The Alliance of Nurse-Midwives and Maternity and Neonatal Nurses of Newfoundland and Labrador

(A Special Interest Group of the ARNN)

Newsletter No. 9 (new issue) - January 1994

We are now into another year which promises to be very interesting as far as midwifery and maternity nursing are concerned. This Newsletter contains reports on meetings that have occurred during the last few months and actions that the Alliance members have taken. The copy of the last letter sent to ARNN regarding the proposed Future Nursing Curriculum is included, but due to lack of space the letters sent from the Alliance (as a whole) and from the Midwifery Association in response to the Provincial Advisory Committee on Midwifery Discussion Paper are not included. (Cathy Wyse has the former and I have the latter if anyone wishes to read them). The ARNN Position Statements on Midwifery and SIG are included and the WHO Codes on breastfeeding.

As this is another year the membership fees are due and a membership form is attached at the end of this Newsletter. As you will remember, it was agreed at the September 1993 meeting that the fees should be $20 for midwives and $15 for others. This is the first increase for over 10 years. Please send the completed form and a cheque to Clare Bessell, the Alliance treasurer. (If you are unwaged and there is a problem with paying this registration fee please advise either Clare or myself).

We are in the process of arranging for the National Midwifery Conference which will be held in St. John's on May 6th and 7th. As this coincides with the CCM annual general meeting CCM representatives will be coming from across Canada. It is customary for the host province to billet the representatives, therefore, please let me know as soon as possible if you live in the St. John's area and would be willing to have one or more representatives billeted with you. Also I am looking for volunteers to help with the planning for these days. A first poster is attached for you to copy and display.

Please send me your contributions for the next Newsletter as soon as possible. Reports on conferences, abstracts from articles, news items, book reviews, etc. Thank you to those who provided materials for this Newsletter.

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National Midwifery Conference and CCM meeting. St. John's, NF. Friday, May 6 and Saturday, May 7, 1994. "Midwives Today". Call for abstracts for oral and poster/film presentations on any aspects of Midwifery, and for exhibits, by March 1st. See further information in this Newsletter.

Alliance Executive

President: Cathy Wyse
Secretary: Karene Tweedie
Treasurer: Clare Bessell
Newsletter: Pearl Herbert
Publicity: Janet Murphy-Goodridge

Meetings (A summary of the Minutes)

An Alliance meeting was held at ARNN House on October 28th. Seven members were present. Matters discussed included the hunt for copies of the previous Constitution. It was suggested that the target membership of the Alliance be broadened and extended, perhaps beyond that of nurses, and that a new name be sought. However, to be a Special Interest Group of the ARNN at least 80% of the members have to be registered nurses. **What is the feeling of Alliance members regarding the suggestion of expanding and having a new name?**

The ARNN Position Statement passed by the ARNN Council was discussed. The statement is not entirely as had been proposed by the Committee.

The Provincial Advisory Committee on Midwifery Position Paper was discussed and it was decided to meet on November 24th to prepare a joint response.

The Alliance Conference, held September 30th, generally went well according to the evaluations received from the participants. All monies have been received and accounts have been paid.

The Future Collaborative Nursing Curriculum was discussed. A letter had been sent to Marge Hackett, president of the Curriculum Development Committee, who passed it on to Pegi Earle at ARNN. Cathy Wyse has received no response from the Committee. Cathy Wyse mentioned that she had read an article in JOGNN, 22(5), 1993, pp. 410-419, which stressed that fetal monitoring is now considered a procedure which should be taught to all basic students. If this is the case, then the limitations in the draft curriculum become even more obvious. (See further information in this Newsletter). [A further draft of the curriculum was later received by Cathy Wyse and this was discussed at the special meeting on November 24th].

Money to attend conferences was discussed. Cathy Royle has some tapes from the National Association of Neonatal Nurses conference. Apparently Lynn Vivian-Book has access to many journals and magazines and the Tables of Content of these could be copied and circulated. **Do Alliance members have any interest in this suggestion?** If items were going to be borrowed then we would need a "Librarian" on the Alliance Executive.

Cathy Royle of the Provincial Perinatal Program then gave a report of the National Association of Neonatal Nurses conference which she attended in Orlando. She will also be sharing some of the information from the conference via teleconference. Hopefully, she provide summaries of the sessions for a future Alliance Newsletter so that others will be able to avail of this wealth of information.

A Midwives Association meeting was held on November 11, 1993. Items discussed included that the names of midwives had been submitted to Ruth Graham for the mailing of the Position Paper from the Provincial Advisory Committee on Midwifery. There had been 44 midwives identified in the province, but possibly there are more who we do not know about. (Only half of these belong to the Alliance). The Position Paper's questions and answers were discussed, along with the information submitted by members outside

of St. John's. Karen Olsson volunteered to write the Midwives Association's response.

During the summer a midwifery display, put together by Kay Matthews and Karen Olsson, had been exhibited at the National Canadian Public Health Conference when it was held at the Radisson Hotel in St. John's. The original plan to have this display in either the Avalon Mall or the Village Mall on International Midwifery Day had been cancelled (see minutes of June 22). The committee members who compiled a report with recommendations and care plans on cervical prostaglandins for the ARNN had been requested to do the same for vaginal prostaglandins, and this was submitted during the summer. (These are available from the ARNN).

There was an update on midwifery happenings in Canada. A Midwifery Conference was discussed and May was considered to be a good month, and Friday and Saturday the best days as plane fares are cheaper when staying over Saturday night. (International Midwives Day is May 5th). This could give members an opportunity to meet midwives from across Canada and to hear first-hand what is happening about midwifery in their province/territory, and to ask questions.

At the start of the meeting the film from the Ontario Association of Midwives produced by the Michener Institute in Toronto was viewed. This film reflects well the practice of midwives. At the end of the meeting a very rough cut edition of a video "Home Birth" produced by the National Film Board was watched. This had been lent to Pearl for comments. The film contained no current information about midwifery in Canada and appeared dated, although it had been "shot" in 1992.

The 20 year old Atlantic Nurse-Midwives Association Constitution and By-Laws were distributed and at the next meeting we will start to rewrite them for our present Association. We have been unable to locate a Midwifery Constitution written at the time that the Alliance was formed. **A Draft is attached for NLMA members. Please advise Pearl of any comments/suggestions, before February 9th, the tentative date of the next meeting.**

<u>The First National Midwives Conference and the CCM Annual Meeting</u> are to be held in St. John's in May 1994. Friday, May 6th, will be a one day conference and then on Saturday, May 7th, there will be the annual meeting where highlights from around the country are presented by the representatives from the Midwifery Associations.

<u>Call for Abstracts for Conference on "Midwives Today".</u>

No more than 500 words for papers and 250 words for posters or films. Paper presentations will be 15 minutes plus 10 minutes for questions. Papers can be a description of the midwife's role, transcultural experiences, how to cope with the requirements of legislation, developing midwifery education programs, reports of research, consumer support groups etc. (A request has been for a presentation from midwives in isolated areas). Posters will be displayed on felt boards - centre board 3 ft x 3 ft and two side boards 2 ft x 3 ft. Abstracts should be typed (if possible) and sent to Pearl Herbert by March 1st.

GUIDELINES FOR ARNN SPECIAL INTEREST GROUPS

The Association of Registered Nurses of Newfoundland (ARNN) supports the development of special interest groups by registered nurses who have a common concern for professional development in a defined area of nursing practice, education, administration or research.

The ARNN recognizes special interest groups as valuable to the promotion of the profession, to enhancing quality of care and standards of practice and to the development of knowledge and competency through sharing among peers. The expertise of special interest groups is recognized by the ARNN and liaison with the groups provides input into decision-making on relevant issues.

In order to be considered a special interest group of the ARNN, the following criteria must be met:

1. Eighty percent (80%) of the voting members are to be registered nurses.

2. The group's constitution, by-laws, objectives and activities are in accordance with the Registered Nurses Act and By-Laws.

When special interest group status is conferred upon a group, the ARNN will provide:

1. accommodation for meetings in ARNN House, when space is available. Requests are to be made through the Executive Director's Secretary as far in advance as possible.

2. display space is available at the ARNN Annual Meeting. All requests will be treated on a first-come, first-serve basis.

