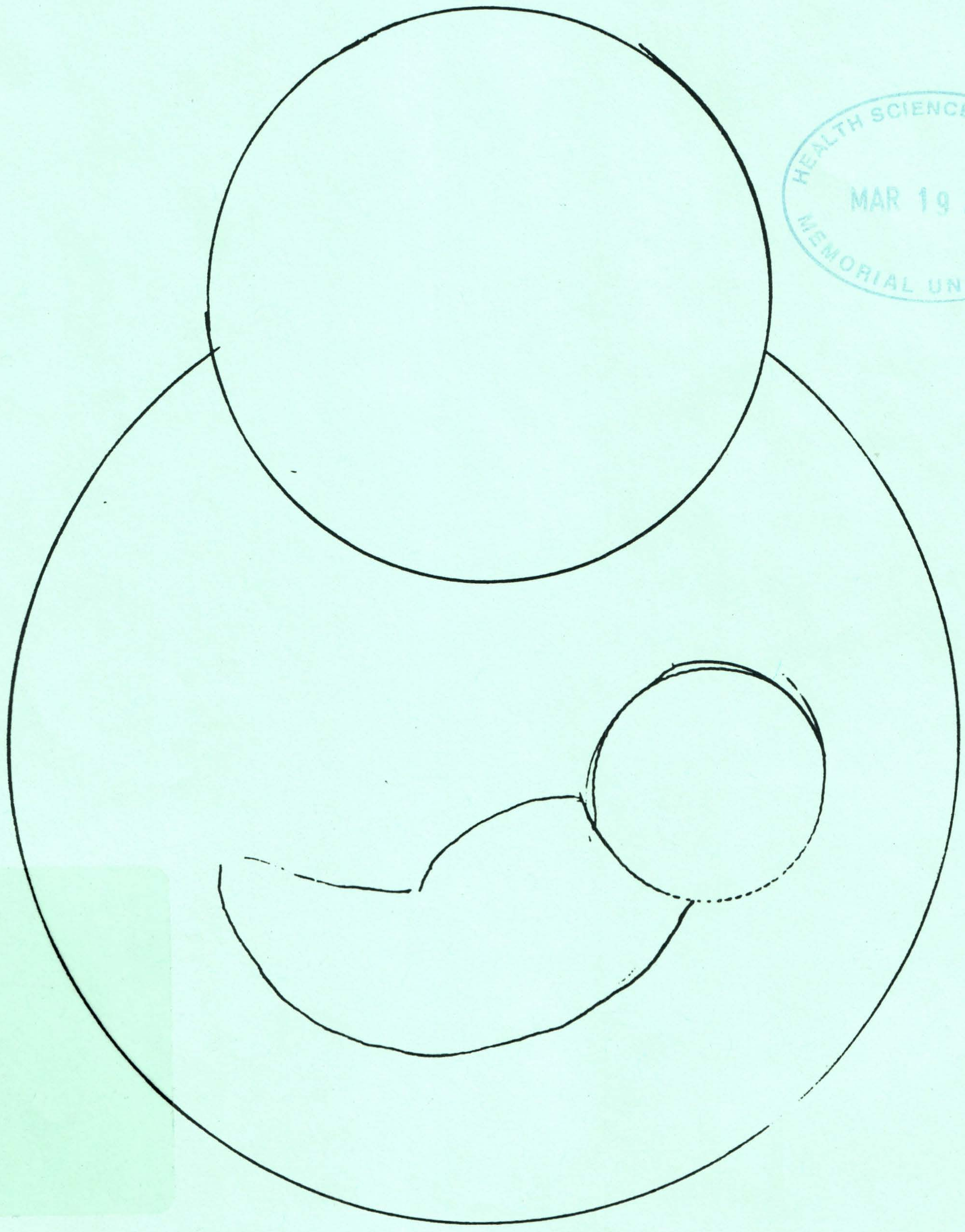
THE ALLIANCE OF MIDWIVES, MATERNITY AND NEONATAL NURSES OF NEWFOUNDLAND AND LABRADOR



Newsletter No. 16, June 1995

The Alliance of Midwives, Maternity and Neonatal Nurses of Newfoundland and Labrador

(A Special Interest Group of the ARNN)

Newsletter No. 16 (new issue) - June 1995

1995 - International Year of Tolerance

Your editor has been 'a-roaming' during the last few weeks. She has been attending meetings and conferences which keeps one in touch with what is happening in the rest of Canada and provides much information on which to report. This Newsletter contains some of this information: the Expert Working Group on Breastfeeding meeting (April 27-28); the National Perinatal Surveillance System (NPSS) Steering Committee meeting (May 2-3), at both she represents midwives. The annual meeting of the Canadian Confederation of Midwives/ Confederation Canadienne des Sage-Femmes (CCM/CCSF) (May 27) in Winnipeg coincided with the "Birth and Beyond" conference where Suzanne Arms (author of Immaculate Deception) was the main speaker. Arrival in Winnipeg was in time to attend the Manitoba Association of Registered Nurses (MARN) lunch and Awards of Excellence in Professional Nursing (May 26). Kristine Robinson, a midwife who nurses at St. Boniface Hospital, received the award for clinical practice. The Outstanding Achievement Award (not routinely given) was to Kathleen Mary (Jo) Lutley. Jo is a midwife who originates from England. She came to Canada in the 1950s to work in Labrador with the Grenfell Mission. In the 1960s she moved to work with Medical Services (Health and Welfare Canada) in the NWT and then transferred to northern Manitoba. She is now retired in name but according to the recommendation not in practice. Also met Karen Macloskie and her family (three children) who some may remember from when she took the midwifery course in 1984/85. Then to Corner Brook for the ARNN annual meeting (June 4-6) where another midwife, Ann McElligott (Hopedale), received the award for excellence in nursing practice. Kay Matthews was elected as 2nd Vice-President. Next to Charlottetown, PEI, to attend and present, at the Canadian Public Health Association annual meeting (June 18-21). At this meeting the Nova Scotia resolution to adopt the Position Paper on Midwifery was Carried. Lastly, returned to Ottawa to attend the Indicator sub-committee of the NPSS Steering Committee (June 23-24). Now in St. John's to get the Newsletter written and mailed. Thank you to those who contributed articles for this issue of the Newsletter.

The Editor was unable to attend the last Alliance meeting but was able to attend the farewell lunch for Cathy Wyse, when the Alliance gave her a locally made brooch. It exactly matched the outfit which she was wearing! Thank you Cathy for being President. **Any volunteers/nominations for the next Alliance President?**

If people do not receive this Newsletter it may because they have not paid their 1995 membership fee. The form is at the back.

Pearl Herbert, Editor, c/o School of Nursing,
Memorial University of Newfoundland, St. John's, NF, A1B 3V6

Alliance Meeting, Thursday, July 6 - CANCELLED
Too many people on vacation

Executive Members

A/President: Kay Matthews Secretary: Roma Quinton
Treasurer: Clare Bessell Publicity: Janet Murphy-Goodridge
Librarian: Bernardine Moyles Newsletter: Pearl Herbert

Summary of Meetings

An **Alliance** meeting held on May 11, 1995, at Kay Matthews house was chaired by Cathy Wyse. Nine persons were present and there were four apologies. Several members had replied and commented on the draft of the Constitution and By-Laws. Inconsistency in wording and typing errors are to be corrected and Janet Murphy-Goodridge will get these documents reviewed legally.

Following the survey of members regarding forming two separate associations it was decided to continue with the present structure and function of the Alliance.

Clare Bessell gave a financial report.

A letter had been received from Colleen Kelly regarding the report in the last Newsletter that "ARNN did not give the Alliance adequate time to respond" to the episiotomy question. After much discussion it was decided that Cathy Wyse would write to Colleen Kelly with a clarification of the statement.

The Alliance presently provides funds when needed for a midwife representative to attend the CCM/CCSF annual meeting. [An important event enabling midwives of this province to be represented nationally]. Money was not needed in 1993 and 1995 as funding was obtained from other sources, and in 1994 the annual meeting was in St. John's. Concern was expressed about the Alliance being able to fund travel to two conferences a year. A sub-committee was formed of Janet Murphy-Goodridge and Clare Bessell to review the available conferences; advise how to apply for funding; inform who will qualify for funding; and accept the submissions from the individuals. The sub-committee will bring the decision to the Alliance members at the next scheduled meeting.

