth process and a lot of knowledge so generally only 1st time mothers attend classes.
Midwives are taught not to disturb women during labour. If they do their job properly prenatally the need for this is avoided.
Investigations should be done prenatally not during labour and birth. The list of medical indications against HB has recently become more flexible, c-section rate nationally is 4% and no monitoring or ultra sound scanning is done unless medically indicated. Mws attend a minimum of 40 births per year.

Mary Cronk - an English midwife who has been practising since 1957 spoke on equiping ourselves to practise safely. She has attended over 1,000 births of which ½ were at home and to date has had no deaths. She was trained to attend HB and observed with concern the changes which turned women into patients who were sent to hospital to be cured of childbirth. In hospital pregnant and birthing women were subjected to the pattern of care used for sick people, and the whole concept of birth changed within the community. She recalls the time when the whole community would be involved in a birth in some way, but the move to hospital eliminated this.
She emphasised the need for mws to equip themselves emotionally to have confidence in their ability as practitioners and to have confidence in the competence of women to give birth. Mws must also support each other; and must recognise they have a duty to learn, keep up to date and make time for research. To practise safely they must have adequate and well maintained equipment, good emergency backup and good communication with local health services.

Melody Weig - spoke on the importance of postnatal care and the midwife as a practitioner. She expressed concern over the diminishing role of the mw and how postnatal care is often neglected. She stated that PN care depends on 2 factors -
1. The mw knows the woman and her family well enough to know what the pregnancy and birth means to them.
2. Time to listen.

She feels the aims of the midwife should be to -
1. Promote breastfeeding
2. To give the woman confidence to use her own resources rather than relying on health professionals.
3. To prevent both physical and emotional problems.

She has observed that there is a strong need for women to be able to discuss the labour and birth and to be reassured they did OK. - plus a further need to discuss mothering issues.
As an independent mw she works with a partner and provides followup visits for 10 days, then every 2-3 days for a further week then once the following week but this is flexible. They use temp. strips on the forehead, latex bands instead of cord clamps, and encourage bathing of the baby for pleasure not cleanliness. She discourages the use of powders, baby oil and zinc & castor oil which leeches vitamins from the skin.
She gives homeopathic Chelidonium Majus 1M for jaundice, and provides information on the options for contraception, immunisation and encourages discussion on resumption of sex.

They have a strict screening procedure and fees in London vary from £400-800. Mws need to have a good business sense to survive there. She and her partner alternate antenatal visits so they are both known to the woman and her family, and they take antenatal classes as well. They will accept breech births at home and the oldest woman they accepted having her 1st baby was 40, the youngest was 18. She strongly challenges the comment made by O&G that a woman over 30 has a senile uterus. She doesn't tell women when to push or check for dilatation internally - she senses when they are ready. She also doesn't hand babies to the mother - she puts them down for the mother to pick up and leaves them to discover the sex of the baby themselves. Very rarely do they need to clear airways or resuscitate babies.

Ina May Gaskin -spoke of the midwifery care on the farm and also of her experiences with the Amish people who call upon them for midwifery care.
She tries to prepare women for the powerful sensation of birth by using ridiculous illusions that seem so funny it makes them laugh and loosens them up ie. it feels like a train is comming through.....
She has noticed that smiling women are less likely to tear or have failure to progress in labour.
They no longer worry about overdue babies as some women get the baby done quicker than others and as long as there is no sign of pathology there is no need for concern or interference.
If there is a sign that induction may be necessary, they first encourage lovemaking as the prostaglandin in semen may activate labour. They also use breast stimulation or if the cervix is ripe - a castor oil cocktail.
The farm mws operated free of charge for 12 yrs, but now charge a fee of $US700. Midwives have to have special qualities and must have a selfless feeling for other women and be able to put all their own problems aside. It used to be essential that they had had children of their own but this is no longer the case.The mw has a priestess type of function with alot of power to influence people so she must be very sensitive. She hates to see people with a strong connection interrupted as so often happens in hospital; and feels a good mw should leave their lives better when she leaves - not worse.

Penny Armstrong - author of "The Gentle Art" spoke of her work as a mw amongst the Amish people in Pennsylvannia who originated from Switzerland. She has attended over 1,000 births at home - the youngest mother she has attended 13yrs, the oldest 47, and the 17th baby of one woman. No multiples are scheduled at home, but she will attend carefully selected breech and VBAC births. When corrected for gross abnormality non-compatible with life she has had no maternal or neonatal deaths. She has never seen a ruptured uterus at home and feels this condition is made, it doesn't just happen. Her comment is that if we neglect our senses and intuition we make mistakes so it is important to be alert and vigilant. There is a need to continue to learn and expand our knowledge base, so read everything and be familiar with all the options available. With her experience, she feels confident enough to say " What is there that can't be done at home?"

## LETTERS

Dear Editor

I feel the proposal offered for consideration in the autumn issue of STM; of Midwifery Centres as a health care option for women is a positive step in two directions -

1. Creating a better atmosphere and enviroment for women to give birth in.
2. Giving midwives the autonomy they desperately need for their profession to receive the recognition and rewards it deserves.

I feel that this project will also raise consciousness about healthy, natural childbearing and birthing; and will make it clearer just who is the guardian of natural birth. This in turn will aid the struggle towards establishing a Direct Entry Specialist Midwifery course for the scores of NZ women who wish to train as midwives but are not prepared to under the present educational (?) regime.
The climate is right for this project to be initiated.

Yours Sincerely
Glenda Southey

I was interested to read your article on Midwifery Centres in STM No. 13. As a midwife I think it presents as an exciting alternative to being employed within the hospital setting or taking a huge drop in salary and variable hours in the domiciliary service.

The possibilities to consumers is extended and I would like to lend my support to this project. I have worked in DS at NWH for 10 years but opted to have my own child delivered at home.
I think any project which allows the midwife to be an accountable practitioner is worth investigating.

Marion Ashby

I believe midwives should make statements about themselves and that the more united in our cause we become the better our care of women and families will be.

Hopefully we will attain the practice we believe is right for midwives in NZ, and I look forward to Massey in June to consolidate beliefs and philosophies.

G. Brunton - Wellington (Thanks for your generous donation-Ed)

26 Feb 1988

Dear Judi:

It was with some apprehension that I read in STM Newsletter #14 that the Newsletter will be 'devoted to specialist midwifery' i.e. direct entry (DE) as the 'new direction'. I sincerely hope that it will still have some energy and space to support the present struggle to make the proposed separate midwifery course a MIDWIFERY course and not a post-graduate nursing one!

After all the major stumbling block to both DE and a separate midwifery course is the nursing profession as represented by the N.Z. Nurses Association (NZNA) National Executive and their nurse advisors in the Department of Health (DOH).

A look at the N.Z. reality shows that in 1986 there were 2982 practising midwives on the midwifery register of whom 176 were DE midwives (from overseas and trained in NZ before the late 1950s). Therefore, the midwifery support for STM comes mainly from nurse-midwives. It would be a serious tactical error to fail to support these in their present struggle. As we need your support now, STM needs the support of this group in the DE campaign.

A good example of the effectiveness of the united front is the Province of Ontario (Canada) which has recently announced its intention to legalise midwifery. This is the result of a protracted struggle which only gathered momentum when <u>all</u> the Ontario midwives - lay-. DE- and nurse-midwives - united in the Association of Ontario Midwives (AOM). This was followed by a strong consumer-based Midwifery Task Force (MTF). The result is that the Government Task Force into the Implementation of Midwifery in Ontario (MTF-O) has recommended (among other things) direct entry midwifery education. However, pressure is being brought to bear on the Minister of Health to stall implementation of the MTF-O recommendations and thus undermine licensed, self-regulating direct entry midwifery.

While Ontario now has government approval to legalise midwifery, the NZ midwife is not legally recognised! Despite our midwifery register (which the careerists in the NZNA & DOH would like to scrap), legally we are mere 'nurses' with a post-graduate nursing qualification.