3. publication of information or articles of interest from the special interest group in the ARNN ACCESS. (Articles must be submitted at least two months prior to publication).

4. use of the duplication equipment at ARNN house at cost.

5. assistance with educational programmes.

In return, the ARNN:

1. may meet annually with representatives of special interest groups for information-sharing and discussion.

2. requests an annual report from each special interest group to be submitted by April 1 for inclusion in the ARNN Annual Meeting Folio of Reports.

3. reserves the right to request representation from special interest groups on an ad hoc committee established in relation to that specialty , or to seek their assistance where necessary on relevant issues/projects related to the specialty.

Applications are available from ARNN House. When returning the application, please include a copy of the group's constitution and by-laws. (Approved by ARNN Council, 5 and 6 October 1992)

Future Nursing Education in Newfoundland and Labrador

Background. Those who attended the 1992 ARNN annual conference may remember receiving a copy of the "historical overview of activities related to the organization of the future nursing education system in Newfoundland". This document includes relevant dates for the 10 years from 1982. In 1982, when the Canadian Nurses Association (CNA) met in St. John's, the position adopted by the CNA was "that by the year 2000 the minimal educational requirement for entry into the practice of nursing should be the successful completion of a baccalaureate degree in nursing". Also that year the members of the ARNN passed a resolution that there should be a committee to provide direction for the transition from diploma to university education. Since then several committees have been formed. On June 8, 1992, the "Strategic Plan for Future Nursing Education" was presented to the Honourable Chris Decker, Minister of Health and Honourable Philip Warren, Minister of Education. (A copy of the report is at the ARNN).

The Advisory Committee on Basic Nursing Education (BEAC) is composed of the Directors of the five Schools of Nursing and the ARNN Nursing Education Consultant. It has been agreed that the future education curriculum is to be jointly developed by all Schools of Nursing in the province and that the diploma schools to have an affiliation with MUN. Both a diploma and a degree exit are to be included. In 1992 the Newfoundland Hospital and Nursing Home Association endorsed the proposed Future Nursing Education Model.

In October 1992 the Association of Nurse Educators in Newfoundland and Labrador (NENL) organized a workshop on the Provincial Nursing Curriculum at which some instructors in the Calgary Conjoint Program presented. It is this Calgary program on which the model for our province's curriculum is based. The NENL is also arranging another conference in March 1994 at which Drs. Bevis and Hill will present on their caring and critical thinking curriculum model. (Further information from Pegi Earle at ARNN).

In January, 1993, the Future Curriculum Development Committee, composed of a representative from each School of Nursing and Marg Hackett (MUN) as chairperson, started a 6 month secondment to work on the curriculum followed by 6 months of occasional meetings. At the end of this time they are to submit a final report to the BEAC, (and after this it would be circulated to others). During 1993 the Committee has organized presentations to the faculties of the five Schools of Nursing, and obtained feedback from the faculty members by means of survey questionnaires.

Maternity Nursing. During 1993 drafts were received by faculty members of a proposed curriculum and as these drafts were rewritten and developed it became apparent that both the proposed theory and clinical practice of maternity nursing care were very minimal. Therefore, at the Alliance meeting on September 15, 1993, the issue was raised and discussed. It was agreed that "a letter outlining these concerns will be submitted to the Curriculum Committee. All agreed that the Alliance should respond as a group, as we are concerned with quality maternity and newborn care, and the President will sign the letter". The letter was sent on September 16th and besides expressing the concerns of Alliance members requested that the members be able to view the draft documents related to the proposed curriculum. Also, because the Alliance is a Special Interest Group of the ARNN, members be given an opportunity to provide input into the maternity sections of the new curriculum as these are developed. The President received no acknowledgement of this letter, but in mid-November she did receive a questionnaire requesting input regarding the latest draft of the proposed curriculum. This was discussed at the November 24 meeting (at which it was originally planned just to answer the questions in the "Provincial Midwifery Discussion Paper"). Maternity nursing is now part of other courses such as anatomy and physiology, and medical nursing (as also is paediatric nursing). It is not a course on its own. Below is the covering letter submitted with the questionnaire, on December 13th, to Pegi Earle.

"Thank you for your letter and the material package with the information on the proposed new collaborative curriculum. Our interest group members have examined the curriculum outline and would like to submit our comments and concerns.

First, we would like to sincerely acknowledge the hard work which has gone into the proposed curriculum and recognize that it is no easy task to satisfy all participants in the process. Generally, we find that there are differences in opinion among our group about elements of the curriculum, some like some aspects of it and some liking other aspects. However, we are unanimous in our concern about the lack of theory and clinical practice in maternity nursing in the curriculum generally and in the course outlines in particular.

We recognize that the maternity client fits into a wellness model, but it is important to recognize that the healthy maternity client can develop pathologic conditions which impact on the childbearing process. This may occur at any point from pre-conception through to the postpartum and neonatal periods. If one of the roles of the neophyte practitioner is that of direct care giver, we believe that effective care of the childbearing family requires assimilation of a specific body of knowledge to be able to provide that care. This body of knowledge is basic to the application of teaching/learning principles, counselling skills and community health nursing practice which appear to be well represented in the proposed curriculum. To acquire this body of knowledge, students need to spend some time under the supervision

of competent faculty in prenatal, postpartal and neonatal clinical assignments. Is it proposed to do this in the 4-week extended clinical 1, or in the Clinical Elective practicum? If so, it will be impossible to rotate all students through in four weeks.

Concerns have also been raised in other healthcare committees about the lack of breastfeeding content and skills taught in the present curriculum. These concerns will not be addressed under the proposed curriculum as presented in the draft outline.

With regard to the graduate nurse in the year 2000, there is already an increasing emphasis on early hospital discharge of mothers and babies. This emphasis on early hospital discharge requires a well-educated, experienced nurse with a sound theoretical and practical background to provide effective care, advice and counselling to the woman and her family. Research has shown that conflicting advice is a major problem for new mothers. Most professionals who work with childbearing families consider that nurses need more preparation for their role rather than less.

It has occurred to us that possibly the Committee might place nursing of the childbearing family in the Nursing Practice for Health Promotion Across the Lifespan course. However, clinical opportunities will be very limited in this course particularly if it is only offered in one semester. Furthermore, with this proposed model, as with any extended clinical, we can envisage problems with clinical placement due to there being only one maternity unit in the city. Another problem, if this course is designed to provide maternity clinical experience, is that nutrition/diet therapy and pathology are not offered until Year 2. Both these courses are important pre-requisites to prepare the student for the care of mothers and fetuses/neonates in childbirth.

At present, there is an ARNN expectation of 200 hours instruction in maternity nursing. There is also a list of both basic and advanced clinical competencies in this area. Can these expectations be met in the proposed new curriculum? Is there an intention to revise these requirements? Will they fulfil the CAUSN and ARNN approval/accreditation requirements?

The Committee may have already considered these issues and are able to address our concerns. We appreciate the opportunity to give feedback to the Committee and wish you success.

Respectfully submitted,
C. WYSE
President"

Is your Agency/Facility "Baby Friendly"?

World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) Codes

Marketing Code for Breast Milk Substitutes (1981)

Summary of the Code's Provisions:

1. Infant formulas should not be advertised to the public.
2. No free product samples should be given to mothers.

3. Infant formulas should not be promoted in health care facilities.
4. Manufacturers should not send company nurses to advise mothers.
5. No gifts or personal samples should be given to health care workers.
6. Product labels should not include words or pictures (including pictures of infants) that idealize formula-feeding.
7. Information given to health care workers about infant feeding should be scientific and factual.
8. Information on formula-feeding (including product labels) should include an explanation of the benefits of breast-feeding and the costs and hazards of formula-feeding.
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for infants.
10. All infant formula products should be of high quality and appropriate for the climate and storage conditions of the country in which they are to be used.

(The Canadian Government signed that they endorsed this Code but it has never been legislated).

Protecting, Promoting and Supporting Breast-feeding The Special Role of Maternity Services (1989).

Summary of the Code's Provisions:

Every facility providing maternity services and care for newborn infants should be "Baby-Friendly". They should:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
4. Help mothers initiate breast-feeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

For folders and further information on the above contact, either your local UNICEF office or Dr. Penny van Esterik, Coordinator,

Department of Anthropology, Ross Building, York University, North York, Ontario M3J 1P3.