As Cathy Wyse was moving to northern BC Kay Matthews agreed to be President until the September meeting when an election for President will take place. (Kay is out of the country for June and July). We thank Cathy for being President and wish her well in her new location. June Cousens resigned from being secretary and Roma Quinton (childbirth educator at the SAGGH) agreed to take this position. Clare Bessell (treasurer) and Janet Murphy-Goodridge (publicity) agreed to continue in their positions.

The Alliance was asked by ARNN to examine the possibility of the administration of intracervical prepidil gel becoming a nursing function. Clare Bessell has contacted the Provincial Perinatal Programs across the country and is reviewing the literature on the subject. The Alliance will respond to the ARNN after Clare has gathered all of the information.

A discussion took place on having a Fall conference. Suggestions are requested for the July meeting.

The **Midwives Association** has been meeting with the **Friends of Midwifery** to plan meetings with health care providers to lobby for

midwifery. Planning meetings were held on April 22nd, May 10th, and June 14th. Future meetings will be planned and to know the time and place of these contact either Pearl Herbert (737-6755) or Janet Hiemstra (579-4453).

Lobbying costs money for travelling to appointments and the Midwives Association has no funds independent from the Alliance. (The small profit from the Midwives Today conference was placed with the Alliance). This is a matter which will have to be considered in the near-future.

Soon Karene Tweedie will be leaving the province. Karene has been the secretary for the Midwives Association for a number of years. We will need a new secretary so volunteers are requested to contact Pearl as soon as possible.

<u>Letter from S.E. Nigeria - Kay Matthews (Safe Motherhood Project)</u>
June 12, 1995

I have been very busy since my arrival as I had to have a major report to Dr. Walley by last Thursday. We are extending the Traditional Birth Attendant (TBA) program to another local government area and the partograph project to two more health centres. Unfortunately, there have been nurses' strikes (the government hospitals and health centres close down when this happens and even critical emergencies are turned away) which has affected our outcome statistics. We know women have died because they could not afford to go to the private clinics for treatment. However, they were not on strike last week and there were three maternal deaths. It is unreal. Yesterday, on our way back from the community we heard the Labour Ward midwife calling the doctor on call to tell him they had a woman just admitted critically ill with a ruptured uterus.

Out in the community, Margaret Akpaidum et al. took me to a TBA's house where I was introduced to a 15 year old primigravida of undetermined gestation, very small stature, very anaemic and destitute. Her story is that she was a housemaid in Lagos and became pregnant. The master of the house was furious and sent her home to her parents, who sent her to her old grandfather, who is almost destitute himself. The TBA has taken her in and is feeding her. This is an example of the liaison between the TBAs and the team to identify high risk pregnancies. We took her to book at the local health centre where they will monitor the pregnancy and give her vitamins and iron. Next week they will take her to Anua to the high risk clinic to see Dr. Ann Ward. She will deliver at St. Luke's unless there is a strike. If there is a strike she will be one of those left to the best efforts of the TBA. It cost 30 Naira to book at the health centre and 100 Naira to book at the hospital, 130 Naira total. I paid it and, lest you think I am uncommonly generous, that is about $1.60. Still, it was more than she had. That is what we are up against. I should tell you the nurses are on strike because they have not been paid any salary for five months!

Midwifery in Canada - May 1995

British Columbia

On March 16, 1995, the Minister of Health announced the establishment of the College of Midwives of British Columbia and the appointment of a nine person Board. The Board has three public members, one of whom has been a leader with the Midwifery Task Force, the rest are all midwives active in practice; one is an aboriginal midwife. The Midwifery Regulations have been passed by the Cabinet of the B.C. government and officially designate midwifery as a health profession under the Health Professions Act - the Act that covers all health professionals which have not previously been regulated or have not had their own regulatory act. The title "midwife" is reserved for those registered with the College of Midwives. There is provision for traditional aboriginal midwives to be registered with the College of Midwives. The Board will set the standards of midwifery practice, educational and licensure requirements. The Minister of Health announced that he expected that there would be midwives practising in B.C. by the Fall of 1996.

The B.C. government is planning on establishing some birth centres and these are expected to be ready to coincide with the midwives being registered to practice. There will also be a government funded Home Birth Demonstration Project. Initially midwives will only be allowed to do home births within this project. The project is not to address safety of home births, but how best to organize home birth services.

Alberta

An announcement was made on May 24, 1995, that the registration process is now in place. It is anticipated that the first Midwives will be licensed in Alberta by the end of this year. The portfolio requirements have been outlined and the multi-faceted assessment is currently being constructed. The process is very time consuming and the sub-committee of the Midwifery Regulatory Advisory Committee (MRAC) charged with the development of the process has been meeting weekly. Midwives who wish to apply to be licensed in Alberta should contact the MRAC now. (Laurie McCreary-Burke, Research Officer, Professions & Occupations Division of Alberta Labour, 5th Floor, 10011-109 Street, Edmonton, Alberta T5J 3S8 (Telephone: 403-427-2655)).

Saskatchewan

The Midwifery Advisory Committee to the Minister of Health has commenced meetings and is currently conducting a needs assessment to see if there is a need for midwifery in the province, and if a need is found how would midwifery be implemented. There are more midwife-assisted births in the cities than in the rural areas, as the cities are where most midwives are located. Some community and political groups have passed a resolution to support the legalization of midwifery. The Regional General Hospital staff in conjunction with the Regina Community Clinic are proposing a

hospital midwifery pilot project.

Manitoba

In May, 1994, the Minister of Health announced that in Manitoba midwifery would become an independent, self-regulating profession. In November, 1994, members of the Midwifery Implementation Council (MIC) were appointed and Dr. Carol Scurfield is the chairperson. Within the next few months, midwives who currently hold certificates from other jurisdictions will be invited to update their credentials in preparation for active practice. A call will be made for sites where this upgrading can occur. A collaborative education program is being discussed with other western provinces. Several midwives from the Association of Manitoba Midwives are currently working in midwifery projects at Winnipeg's two tertiary care centres (St. Boniface Hospital and the Health Sciences Centre).

Ontario

Autonomous midwifery was implemented as from January 1, 1994. Midwives have to be licensed to practice. Since implementation there have been many requests for a midwife-attended birth, so much so, that the midwives can not meet the demand. For example, last year in London that midwife was unable to meet the request of over 200 women. The midwives are paid a salary; the scale starts at $55,000.00 (similar to the top salary of a registered nurse) and increases by annual increments. The midwife is expected to provide continuity of care to a certain number of mothers, but she can work part-time and receive a proportionate salary. There is a male licensed midwife. For the birth of a baby all the midwives have to have another midwife, or designated attendant present. The education programs at the three universities, commenced in 1993, are progressing well.

Quebec

In 1994 a group of midwives took the second integration and updating midwifery programme at the University of Quebec in Trois-Rivieres. This was the last series of examinations to be able to qualify to practise in the Bill 4 pilot-projects. Women who were midwives in another country have had language problems with the examinations. Others who did not pass the examinations are attending mothers at home. As there is no College of Midwives, and legislation is not implemented outside of the pilot-projects, the title "Midwife" is not protected.

The eight pilot-projects (one of which is at the Povugnituk Hospital) are in place. In March, 1995, the Outaouais Birth Centre in Gatineau celebrated its first birthday with a party attended by the 81 families who had given birth during the year.

The transfer of mothers to hospitals was slowed by lack of medical collaboration. But the Minister of Health intervened to ensure that there was no discrimination for mothers transferred by midwives. The requisitions from midwives for laboratory work and

ultrasound examinations were not being accepted and so the mothers had to travel many miles, sometimes to Ontario, which added to the "cost of midwifery". The Quebec government was having to pay Ontario for health care services. The Minister of Health intervened so that midwives can now request these services. Some of the centres, such as Cote des Neiges are receiving cooperation from the physicians.

The Minister of Health has expressed his intention of seeing the projects through until 1998. After then it is not known what will happen. Midwifery education needs to be planned. (The pilot-project method would appear to be more expensive than just legislating midwifery as there will be duplication of processes).

Northwest Territories

Reorganization has been completed and the Department of Health and Social Services has been amalgamated. The Birthing Project at Rankin Inlet continues to progress well. At the end of April there had been 29 births. The Central Arctic, still in Kitikmeot, is preparing a proposal for Regional Midwifery Services as an expansion of their current Maternal and Child Program. They hope to commence by September 1995, or January 1996 at the latest.