Recently (23.1.88) Karen Guilliland (Chch), National President, Midwives Section (NZNA) visited Goeffrey Palmer, Chairman of the Cabinet Social Equity Committee & Minister of Justice. He said he 'believed there was a law which inhibited midwives from being independent' and seemed receptive to changing this and also to challenging the O&G monopoly of childbirth. He said he had never had a midwife in to see him

before and was delighted to have talked to one. Karen assured him it would not be the last time as midwives are fighting for survival. She also put the case for DE training. Can STM afford to alienate this support in a single-minded 'devotion' to specialist midwifery? Specialist midwifery can be a priority for STM but we are all involved in the long and crucial struggle to reclaim and legalise midwifery as a profession in its own right. We must stand together and fight the battles in the stages called by our opponents. Until such time as we can gain the offensive, they will initiate the battles on their grounds and to their best advantage. Don't let them split our ranks! That would be suicidal and is an old, old tactic called 'divide and rule'.

While I support all the arguments for specialist midwifery training, I maintain that we have to stand together - all midwives and consumers - to regain legalisation and midwifery training for ALL midwives.

Joan Donley

Joan Donley

## OLD AND NEW PARADIGMS OF HEALTH

| THE OLD PARADIGM | THE NEW PARADIGM |
|---|---|
| 1. The person is a machine in either a state of good or bad repair. The idea is to fix up these parts. | Holism - the concept of energy; the interrelatedness of the universe; an understanding of pattern. |
| 2. The professional works to get rid of the disease. | Disease is seen as giving us information. |
| 3. The professional is the authority. | The professional is the partner with the client. |
| 4. Dependence | Self-reliance |
| 5. Emphasis on efficiency | The emphasis is on human values. |
| 6. The mind is a secondary factor in organic illness. | The mind is a primary or co-equal factor in all illness. |
| 7. Positive is seen as good. Negative is seen as bad. There is an emphasis on casual relationships. | Positive and negative are equal. What is, is perfectly all right; the quality of being. |
| 8. Competition | Cooperation and mutuality. |
| 9. A focus on "product" | The focus is on the "process" |

# Midwifery: a survey of services

Photo: Scottish Health Education Unit

**What do people think about current midwifery services and what would they like to see provided? An NZNA committee which was set up last year to rewrite the 1981 Maternal and Infant Nursing Policy carried out a public survey recently to find out. One hundred organisations were contacted and, of those, 140 responses were recieved from 38 groups. The following is a summary of the findings.**

OVER 60% of "consumers" responding to the NZNA poll on midwifery services indicated a very positive view of midwives and the service they provide. Many of the comments focused on personal characteristics, such as "warm", "enthusiastic", "supportive" and "caring". Others identified midwives' professionalism and their focus on a non-interventionist, health-oriented approach to birth. The role of effective communication in midwifery care was reflected in many responses.

"The patient's wellbeing and confidence is enhanced by a midwife's presence. The midwife maintains an interest in mother and baby throughout the labour and birth and so builds up trust in the mother."

These remarks highlight consumer's focus on the process of labour and birth. Other responses identified antenatal care as the area where midwives were seen to be most valuable. Others focused on the superior standard of care given by the midwife in the home, after the hospital stay. Twenty-five responses (11%) tempered their acknowledgement of the excellent service given with the comment that midwives do a great job given their harrowing working conditions — eg, their low status in the hospital hierarchy and low pay for domiciliary midwives.

A substantial number of consumers detailed difficulties in the relationship between midwives and doctors. One consumer group claimed that midwives do much at a birth but doctors get much more praise, profit and prestige.

The survey pointed to a clear differentiation between hospital birth and home birth.

"The service provided by domiciliary midwives is first rate. Consumer satisfaction with home births is incredible — in no small part due to the policy of midwives being sensitive to the needs of birthing women and seeing the birthing process as belonging to the woman and her family."

Continuity of care was cited as a central feature of domiciliary midwifery.

Another submission stated that the present clinical system does not cater for the cultural needs of Maori women and other cultural groups. Present child birthing practices only alienate Maori women further from their whanau. Maori women very rarely practise the return of the placenta-whenua to the land-whenua.

The inadequacies in the current midwifery service were often seen by respondents as a reflection of the structures in which midwives work rather than a criticism of midwives themselves.

A few responses recorded their negative experiences of midwifery services, saying midwives don't support women in labour as much as they should.

## Future midwifery services

The second question asked consumers what they would like midwifery services to provide in the future. Their responses reflected a broad understanding of the current limitations of the midwife's role and an expressed faith in the potential of the midwife to provide a greatly expanded service in the future.

A chance for the woman to meet, during pregnancy, the midwife who is to attend the birth was stated by a signifi-

cant number of responses. The crucial nature of the experience of labour was reflected in several pleas for the midwife attending the woman in labour not only to be known to the woman previously but also to stay with the woman throughout the entire process of birthing. Ideally, the same midwife should attend the woman in the first days after the birth.

Choice is the underlying concept behind the 30% of responses who stated that future midwifery services should include a nation-wide domiciliary service.

Several replies focused on the necessary change in legislation to allow a midwife to practise autonomously.

Suggested changes to hospital services included an extended ante-natal education programme, greater choice in the physical environment, eg birthing centres. Respondents were clear that, in the post-natal period, support in breast-feeding was the top priority and the area where midwives lacked expertise.

"For advice on breast-feeding, I don't think I would ask a midwife. Some midwives are very insensitive about their handling of the mother's breast and baby when trying to help. This can be very upsetting to a shy mother."

There was a need for consistent ward policies and practices, and better educational preparation for midwives on breast-feeding.

Suggestions for midwifery education covered recommendations for the basic preparation as well as a plea for compulsory in-service and refresher courses. Support for direct entry programmes came from several respondents. One response said:

"Making entry into midwifery less tedious with attractive incentives might alleviate the staffing shortages that are present in many centres."

## Current involvement in decision-making

The vast majority of consumer groups believed they had no current involvement in decision-making about midwifery services. Those who responded positively contributed to decision-making at the local level by individual and group discussions with midwifery staff in maternity hospitals, submissions to area health boards, service development groups and obstetric review committees.

## Future involvement in decision-making

Some respondents did not know of any ways in which they could be involved in decision-making about midwifery services. The majority of respondents, however, supported the idea of consumer involvement at every level from individual to national.

"The real decisions about midwifery services should be made by women, not an isolated elite of experts who seek to impose their own value judgements on the process."

## General comments

Only half the responses contributed to this section. For some consumer groups, power was seen as the central issue.

"The heart of the problem is the balance of areas of responsibility between obstetric specialists, the general practitioners and the midwives. As the specialists encroach further on the territory of the general practitioner, so the GP will take over what has previously been the territory of the midwife."

In conclusion, the essence of consumer group contributions appears to be encapsulated in the following statement:

"We commend the midwives' support and understanding of each mother's particular needs, and ask that the New Zealand Nurses' Association continues to make this the focus of any policy changes." ■

## B I T S & P I E C E S

* Induction of labour -
A survey of the literature over the past 10 years concerning induction of labour after 40 weeks claims the medical profession is now questioning the safety of this practice. One UK study also shows that only 2% of women want to be induced, and that women do not want to take part in a process that takes control out of their hands. (Nursing Times)

* Risks with use of prostaglandins -
An Irish hospital has stopped administering prostaglandins for the induction of labour following the death of a mother and baby assosiated with the hormone; and the National Drugs Advisory Bd. sent out circulars to O&G's cautioning the use of prostaglandins. (Irish Medical Times)

* Epidural linked to 7-fold increase in forceps birth -
Dr Susan M Cox and associates at Baylor College of Medicine report that epidural anesthesia during labour results in a 7-fold increase in the need for forceps assisted vaginal deliveries. Charts of 296 women who had epidural anesthesia during labour were compared with those of 822 women who did not.The overall forceps rate for those who did not have epidurals was 4.1% compared with a rate of 28.4% among those who did. The 2nd stage of labour was increased from 16 mins in the spontaneously delivered women who did not have epidurals to 50 mins in the women who had epidurals and gave birth spontaneously, a greater than 3-fold increase. (Ob. Gyn New 1987)

# A LOLLY SCRAMBLE?

## JOAN DONLEY CONTINUES THE DEBATE ON MIDWIFERY EDUCATION

**After a decade of struggle New Zealand midwives have finally gained approval for separate midwifery education. "Separate" means that education will be removed from the Advanced Diploma of Nursing (ADN) as a "midwifery option" and become a separate course in a number of centres, commencing in 1989.**

**Unfortunately the inadequate midwifery option** will still be available in a number of ADN courses, according to the press release from the Ministers of Health (David Caygill), Education (David Lange) and Women's Affairs (Margaret Shields). The Midwifes Section, New Zealand Nurses Association (NZNA), the only political lobby that midwives have, welcome the separate course, but oppose the continuation of the midwifery option with the ADN. A recent Department of Education evaluation of the ADN courses found that both the clinical and theoretical components of the midwifery option were deficient.