Expert Working Group for the Promotion of Breastfeeding. December 2 - 3, 1993. Pearl Herbert, as Co-Ordinator of the Canadian Confederation of Midwives, was invited to attend this meeting in Ottawa. The following information is from her notes.

The meeting was chaired by Margo Craig Garrison and Rosemary Sloan of the Family and Child Health, Health Promotion Directorate, Health and Welfare Canada. Those present represented varied multi-disciplinary associations including CNA, Medical Associations etc.

The objectives of this meeting included: Information sharing; the functions of the working group; and to set future directions.

Information sharing.

Everyone present gave information on how their group/agency was involved in breastfeeding. There were more than 24 representatives and the following is given an example of the information provided:

Elizabeth Shears, Nova Scotia Dept. of Health, represented all provincial health departments. The Grace Maternity Hospital in Halifax has a new Breastfeeding Protocol ($20) and prenatal books have been printed.

Pierrett Tremblay, Ligue La Leche, had a grant from Health and Welfare Canada to make a video film. The Quebec Government is entering into a contract with formula companies and are either going to offer three formulas a year or to have one formula a year and the companies rotate. The mothers will make a decision as to which formula to use in consultation with their doctor.

Mary O'Brien, Canadian Dietetic Association. Breastfeeding is one of the goals. Facts sheets are being produced in different languages with a grade 5+ reading level. In Newfoundland four regional nutritionists are involved.

Marilyn Sanders, and Fernande Meilleur, past director, UNICEF Canada and Baby Friendly Hospital Advisor. The Baby Friendly Initiative is greatest in B.C., Manitoba and Newfoundland also have an Initiative. There are 200 hospitals around the world who are Baby Friendly, and Asia is the leading continent and Sweden the leading country. The aim is for all hospitals to be Baby Friendly by 1994.

Jacki Glover, IBLC. Nurses in Alberta are frustrated by lack of support from the AARN. Telephone calls are received 24 hours a day from mothers who have breastfeeding problems including latching-on.

Reg Sauve, Canadian Paediatric Society. The 1978 statement on breastfeeding is being reviewed. The preterm infant feeding statement has been finalised, and they have concentrated on the very low birth weight baby. They aim to produce a bulletin every two months.

Maureen Fjeld, Canadian Lactation Consultant Association. There are over 200 members from various disciplines, 150 candidates wrote the examination this year and they are considering forming chapters.

The regulations concerning recertification are being reviewed. (She told me afterwards that the Lactation Consultant course is now being taken by some people who consider it as another way of keeping a job rather than because they are especially interested in breastfeeding. In fact some have finished the course and then had a baby which they have bottle fed).
Jennifer Peddesden, Canadian Association of Pharmacists. The aim is to speak to the faculty in the Schools of Pharmacies across Canada and to promote the Health and Welfare Canada 10 Steps. Pharmacists need to know the hazards of formulas. In the stores it is often the store people who sell the formula but pharmacists do get asked questions.
Elizabeth Sterken, INFACT Canada. Their aim is to protect and promote better baby health and this includes breastfeeding. Eight provinces are represented on the executive committee. They are involved in education, lobbying, stimulating letter writing to magazines and others. After World Breastfeeding week networks were developed. Background papers and posters were developed for use at the local level. A third French newsletter is in the process of being written and it is hoped to have the newsletter available in French on a regular basis. The priority of INFACT members is to introduce the WHO Code to control breast milk substitutes (which has not been legalized in Canada).
Joanne Roulston. Health Promotion Directorate Funding. Money is only awarded to non-profit, non-governmental groups for national surveys. There is help for projects amongst low income and aboriginal people. Brighter Future is a federal program and has four different sections.
Halina Cyr, Nutrition Programs Unit, Health Promotion Directorate. They produce Canada's Food Guide and are working on guidelines for preconception and pregnancy.
Cathy Royle, Newfoundland Provincial Perinatal Programs. The Breastfeeding Coalition is spread all over the province. The terms of reference have been established. Breastfeeding has risen from 38% to 39%.
Verity Livingstone, Vancouver Breastfeeding Centre, Dept. of Family Practice, UBC. They have a multidisciplinary lactation clinic, and then there are satellite centres. They are using the UNICEF approach. They are developing a breastfeeding kit which will contain four video films for professionals. Next year there will be a "train the trainer" workshop.
Margaret Moyston Cumming, Epidemiology and Community Health Specialities, Medical Services Branch. The regions are doing a breastfeeding update, but the Yukon has opted out. The "Bonding Circle" video is now being produced in French. There is a lack of notification about mothers being sent home to the isolated areas. (She is a British trained midwife).
Patricia Nidhay, Perinatal Education Program of Eastern Ontario. The breastfeeding coalition group deals with health professionals. They have a breastfeeding manual. They are trying to get mothers to supplement with a cup instead of with a bottle. Aim to have breastfeeding viewed as a cultural norm, and breastfeeding

facilitators in all of the Eastern Ontario hospitals. The Mayor of Ottawa supports breastfeeding.
Marie Labreche, Family and Child Health Unit, Health Promotion Directorate. Reports are being written in Best Wishes, Expecting and other prenatal and postnatal magazines. The New Baby and Child Care Encyclopedia has just been printed. Youth is a new magazine.

The report given by Pearl Herbert, Canadian Confederation of Midwives. (There are 10 midwives associations, plus contact persons for PEI and NWT. New Brunswick and the Yukon are at present without contact persons). The continuity of care that midwives give to women during the child bearing cycle provides an opportunity to teach and support mothers with their decision about feeding before the baby is born. Then after the birth they can help mothers with breastfeeding. Midwives are available at all hours of the day and night, seven days a week. Last May the International Confederation of Midwives (ICM) issued a policy statement on breastfeeding. The ICM: "recognizes that breastfeeding is an important child survival strategy and has health advantages for the mother. ICM therefore supports the right of all infants to be breast fed. ICM further supports the right of mothers and families to receive accurate information about, and counselling for, successful breast feeding. In keeping with this belief, the midwife should:

i. accept her unique and vital role in the promotion of breastfeeding at a governmental, institutional and individual level.
ii. actively assist women to achieve success in breast feeding through education and practical advice.
iii. maintain and implement an up-to-date research based knowledge on all aspects of breast feeding.
iv. encourage the provision of facilities which enable women to continue to breast feed.
v. accept responsibility for educating other health care professionals in the importance of breast feeding.
vi. teach students of midwifery and auxiliary health workers the art and practice of breast feeding.

(cited in Midwifery, 9, 1993, p. 170)

(The CCM has not yet discussed this policy as it was published after their annual general meeting).

CCM members reported on breastfeeding at the last telephone conference (November 25, 1993). In PEI a committee is being instituted and the contact person is on this committee. In Ontario it has been found that there is a growing number of people taking the Lactation Consultant courses and then sharing their expertise so that the mothers feel that they are being bombarded with information. Often this information is not consistent and they are receiving conflicting advice. Some mothers are then deciding not to breastfeed. Canadian Guidelines are needed for consistent information.

In Newfoundland a midwife is a project co-ordinator of "A Study of Infant Practices in Newfoundland and Labrador". This study has received funding from the Sick Children's Hospital fund,

Toronto. The objectives are to: identify infant feeding practices of a selected sample . . . during the first six months; establish reasons for any changes from the initial method of feeding in the hospital; determine how closely mothers adhere to the infant feeding practices recommended by Health and Welfare Canada; determine whether there are any regional or ethnic differences in infant feeding practices. The mothers were interviewed four times, once in hospital and then by telephone at one, four and six months. There were 850 mothers who continued in the study until the baby was six months old. The last interviews were this past summer and the analysis has not yet been completed.

This month midwives who work in Labrador are organizing a Breastfeeding Conference. [This conference was postponed because the key note speaker was indisposed].

Reports were given on the Progress of various Projects

Breastfeeding Support and Breastfeeding Support Services in North America presented by Joanne Gilmore and Theresa Agnew.