Two lay midwives are practising in the southern NWT and have made request to two hospitals to practice to gain more deliveries in order to prepare themselves to be eligible to apply for registration in Alberta. This is a concern to the Nursing and Medical Associations and a committee has been formed to discuss "Midwifery Issues".

Yukon

There is no legislation in place but midwifery is becoming an issue for discussion as two Ontario Midwives are setting up practice in Whitehorse.

Nova Scotia

The midwives keep busy with home births. The midwives attend mothers in both Nova Scotia and New Brunswick, and occasionally go to PEI. They are also asked for input by various committees, including hospital committees. The Isaac Walton Killam Hospital and the Grace Maternity Hospital are in the process of amalgamating.

New Brunswick

A consumer group has been formed to lobby for midwives.

Newfoundland

Requests continue to be received from parents for midwives to provide care and/or be labour support persons. Women often find it difficult to understand why midwives cannot practice here as they do in other provinces. The mothers who do have a midwife appreciate the support, not only during labour, but during pregnancy and the postpartum period. At present without legalized midwifery there is no choice for mothers during childbearing and there is little continuity of care.

Expert Working Group on Breastfeeding meeting, April 27 and 28
(from Pearl Herbert's notes)
The Canadian Hospital Association (Michelle Abigali) members approved a policy statement on breastfeeding in March 1994. The Ontario Hospital Association has established a policy statement and is promoting breastfeeding through educational resources.
The Canadian Institute of Child Health (Denise Avard) is revising the "Breastfeeding Guidelines for Professionals". Since June 1994 CICH has sold 480 copies of these guidelines. Now revision is needed for allergies, AIDS, vitamin D supplements, drugs, smoking, and the Postpartum Parent Support Programme. They are asking for people with suggestions to contact them as soon as possible.
The Canadian Lactation Consultant Association (Maureen Fjeld) has established three project teams to address objectives for the next few years - An Education Project Team; The WHO Code Project Team; and a Third Party Insurance Project Team. Membership in the CLCA is not restricted to certified consultants but for $25 interested persons can join and receive four annual newsletters. (Cheques payable to CLCA/ACCL, to Karen Grue, 852 Knottwood Road S., Edmonton, Alberta T6K 3C3).
Canadian Nurses Association (Roberta Hewat) reports that nurses in Newfoundland and NWT have been involved in research projects. New Brunswick will present an updated Position Statement on Breast feeding and Breastmilk Substitutes to the NANB Board, and in Ontario the RNAO accepted a statement on breastfeeding. The Alberta Association of Registered Nurses endorsed in principle the WHO/ UNICEF statement "Protecting, Promoting and Supporting Breast feeding: The Special Role of Maternity Services" (1989) and the WHO Code for the Marketing of Breastmilk Substitutes (1982). The Registered Nurses Association of BC continues to act as the secretariat to the BC Baby Friendly Network. The International Council of Nurses has provided the CNA with a draft agenda identifying resolutions which could be discussed at their 1995 conference.
Canadian Paediatric Society (Reg Sauve) nutrition committee has discussed the need for a Baby Friendly Hospitals document in hospitals which do not have a maternity unit. The Human Milk Banking Statement is under preparation. The Infant Feeding statement is being revised and updated. The Canadian Medical Association Journal has accepted the Preterm Infant Feeding Statement for publication.
Canadian Pharmaceutical Association (Jennifer Peddlesden). A policy statement on breastfeeding is being presented to the Board. She is trying to obtain information regarding breastfeeding content in the curriculum of Canadian Schools of Pharmacy. **Would like the names of any pharmacists who are interested/supportive of breast feeding.**
Canadian Public Health Association (Robin Moore-Orr). A motion in support of breastfeeding was passed at the 1994 annual CPHA meeting and letters in support of the resolution were sent to the Federal and provincial/territorial ministers of health. A draft report from the Postpartum Parent Support Programme is currently being reviewed. They are working on the development of a National Child

Health Record which will include information on infant feeding.
Infant Feeding Action Coalition (Elizabeth Sterken) produced the World Breastfeeding Week kit. A small survey was conducted and people were in favour of retaining August as a launch for a national breastfeeding week in the Fall. INFACT Canada Newsletters are produced quarterly (which are received by your editor). A hospital discharge kit is being produced. The Norwegian video "Breast is Best" is very well received.
La Ligue Leche (Pierrett Tremblay) are translating the ILLL "Breast feeding Answer Book" and the "Womanly Art of Breastfeeding".
Lethbridge Regional Hospital Breastfeeding Support Service (Jackie Glover). Medicine Hat Community College is planning to offer two credit courses on breastfeeding.
Newfoundland and Labrador Provincial Breastfeeding Promotion Coalition (Cathie Royle). A questionnaire was sent to all hospitals providing obstetrical care regarding the 10 steps. Several hospitals responded and overall indicated that they either did or were in the process of adhering to many of the steps. However, the majority of those who responded did indicate that contracts were held with formula companies. Supported the Newfoundland Pharmaceutical Association in its passing a resolution in support of breastfeeding. Breastfeeding initiation rate continues to rise to 45% in 1994, and in 1995 over 50% in some areas.
Perinatal Education Program of Eastern Ontario (Patricia Niday). Breastfeeding week will be September 16 to 23, 1995. Breastfeeding Facilitator Program for Staff Nurses was completed in four study sites. Outcomes include staff knowledge, role performance in influencing the climate for breastfeeding through staff development, peer consultation, and revision of unit policies and practices, maternal perception of breastfeeding support in-hospital and breastfeeding duration at 6 weeks. Results presented at the 1994 National Breastfeeding Symposium in Vancouver, and the May COGNN National Conference in Montreal. The University of Ottawa elective Breastfeeding Course has been offered twice and will be evaluated.
Provincial Governments (Elizabeth Shears). Nova Scotia is developing a "Breastfeeding Standard for Nova Scotia".
United Nations Children's Fund (Marilyn Sanders) has been providing information on the Baby-Friendly Hospital Initiative (BFHI). Last November a BFHI/breastfeeding proposal was put together to be included in a larger "Network of Centres of Excellence" proposal submitted to federal funding bodies by a group led by Dr. Michael Kramer of Montreal. Three proposals were submitted by different groups and only one will be selected for funding; the final decision will be reached in July.

It was also noted that Mead Johnson are carrying out direct marketing of their formula and breastfeeding by using nutritionists who are unaware of the WHO Code. Canada has not legalised the Code. The Ontario College of Nurses has a statement on marketing as does also the RNABC (and several other RNAs). In BC there is a case before the Human Rights Board where a woman was told that she could not attend a meeting because she would need to breastfeed her baby.

Canada's National Plan of Action for Nutrition/Status Report (Mary Bush, Nutrition Programs, Health Canada). The National Plan of Action is designed to ensure integration of nutrition consideration in policy and programs in health, social and economic development. To identify priority areas and build commitment. "The Strategies for Population Health" (1994) recognizes strategies which influence health. Action to work to protect, promote and support breastfeeding and promote improved access to community-based breastfeeding support groups. Promote breastfeeding from school age and provide support for mothers returning to work.

Marketing Breastfeeding (Rob Hyams) spoke on how the sponsor (corporation) supports the activities, program, or cause of the other partner (government/ngo) in return for some type of recognition. The PSA film on breastfeeding is still available for TV to be run as a public service announcement and include the information that it was used for the Commonwealth Games.

Public Opinion Research on Breastfeeding was obtained at the end of last year by means of 12 focus groups divided into teens (15-19) expecting first baby and planning to use formula; 20 to 30 year olds planning to use formula; and breastfeeding mothers discontinuing in <1 month; <4 months; 4 months and longer. The woman's mother was most influential in making decisions about feeding [similar to other studies!]; formula more convenient and less restrictive; breastfeeding an embarrassing activity. There was a consensus that smoking and breastfeeding are incompatible. Fathers considered that bottle feeding helped bonding, gave more freedom to the mothers, and less embarrassing. Nutritional benefits and cost arguments were not persuasive among these groups. Those who terminated early had a high level of knowledge on "breast is best" but low on nutrition and the physical effects to the mother. Expected breastfeeding to be emotionally fulfilling and natural so that baby automatically knew what to do. Partners were not sufficiently informed to offer much support. Breastfed at home. When discontinued breastfeeding felt relief and guilt, and some felt disillusioned by the whole experience. Need education, show-and- tell sessions, and support, and to include both parents.

Health Canada has a "Brighter Futures Research" book (1995) which provides the abstracts of the 20 projects being funded by NHRDP. The book is available from the Minister of Supply and Services Canada (cat. no. H74-47/1-1995E).