In her letter to Broadsheet (Jan/Feb 1988) Gay Williams, Executive Director, NZNZ, says that NZNA "Supported a separate course for midwifery..." This bends the facts considerably. In 1980 the midwives section put a remit to the NZNZ conference, for urgent consideration by the Minister of Education, for a separate midwifery course leading to registration, leaving the ADN for midwives wishing to further their education. Since this remit was passed (as were similar remits in 1984 and 1985) it could be said that the NZNA supported the midwives.

However, the NZNA executive, which holds the power and has the responsibility to carry out conference decisions, did not support midwives. In fact, as the elected executive (the body that is recognised by government as representing nursing interests), the national executive has ample opportunity to sabotage the efforts of midwives at grassroots (conference) level. National executive members hold meetings with and deal directly at administrative level with the Departments of Health and Education, the Hospital Boards Association, the New Zealnad medical Association and the Nursing Council of New Zealand. In addition, it nominates the nurse advisors to the senior administrative structure of the Departments of Health and education. None of these nurse advisors have a midwifery qualification, yet midwives have no advisors to represent their interests. But as Pat Carroll, former NZNA executive director, pointed out to the Christchurch midwives, since there are only 600 midwives who are NZNA members and more than 20,000 nurses, such a small group of midwives cannot expect to sway the opinions of the nursing profession.

In 1984, after midwifery had been further undermined by the Nurses Amendment Act (1983) and midwives were becoming increasingly strident in their demand for separate midwifery education, the NZNA executive saw a need to gain conference support for it opposition to this. Therefore an ad hoc committee prepared *Nursing Education in New Zealand: A review and Statement of Policy*. Two of the 31 recommendations dealt with midwifery and bridging courses, and both were defeated at the conference. The one on midwifery claimed that a separate midwifery course "poses professional and educational difficulties" and reiterated the NZNA policy that midwifery is merely a postgraduate course of nursing and that the existence of the midwifery register is incidental to these (nursing) principles. Midwives, on the other hand, claim that midwifery is a profession in its own right and the maintenance of the midwifery register is crucial to survival.

The other recommendatin called for termination of the bridging courses which enabled hospital trained nurses to obtain a comprehensive registration. The ministers annnounced that these have now been discontinued and the funds will be diverted to establish the separate midwifery courses.

The NZNA considered that the two defeated recommendations were "integral to the (education) policy and its development". And indeed they were, as the original concept of a comprehensive registration was of one integrated course, rather than a second programme added. In an attempt to reverse the 1984 conference defeat, the Northern Nurse Educators Section put a remit to the 1985 conference to support the two recommendations defeated in 1984. They argued that midwifery is built on concepts developed in the basic nursing programme, that midwifery cannot be regarded as a baisc course, therefore a separate course would be a regressive step, an unacceptable cost to the country and a duplication of educational resources. This was also defeated. It

is interesting to note that the department of education considers that midwifery is a basic course, saying in the evaluation that combining a basic course (midwifery) with an advanced diploma did justice to neither.

However, it is the shortage of midwives rather than the inadequacies of the training that was the spur for the separate midwifery courses. Where the six-month St Helens programmes trained approximately 157 midwives a year the ADN courses, 1981 – 86, have produced only 134 midwives. More than 85 per cent of our midwifery workforce is imported from overseas and there is still a serious shortage. New mothers are being discharged from hospital early with no follow-up, and recently Auckland St Helens, which is ten midwives short of its quota of 63, had to close its doors to unbooked women in labour.

Whether this separate midwifery course will be of benefit to mothers and babies depends on how a midwife is defined. The midwives section of NZNA accepts the WHO/ICM definition of a midwife and this had been endorsed at conference. Whether a midwife is an independent practitioner or an obstetric nurse is not a matter of semantics, it is crucial to the survival (or extinction) of the midwife in New zealand. Already the battle lines are drawn, first to define the midwife, then to structure the course to produce the midwife defined. It would be unrealistic, even delusional, to expect that a separate midwifery education which conflicts with NZNA policy will proceed without a mighty struggle. Already there are moves to make this yet another comprehensive nursing course.

Northland Polytechnic has a meeting in January to investigate the feasibility of midwifery education in Northland. In line with NZNA policy, the Northland tutors decided that the WHO definition of a midwife is not relevant to New Zealand, only to Third World countries! If there is any rationale at all to this idiotic statement, then it is that the midwifery profession has been so completely subsumed by the nursing profession that midwives have become nurse-midwives, completely embracing the medical model of childbirth, based on fear and dependence on doctors and technology. As one of 28 New Zealand midwives who attended the International Confederation of Midwives (ICM) Congress in The Hague last August, I would be proud if I could claim to be able to function on a par with midwives from the Thirs World!

This "Third World" argument was used to try and undermine the concept of primary health care (PHC). In a paper presented to the Norman Peryer Forum, Gloria Powell, tutor at Manukau Tach, refuted this argument, pointing out that the Alma Ata Declaration, upon which PHC is based, urges self-reliance, community participation and shared decision-making. She quoted Dr Mahler, then director of WHO, who says nurses work with people whether in Amazon river forests or in intensive care heart transplant units. By the same token, midwives support and assist women during pregnancy and labour whether on the African veld or in National Women's Hospital.

Since NZNA has no difficulty in accepting the ICN(1966) definition of a first level (registered) nurse, why reject the ICM/WHO definition of a midwife, unless it is in their interests to do so? And this appears to be the case. Northland favours what they call the "family Health"(FH) nurse, who will do everything a midwife does, and more, to provide continuity of care from birth to menopause. This FH nurse, who would be trained in an integrated comprehensive nursing course, in line with the NZNA "generalist" philosophy of nursing, which encompasses maternal and child health, would make the "old" midwife redundant, they claim. A recent Department of Health management consultant's survey of the health services asks why so many middle management nurses are pushing papers around instead of caring for patients. Do we really need more FH middle management nurses pushing around papers on birth to menopause, rather than midwives supporting and caring for women?

One of the obstacles in the training of midwives is access to clinical material, since obstetricians have monopoly control of it and use it to train twice as many obstetricians as New Zealand needs, even according to their own estimates. So the obvious and logical place to establish a separate midwifery training would be Auckland's St Helens, which could be placed under the Department of Education and restored to its former role as clinical training for midwives.

The Department of Health has set up a "Working Party on Midwifery, Bridging and Related Courses", dominated by the nursing profession. Of the 14 members there are only two who represent the midwives section – Karen Guilliland (Christchurch, national president of the midwives section) and Sally Pairman(Dunedin, chairperson, Otago midwives section), and they had to practically gate-crash the first meeting, in September 1987, called by the Department of Health on midwifery education. Only two others have a midwifery qualification – one is a polytech head of department (HOD) and the other is a long-standing NZNA executive member. The remaining 10 hold nursing qualifications only, and include Gay Williams, four senior nurse advisors from the Departments of health and Education, and three representing polytech HODs. How dare these members of the nursing profession who do not even know what a midwife is, define her and decide on her education.

Obviously, if this separate education is to be a midwifery course and meet the needs of mothers and their babies, not only must midwives form their own organisation and speak for themselves, demanding direct representation on the boards of health and education, women must challenge the medical monopoly of childbirth and take control of their own bodies. Together we can do it! ■

**WORLD HEALTH ORGANISATION DEFINITION OF A MIDWIFE.**

A midwife is a person who is qualified to practise midwifery. She is trained to give the necessary supervision, care and advice to women during pregnancy, labour and the postnatal period, to conduct deliveries on her own responsibility, and to care for the newly born infant. This care includes preventive measures and detection of abnormal conditions in mother and child, the procurement of medical assistance, the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for parents, but also within the family and the community. The work should include antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and childcare.