Theresa Agnew was commissioned by the City of Ottawa to write the back ground papers. She reviewed 900 articles and reports. She discovered that Dr. Lawrence in the USA has over 30,000 articles on her data base. She looked at how support enables continuation of breastfeeding. Not much is documented on Canadian programs. In the USA she met with ILLL persons including their founders, and accessed their breastfeeding data base. She also met with WIC persons. She was very impressed with the Chicago Task Force people who are working together with the WIC program.

Ms. Agnew then gave recommendations from the literature review, survey findings and discussions. She found that the definitions were not consistent. The key recommendations included training for health care professionals, to focus on women's social support networks, and to have multiple levels of support. She questioned whether socio-economic status is a good guideline as there is so much unemployment and whether education level would be more applicable.

Discussion included that there is no Breastfeeding list in the Yellow pages. (These pages are set and headings are not changed). The airports have a bottle to show the direction to the baby's changing room.

We viewed the three video films produced by Ligue La Leche, L'Art de l'allaitement (1993). They showed a pregnant woman considering whether or not to breastfeed, mothers breastfeeding their babies of various ages, and problems that mothers encounter when breastfeeding. From just viewing and not understanding the words the mothers were too smartly dressed complete with make-up, jewellery and not a hair out-of-place, and no housecoats or dirty dishes, even when the baby apparently would not sleep at night. The father was shown folding baby clothes.

Family Centred Maternity Care Survey - the presentation of the results of the Infant Feeding Component by Cheryl Levitt and Louise Hanvey.

The first survey was in 1985 and was reported in Dimensions and in Canadian Nurse. This is the third survey in which 523 hospitals provided data. The analysis which is by province, and the hospitals are not identified, has been completed but is not yet checked and ready for distribution. Hospitals were assessed on the 10 points for Baby Friendly Institutions. In some provinces they are very good and in others they have some way to go before meeting these standards. Questions were asked as to whether or not the person who completed the questionnaire really knew what happened in their agency and if the hospital policies were really being followed. There was a section for "not known" but perhaps the person did not realise that they did not know. Even if there were contracts with drug companies formula samples did not have to be given to the mothers when they were discharged home. However, the mothers who were bottle feeding perhaps did not have a choice of formula with which to feed their baby. Watch for the results of this survey when they are released in a few months time.

Marketing Plan for Breast-feeding Promotion - presented by Rob Hyams, program Promotion Division, Health Canada.

A series of full-coloured photographs are being distributed over several months. They are designed for specific target groups. The objectives are to encourage and support breastfeeding, to encourage breastfeeding to be carried out for a longer time period, and to provide a positive climate for breastfeeding. Primary goal is to provide assurance that breastfeeding is perfectly acceptable anytime and in any place. Secondary goal is to provide breastfeeding mothers with assurance that it is alright. There will be posters, advertisements in magazines, transit boards, bill-boards. Distribution will begin at the beginning of 1994 to health professionals. The posters will be either in French or English. The time plan is in 1994/1995 to be targeted at mothers and their partners. In 1995/1996 to be targeted at mothers, partners, grandparents, and general public. In 1996/1997 the target group is the public and in 1997/1998 youth and the public. The photographs will be receiving ongoing evaluations.

Watch for these photographs during the coming months, and if requested, posters will be sent to those who attended this meeting. Cathy Royle will have some at the Newfoundland Provincial Perinatal Program Office, therefore Pearl did not request any. The address for CCM members to write was given on the Agenda of the telephone conference.

Expert Working Group on the Promotion of Breast-feeding - Terms of Reference. These were discussed and formulated as follows:

Mission. Protection, promotion and support of breast-feeding within Canada as the optimal method of infant feeding.

Goal. Re-establish breast-feeding as the cultural norm for infant feeding within Canada.

Objectives. 1. Provide ongoing expert advice and recommendations on breastfeeding to governments and organizations for research, policy, programme development and direction.
2. Facilitate the development of collaborative strategies to protect, promote and support breastfeeding in Canada.
3. Provide a forum for addressing breastfeeding issues brought forward to the network.
4. Share information and maintain ongoing communication between governments and organizations to protect, promote and support breastfeeding.

I then had to leave to catch a plane before the end of the meeting. The next meeting has been suggested for either May or June, 1994.

World Breastfeeding Week in Newfoundland and Labrador submitted by Janet Murphy-Goodridge and Karen Olsson.

The second annual World Breastfeeding Week (WBW) was celebrated August 1-7, 1993, in Newfoundland and Labrador with many activities occurring throughout the province. Much of the organization of activities stemmed from a newly formed provincial committee. Currently in our province, only about 38% of women initiate breastfeeding compared to the Canadian average of 75%. The concern over this low initiation rate and the need for a coordinated approach to breastfeeding promotion led to the establishment in 1992 of a Provincial Breastfeeding Promotion Coalition (The Coalition). The Coalition has broad representation from government, community health, maternity services, academic institutions, nursing and special interest groups. It's goals are to reestablish breastfeeding as the cultural norm for infant feeding in Newfoundland and Labrador. The Coalition aims to do this by improving breastfeeding knowledge, attitudes, practice and skills through public and professional education and promotion. WBW was an excellent opportunity for the Coalition to begin to achieve some of it's goals.

The local organizers of WBW believed that the goal of this year's theme - "Breastfeeding - What's stopping you?" - which was most relevant to Newfoundland and Labrador was the creation of mother and baby friendly environments for breastfeeding. The Provincial Department of Health distributed 350 copies of INFACT Canada's educational kit and posters for WBW to physicians, public health nurses and hospital/health units across the province. The WBW posters were placed in fitness centres, libraries, day care centres and other key public buildings in the St. John's area. Informational displays were set up during the week at the Village and Avalon Malls. Public health nurses recognized the week with displays in their health units and social events with mothers and babies at the St. John's and Mt. Pearl breastfeeding support clinics. The Grace Hospital organized a display booth in the cafeteria and included a staff questionnaire about the basics of breastfeeding. A social was held at the hospital's breastfeeding

clinic. The highlight of the week in the St. John's area was a WBW picnic in Pippy Park with entertainment by a local children's entertainer. One hundred and thirty mothers, babies and their families enjoyed the warm sunshine, singing and picnic. This event was preceded by a La Leche League Walkathon through the park.

Media coverage of WBW was extensive. A television advertisement showing two women breastfeeding their infants and socializing with their families in a local park aired for two weeks in August. The funding for this advertisement was provided by the Alliance of Nurse-Midwives, Maternity and Neonatal Nurses of Newfoundland and Labrador, The Janeway Foundation, and OXFAM Canada. At the beginning of the week, CBC radio interviewed a La Leche League leader and a local breastfeeding mother and followed up later with a second interview with a nursing supervisor at the Grace Hospital, two breastfeeding women and the local chairperson of INFACT Canada. The CBC evening news show "Here and Now" had a lead story on WBW focusing on the theme of the mother-baby friendly environment. The 2.5 minute film clip was the result of 4 hours of breastfeeding and chatting with two breastfeeding mothers in a local park and shopping malls! We were fortunate to also include one mother who had bottle fed her infant and she was able to articulate the reasons for her choice and the barriers present in our society towards breastfeeding. The interview was picked up by CBC Newsworld and aired nationally. The Evening Telegram devoted an entire lifestyles section page to WBW and again focused on the theme and working mothers. The City of St. John's and the Province of Newfoundland and Labrador both made proclamations regarding WBW.

The St. John's area was not the only part of the province to celebrate WBW with such enthusiasm. There were news articles in local papers in the Burin and Clarenville areas. At the Burin Public Health and the Harbour Grace breastfeeding clinics special parties were held for all breastfeeding mothers and their babies. A photo display of breastfed babies was prepared by public health nurses and displayed in the Burin Health Centre. Public health nurses in the Whitbourne area also had displays in physician offices and pharmacies. Public service announcements for WBW ran in several communities. The town council of Whitbourne proclaimed WBW with a ceremony and social event.

The Western region of the province also held various activities in recognition of WBW. There were breastfeeding displays by public health nurses in the Western Memorial Regional Hospital and the Sir Thomas Roddick Hospital. A welcome wagon baby shower included a display and discussion on breastfeeding. A regional nutritionist was interviewed by CBC radio. The Newfoundland Herald, a local TV news magazine which is distributed across the province, had an editorial and advertisement for WBW.