Baby Friendly Hospital Initiative and Breastfeeding Resources

FREE items

"Take the Baby-Friendly Initiative!" - a 15 page brochure providing an overview of the BFHI-UNICEF

"Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding" - an 8 page foldout leaflet containing the text adopted in 1990.

"The Baby-Friendly Hospital Initiative Action Folder" - a 6 page leaflet containing background information on the BFHI and proposals for action - World Alliance for Breastfeeding Action (WABA)

"BFHI News" - a monthly newsletter

"UNICEF Poster" - 10 steps to becoming a baby friendly hospital 11" x 17"

UNICEF Audio Visual Materials (available on free loan)

Items for Sale (add 15% p&p)

BFHI Program Manual Parts 1 and 2 (54 pages) - $5.00

BFHI Manual Part 4 (55 pages) - $5.00

BFHI Resources for Advocacy and Training Part 5 (25 pages) - $2.50

BFHI Manual Part 6 - $2.50

Breastfeeding Management and Promotion in a Baby-Friendly Hospital - 18 hour course for maternity staff (168 pages (English or French) and includes 40 slides) - $50.00

Training Guide in Lactation Management - 80 hour course to train trainers by UNICEF and the International Baby Food Action Network (289 pages (English or French)) - $25.00

For further information contact: Marilyn Sanders, Advisor, BFHI
UNICEF Canada, 443 Mount Pleasant Road, Toronto, ON M4S 2L8
(Fax: 416-482-8035)

Family-Centred Maternity and Newborn Care National Guidelines Revisions Project from Charlene MacLellan

The Family-Centred Maternity and Newborn Care National Guidelines, last published by Health Canada in 1987, are to be updated and rewritten through the Canadian Institute of Child Health (CICH). A meeting of the core group was held in Ottawa on March 27, 1995, and was attended by 25 members, including the CICH staff, representatives from various professional groups, plus consumer representation - all people involved in the provision of care to mothers and babies in Canada.

The Guidelines are used mainly by maternity units of hospitals and are helpful to these departments in policy setting. As midwifery was not recognized in 1987, when the current Guidelines were published, midwifery content is strikingly missing from the Guidelines.

If a member of the Midwives Association is willing to volunteer as a "user" of these Guidelines when they are revised, please let Pearl Herbert know so that your name can be forwarded to Charlene who is representing CCM/CCSF.

National Perinatal Surveillance System Steering Committee, May 2 and 3, 1995 (from Pearl Herbert's notes)

A meeting of the NPSS Committee was held in Ottawa and I attended to represent midwives. It was chaired by Dr. Michael Kramer (Professor, Department of Paediatrics and Epidemiology/ Biostatistics, McGill University). The surveillance system is used to show trends over time and raises a "red flag" where there could be a problem. The NPSS will not just collect data but will also provide feedback. It is not a research system. The NPSS is considering reproductive as starting with pre-conception.

The mission of the NPSS is to contribute to improve the health of mothers and babies in Canada by implementing a national perinatal surveillance system. A system of data collection, data analysis, and response to be established; to identify disparities between sub-populations in Canada and in the health of mothers and babies; to reduce the disparities; to identify trends and promote areas where the health of Canadian mothers and babies can be improved through national and international comparisons; to identify and promote effective and efficient care of mothers and babies; to promote education and training in surveillance. There are also principles to ensure that this is carried out. Andre Lalonde (Professor of Obstetrics and Gynaecology, University of Ottawa, representing SOGC) was unable to attend the meeting, but it was understood that he had already introduced SOGC to the need to have the same perinatal surveillance document used across Canada.

"Sudden Infant Death (SIDS) refers to the sudden and unexplained death of an apparently healthy infant less than one year of age, which remains unexplained even after a full investigation" (Joint Statement of The Canadian Foundation for the Study of Infant Deaths; Canadian Institute of Child Health; Canadian Paediatric Society; Health Canada, August 1993). SIDS is now listed by Statistics Canada as a mortality variable.

Presentations were given by members of Statistics Canada on the linkage available for different files; on the family data which is collected monthly across Canada except for NWT, Yukon, and non-telephone households; on the "National Longitudinal Survey of Children" started in 1994, to sample 25,000 children aged 0 to 11 years. This latter survey is part of the Brighter Future Program which was started in 1992 because of the lack of national data and the findings from the first cycle should be released by the Fall. The "National Population Health Survey" has samples from all provinces and territories, and is longitudinal and cross-sectional. We were told that the latest Vital Statistics figures are available for 1992 when there were 398,642 births; 2,515 stillbirths; 196,535 deaths; 164,573 marriages, 79,034 divorces. A problem occurs as the definition of stillbirth varies across the country and these definitions are often legislated and therefore cannot easily be synchronised.

Information was given on the Canadian Institute for Health Information (CIHI). On the recommendation of the National Health Information Task Force CIHI was incorporated in December 1993, and in January 1994 the Hospital Medical Records Institute (HMRI) and

the Management Information Systems (MIS) Group voted to dissolve and form the new Institute. Hospital information is collected and they now want to expand to capture births outside of the hospital.

Information was given on the site visits to the Perinatal Surveillance Systems in Nova Scotia, British Columbia and Prince Edward Island. The database manager of the BC Perinatal Database Registry (PDR) reported on their system.

Reports by the NPSS Response Sub-Committee and the Indicator Sub-Committee were given.

I am a member of the Indicator Sub-Committee and we had another meeting in Ottawa on June 23-24. Possible indicators were discussed and how to have a system of auditing.

The next meeting of the NPSS is in September. If you have questions please let me have them by the beginning of September. **I should be interested to know what you consider should be indicators for this province.**

Mothers Lacked Information on Pre-Eclampsia

A major national survey carried out for Well-Being, the health research charity for women and babies, and Action on Pre-eclampsia (APEC), has found that most pregnant women are unaware of the dangers of pre-eclampsia. In the UK as many as one first-time mother in every five is at risk of pre-eclampsia, and some 70,000 pregnancies every year are affected. Results showed that:
86% of respondents had heard of either pre-eclampsia or toxaemia; 61% knew that high blood pressure was a key symptom; 22% knew pre-eclampsia could be dangerous for the unborn baby; 13% knew that delivery was the only cure; 13% knew that first-time mothers were most at risk. Most thought that the disease could be prevented by lifestyle adjustments such as resting, giving up smoking and drinking, or losing weight, when in fact there is no effective means of prevention. Only a minority were aware that the presence of protein in the mother's urine is a key sign of pre-eclampsia. 60% thought that all complications in pregnancy were preventable with good care, which is not true of pre-eclampsia; only 50% of respondents aged 17-25 had heard of pre-eclampsia and only 34% of those knew that it could be dangerous for the mother.

Further information and copies of the survey report are available from: Isabel Walker, Director, APEC, 31-33 College Road, Harrow, Middlesex HA1 1EJ, England.
(cited in Midwives, 108(1286), 93)
Are women in Newfoundland any better informed?

ARNN 41st Annual Meeting - Energizing Nursing: Managing Changing Times Optimistically. June 4-6, 1995, Corner Brook.
(Summarized from Pearl Herbert's notes)

The Education sessions were presented on Sunday afternoon. Barbara Hawley (St. Clare's Mercy Hospital) spoke on Program Management: Challenges and Opportunities. Program management was first introduced to Canada at the Sunny Brook Hospital. The aim is to provide a greater account of the effectiveness and quality of patient care with improved patient outcome. Decisions are made by team members. There are advantages, such as improved strategic planning, organizational stream lining, commitment from within, entrepreneurship, turf protection is difficult so better resource allocation. The disadvantages include the need for professionals to assume new roles for which they may not be prepared, an increase in tension and anxieties among staff who may experience a sense of devaluation and loss of employment. This results in stress and the fear of losing status and control, inflexible staff allocations. Evaluation is by a person outside of nursing and less expensive providers may be hired. There have been evaluations of program management but the right mix of providers is not yet known. (Also: Hawley, B. (1995, April). An introduction to program management. Access, 15(2), 2-3).

Linda Hollett (St. Clare's Mercy Hospital) spoke on Research-Based Practice: A Strategy for Change. She started by presenting an overview of the history of nursing practice from 1932 to the present. Although there are many theories on nursing practice complete knowledge is often not yet available. It is vital to have an education component to ensure that everyone is doing the same thing. Strategies for change include: education, administrative support, supervision of research utilization, resources for research. Need to learn about research either in formal education courses, workshops, from a mentor. There needs to be a commitment proceeding down from the top levels as research should be included in the department's philosophy, standards and policies. Information is then disseminated e.g. by newsletters, and any changes to policies to be in line with research findings. Changes include the process of unfreezing, moving, refreezing. Identify what needs to be changed, review literature, plan, implement, evaluate outcome.