## Doctors' Power Over Women

Women are the major consumers of health care but our reproductive health is dependent on the attitudes and skills of men who dominate medicine, in policy-making and practice. Women's relationships with their doctors must be based on mutual respect and understanding, says the Ministry's submission, but too often women fear doctors whose attitudes towards them can be insulting. Battling against this unequal relationship should start at medical schools.

Trainee doctors should be taught about racism and sexism, and such practices as internal examinations on women under anaesthetic must stop. Ethics and human relationships should form a major part of doctors' training and compulsory continuing education is needed so that doctors who have finished their training keep up to date with social as well as medical changes.

## Getting Women On Board

The lack of women in high-level decision-making is the concern of the Women's Appointment File. The File is a listing of women who are available for nomination to statutory boards, government committees and other official bodies. Suitable names are put forward when vacancies on these boards and committees come up so that more women can be appointed to them.

Set up in 1979, the File has been run by a committee of representatives from several women's organisations and serviced by the Ministry.

Last year the Minister of Women's Affairs asked for a review of the Women's Appointment File. As a result, it was decided that the File should be fully merged with the functions of the Ministry and run by us since it is one of our tasks to advise the Government on suitable nominees for appointment to official boards.

If you would like your name to be on the Appointment File so that you can be put forward for nomination, contact Linda Oliver of the Ministry's Information Unit.

Ministry of Women's Affairs
No. 7 Newsletter.

NZNA MIDWIFERY POLICY STATEMENT - Feb'88

This is an excellent and progressive document, sensitive to both the needs of the midwifery profession and clientele, and should be read by everyone with an interest in midwifery and childbirth issues; and commented upon.

The following brief abstract includes the introduction and recommendations.

In March 1986 an ad hoc committee was set up by the National Executive of the NZNA to prepare a new policy statement on Maternal & Child Health; in response to the concern of the Midwives Section that the 1981 statement was out of date.

The 1984 Report of the Working Party looking into Education for the Role, Scope and Sphere of Practice of the Midwife in NZ also included a recommendation that the NZNA 1981 Policy Statement on Maternal & Infant nursing be revised and updated in the light of current community needs and professional developments.This policy statement has been prepared in response to these assertions.

The ad hoc committee consisted of 5 members: 3 appointed by the Midwives Section -
Steph Breen - National Secretary, NZ Nurses Union
Jenny Johnston - Domiciliary Midwifery & Nursing Tutor
Carol Hosken - Midwife & ex-president Midwives Section

Eve Brister - Professional Services Committee appointment
Glenda Foster - National Executive Representative

## RECOMMENDATIONS:

### EDUCATION

1. THAT urgent steps are taken by NZNA to ensure that the post registration nursing courses for the promotion of midwives be separated from the ADN courses within Technical Institutes.

2. THAT learning opportunities within in service departments and at local Tech. Institutes be developed to meet the specific education needs of all practising midwives.

3. THAT all new practitioners receive an orientation to midwifery in their specialty, and that this orientation be modified to meet their own professional learning needs.

4. THAT preparation for domiciliary midwifery practice be given more prominence in midwifery education programmes.

5. THAT a Direct Entry Midwifery Programme be considered as an option.

6. THAT the present sponsoring and funding for midwifery students be considered on a central basis as well as from Hospital Board funding.

RESEARCH

1. THAT all practising midwives be encouraged to develop basic knowledge and skill in research.

2. THAT employing agencies and the midwives within them be alerted to the potential value of the services of the midwife researcher; and that provision be made for this professional in the career structure.

POWER & POWERLESSNESS

1. THAT midwives fulfil their role encouraging and supporting clients to empower themselves.

2. THAT midwives realise and utilise their own power.

3. THAT midwives and their clients participate in decision making about maternal and infant health services at every level, locally and nationally.

4. THAT midwives take positive steps to ensure that the nature of their independent and collaborative relationships be acknowledged and accepted.

5. THAT midwives take steps to eliminate the racism that exists in the health care system.

SPHERE OF PRACTICE

1. THAT clients are provided with continuity of midwifery care throughout the whole child-bearing process.

ROLE OF THE MIDWIFE

1. THAT the present legislation be amended to permit midwives to assume full responsibility for their clients mwfry care.

2. THAT an action group be established in consultation with the Midwives Section to work towards the implementation of this policy statement.

3. THAT midwives ensure that the Standards of Midwifery Practice, Service and Education are used and updated, as necessary. (NZNA Midwives Section 1987)

4. THAT midwives recognise and promote international midwifery networks.

WORKFORCE DEVELOPMENT

1. THAT adequate numbers of midwives be employed in the health agencies providing maternal and infant service.

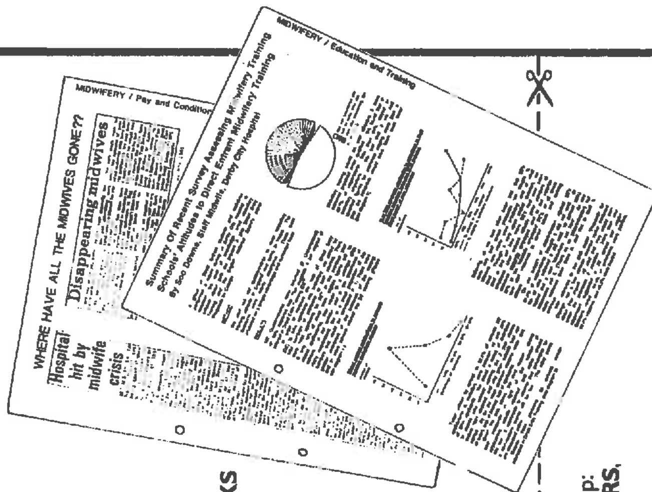
2. THAT numbers of midwives being prepared be based on a survey of numbers in practice and their retention rates.

3. THAT the Department of Health collect workforce data on the number of designated midwifery positions and the number of midwives employed.

4. THAT health agencies arrange paid placement for nurses wish ing to gain experience prior to undertaking the midwifery programme.

5. THAT midwives and their employers take active steps to eliminate organisational barriers to professional practice.

6. THAT domiciliary midwives income have parity with that of midwives who work in hospitals.



MIDWIFERY / Pay and Conditions

WHERE HAVE ALL THE MIDWIVES GONE??

Disappearing midwives

Hospital hit by midwife crisis

MIDWIFERY / Education and Training

Summary of Recent Survey Assessing Midwifery Training Schools' Attitude to Direct Entrant Midwifery Training

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-17-



# GDR work teams solve maternity leave problems

**MORE than half of the 8.5 million working people in the German Democratic Republic are women. In some branches of industry production is mainly in their hands.**

**The Nationally-owned leather goods factory in Schwerin in the northern part of the GDR has 2000 employees; 70% of them are women. Their average age is 25.**

A young woman giving birth to her first child is entitled to 12 months paid leave (six months maternity leave on full pay and another six months on a slightly reduced wage). A woman who gives birth to her third child is entitled to 18 months paid leave.

Although this measure makes life much easier for working mothers and their families, it causes problems for those factories which have many young women employed.

Although the young mothers stop working for 12 months they continue to be employees of the factory and enjoy all the rights of employees, including health insurance and free medical treatment. They can return to the factory at any time, and nearly all resume work after their leave. According to the GDR Labour Code, the manager has to see that they go back to exactly the same work as before or get other jobs to suit their qualifications.

At the Schwerin leather goods factory the management and the trade union discussed the problem of experienced bag makers leaving the factory because the work did not fit in with being a mother. They decided to start an experiment. They installed an assembly line which is operated specifically by mothers with very small children. These women work only normal shifts. Since the experiment was started two more assembly lines have been put into operation and although there is always a loss of working hours—due to the 'baby year' and sickness of children (when children are taken ill their mothers are granted paid leave)—the shift plan is always fulfilled.

The bag-makers at the Schwerin leather goods factory like assembly-line work. All start their 'baby year' knowing beforehand where they will work when they come back. They return to work teams where they meet with understanding and receive assistance from the company and trade union. Their problems are also those of their colleagues. Together they find solutions that are acceptable to all. ■

> "The growth potential in hospitals is unlimited. It's better than Kentucky Fried Chicken."
>
> *—Jack Massey (who resigned from the Chair of Kentucky Fried Chicken to head the Hospital Corporation of America.)*

# Midwives said no to care for unaware mothers-to-be

By LIZ JARVIS

Midwives refused to care for women in labour who did not know they were part of a Middlemore Hospital research trial.