The enthusiasm and hard work of breastfeeding supporters across Newfoundland and Labrador have helped in generating significant awareness for breastfeeding both locally and nationally.

Birthing in the '90s submitted by Eleanor Nolan. From Health News published by the University of Toronto Faculty of Medicine.

During this century the decline in the maternal and perinatal mortality rates have been largely attributed to medical expertise. During this time there have been improvements in health and hygiene, and family size is smaller. There has also been the belief that hospital births improved newborn survival rates and medical techniques have been introduced. Many of these modern techniques can increase the chances of having a healthy baby, especially for high risk pregnancies. Examples of some of these techniques include the identifying and treating maternal hypertension, immunization against rubella, persuading women not to take drugs or drink alcohol while pregnant, detecting fetal anomalies which will require urgent treatment as soon as the baby is born, and advanced genetic screening. "However, many health professionals and the lay public now question today's medical intervention in childbirth and wonder about the extent to which certain techniques really improve birth outcomes. In fact, there's a growing trend against medical intervention for normal, low-risk births. Many obstetric practices of the past 20-30 years are being reassessed for their efficacy and cost to the healthcare system. For instance, routine electronic monitoring of the fetal heartbeat in labour is now under fire".

Pregnancy care is moving from 'intensive care' to 'lower-tech' care because of the pressure from family practitioners, midwives and women themselves. There is now emphasis on "caring" in pregnancy as nine months of critical development have been survived by the time that the baby is born. "Studies are suggesting that stress in pregnancy may be related to poor obstetric outcomes, and that women with fulfilling relationships are better adapted to parenthood". Pregnancy care starts before conception and includes screening and counselling regarding medical, life-style and nutritional practices. In pregnancy usual exercise activities can be continued although those involving violent exertion (e.g. downhill skiing), heavy lifting, underwater pressure (e.g. scuba diving), hot water (e.g. saunas), are not recommended. A well-balanced diet "is advised with an overall calorie intake of about 1800-2500 a day by mid-pregnancy - depending on a woman's size, weight and activity levels". Several medications are teratogenic, e.g. diuretics, tranquilizers, some laxatives, anticonvulsants, sleep-aids, some cold remedies. The woman should discuss essential prescription drugs with her doctor before she becomes pregnant.

More first-time mothers are now over 30 years of age. A study of 4,000 first-time pregnancies carried out by New York's Mount Sinai School of Medicine "found older mothers no likelier than younger first-time mothers to deliver prematurely or have stillbirths". The possible risks were linked to pre-existing medical disorders and "the higher risks of bearing congenitally defective babies".

Tests, such as ultrasound, can detect certain abnormalities, for example intrauterine growth retardation, neural tube defects, and may be able to detect a marker (a swelling behind the baby's

neck) for Down's syndrome. The results from an ultrasound examination can reassure parents and also enable them to view the baby as being real. The disadvantages of ultrasound tests are that they are expensive, not completely accurate, and their safety is not known. "In September 1992, the Canadian Task Force on the Periodic Health Examination . . . did <u>not</u> recommend regular, routine, serial ultrasound exams for all pregnant women". Amniocentesis can detect fetal abnormalities but carries a 1:200 risk of spontaneous abortion. Chorionic villus sampling carries a 1:100 risk of spontaneous abortion. Since July 1993 the safer triple screen blood test for alphafetoprotein, estriol and human chorionic gonadotropin has been offered to all pregnant women in Ontario.

What a pregnant woman needs is a really supportive caregiver for both pregnancy and birth. "Someone with whom she feels at ease, who encourages her and her partner to ask questions, with whom she feels able to discuss any worries. . . . Trusting relationships, informed decisions and good communication are the cornerstone of maternity care".

<u>A Nonpenetrating Fetal Scalp Electrode</u>. An article received from Ms. Nikodem (who was at the ICM Congress), a midwife at the University of Witwaterstrand, Johannesburg. (Reported by Hofmeyer et al. (1993), <u>British Journal of Obstetrics and Gynaecology</u>, <u>100</u>, 649-652).

To avoid penetrating the fetal skin, and the subsequent risk of infection, a nonpenetrating scalp electrode for intrapartum monitoring was designed and tested. This electrode can be placed on either the scalp, even when there is thick hair, or on the buttocks, and the position is maintained by means of suction.

Consents to participate in the study were obtained from 15 consecutive mothers. Two attempts were unsuccessful and the quality of FHR tracing in 12 of the remaining 13 was considered good. For 10 mothers the electrode remained in place until the baby was born. The babies were examined immediately after birth and then daily. Transient redness of the fetal scalp at the site of the electrode placement was noted in six babies and fine vesicles in two babies, which disappeared within two to three days. Less suction pressure eliminated the occurrence of these problems.

The electrode has been further revised and tested. Application for a provisional patent has been made. The article shows comparisons of FHR tracings using the conventional methods with the use of this nonpenetrating electrode.

<u>Providing Health Insurance to Low-Income Pregnant Women Increases their C-Section Rate</u>. From <u>Research Activities</u>, Agency for Health Care Policy and Research, U.S. Dept. of Health and Human Service, Public Health Service. (No. 168, September 1993, p. 1).
Health insurance was provided to low-income pregnant women but it was found that this did not necessarily improve their health but

did increase the likelihood that they would have a cesarean section. "This suggests that decisions to perform C-sections are affected by the insurance status of patients, independent of their clinical circumstance, says Jennifer S. Haas, M.D., M.S.P.H., of Harvard Medical School and Brigham and Women's Hospital". The researchers found that "in 1984 before the Healthy Start program began, uninsured women were less likely than insured women to have a C-section" but they had higher rates of pregnancy-induced hypertension, abruptio placenta and stayed in hospital longer than their babies. Between 1984 to 1987, uninsured women and those in the Healthy Start program showed no significant differences in adverse outcomes compared with insured women but there was an increase in the cesarean section rate (5% compared to 3% for insured women).

Nursing Regulation: Developing an International Network from the Executive Director's Message. (1993, October). Communique, 18(4), 5. (College of Nurses of Ontario).

"A unique event for nursing regulation preceded the International Council of Nurses Congress in June of this year when the First International Standing Conference on the Regulation of Nursing and Midwifery was held in Madrid, Spain. The conference was conceived and organized by the United Kingdom Central Council (UKCC) for Nursing, Midwifery, and Health Visiting. It had as its objectives:

1. to provide an opportunity for information to be exchanged on the regulation of nursing and midwifery;
2. to establish and develop a network for issues of common concern and interest relating to regulation to be explored;
3. to provide a focal point to assist colleagues to develop regulatory systems for the benefit of society and for the necessary development of the professions and their standards; and
4. to explore means of addressing international issues relevant to regulation and standards.

In 1983 the International Council of Nurses (ICN) undertook a comprehensive review of the field of nursing regulation. The worldwide scene was surveyed and the overall findings revealed: lack of clarity in regulatory mechanisms including the meaning of "nursing"; lack of co-ordination among agencies and levels of government and levels of nursing; legal scopes of practice defined too narrowly; standards of practice highly variable; and wide variation in the role of the profession in regulation. . . . By the 1990's the timing was ripe for exploration of an international network.

Twenty-nine countries were represented at the 1993 conference. Three keynote presentations provided a broad perspective to participants. . . . "Regulation: The International Midwifery Picture" (speaker: Jane Winship, Professional Officer, Midwifery, UKCC). . . . Participants possessed a range of experience and sophistication in nursing and midwifery regulation, and came from

countries with wide variations in the recognition and status of nurses and midwives, in social conditions, and in health care delivery systems. . . . There was extensive interest in the development of an ongoing network for the regulation of nursing and midwifery. . . . Broad consensus existed on the need to share information and experiences on regulatory activities, processes, and legislation. Issues such as scope of practice, standards for practice and education, registration . . . and professional conduct and discipline, were identified as highly relevant. A recurring theme was the question whether nursing and midwifery be regulated together or separately. The need for data relating to nursing and midwifery regulation, and a roster of experts in the various aspects of regulation, was perceived as important to providing an effective network. To move toward this goal, an interim conference will be held in 2 years in London, England, and a second standing conference in June, 1997, immediately preceding or following the ICN Congress in Vancouver, British Columbia. . . . We have much to learn from our international colleagues and much to offer as we work towards a global sharing". (Material published in the Communique may be reprinted without permission, if credit is given).