Donna Dobbin (Western Memorial Regional Hospital) spoke on Quality Management: The Relationship to autonomous Practice. She started by quoting Phillip Hassen "Quality improvement involves all staff in a hospital empowered to continually improve the systems within which they work so that they may do their job better every day, and so the highest possible level of quality care may be reached". Need to focus on the customers - both internal and external; on improving work processes to produce consistent, acceptable outputs; on utilizing the talents of those with whom we work. Autonomy versus empowerment; autonomy being free to act and empowerment being given the authority to act. Empowerment needs capability, alignment, trust.

Ann Tapp (Canadian Nurses' Protective Society) spoke on Risk Management: Techniques to Ensure Competent Practice. She noted positive actions such as correct documentation, communication, following policies and procedures, safe equipment. Negative actions include failure to respond to patients' call lights, failure to give adequate patient teaching, unsafe practices with equipment and procedures. The trend is now to record the serial numbers of equipment so that they can be traced if necessary. When providing care use the clock in the room rather than everyone's personal watches. Not to provide indications in the chart that there was a concern for practice, e.g. incidence report was completed. Lawyers pick on "words" and then use them for their own purposes. Some words can have multiple meanings e.g. reassure (did not take seriously); appears (did not know what was observing). Third party charting should not be carried out. Always chart what one did and do not chart for someone else, as often happens with the recording of routine vital signs. In Laidlaw v Lions Gate (BC) the judge ruled against third party charting. Chart only facts and avoid statements of opinion. If a "late entry" follow the hospital procedure. Do not squeeze a late entry into the chronological order but place it in the time of writing space and state why it is late. Try to avoid late entries. Good communication with patients averts later problems and complaints. Do not apologize or assume responsibility for any happenings. If there are any possible problems or questions consult with the CNPS 1-800-267-3390 IMMEDIATELY. Do not wait for action to be taken, do not discuss issue with others or with your own lawyer until after being advised by CNPS. Do notify the employer. Follow the guidelines in the "Liability Protection" leaflet from CNPS. Payment for this service is included in the ARNN annual registration fees.

The next day, after the welcomes and other business Dr. Angela Baron McBride (University of Indiana) gave the keynote address: Energizing Nursing. Handle challenges and do not expect to be perfect, but concentrate on the positive aspects and have a positive view of Self, and be optimistic. If view things negatively then can eventually convince others that they should also be negative. Those who concentrate on the negatives aspects are reluctant to take risks and keep seeking reassurance from others.

Early in a career one needs to be considered special, and then progresses to being aggressive, and eventually becomes secure enough to ask for explanations and being willing to delegate tasks.

Dr. McBride spoke on the "hardiness" literature. The need to view change as an opportunity. To "take care of yourself". "Be good to yourself". If always accept ideals then have to deal with realities and discrepancies. Unable to accomplish important things if look as if you will collapse in the process. Nobody has it perfect, but the goal is to do as well as one can with limited time, energy and resources. Not to take on every opportunity that comes along.

Avoid "Magnification" - messed everything up; "emotional reasoning" - feeling negative; "Personalization" - taking on the

mistakes of others; "Victimization" - the worst things always happen to me. Expect to come out on top and focus on the attributes that makes one appear advantaged. Reconstruct negative events to highlight the benefits learnt. Be ready to congratulate colleagues. Nurses are used to working with others whereas physicians are used to being the "captain" in charge and are in a poor position when not directing others. The public still thinks of nurses traditionally but we have to move from the present to the future. Vibrancy is ours if we take ourselves seriously.

Other presenters included: Madge Applin (President-Elect) on the Changing Future Directions of Nursing - Moving Forward. Kathryn Follett (Hoyles Escasconi Complex), Betty Lethbridge (Charles S. Curtis Memorial Hospital), Eleanor Gardner (Dept. of Health), and Joan Rowsell (ARNN) on the Standards of Nursing Practice Revision Project. Karen Carroll (General Hospital), Helen Lawlor (Dept. of Health), Eileen Humphries (St. Patrick's Mercy Home), and Colleen Kelly (ARNN who was unable to be present due to illness), on Scope of Nursing Practice for Ratification. Christine Way (MUN School of Nursing) gave the report on the analysis of the Impact of Health Care Reform project. Linda Norman-Robbins (Western Memorial School of Nursing) and Dorothy Andrews (Collaborative Nursing Program) gave the Future Nursing Education Update.

Business sessions included Resolutions and Motions. Resolutions moved by Pearl Herbert and seconded by Kay Matthews were: "That both the cognitive aspects and the psychomotor skills [for breastfeeding] be added to the Standards and Criteria of Professional Competence for Beginning Practitioners of Nursing in Newfoundland". DEFEATED.
"That the ARNN establish an ad hoc committee to develop guidelines to ensure that the registered nurses who do not have the necessary knowledge and skills, to assist mothers with breastfeeding, are able to obtain these". CARRIED.
"That the ARNN develop a position statement on breastfeeding". CARRIED.
Motions moved by Hilda Bellow and seconded by Judy Wells included "that a postage paid envelope be included in all questionnaires and surveys sent out to the membership of the ARNN". CARRIED.
A motion for ARNN to encourage the CNA to discuss with the Canadian Bar Association the legalities of providing safe competent and ethical nursing care was also CARRIED.
Motions for ARNN in conjunction with the NLNU to meet with CNA to discuss the increasing liabilities that RNs face when working with auxiliary health care/unlicensed personnel was DEFEATED. (Provincial regulations are that only RNA and above can provide care in institutions).
Also that ARNN and CNA lobby to have public data regarding levels and mix of nursing staff and patient outcomes made public. DEFEATED.
(Exact wording not remembered as amendments were proposed and voted on).

The ballot results showed that Kay Matthews was elected as 2nd Vice President. Coleen Brown and Wanda Wadman as councillors.

Sherry Rumbolt (Western Memorial Regional Hospital) gave a lively closing presentation on Energizing Nursing. It's Up to Us". She started with a story and then some history. Wars enable changes to be made such as with Florence Nightingale, Edith Cavelle. We cannot go back in time but can take past knowledge and compare it with the present. Our opinions matter and managers can listen to staff concerns and be supportive. All need to work together for improvement and remembering it is important to laugh. What is painful now in six months time will have improved. The under utilization of research may be because we do not network and research is not marketed. We can do anything if we have the commitment. This is our career and energising nursing is up to us. It is worth it.

There were also fun times. A reception on Sunday evening. On Monday evening there was an informal dinner and entertainment entitled "Nursing in the 21st Century". The Corner Brook nurses have many talents including painting robots, and glide dancing. Skits included one by the students - surgery to replace a brain with a cauliflower! There were many door prizes. The Awards of Excellence were made at this dinner. Anne McElligott RN, SCM (Hopedale) received the award for nursing practice; Joan Crawley RN, BVoc.Ed (St. Clare's) received the award for nursing administration; and Christine Way RN, PhD (MUN) received the award for nursing education.

Babies are Alleged to have Died Because of Cut-Backs in the U.K.

"Babies are alleged to have died at a maternity hospital because of cost-cutting sackings of maternity staff. Blyth Valley Labour MP Ronnie Campbell has accused Cheviot and Wansbeck NHS Trust of replacing fully qualified midwives at Ashington Hospital with cheaper, less experienced staff to 'save some money'. The policy, he says, has resulted in the deaths of at least two babies at the hospital's maternity wing. The problem is said to centre on a £1 million debt facing the Trust. Mr. Campbell claims Trust officials decided to save money through cutbacks in hospital workers, particularly midwives and nurses. For while midwives can command up to £7 an hour the Trust found it could employ health care workers for as little as £2.80 an hour. According to the MP, one gynaecologist complained in writing to the Trust's chief executive and the chairman of the Northern RHA. Mr. Campbell said the gynaecologist was amazed at the exhaustion of the staff, who were overworked and worried, and warned that lives would be lost if something was not done. But nothing was done, says the MP, and the outcome was the death of two babies. The Trust later appealed to some of the midwives who it had made redundant to return" (Parliamentary Report, (1995, March), Midwives, 108(1286), 92).