Midwives concerned about a labour research trial refused to manage women in labour who were unaware of their participation in the trial until they were informed and gave consent, hospital midwives and women's health group Maternity Action said.

A drug which speeds up contractions known as oxytocin or syntocin was used in a research trial at Middlemore Hospital by specialists Professor Colin Mantell and Dr David Ansell.

Maternity Action spokesperson Lynda Williams said the specialists were looking at the use of the well-established labour drug to reduce the hospital's caesarean section rate but not all women were informed of their part in the trial.

"A lot of the women were not told until the midwife insisted during labour. The oxytocin changes labour and a first-time mother could lose control of the birth because of the pain — a woman can end up tied to the bed with a drip with oxytocin in an arm having epidurals for the pain and foetal monitor machines to check the baby.

"Oxytocin makes contractions go from being widely spaced to fast and very hard and painful."

Midwife Lesley Hinson said doctors decided to use women for the trial but the women did not know they were being treated any differently.

"Women presume everything is done for them in the best interests but they have to ask what the options are," Mrs Hinson said.

Midwife Sarah Hodgetts said she was worried Middlemore Hospital would get a reputation and women would be frightened — the midwives gave the best possible care in sometimes very difficult conditions she said.

**The plan put forward by the Gibbs Task Force is hardly a surprise. With prominent free-marketeer Alan Gibbs of the Business Round Table at the helm, the only question was, How much free market would it promote?**

The plan calls for the corporatisation of area health boards which would then compete with one another, private hospitals and voluntary organisations to supply services.

The report would put us straight on the path to privatisation.

Criticism has come thick and fast from many quarters. Public watchdog group, Private Eye, has called the report "shoddy." It says it takes a simplistic approach and is strewn with platitudes, anecdotes and contradictions.

With the free market advocates' lobby to get rid of quangos (semi-autonomous government departments), this report pushes for the setting up of new ones.

Bold assertions of how to make massive savings are made with little convincing evidence to back up claims.

The proposals will benefit the expanding private sector but they won't work for people. The health debate has been hijacked by the 'new right' and others with vested interests in private health care. In typical style, they have taken a genuine human concern, the waiting list for public hospitals, and marketed it. By helping people to lose confidence in the public health system, they have increased spending on private insurance and created a demand for more private hospital care.

A Television One Close Up programme in 1980 looked at the flourishing world of private health services. It showed that the areas with the most private facilities had the longest waiting lists: i.e. that the public system suffers because scarce resources are drained off into the private sector.

Our public health system certainly has weaknesses, but there is no need to destroy the system to put them right.

Although there are inefficiencies, we do better than many other countries. According to Private Eye, "we spend 50% less per person than the OECD average and the US's per person spending is almost three times ours."

Improved management and planning is essential, but this must involve those who work in the health system and the communities who use it. Public health is a concern of the Government and the community at large. Neither must default.

David Caygill, as Minister of Health, has said that he wants to hear the public response to this report. The various strands of the labour movement must leave him in no doubt as to how we feel.

Turning the health system over to private business won't produce healthy people—just bloated profits. ■

# Midwives want new training

*By YVONNE MARTIN*

Allowing midwives easier access to the workforce will relieve the present midwife shortage, says the Auckland Home Birth Association.

The group and Save the Midwives Association are lobbying the Government for new legislation that will mean midwives do not have to train as nurses.

"A lot of women are drawn to midwifery, but are not interested in nursing," said Home Birth Association president Brenda Hinton.

For several years midwifery training has been offered to registered nures only as part of the advanced diploma of nursing.

A new system proposed by the Government for 1989 has nurses able to undertake a course devoted solely to midwifery.

But the associations want a separate three-year direct entry course for those interested in becoming midwives.

At present the majorit of midwives have to leav New Zealand for the bet ter training offered over seas, sad Ms Hinton.

St Helens Hospital i among the hospitals shor of midwives and it ha had to divert emergency labour cases to Nationa Women's.

There were 3621 regis tered midwives in 1981 compared to 2982 in 1986

Of the 206 midwive that registered in 1986 only 38 had trained i New Zealand.

Herald 26.1.88

Auckland Star 4.3.88

# People want health say

WELLINGTON (PA). — People want more control over their health and therefore a bigger say in the medical treatment they receive, says chief health officer Karen Poutasi.

She told the congress of the Royal College of Obstetricians and Gynaecologists at its meeting in Wellington that doctors should recognise that patients wanted to know more about what doctors were doing to them why and what the side-effects might be.

She said obstetricians and gynaecologists found themselves in the front line in the information battle. Although most babies were born in hospital, pregnancy was not an illness and women did not want it turned into one.

Natural versus hi-tech births were not the issue, instead the focus was on relationships between doctors and patients, including patient demand for more information.

Women particularly were unhappy with the health care they received, Dr Poutasi said. A recent *Medical Journal* survey found 73% of women were unhappy about the health service.

Traditionally, doctors decided what to tell and what not to tell patients.

But in Canada and Australia the position had changed to such an extent that doctors were not required to give patients enough information to make their own decisions about any health risks.

Herald 15-4-88

### *Small Hospitals*

Sir,—Through my education and experience it seems to me that the most cost-effective health service a country can have is one which encourages people to be responsible for their own health.

To close the majority of small, community-based hospitals and herd women into large base hospitals for normal deliveries appears to be in direct contrast to this philosophy.

For many mothers and families, the alienating environment of high-tech base hospitals is enough to subdue them into acceptance and submission. Separated, in many cases, from family and family doctor, overwhelmed by technology and formalities, the labouring mother loses touch with what her body is telling her to do to meet her needs.

The stresses placed on labouring mothers in such an environment can be a direct cause of complications requiring the use of expensive high-technology. Between 80 and 90 per cent of births should be a normal, non-medical event.

What is happening to our society? Are we so concerned about money and efficiency that we sacrifice basic human needs? To me humanity is all-important . . .

**Margaret Campbell.**
Te Aroha.

# Area health boards: will they mean better services for women?

New Zealand's health system is undergoing massive change. Part of this is because of the changeover from hospital boards to larger area health boards. Area health boards are a partnership between the community, the Health Development Units (formerly District Health Offices) and hospital boards. The Health Department says that decisions to establish area health boards are likely to be finalised this year.

**What is this going to mean for women? Will the new structure make it harder, especially for women with poor access to health services to get good health care?**

The Ministry of Women's Affairs wants to make sure that women's health needs are met by area health boards. An outline of the Area Health Boards Act 1983 shows how you can get involved in the planning and provision of health services to make sure they meet your needs and those of your family, community, iwi and hapu.

## Area health boards are set up to:

- promote the health of the community and reduce sickness, injury and disability
- provide health education, disease prevention, treatment and rehabilitation services
- ensure the best use and fair distribution of resources
- co-ordinate services with voluntary and private health sectors.

**Initiatives such as well women clinics, women's health collectives, Maori health clinics and maatua whangai can be asked for here. The groundwork should be done by local women before the area health boards is set up.**

### Advisory Committees

Before an area health board can be established the existing hospital board must set up an advisory committee (sometimes called a consultative or steering committee) to explain the change and discuss local health concerns and opinions, and set boundaries.

**These committees should involve hospital, Health Department and private sector people as well as community representatives. If you feel there has not been enough consultation, write to your MP and the Ministers of Health and Women's Affairs.**

## What the boards will look like

### Membership:

When an area health board is set up, it is run by a board of up to 14 elected community members plus up to 3 people appointed by the Minister of Health.

**Write to the Minister of Health asking that at least one (preferably more) of the appointed members be a woman and/or Maori consumer representative.**

### Standing Committees and Service Development Groups:

These are committees that can represent your interests on area health boards. Boards do not have to set them up unless you ask them to.

**Ask for a women's health standing committee to monitor women's health and a service development group to make sure women's health services are set up. These groups can have consumer representation although they're likely to consist mainly of health professionals. Make sure that women you feel will represent your health needs are nominated onto these groups.**

### Community committees:

An area health board may set up committees to represent particular communities in the area.