Association of Registered Nurses of Newfoundland (ARNN) Position Statement on Nurse-Midwifery passed by Council on October 3, 1993.

The ARNN supports the recognition of the nurse-midwife as a health care professional qualified to provide comprehensive family centred care during the period from preconception to post-partum.

Nurse-midwives are considered the experts in normal pregnancy, labour, delivery, and post-partum. The educational preparation of the nurse-midwife includes the successful completion of a nursing education program and a recognized midwifery program. The roles of the nurse-midwife include:

1. Giving the necessary supervision, care, support, advice, and management during pregnancy, labour, delivery, and post-partum to low risk women, their babies, and family members in collaboration with other members of the health care team.
2. Conducting normal deliveries on their own responsibility.
3. Providing highly skilled care to the high risk mother and her baby in collaboration with members of the health care team.
4. Recognizing abnormal conditions during the care of the mother and baby, referring to a physician for medical care, and providing care during an emergency in the absence of a physician.
5. Providing family centred counselling involving preconception care, prenatal and childbirth preparation, common gynaecological problems, family planning, and child care.
6. Providing health promotion programs related to preconception, pregnancy, labour, delivery, and post-partum care in hospital and community settings.

Currently nurse-midwives are accepted health care professionals in certain areas of our province. In the hospitals at

Goose Bay and St. Anthony, nurse-midwives manage all normal labours and conduct all normal deliveries.

The ARNN believes nurse-midwifery care should be accessible to consumers in all areas of the province. As the experts in normal pregnancy, labour, delivery, and post-partum care, nurse-midwives should practice on their own responsibility; that is, have authority over their scope of practice. The scope of practice for nurse-midwifery should include admission and discharge privileges, prescriptive authority, and ordering of appropriate diagnostic tests. Nurse-midwives are able to practice in a variety of settings, including for example, hospitals, independent practice, physician clinic's, and health units.

ARNN believes that nurse-midwifery is a viable, safe alternative to the current model of providing care to low risk women during their childbearing years. Nurse-midwives have the potential to make a significant contribution to health care in Newfoundland. ARNN supports the legalization of nurse-midwifery through amendments to the Registered Nurses Act Chapter R-9 R.S.N. (1990). ARNN believes that nurse-midwives should set the standards for midwifery education, licensure, and practice.

DEFINITIONS: Post-partum refers to the 6 to 8 week period following the delivery of a baby.

Normal pregnancy, labour, delivery and post-partum refers to the care of low risk mother and baby.

Canadian Confederation of Midwives Telephone Meeting. November 25, 1993, commenced at 2230 and adjourned at 0015 (Newfoundland time).

Items included:

Highlights from around the Country

Alison Rice, Midwives Association of B.C., reported that the Implementation Advisory Committee consists of midwives, registered nurses, physicians, consumers, and is working on the midwifery regulations. It will be 1½ years before the Midwives College is formed.

Maureen Morewood, contact person from NWT, reported that the Rankin Inlet community project had been delayed over the summer months because of building renovations and a new minister of health. The midwives are already working in the community and although the official opening has not occurred there have been four births (two were high risk but the mothers refused to leave the community). There are to be evaluations after one and two years.

Sandra Botting, Alberta Association of Midwives, reported that the Midwifery Advisory Committee meets regularly. They are working on the regulations, standards, guidelines for transfer and transport, principles of care, consent, choices, etc. They are looking at what Ontario has done. Aim to be finished by the end of the year. Linda Graham was hired 1½ years ago by the Minister of Health to look at midwifery models, and hiring practices. There is to be a midwifery conference in Calgary on October 21 and 22, 1994.

Eileen MacKenzie, Midwives Association of Saskatchewan. Friends of the Midwives have visited the Minister of Health who is considering cutting costs and wants to get midwifery moving in that province. The Government Advisory Committee consists of seven professionals and seven consumers.

Florence Klassen, Association of Manitoba Midwives. Dr. Manning was employed by the Government to advise on costs, not on midwifery, and his report was released to selected persons. The Birth Network consists of any consumer group who is interested in childbirth. They are to meet with the Minister of Health on December 7. This group did a press conference suggesting the Manning Report not be touched by the Government.

Darlene Birch, Traditional Midwives of Manitoba Collective, was absent.

Elana Johnson, Association of Ontario Midwives. They are one month away from Proclamation Day. Every area required by the regulations has been covered. The College of Midwives has sent applications for registration as these have to be ready before proclamation otherwise the midwives are practising illegally. Funding will begin in early 1994, and this will be by transfer of pay to the agency, not fee for service. The practices will have to work out how to pay each midwife. They have to have someone in a position to accept the money regardless of where the midwives are working. There is a salary scale starting at $55,000 and annual increments of $2,000 to $75,000. The College fees are $5,000 plus malpractice insurance. The midwife has to demonstrate that she has a certain number of mothers who she follows through. There have to be two midwives at each birth.

There were 63 midwives who successfully completed the Michener Institute preregistration course. There are some who have incompletes and have a limited time to get finished. On October 22nd there was a ceremony at the Michener Institute and the Minister of Health made a speech and presented the graduates of the program with a pin. The university courses commenced this Fall and there were 450 applicants for a total of 26 full time places at the three sites. Thirty-three accepted as a mixture of full and part time students. The faculty members are part-time as they spend half of their time in their own practice.

Francoise Frene, Alliance Quebecoise des Sage-Femmes Practiciennes and Christine Paradis, Association des Sage-Femmes du Quebec. On June 28th they received their papers indicating that they had met the midwifery requirements. Those who were unsuccessful in the examinations have been offered three blocks of study to provide the necessary information but it is difficult to obtain clinical experience as the university is not affiliated to any hospitals. These midwives are unable to leave the province because they have other commitments. A pilot project has commenced in Gatineaux, and others are getting ready to start.

Charlene Maclellan, Association of Nova Scotia Midwives. The government has changed and they have a new premier and a new minister of health. The members of the association have met with the policy and planning committee. Charlene and Louise were invited

to give a presentation at the Grace Maternity Hospital on delivering with an intact perineum. They were then invited to a New Brunswick hospital to repeat the presentation. Dr. Parish's project has received partial funding but has not moved forward from there.
Pearl Herbert, Newfoundland and Labrador Midwives Association. In September the ARNN called a meeting of six nurse-midwives to discuss midwifery concepts. The committee took the International Definition of a Midwife as a guideline and these statements (with nurse-midwife added) were presented to Council and accepted. Earlier this year the Provincial Government Department of Health formed an Interdisciplinary Advisory Committee which has distributed a Discussion Paper to all interested groups and persons. The answers to the questions raised are to be in by the beginning of next month, and the recommendations have to be given to the deputy minister of health by January 1994. The video about midwifery from the Michener Institute and Ontario Association of Midwives is very useful to show individuals and groups. The Association had a midwifery display at the Canadian Public Health Association's annual conference when it was held in St. John's in July. The School of Nursing at Memorial University of Newfoundland is considering the possibility of a Midwifery Degree; if a need can be shown to exist for such a program. Financial cutbacks mean that sufficient students are needed for all programs.
Fran Wertman, contact person PEI. There is no official statement on midwifery, and only a role for nurse midwives appears to be considered. The most recent CMA "Revisions to Non-Physician Obstetrical Care Policy" (May 1993) does not seem to confine midwifery to nursing. She does not know of any other midwives in PEI. (**Do you have the addresses for midwives in PEI e.g. Alison Squires**?)
No contact persons for the Yukon, or for New Brunswick.

Midwifery Belongs Outside of Nursing

On January 4, 1994, Karen Olsson was invited to be on a panel discussing "Midwifery Where Does It Belong" at the St. Clare's Mercy Hospital School of Nursing. The following is from her presentation.

Midwifery is a distinct profession in and of itself and deserves to stand on its own within the health care system; a separate identity from medicine and nursing. In the following I will present arguments that support midwifery being outside of nursing for the benefit of the discipline and practice of midwifery and for the benefit of the health consumer.