A Weekend with Suzanne Arms, Winnipeg, May 26-27. (Arranged by the Manitoba Traditional Midwives Collective).

On Friday evening there was a reception, followed by a talk by Suzanne Arms. Since her first books, one of which was Immaculate Deception, she has become less angry and more analytical. Changes have been made in maternity care and mothers are becoming less militant. She has now written Immaculate Deception 2.

On Saturday morning Suzanne Arms spoke on the topic of Political Organizing. Must be careful of the wording of statements, to ensure that we get what is needed. Men are needed to help in the organizing, but women need to ensure that they are the ones in charge. In Colorado midwifery is now legal, but midwives cannot be members of another profession. If they do not register for one year then they lose their license and so cannot register the next year. In California legislation had so many amendments that it was unrecognizable, but a female politician was eager to get it passed and now it does not benefit midwives. Need to make use of those who are good at lobbying, at doing public relations, at educating the public. Need more research on midwives and to locate midwives in Canada. Education should be of quality and flexible but she does not believe in examinations and licensure.

Saturday evening there was a talk by Suzanne Arms and she showed two carousels of slides (some very old as cesarean sections were by the laparotomy method). The talk was then followed by a panel discussion. Somehow most of the people present considered that licensure would only put midwives under the power of doctors - when licensure is how midwives are going to be independent from the medical profession by not having to rely on them for requisitions and prescriptions. Licensure will protect the mothers by ensuring that midwives provide good care. If midwives know that they give good care and the rationale for their actions why are some not eager to prove this?

Shaking Your Baby Can Kill

In the UK. the Department of Health and the National Society for the Prevention of Cruelty to Children (NSPCC) have produced a new leaflet "Handle with Care", which is available, free of charge, from the NSPCC, and Mothercare and Children's World stores. Very young children have a large and heavy head compared to the rest of their body. Shaking makes the head move back and forward very quickly and with great force, which can result in the tearing of the tiny blood vessels in the brain. Serious damage ensues with developmental delay, blindness, and convulsions. In one Liverpool hospital over a three year period 44% of the babies admitted into intensive care with shaking injuries died, and the remainder now have serious disabilities.
(cited in Midwives, 108(1286), 93)

Contamination of Laparoscopic Insufflators with Patient Fluids
Medical Devices Alert No. 106 of Health Canada, dated February 3, 1995. "The Health Protection Branch has been informed of several recent incidents in which the internal gas circuit of a laparoscopic insufflator was contaminated with patient fluids during a laparoscopic procedure, after the gas flow had been temporarily shut off". Safety precautions are then listed.

Hands-on, Hands-poised study

The Medical Research Council (UK) is funding a midwifery randomised research study to compare perineal, vaginal and labial pain between two methods of delivery:

1. The Hands-On technique - in which the midwife's hands are used to flex the baby's head, guard the perineum and use lateral flexion to deliver the shoulders.
2. The Hands-Poised technique - in which the midwife keeps her hands poised, prepared to put light pressure on the baby's head in case of rapid expulsion, but not to touch the head, perineum or shoulders otherwise.

The aim is to recruit 8,500 mothers in 15 months. Delivery details are completed following the birth. Then the mothers and midwives are asked to complete further questionnaires and assessments at 2 postpartum days, 10 postpartum days, and the mother is sent a further questionnaire three months later.
(cited in Midwifery Matters, Issue 65, Summer 1995, p. 11)

Midwifery in Belgium Adapted from an Email message from Patrick Hublou in Flanders (tau@macbel.be)

New regulations for midwifery training in Belgium have been approved, thereby bringing Belgium's midwifery training up to the level regulated by the European Community. This training commences with the next academic year. The length of training in Flanders will be 3 years separate from nursing training. In Walloon there will be 1 year of basic nursing, 1 year of nursing with some midwifery, plus 2 years of midwifery (to equal 3 years of midwifery training). The curriculum has been totally reformed to fit the profile of a midwife. They are discussing the midwife's responsibilities and practices, and the prescribing of a limited number of medications.

The midwifery associations have been reorganized. There is the recently formed Flemish Organization of Midwives which has been recognized by the Flemish Organization of Obstetrics and Gynaecology, and by many important national and international organizations, to represent the Flemish midwives. The OCVB/CCAB organization, which groups Flemish and Walloon midwifery organizations, has decided that in future only midwives can belong to these organizations. This way the Belgian delegates to the ICM and the EC will represent Belgian midwives and give expression of the new midwifery profile at the international level.

PREP (the UKCC Post-Registration Education and Practice)

The PREP legislation came into affect from April 1, 1995, and there will be at least three years to meet the new requirements. Those who are registered with the UKCC should have received the package of fact sheets. They can be obtained from the UKCC, 23 Portland Place, London W1N 3AF (Fax: 1-44-171-436-2924).

The first time that the registration is renewed after March 31, 1995, the person is advised as to what is required to be completed during the next three years. There will be a Notification of Practice form to be completed every three years (and practising midwives will also continue to complete the legally required annual Notification of Intention to Practise form). There is also a minimum of five days (which do not have to be taken together) of study or equivalent to be undertaken every three years. A Personal Professional Profile with details of the person's Professional Development has to be maintained. This information will then be held for six years. This also applies to those working overseas. If the PREP requirements are met then a person returning to the UK to work will not be required to undertake a Return to Practice programme. If a person has worked for less than 100 days/750 hours in the previous five years they will need to complete a Return to Practice programme which will include from 5 to 21 days of study plus relevant supervised practice. On completion of the programme there will be an evaluation where learning outcomes have to be demonstrated.

The study requirements are divided into categories on which a person may choose to focus. These are: Patient, client and colleague support; Care enhancement; Practice development; Reducing risk; Education development. Competencies have to be reviewed, learning objectives set; action planned and implemented. Evaluation has to include what happened and what was actually learned. An accurate record of all the learning activities have to be recorded in the Personal Professional Profile, and kept for a minimum of six years.

The Personal Professional Profile is different from a curriculum vitae and most portfolios. The Profile is a confidential document in which the person assesses their current standards of practice; develops analytical skills; reviews and evaluates past experiences and learning; self-appraisal and descriptions of incidences; setting goals and formulating action plans; and formal learning activities. As from April 1, 2001, the UKCC will have a formal audit system, but until then the registrants will be required to make a formal declaration confirming that these statutory obligations have been fulfilled. Between 1995 and 2001 the UKCC will also be carrying out pilot studies and asking the members to provide evidence to support the claim that the requirements have been met.

As from October 1995 new programmes leading to qualification of specialist practitioner will start to become available in education institutions, and will last a minimum of an academic year. All programmes will have to conform to the standards by the 1998 academic year. Credits from appropriate prior learning (APL)

and prior experiential learning (APEL) may shorten the programmes. Enroled nurses must achieve conversion to first-level registration as part of working towards the specialist qualification. To enter the programmes the person has to be registered on the appropriate part of the UKCC register, and to have gained a sufficient amount of professional experience. The UKCC will be reviewing the programmes offering Masters and PhD degrees and may consider the recording of such qualifications in due course.

Advanced practice is considered important and is concerned with: Adjusting the boundaries for the development of future practice; Pioneering and developing new roles which are responsive to changing needs; Advancing clinical practice, research and education to enrich practice as a whole; Contributing to health policy and management and the determination of health needs; Continuing the development of midwifery in the interests of the mother, the baby, the family and the health services/nursing in the interests of patients, clients and health services. Practice is advanced by: Innovations in practice; An increase in research and research-based practice; The provision of expert professionals who will have a consultancy role; High level professional leadership; Increased political and professional influence in respect of the development of services; Expert resources e.g. supervision, management, education.

The above is a summary of the Fact Sheets. Profile binders can be obtained from various agencies e.g. National Boards, MIDIRS. (£9.95 plus postage, MIDIRS, 9 Elmdale Road, Clifton, Bristol BS8 1SL, England. Annual membership is £42.00)

The Aggressive Non-Nurser: The Baby Who Will Not Nurse

(contributed by Pamela Browne from a presentation by Barbara Haiser at LLLI Conference, July 24, 1991)

The aggressive non-nurser (ANN) must be distinguished from the reluctant nurser. The reluctant nurser is often post-term, and the labour and delivery is often complicated by some sort of medical intervention(s). Baby is generally sleepy, but may be agitated. Baby is a "poor" feeder which usually leads to a frustrated mother and baby.