**These are your best chance to have a say on health issues. You may have to push the board to set up community committees.**

### And remember:

people appointed to all of these committees and groups may be paid for their time. Ask your board for adequate payment.

## Central control

The Minister of Health can give instructions to health boards.

**Whether the Minister will use that power depends on whether we all take responsibility to tell the Minister about our health concerns.**

## Getting women's voices heard

Women are the major consumers and providers of health care but we are under-represented at decision-making levels. As well as going through all the channels described here, you can contact your hospital/area health board or Health Development Unit directly and tell them what services you want in your area.

**Get to know your board members and staff. Ask them what policies they have on women's and Maori women's health. For example, what are they going to ensure: a good cervical cancer screening programme; an abortion service; a home birth if you wish it; that childcare is available for board workers and committee members? You can organise meetings and hui on women's and Maori women's health and invite women board members and**

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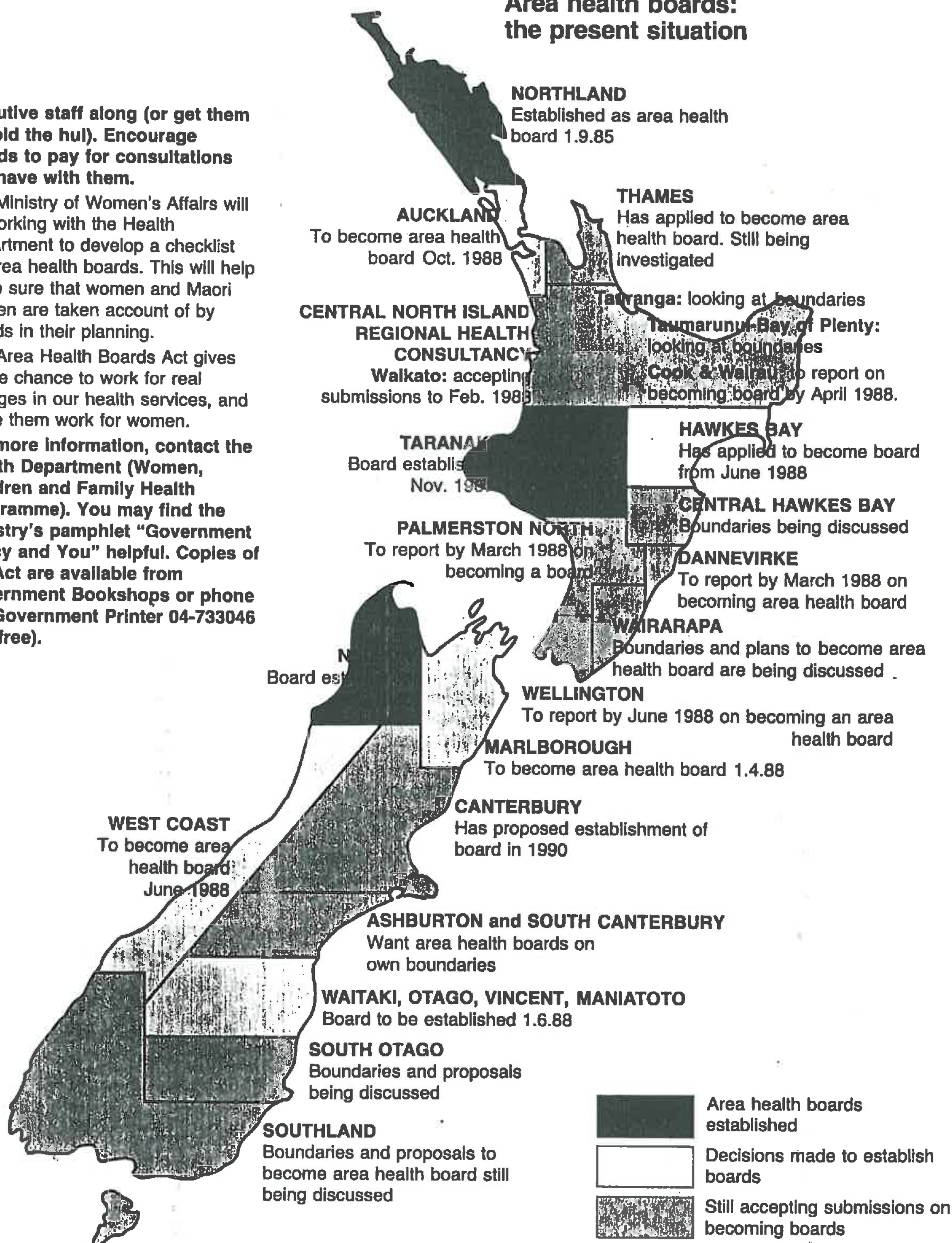
AOTEAROA BIRTHMOTHERS SUPPORT GROUP - is for women who have lost a child by adoption. The group started in July'85 out of a common need for women to support women thinking about, starting to search and on making contact with their daughter or son.
For further information write to -
PO Box 5479, Wellesley Street, Auckland    Ph. 32441 ext 851

**executive staff along (or get them to hold the hui). Encourage boards to pay for consultations you have with them.**

The Ministry of Women's Affairs will be working with the Health Department to develop a checklist for area health boards. This will help make sure that women and Maori women are taken account of by boards in their planning.

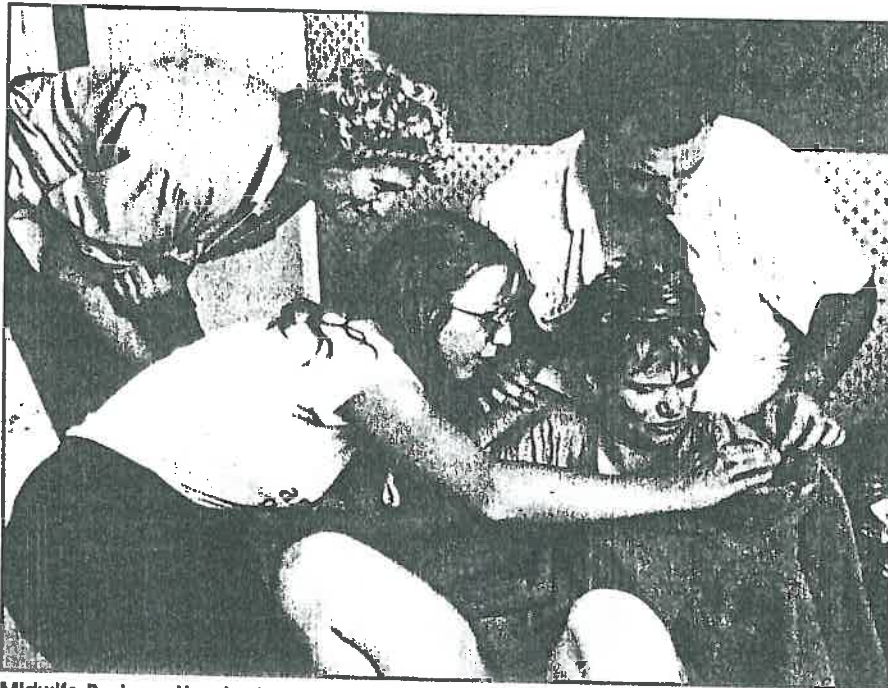
The Area Health Boards Act gives us the chance to work for real changes in our health services, and make them work for women.

**For more information, contact the Health Department (Women, Children and Family Health Programme). You may find the Ministry's pamphlet "Government Policy and You" helpful. Copies of the Act are available from Government Bookshops or phone the Government Printer 04-733046 (toll free).**




*Information supplied by the operations section of the Health Department*

"Many health policymakers still see health in purely medical terms and interpret all health costs as expenditure and not social investment."
Dr Halfdan Mahler World Health Organisation Director-General



Midwife Barbara Hasslacher assists at the home birth of the child of Wellington parents Jude Huygens and Mike Osborne.

# Birth at home

**Barbara Hasslacher*comments about homebirth as an option and shares some of her experiences and feelings as a home-birth midwife. (Edited from a paper, "Reflections of a Home-birth Midwife in New Zealand".)**

IT IS THE WOMAN herself who delivers her baby. Midwives, doctors and birth attendants are all *assistants* to the woman, with the exception of the caesarian birth. Even with a forceps delivery, the woman needs to continue pushing, so the doctor is still in the *assisting* role. Though with increasing hospitalisation over the last few decades, women have become dependent on hospital services.