Before I launch into my arguments on why midwifery should be outside nursing let me assure you that I have nothing against nursing. I am a nurse, I even have a Masters in nursing, and I am also a midwife, a graduate of the MUN diploma programme of Outpost Nursing and Nurse-Midwifery. Although I believe that nursing is an asset to midwifery and I am glad I have taken both programmes, I do not believe that one has to be a nurse to be a midwife.

If it is going to maintain it's "uniqueness and separate nature" (MacMillan, 1992, 151), midwifery must maintain its

independence from nursing. The discipline of midwifery has a distinct philosophy in which pregnancy, labour, and delivery are seen as a normal process of life; "a manifestation of health" (Parliamentary Correspondent, 1992, 108). Therefore, a mother-to-be is treated as a healthy individual not as a patient; medical intervention is not introduced until a medical problem is identified. As a result midwifery practice as compared to obstetrical practice has a lower rate of use of medical intervention and a lower rate of maternal and infant mortality and morbidity.

Furthermore, in practice, midwives are distinct from obstetrical or maternity nurses. Midwives differ from all nurses in one major area and that is that a midwife is "directly responsible for management of labour and delivery and works in collaboration with obstetricians" (Kay Matthews, 1991) and other health care workers involved. This means that a midwife working with a mother in labour and during delivery does not take orders from a physician or obstetrician but rather calls them in for consultation when necessary. When I did two months clinical experience at the Simpsons Maternity Hospital in Edinburgh, Scotland I observed just how much respect was given to a midwife's decision. There a physician, obstetrician, paediatrician, or neonatologist would not enter the labour and delivery room until invited by the midwife. All normal low risk pregnancies were managed completely by the midwife and high risk pregnancies were managed by the midwife in consultation with the obstetrician. This presently applies to midwives working in St. Anthony and Goose Bay, the only places that midwives can legally practice in this province.

In addition, in practice, a midwife working in the community, a small hospital, or in private practice, also differs from a nurse or other health professional in that a midwife is able to provide continuity of care to a pregnant woman prenatally, through labour and delivery and into the postpartum period. A midwife or group of midwives is responsible for the complete care, referring only when necessary.

In a related and very important issue, the promotion of breastfeeding, midwives provide valuable information and support to mothers during infant feeding decision-making and once the infant is born.

Given the distinct philosophy of midwifery and the unique roles and status of a midwife, special education is required in order for a person to become qualified to practice. To qualify as a midwife one must do a three to four year direct entry programme or a 1 to three year programme post nursing. As a 1980 University of Washington study concluded "midwives can be trained to render a high standard of services without having first undergone basic nursing education" (Barrington, 1985, 161). However, few nursing education programmes are able to accommodate the extensive and intensive education and practice required for a good foundation in midwifery. In my two year nursing diploma programme I "saw" four deliveries. In a recent proposed nursing curriculum the word maternity or obstetric was not to be found.

Midwifery placed under nursing will be at risk to lose control over the education, licensure or discipline of midwives. Midwifery will be at risk to becoming medicalized. For example, if midwifery were put under nursing as a specialty of nursing, the necessary transfer of medical functions or the delegation of medical acts would be under jeopardy to be recalled should the ARNN or NMA deem them unnecessary. Midwifery would no longer be permitted or at the least, midwives would have their practice greatly restricted. Midwives working in a hospital would be the most vulnerable. They would be the first to find that they would no longer be able to practice as midwives, they would end up working as obstetrical nurses. Or on the other hand, from the example in Quebec, midwives would be forced into providing care beyond their scope of practice. Under the Quebec Bill 4 (1990), Bill on the Practice of Midwives in the Pilot Projects, nurse-midwives were vulnerable to being called on to do relief work for obstetricians or anaesthetists. Job security is in jeopardy in either case.

In the UK we find midwifery in a crisis. As Pearl Herbert reported in the ALLIANCE Newsletter of January 1992:

> Midwives once had a separate register from nursing and a central midwives board. Now there is only one register kept by the United Kingdom Central Council. Although midwifery matters are supposed to be decided by midwives this does not always happen. Midwifery practice, disciplinary action, and education all fall jeopardy to outside controls including nursing and medicine. (pp. 3-4)

For the health consumer midwifery must remain autonomous. In these changing times, the restriction of midwifery to nursing would be an archaic step indeed. It would isolate Newfoundland from other provinces in Canada and indeed the rest of the world. Direct entry midwifery schools have been or are being set up in British Columbia, Alberta, Ontario, Quebec and the UK. In Europe a direct entry midwifery programme is common. Certainly for the present hard economic times one could argue that it would be impractical to hire direct entry midwives for small communities in Newfoundland. What would they do if the maternity ward was quiet? However, we need to be flexible and ready for the future. For example: should midwifery be legalized in Newfoundland and Labrador, and should there be a shortage of available-to-practice nurse-midwives, then direct entry midwives from Quebec, Ontario, Alberta, British Columbia, UK, Europe, would not be able to practice here. Or, how would one include traditional birth attendants or culturally oriented birth attendants who are being trained in some parts of Canada? We need to keep all doors open. The agency hiring midwives will decide what qualifications are needed -- ie the practicality of a direct entry midwife. In Newfoundland direct entry midwives would be well qualified to work in large urban based hospitals or set up private practice. If we restrict midwifery to nurse-midwives now, we will not have the option down the road to accept direct entry midwives.

Further by restricting midwifery to nursing one is reducing the choices of birth attendants available for the health consumer.

In Nova Scotia a consumer group of 200 to 300 people are demanding a direct entry midwifery programme be set up (ALLIANCE Newsletter, June 1993, 2). As health professionals we need to meet the needs of the people. By restricting midwifery to nursing we also put mothers and babes at risk. For example, in California lay midwives were outlawed, yet hundreds of women still seek their services because of their belief that nurse-midwifery/obstetrics has over medicalized pregnancy, labour and delivery (Barrington, 1985, 127). Because lay midwifery is illegal in California, a lay midwife has no back up when needed and no permission to make medical referrals. In the UK a study showed that choice of birth attendant and place of delivery were high consumer demands. Women need to have an alternative to medical care. They have the right to choose their birth attendant. If midwifery is placed under nursing, only nurse-midwives will be allowed to practice and the risk is high that pregnancy, labour and delivery will become medicalized. Hence, women in Newfoundland and Labrador will be reduced to the present situation of limited choice of birth attendant and no choice of place of delivery.

Midwives must have control over the education of midwives, midwives must have control over the licensure of midwives, and midwives must have control over the disciplining of midwives. Otherwise the autonomy of midwifery is threatened and thus the uniqueness of midwifery will be lost. A health care system without the independent profession of midwifery is not complete and health consumer's choice is limited.

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Other News

Our recession is not as bad as that being experienced by others.

In Nigeria and Cameroon government workers, including nurses and midwives, have not been paid for many months.
In Saudi Arabia nurses have not been paid since before November (as reported in the January 5th issue of the Nursing Times).

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Respect nature's way

THAT there should have been two quite different reports between Christmas and the New Year about artificially engineered births is evidence of the speed with which advances in genetic technology are occurring. First there was the 59-year-old British mother who gave birth to twins on Christmas Day, after being impregnated with embryos in a Rome clinic. Now comes news of a plan by doctors in a Cambridge clinic to implant a white woman's eggs into a black woman married to a man of mixed race. This follows hard on the heels of a similar operation in Italy performed on a black woman who chose to be implanted with a white woman's eggs on the grounds that her child would have a better future if it was white.

Our instinctive response is to be repelled by such tampering with nature. But it is not a simple matter. Where advances in medical science can be shown to be in the interests of the patient, it is usually wrong for others to interfere, except in circumstances where the cost to the public far outweighs any benefit. There will be those who argue that the woman about to be treated in Cambridge has every right to choose the colour of her child, just as they argue that it is nobody else's business if a woman 20, or even 30, years older than the natural childbearing age chooses to have a test-tube baby. What they overlook is that no woman has the automatic *right* to bear a child; it is the child who has the right to a suitable upbringing. A child comes as a gift of nature: parental love can be so uncomplicated precisely because it is not directed at a consumer item. Children who are made to order for parents of an exceptional age or a different colour may well not look kindly on them as they grow older.