Haiser cited a case history to exemplify the ANN:
G1 mother who delivered as planned at home, with no medications, she had a short labour and experienced no problems. The baby was born SVD on to mother's abdomen and the baby immediately arched his back, thumped his mother's breasts with his hands, and cried frantically. Breastfed very poorly over the next two days. The mother was very calm, but the baby was hysterical. The baby could suck, but for some unknown reason would not breastfeed and was very unhappy. The mother felt totally rejected by her baby. Treatment took three weeks for the baby to fully breastfeed and he was fed banked expressed breast milk in the interim.

Before diagnosing ANN one needs to rule out:

1a. Physical and medical problems in the mother which may include: emotional, stress, breast problems (therefore need to examine breasts). Query breast trauma; breast surgery; maternal drug use. Taste of breast milk, ask mother to taste her milk, if sour mother may be eating too much citrus etc. Positioning at the breast e.g. hyper/hypo-extension of the baby's neck.

1b. Physical and medical problems in the baby which may include: Forceps delivery; fractured clavicle; cleft palate; cephal-haematoma; aggressive naso/oral suctioning at birth; tongue tie; post circumcision; allergy (there is usually a strong family history if baby is allergic at this early stage).

2. Sucking disorders e.g. nipple confusion.

3. Iatrogenic problems e.g. hospital policies that include separation of the mother and her baby; supplements given to a breastfeeding baby.

Management:

1. Environmental controls - if the baby is sleepy then reduce the room temperature, avoid overdressing. If the baby is over-stimulated then lower the lights, try and reduce stimulation by toddler siblings. It is obviously extremely helpful to do a home visit to assess environmental factors.

2. Staff inservices as a forum to give viable alternatives to staff regarding harmful breastfeeding advice and practices e.g. one hospital routinely gave nipple shields to all mothers having breastfeeding difficulties, which in turn created more breastfeeding problems down the track (at home). The alternate solution offered was to use breast shells when breastfeeding mothers had nipple/areola problems. The shells were used with great success.

3. Develop a feeding plan i.e. to guarantee that the nutritional needs of the baby are met. These ANN babies do not just have problems because they are breastfeeding. They appear to be very unhappy babies regardless of the feeding method chosen. Keep everything as non-forceful as possible i.e. do not force the mother and/or the baby to breastfeed at a feed time. However, the baby does need to be fed. Therefore, the mother needs to be given choices of feeding methods, and whatever the mother chooses (including a bottle) is fine. Mothers of ANN babies experience extreme levels of stress, and therefore it is very important to offer them choices. If the baby does attempt to breastfeed ensure that the mother understands the importance of a correct latch. Haiser told of her technique - support the breast, then with fingers below the areola and thumb above gently press in towards the chest wall. If the thumb is impressed slightly more than the other fingers it results in the nipple angling slightly upwards, so if the baby is brought to the breast the mother's nipple/areola is directed more to the baby's hard palate. This seems to cause increased stimulation of the upper palate nerve endings resulting in a greater suck reflex.

4. Positioning is a problem for these ANN babies whether they are breastfed or artificially fed, because they usually do not like to be held. Therefore, alternatives such as feeding with the baby sitting in a car seat or laying on a bed to decrease handling, are often successful. If the mother wishes to breastfeed but the baby is not yet amenable, then the mother must express. Double pumping is preferred because it is more efficient and less time consuming; which is very important for these mothers.
5. Supplementation - discover with what the mother is most comfortable, and which method she chooses to use e.g. Supplementary Nursing System (SNS), bottle (preferably using a Habermann teat or a NUK teat inserted ALL the way into the baby's mouth so that the baby's flanged lips are up against the bottle's cap), spoon (although this is very slow), cup (easiest), periodontal syringe, finger feeding.

An explanation of the process and emotional support is very important for the mother because she will probably feel totally rejected by her baby. Educate the mother about what is happening and what is expected to happen in the future. It will be helpful if she can have very small goals, so that she feel that they are manageable and achievable. As small improvements do occur point these out to the mother as she may not see them herself. Close support for the mother is essential including support from her partner, family and friends. Everyone will need education and support from the professional caregiver.

The expected course and outcome of an ANN learning to breastfeed:

1. The baby fighting and screaming at the breast with an hysterical type of cry. This baby is different from a colicky baby, as holding an ANN baby does not improve his cry, in fact the cry is usually exacerbated. The baby will hit the breasts with his fists and will hyper-extend away from the breast. At this stage it is important to reassure the mother that her baby is NOT upset with her in particular, that no matter who holds the baby his behaviour will be the same. At this time the feeding plan, discussed above, will need to be developed, including ways of feeding which allow the baby to be minimally handled.
2. Next, the baby may either just cry, or cry uncontrollably when being held, but is alright when laying down. Suggest that the mother lay down on the bed next to her baby but not necessarily touching him. Bonding is frequently affected between mothers and their ANN babies, but when laying down eye contact and talking can occur in a way that can be comfortably tolerated by the baby. Try to discover what upsets the baby e.g. bright lights, and what soothes e.g. types of music.
3. When the baby is willing to be held the non-cradle positions are usually preferred e.g. walking with the baby held upright, the football hold, turning the baby outwards so that he looks away from rather than towards the mother. These babies usually do not like to be swaddled.

4. The baby progresses to being willing to be held in the cradle position, and progresses to being held in that position with the breast uncovered. Suggest that the mother begins holding the baby in the cradle position at a non-feeding time and gradually works-up to exposing her breast.

N.B. With ANN babies each of these stages may last for days and so the whole process often takes weeks.

During all of these stages the mother needs to be pumping, and feeding the baby by some alternative way whilst waiting for the baby to progress hopefully to breastfeeding. Some mothers prefer to feed their baby, others find it too stressful and therefore prefer that someone else does this.

5. Next the baby becomes tolerant of the cradle hold at the bare breast. Now is the time to transfer over to finger feeding if the baby has been fed by any other method. This gets the baby accustomed to having something soft in his mouth and encourages him to relate a feeling of fullness to being held in the mother's arms at her breast. This is a very gradual progression, led by the mother and the baby's caregivers. Suggest that the mother gradually begins to stroke her baby's cheek with her breast, and the baby will eventually root. Allow, within reason, the baby to do whatever he wants to at the breast. Praise the mother and the baby for all of this. Mothers often become very excited at this stage and expect the baby to breastfeed immediately, but it may be a slow process.

6. The significant stage is when the baby starts licking at the breast. The tongue must come out to breastfeed and so licking is a very positive sign. Gradually the baby will attempt to suck and play with the nipple in and out of his mouth. Once this stage is reached allow the baby to have as much access to the breast as he can tolerate. Be paced by the mother and the baby as now the baby may latch on himself. Sucking may begin with flutter sucking and gradually become a more nutritive suckle, or the baby may begin to suckle perfectly when he first latches on. When the baby starts to retain the nipple/breast in his mouth then begin to progress from finger feeding to breastfeeding. If the baby is hungry and needs settling then may need to start with finger feeding and then transfer over to breastfeeding. Begin with short sessions at the breast, lengthening breastfeeding as it is tolerated by the baby. Begin with short sessions at the breast, lengthening breastfeeding as it is tolerated by the baby. Some mothers use SNS at this point. Some mothers find that at this stage their baby does not tolerate having no breast milk immediately available when breastfeeding begins i.e. they are not accustomed to suckling to induce letdown, therefore the mother may need to induce her letdown before breastfeeding e.g. pumping, massaging, or allowing the baby to play around with the breast and then pumping on the other side to elicit letdown in the breast that the baby has.

7. Finally the baby progresses to breastfeed without immediate letdown i.e. tolerates suckling to induce letdown. As the baby relies totally on breastfeeding one needs to watch the baby closely to ensure that he is receiving adequate milk (volume and calories), by observing diapers and perhaps weight. If the baby continues to do well for three days then the closer observation can be relaxed and one can be fairly certain that exclusive breastfeeding is meeting all of the baby's needs.

ANN occurs in varying degrees and for varying lengths of time. Frequently progression is two steps forward and one step back. The above steps are for the extreme ANN, other babies may skip some of the steps. Babies who are very nipple confused may also go through these steps, perhaps missing some steps. Frequently, if the mother continues to work towards breastfeeding in the described progression, then as the baby reaches a growth spurt he becomes sufficiently hungry to move on to breastfeeding more quickly. Turn-arounds often occur at times of growth spurts for both ANN and nipple confused babies. This whole process is only possible if the mother and the father receive much support, help and information. The father usually feels as completely frustrated as the mother.