It is a great shame to see women losing faith in their body and in nature. It is possible to see, on studying the history of obstetrics, the extent to which the control of childbirth has been taken away from women and entered the arena of politics. The last 40 years has seen an acceleration of this process.

But some women are still choosing to give birth at home. Contrary to popular belief, they come from all walks of life, with an age range from late teens to early 40s. The main reasons for this choice include a wish to remain in control of their birthing experience, to be in a familiar environment and to have attendants whom they know and trust.

In Wellington last year, one third of all our cases were primigravidae (first-time mothers). The transfer rate (usually for prolonged labour) is higher in this group (20%-30%) whereas with multigravidae it is less than 5%. Sometimes there are requests for analgesia, resulting in transfers, as we do not carry narcotics. Personally, I had no transfers due to an emergency.

Although the doctor has the legal responsibility and determines the criteria for acceptance of a home-birth case, it is the midwife who assists the woman during delivery. To do this, a good midwife must possess all of the qualities of caring, as well as the ability to teach without prejudice, have a keen sense of humour and a personality to inspire. The outcome of the birth may well depend on the midwife's manner.

With the responsibility of doing home births (and without a doctor over my shoulder) I have used my initiative and skills with confidence and trusted in my intuition.

As the tendency to embrace modern technology has prevailed, some of this basic caring has been neglected.

## Considering the objections

The question of safety surfaces every time the topic of home births is discussed. It has to be said at the outset that no particular location ensures a normal outcome. However, it is possible to create a setting where all precautions have been taken. By this I mean that the pregnant woman must be responsible during her pregnancy by ensuring that it remains in the low risk category, finds herself a willing doctor and midwife, books in and familiarises herself with her local hospital and, finally, adequately prepares her home and herself for the new arrival.

Within the safety question, the distance from the hospital also arises. Most home-birth midwives carry primary resuscitative equipment, much the same as secondary maternity units. Therefore, there is no difference between transferring a woman from home or from these secondary maternity units.

With regard to the management of pain, this is where midwives, their skill, and their ability to act as co-ordinators with support persons, come into their own.

I learnt to alternate between activity and rest in labour. There are many ways of supporting women through labour using methods such as homeopathy, acupuncture/pressure, massage, verbalisation, visualisation, hot/cold compresses, diversion, change of position or movement — all dosed with much reassurance and encouragement.

Occasionally a call for analgesia is made, but usually, following a change of tactic, the thought is quickly forgotten; also, it often tends to coincide with transition. If I had offered them drugs, they would probably have accepted. But without drugs, the women manage to cope fine through to the end.

Women are so vulnerable in labour. It is important to remember just how much psychology is involved in childbirth. With home births, the midwife has the advantage of knowing the woman before labour so that she can work with the woman more easily than were she a stranger.

## Considering the advantages

The home birth option seems to suit those women who are assertive, feel comfortable about their body and pregnancy, and who have the confidence that they simply can do it at home! The birth at home takes place with the least fuss. In hospitals, we are too conscious of the clock, measuring dilation by the hour! ☞

*Barbara Hasslacher is a registered nurse and midwife, UK trained, and practised as a homebirth midwife in Wellington from February 1987 to February 1988.

At home, the women is at the centre of attention, not the setting, the doctor, the machinery or the shift of the midwife. There is one-to-one care given, and there is no outside disturbance to the flow of labour. Also, the whole family is considered; there is no hassle about the presence of children or friends. Children may be easily brought in straight from their beds in the case of night births. Privacy is ensured. For example, I had the experience of supporting a woman in the only place comfortable to her at that time and this was on her toilet; she dozed there for one-and-a-half hours! I just do not see this happening in a delivery suite setting.

Early bonding and successful lactation is achieved at home because of there is minimal disturbance to the process. Women are encouraged to feed on demand from the outset. There is no timing of feeds. Through continuity of care with the same midwife there is less conflicting advice given and consequently fewer problems.

In the home birth, the father's participation is fully utilised and supported. Following a hospital birth, fathers generally go home. It seems unfair to separate the family unit so soon after a shared birth. There is a need also to promote early father-baby bonding.

The above are a few pointers on advantages of the home birth option.

TO SUMMARISE, the home birth option is for the well motivated and committed woman/couple. She builds a relationship of trust with her midwife and decisions are made jointly. The home-birth midwife accepts a position as guest in people's homes. She has regained faith in nature's way (and I do not say this glibly) and has become in tune with herself. Indeed, one of the greatest skills I have learnt in doing home births is in the art of inactivity — to give space to the flow of labour and to interfere as little as possible unless for sound reasons, and then with the woman's consent.

One of the best qualities a midwife can have is an ability to adapt to the individual needs of a woman which results in a satisfied customer, whatever the place or type of delivery.

Midwives should be guardians of normal midwifery. The role of the New Zealand midwife has been greatly eroded and may yet continue to deteriorate unless we unite and stand our ground.

The most controversial aspect of childbirth is deciding when and if intervention is necessary.

At the WHO Inter-Regional Conference for Birth in 1985, 15 recommendations were made, all of which are highly commendable, albeit idealistic. For the purpose of this article and because of space, I wish to quote the first and last :

"The whole community should be informed about the various procedures in birth care, to enable each woman to choose the type of birth care she prefers."

And:

"Technology assessment should be multi-disciplinary and involve all types of providers who use the technology. The woman, on whom the technology is used, should be involved in planning the assessment as well as evaluating and disseminating the results."

Home birth practice stresses the need for shared responsibility. All women should take back responsibility for labour. While recognising that not all women are able to effect a drug-free labour, and in most cases women are happy to give birth in a hospital, it is nonetheless wrong for hospitals to take over full responsibility.

We are living in an era where people are requiring greater information than previously. As professionals, we need to listen to the demands of the consumer, especially since we should all be working towards the same goal. So why is anyone feeling threatened? It is to do with control?

IN THE FINAL analysis, words are quite simply inadequate to fully project the whole experience of a home birth; its full implication can only be appreciated by being there.

On a personal level, I enjoyed being a home-birth midwife for a number of reasons.

Firstly, I operated independently and I feel that my training adequately prepared me for this role. Secondly, I have derived much pleasure and professional satisfaction from working with families on a closer level than I had done previously in hospitals. Thirdly, my skills were fully tried in the home environment. I was entrusted with considerable responsibility and I embraced it willingly. Fourthly, I feel that my experiences made me a more complete human being and woman. In all, as a woman supporting women in their experience of childbirth, 1987 was for me an essential period of growth and development.

And since our conditions in the community are somewhat poorer and less secure than those of our hospital counterparts, I would say that working as a home-birth midwife is definitely a labour of love!

*For further inquires on home-birth midwifery, contact: Jenny Johnston (phone Wellington 898-258), or the Wellington Home Birth Association, PO Box 9130, Courtenay Place, Wellington.*

## Options...for some

**Barbara Hasslacher outlines the homebirth option, the costs and the workload.**

UNDER CURRENT New Zealand regulations, the home birth option is restricted to areas where (a) a domiciliary midwife is in practice or (b) a GP is willing to take overall responsibility.

Domiciliary or home-birth midwives are paid on contract by the Health Department and are thus considered self-employed for tax purposes. Payment can be made for three ante-natal visits, labour and 12 post-natal visits — and this is paid only on completion of the case.

The current package amounts to $390 (before tax), since a 44% increase was made, after persistent representations, last August.

There is also a tax-free mileage allowance but no allowance for any extras, unsocial hours, night calls, weekend or overtime work, holiday or sick pay. There is considerable time spent travelling due to a shortage of home-birth midwives. Because the doctors in some localities will not agree to it, there are many areas in New Zealand that do not have a viable home birth option, despite the presence of a willing midwife, as on the Kapiti Coast.

Furthermore, these same doctors will not refer women on, or invite a willing doctor into their "territory", for fear of losing clients.

About 1% (500 births per annum) of total births take place at home. This would increase with more homebirth midwives and greater tolerance of the option. In fact the home birth option has only been tolerated partly because a home birth costs half that of a hospital birth.