There is a further objection to be made. The potential for genetic engineering is almost limitless, and all industrial nations are going to have to think hard, every step of the way, about where to draw the line. This goes against the grain of Western society nowadays, where technological advances are not thought of in terms of their moral ramifications but simply as to whether they work well; and where anything medically possible is quickly taken to be the right of all who can afford it. Not only patients but many doctors think like this. The danger is that, by accepting each incremental advance in genetic engineering, we end up accepting medical interference on a huge scale with births, whether of animals or of human beings.

There may still be time to check this process. Thought should be given to setting up an international non-governmental body with the task of devising rules which delimit genetic interference with human procreation. These rules can then be given statutory force by appropriate national organisations — such as, in Britain for example, the Human Fertilisation and Embryology Authority. There are times when our instincts should be relied upon; when moral considerations have to come into play. This is one of them.

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Victorian views on childbearing

SIR — The twin feats of the Italian fertility professor, Severino Antinori, and "the woman of 59" (report Dec. 27) suggest that our 19th-century judiciary was more "with it" than we nowadays assume. It was, at any rate, more far-sighted than certain legislators in the 1960s.

In the 1888 case *re Dawson*, Mr Justice Chitty — applying what is known in legal parlance as the rule against perpetuities, which prevents trusts from tying up property indefinitely — insisted that a woman aged 60 was to be regarded as still capable of bearing children. Subsequent judges upheld this position whenever the issue resurfaced, and in the 1949 case of *re Gaite* the judicial reasoning solemnly proceeded on the basis that a girl aged less than five could give birth.

To most people, including legal academics, these ideas were "almost unbelievable nonsense". In their eyes the fanciful judicial world seemed to be populated by "fertile octogenarians and precocious toddlers".

Parliament finally decided that if the dotty judges were not going to do so, it would take it upon itself to restore sanity. Section 2 of the 1964 Perpetuities and Accumulations Act decreed that there be a presumption that no woman under the age of 12 or over the age of 55 is capable of childbirth.

There have been numerous mothers under the age of 12 since then, and now we have one well over the 55 limit. Is it not time for the draftsmen to redraw the parameters (as they have over the the age limits for murder convictions)?

Alternatively, given the hurried march of science, they could save further alterations by abolishing the age limits altogether.

PHILIP EADE
London, W12

Ontario delivers after hard push for midwifery

Province officially recognizes practice today, allowing government-paid midwives to attend births in hospitals, homes

BY ROD MICKLEBURGH
Health Policy Reporter

TORONTO — Canada has lost its long-standing status as the only industrialized Western country without officially sanctioned midwives.

Regulations governing the practice of midwifery in Ontario came into effect today, ending decades of struggle for recognition of the service in the face of fierce opposition from the medical profession.

Other provinces, particularly British Columbia and Alberta, are also moving to recognize midwifery.

"Will it make a difference? Absolutely," said Kathi Duncan, treasurer of the Association of Ontario Midwives and a practicing midwife for the past four years.

"It's exciting. We will finally be recognized as health-care givers and be able to work at a much more intimate level with other health-care providers."

As a recognized profession under the new Regulated Health Professions Act, publicly funded, licenced midwives will be available for both home and hospital births.

"Before, we weren't allowed to 'catch' a baby when it was born in a hospital. It had to be done by the doctor, because we couldn't practice as a professional in the hospital," Ms. Duncan said.

"This gives us the opportunity to provide care to women wherever they give birth. I'm really looking forward to my first 'catch' in a hospital."

'I'm really looking forward to my first "catch" in a hospital.'— Kathi Duncan, midwife

Initially, nearly 60 midwives will be available for duty in Ontario, all graduates of a special one-year program at the Michener Institute for Applied Health Sciences in Toronto.

They will be paid a base salary by the government of about $55,000 a year, which can go higher or lower depending on experience and number of clients.

Most registered midwives will not be permitted to take on more than 80 clients a year or fewer than 20.

Ms. Duncan said a midwife with many years experience and a maximum of 80 clients would earn an annual salary of about $75,000.

"We'll certainly be making more money this way," she said. "Before, we charged clients a fee, but that was a sliding scale based on their ability to pay.

"And we had to be on call for six months at a time, 24 hours a day, seven days a week. Then you'd collapse for a month.

"When you think that sometimes you'd be at a birth for 40 hours, the hourly rate wasn't very much. For the most part, a full-time midwife has been earning around $20,000 a year."

However, some doctors are a little taken aback by the midwives' salary range, arguing that doctors are paid considerably less under the Ontario Health Insurance Plan for deliveries.

In a recent letter to a medical publication, Sudbury doctor John Hollingsworth said an obstetrician may receive as little as $350 for full care of a mother and her child from the time of the first prenatal visit to six weeks after delivery.

"This fee includes the delivery and is dwarfed by the sliding scale of midwives' fees," Dr. Hollingsworth said.

The latest fee schedule pays doctors $244.70 for a normal, vaginal delivery, with a 50-per-cent bonus if the birth takes place between midnight and 6 a.m. Routine prenatal visits pay $18.70, while an initial general assessment of a pregnant patient pays $48.20.

Midwives counter that they spend far more "education time" with their clients than doctors do, and remain with the mother throughout the delivery, rather than being present only at the last moment, as many obstetricians are.

Some studies have shown little benefit in outcome from increased education and social support from professionals during pregnancy. But 80 per cent of women surveyed in a 1990 British study said they appreciated being able to talk about their problems with midwives, who made a minimum of three home visits and were readily available through pagers and by telephone.

Ms. Duncan said she believes that by recognizing and paying midwives, the Ontario government will save money, particularly in hospital costs.

Home births will probably increase, she said, and clients who choose a hospital birth could often opt for early discharge. "We can have them going home six to 12 hours after their baby is born."

'We'll certainly be making more money this way.'

Ms. Duncan added that past studies have shown lower rates of cesarean sections, episiotomies and epidurals for midwife-assisted births.

Others complain that too few midwives have been licenced in the province, eliminating many who used to practice.

For years, midwifery has existed in a kind of legal limbo in Ontario. It was not officially sanctioned or regulated, but no action was taken against those who practiced.

Now, only those registered with the new College of Midwives of Ontario may legally practice, freezing out those who were not accepted for the program at the Michener Institute.

In Eastern Ontario, critics have complained that only one full-timed and two part-time midwives are available now, compared with the 14 who previously worked in the area.

All future Ontario midwives will be graduates of newly established midwifery courses at three Ontario universities - Ryerson in Toronto, McMaster in Hamilton, and Laurentian in Sudbury.

Ms. Duncan gave credit to the province's NDP government for moving so quickly to implement the midwifery program, which had been promised for years.

"This has never been done in Canada before. What's happened has been really great," she said. "It's been done so quickly and with such integrity, all in the interest of maintaining quality of care."

The College of Midwives has drawn up guidelines, in co-operation with hospitals and doctors, governing when births should be handed over to physicians.

CALL FOR ABSTRACTS
for the
NATIONAL MIDWIFERY CONFERENCE

May 6, 1994
in St. John's, NF

"MIDWIVES TODAY"

<u>Abstracts</u> - 500 words for paper presentations and 250 words for poster/film presentations. (Include list of any AV equipment needed)

Abstracts to: Pearl Herbert, School of Nursing, Memorial University of Newfoundland, St.John's, NF A1B 3V6
No later than March 1, 1994.
[May 7, 1994, will be the Annual General Meeting of the Canadian Confederation of Midwives]

THE ALLIANCE OF NURSE-MIDWIVES, MATERNITY AND NEONATAL NURSES OF NEWFOUNDLAND AND LABRADOR

APPLICATION FOR MEMBERSHIP
1994

Name: _____

(Print) (Surname) (First Name)

Nursing Qualifications: _____

Full Address: _____

_____

Postal code: _____

Telephone No. _____ Fax No. _____

Work Address: _____

_____

Nursing area where working: _____

Retired: _____ Student: _____

Unemployed: _____

I wish to be a member of the Alliance and I enclose a cheque for

$_____. (Cheques made payable to the Alliance)

Membership for midwives is $20.00 (as this includes the Canadian Confederation of Midwives membership fee of $5.00 a midwife which the Alliance has to pay).
Membership for those who are not midwives is $15.00.

Signed: _____ Date: _____

Return to: Clare Bessell, (The Alliance Treasurer),
37 Smith Avenue, St. John's, Newfoundland A1C 5E8