Unlike our Australian counterparts, the homebirth option is incorporated in the New Zealand health service — there is no additional cost to the consumer. (Though in Wellington, we also run ante-natal classes for which there is a small fee.)

With transfer cases, the homebirth midwife usually remains with the woman until the birth of the baby, whereby post-natal care is returned to the community as soon as convenient.

## A CHOICE OF BIRTHING

Part 1 : Homebirth & Domiciliary Midwifery
Jennie Nicol, Senior Advisory Officer, Women, Children & Family
Department of Health.

This paper is also well presented and sensitively addresses the issues - following consultation with midwives, other health professionals and consumers.
The following is an extract from the Introduction and Conclusion, but it is recommended to read the paper in its entirety.

This paper arose from the recognised need within the Health Dept. for information on the services the domiciliary midwife offered in the community; the consumer demand for such a service; and the problems encountered in providing it.

It had been apparant for some time that the contract for domiciliary midwives was out of date and inappropriate; not surprising since it was drafted in 1938 and had not been revised since that time. It was thus a matter of urgency that the contract be reviewed and rewritten.

The paper is not intended to be a criticism of the opponents of homebirth but an overall picture of the situation as it is perceived to exist at present by the domiciliary midwives and other home birth advocates interviewed in the course of obtaining material for this paper.

Conclusions -
There is little doubt that the situation with respect to the provision of a homebirth option for women is a precarious one. The pressures from workload, poor pay and medical opposition are all taking their toll and the service appears to be reaching crisis point. Positive moves, particularly with respect to renumeration need to be made or the number of domiciliary midwives could decline to a level where homebirth would no longer be an option.

The domiciliary midwives see themselves as a professional group geared towards normal deliveries; not in competition with obstetricians who are equipped to handle normal birth.

It would also appear that domiciliary midwives and homebirthers are not a fringe group but a dynamic trend." The service is restricted because of the small number of GP's and midwives who can only handle a limited number of clients. This raises the concern of women resorting to untrained lay people.

She quotes Kitzingers statement "the creation of an up-to-date homebirth service is an important function of the health services in a responsible society", and states that to survive, the homebirth service must be nourished.

## DIRECT ENTRY MIDWIFERY - THE EDUCATION OF THE FUTURE: Jill White Eyres -

NZ has been coping with a shortage of midwives for some years. The national shortage has led to the recruitment and employment of many overseas trained midwives, mostly from the UK. While it injects the service with quality and quantity these very precious people serve their contract and move on to other places eg. Australia, Canada, USA or back home. Meanwhile, NZ families remain disadvantaged regarding their special social and cultural needs.

The midwifery profession suffers from a lack of autonomy - the ability to oversee and audit its own members. This derives from a lack of awareness by the general public of what a midwife is and the state of training.

### What Is A Midwife?

It is internationally claimed by both midwives and the medical profession that a midwife is a person who is specifically instructed and qualified to take professional responsibility for the supervision, care and advice to women and their families concerning pregnancy, labour and the postnatal period, to conduct normal deliveries and care for the newborn. This supervision, care and advice includes preventative measures, detection of potentially abnormal conditions in mother and child,the procurement of medical assistance and the execution of emergency measures in the absence of or under the direction of medical personnel.

### What Are The Functions Of A Midwife?

In fulfilling a midwifery role in a modern multi-cultural society a midwife -

- understands the physical, socio-cultural, psychological and spiritual (wholistic) needs of mothers within their family structures.
- has knowledge of political, economic and enviromental factors that may affect families.
- provides education on health, parenthood, childcare and nutrition including the promotion of breastfeeding.
- fosters parent - infant family relationships and is aware of particular circumstances which may lead to family breakdown.
- advises on family planning.
- monitors the growth and development of the fetus during pregnancy and labour.
- ensures the optimal physical, emotional, socio-cultural and spiritual (wholistic) health possible in the mother.
- advocates for the best possible birth experience for the parents, supporting their informed requests regarding the delivery.
- shares responsibility for the safe delivery of the child, recognises complications and makes an early referral for specialist medical consultation.

- monitors the physical and emotional development of the new-born while she or he is accepted into the family network (including the preterm, sick or handicapped).
- ensures the optimal physical and emotional health of the mother while she recovers from childbirth including helping her and her partner to make informed decisions about child care, to take responsibility for their own health and that of their children, and to adjust to their new roles.
- counsels those requiring extra help with adjustment including teenagers, unsupported mothers, those whose pregnancy is at risk and families who experience grief and loss.

Many of these fuctions have been eroded by other professions eg. medical, social workers, physiotherapists. This is because midwifery has been subsumed into the nursing profession.

What about Training?
In NZ Midwifery is subsequent to a 3 yr nursing course. The courses are held over an academic year in Wellington, Auckland, Hamilton and Christchurch and results in a national average of 24 qualified graduates per year.
These terrible figures reflect a lack of enthusiasm amongst nurses to undertake midwifery training following their basic 3 year nursing course. There are many area competing for a nursing background eg. psychiatry, medicine and surgery, geriatrics, orthopaedics.

Nurses traditionally care for the sick.
Midwives traditionally establish relationships with healthy women, focus on prevention of dis-ease and have a large educative role. With the current concern expressed by various influential bodies regarding Parenting (eg. the NZ Board of Health, Maori Elders, MP's) it is imperative that the midwifery profession is given a high profile for their role and functions are vital to establishing optimal wholistic parenting and the healthy growth and development of the child.

The Midwifery Task Force, with assistance of a grant from the McKenzie Trust Foundation are undertaking a feasibility study to gauge the need for a 3 year Direct Entrant Midwifery course (ie. based upon the art and science of midwifery which includes the humanities and appropriate science subjects which is separate from nursing.)

We are seeking your opinions on such a proposal.
Please answer the following questions and send to Save The Midwife - PO Box 183, Ruakaka, Northland by 18th June'88.

Please only answer the questionaire once and encourage others who are interested to also respond. Further copies can be obtained from above address (photocopies are also acceptable). You do not need to provide your name and address, but those who do will receive a summary of the results.
Thank you for your input and contribution to this study.

Name:
Age:
Address:

Questions:

| | | |
|---|---|---|
| 1. I am unhappy about midwifery training in NZ.<br>Comments | yes | no |
| 2. I believe that midwifery is a specialist profession separate from that of nursing.<br>Comments | yes | no |
| 3. I would like to see more midwives recruited and trained to fulfill the special cultural needs of the NZ community.<br>Comments | yes | no |
| 4. I agree that an autonomous midwifery profession is essential to maintain a high standard of midwifery care.<br>Comments | yes | no |
| 5. I agree that midwives perform an essential role in the preparation for positive parenting.<br>Comments | yes | no |
| 6. I strongly urge that a 3 year Direct Entry Specialist Midwifery Course be established in NZ that will be available in accessible areas.<br>Comments | yes | no |
| 7. Answer either a or b -<br>a. If a Direct Entry course becomes available would you apply? | yes | no |
| b. If DE training had been available would you have applied? (please state if a midwife)<br>Comments | yes | no |

SAVE THE MIDWIVES ASSOCIATION SUBSCRIPTION FORM

PLEASE POST TO THE SUBS SECRETARY, Brenda Hinton, 2 Sherwood Ave, Grey Lynn, Ak 2.

NAME____________________ ADDRESS____________________

____________________ PHONE________

Midwife?_____ Mother?_____ Other?_____ NEW?_____ RENEW?_____

ANNUAL SUB (Your Choice) $20____ $10____ $5____ Australia $NZ 20 Intl $NZ 25

I can help with: typing____ artwork____ phoning____ subs____ newsletter____

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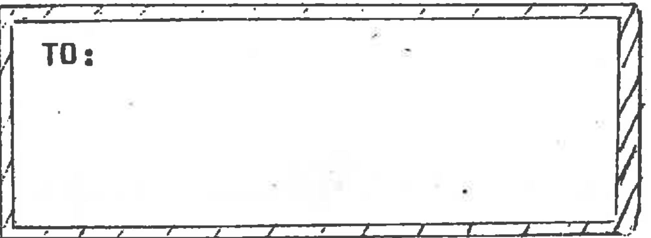


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