A person in the audience who had worked with babies with varying degrees of ANN stated that her theory was that these babies have not completed their CNS development in utero. If this can be explained to the parents in these terms it helps them to understand. She said that the ANN babies who she has worked with all grew into perfectly normal children.

Immunizations: A Benefit or a Risk?
Why Some New Mothers May Have Worries Regarding Immunizations

Janet Dwyer, while a 4th year nursing student,
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The implementation of routine immunization of babies, children and adults in Canada since the early 1940s has been viewed as a major advancement in the field of preventative medicine (Kuehl, 1992). A dramatic reduction in the incidence and subsequent morbidity and mortality of a wide variety of childhood diseases offers testimony to this point of view. However, immunizations are not without significant side effects. Critics have debated that evidence of such vaccine-associated adverse events have over-shadowed the beneficial effects. As a result much controversy exists in terms of the health promotion aspect of immunizations.

An issue is when there are opposing opinions regarding a topic. The purpose of this paper is to clearly state the issue surrounding immunizations, namely the benefits offered versus the risks associated with this health practice. The history of immunizations and the origin of this issue will be discussed briefly. The author will critically analyze the issue and will justify a personal position. Finally, the impact of this issue on nursing and the health care system will be outlined.

There are several limitations which exist in this paper. The page limit and time restraints restricted the depth and breadth in which the issue could be developed. As well, much of the history of immunizations is from an American context, as it was difficult when researching to pinpoint dates in the Canadian history. The author may also demonstrate a bias in favour of previously acquired knowledge regarding the role of immunizations in health promotion.

History of Immunizations

Immunization, as it is known today, dates back in time to the late 18th century with the experimental work of Edward Jenner. In colonial America smallpox was the outstanding epidemic disease and the greatest cause of infant mortality (Wishnow & Steinfeld, 1976). In Britain, between 1796 and 1798, Jenner began to experiment with the infective matter which caused disease progression "from the horse to the nipple of the cow, and from the cow to the human subject" (Jenner cited in Wishnow & Steinfeld, 1976, p. 430). His subsequent work showed that this infective material, derived without question from cases of bovine cow-pox, could be used to vaccinate humans. He went on to postulate that the vaccination gives life-long protection (which was met with legitimate criticism) and that the vaccination "usually produced a mild disease characterized by a local pustule which has a much smaller mortality and morbidity rate than was usual with inoculation" (Roberts, 1978). Word of Jenner's vaccination spread rapidly throughout the world. Those physicians who were receptive to Jenner's developments were eager and curious to try this vaccine. Benjamin Waterhouse, a Professor at Harvard Medical School, successfully vaccinated his own family with Jenner's vaccine, and went on to enlist the aid of President Thomas Jefferson to help exterminate smallpox (Wishnow & Steinfeld, 1976). With their persistence, smallpox vaccination was firmly established in the United States (U.S.) by 1802.

Jenner made many professional acquaintances with his well-renowned work. In particular, he had a life-long friendship with John Clinch, a physician who in 1775 travelled from England to Newfoundland. Through their correspondence information regarding Jenner's smallpox vaccination first reached North America. The introduction of vaccination into Newfoundland in 1797 came about by the joint efforts of Edward Jenner; his friend, John Clinch; Jenner's nephew, Rev. Dr. George Jenner; Dr. McCurdy, one of the surgeons at St. John's and Admiral C.M. Pole, Governor of Newfoundland (Roberts, 1978). Many countries rapidly adopted Jenner's vaccination making him a prominent public figure.

Discoveries in the immunologies of other infectious disease were slow to follow in Jenner's trail. "The conquest of diphtheria depended upon bacteriologic discoveries in Germany and France between 1883 and 1923, which made prevention of diphtheria an attainable goal" (Wishnow & Steinfeld, 1976, p.444). It was not until 1928 that the first program of active immunization for schools began in the United States. In 1949 a break-through in poliomyelitis research by Enders, Weller, and Robbins lead to the Salk-type vaccine which was licensed for use in the U.S. in 1955.

The Sabin-type live attenuated vaccine was used in other countries between 1957 and 1962 when it was also licensed for use in the U.S. (Wishnow & Steinfeld, 1976). The pertussis vaccine was introduced in Canada in 1943 followed by the measles vaccine in 1965 and the Haemophilus Influenza Type B vaccine in the early 1980s (Casto, 1992). The incidences of several diseases were controlled with the vaccines, as evidenced by dramatic reductions in the number of reported cases of infectious diseases.

Despite the obvious benefits which have resulted from immunizations there have been fatalities. The vaccine developed by Louis Pasteur in the 1890s against rabies did protect some of those to whom it was given but there were also fatal outcomes. This resulted in people questioning the safety of the particular vaccine as well as generalizing their conclusion to other vaccines (James, 1988). Such incidents of vaccine-associated adverse events continue to be present for some who receive routine immunization. While transient effects can occur (i.e. tenderness and swelling at the site), other illnesses (i.e. encephalopathy) can coincide with immunization administration (Blake, 1992; Cherry, Brunnell, Golden & Karzon, 1988; Gale, Thapa, Wassilak, Bobo, Mendelman & Foy, 1994; Middleton, 1990). One of the issues which has arisen from these possible implications is to question whether the benefits of the immunization outweigh the negative aspects? This issue has generated much debate but surprisingly little effort has been spent to learn the details of the vaccine controversy (Middleton,1990). The remainder of this paper will hopefully enlighten the reader in this area.

Current Positions on the Issue

Before presenting the various stands taken with regard to the debate on immunizations it may be helpful to define the term 'immunization'.

> Immunization is the process by which protection from the disease is provided, using either passive or active means. Active immunization consists of inducing the body to produce antibodies in response to some inactivated form of a specific disease entity. Passive immunity is achieved by the administration of an exogenously produced antibody to provide protection against a specific disease for a short period of time. (Kuehl, 1992, pp. 52-53)

Those proponents for immunization feel that immunization is a positive health benefit for children because it prevents them from suffering infectious disease. "Nearly total control of both bacterial (tetanus, pertussis, and diphtheria) and viral (poliomyelitis, measles, and hepatitis B) disease is achievable through appropriate application of available vaccines" (Middleton, 1990, p. 1990). Thus, immunizations offer protection to the individual and prevent substantial outbreaks of infectious diseases through a cost-effective means. "Both live and inactivated polio vaccines have been used in Canada with equal success in preventing the occurrence of paralytic poliomyelitis" (Canadian Immunization Guide, 1993). Those in favour of immunizations state that while side effects may be experienced after receiving immunizations, the

benefits are expected to outweigh the disadvantages (Cherry et al., 1988; Committee on Infectious Disease, 1991; Deisenhammer, Pohl & Grubweiser, 1993; Health and Welfare Canada, 1993a; Hinman, Orenstein & Mortimer, 1992).

Opponents of immunization believe that the immunizing agents are harmful to those receiving them in terms of side effects or adverse events. Various studies investigating the vaccine-associated adverse events have concluded that there may be a causal relationship between immunization and subsequent illnesses (deClavijo & Weart, 1994; Middleton, 1990; Wentz & Marcuse, 1991). Injecting immunizing agents into the body defies the basic principle and ability of the immune system (James, 1988). Finally, still other critics offer evidence that the immunizations are not effective in controlling the incidence of infectious diseases, as supported by recent outbreaks of pertussis in Canada and the increased incidence of hepatitis B (Bentsi-Enchill,1992; Dambrofsky, 1995; Deisenhammer et al., 1993; James, 1988; Kuehl, 1992).

The author takes the position that immunizations do have associated risks, specifically vaccine-associated adverse events. In such instances the risks appear to be greater than the benefits offered by immunizations. These risks should be clearly explained to any individual considering routine immunization. As well, the author believes that the benefits of immunization are being minimized by new strains of infectious diseases which are resistant to immunizing agents. Thus, it is the responsibility of the nurse to educate the community about what is currently known about immunizations so that individuals can make an informed choice regarding their own immunization status.

Critical Analysis

The definition of immunization offered in the previous section clearly states that a specific disease entity, in its inactivated form, induces the body to actively produce antibodies or, as in passive immunity, an exogenously produced antibody is administered into the body (Kuehl, 1992). In either form, a foreign agent, specifically a disease, is injected into the body, supposedly for protection! Are we not counteracting the basic function of the immune system, bypassing the body's best defence mechanism - the skin, and forcing the body to fight against the mild form of a disease which has been thrust into the bloodstream without any warning and without any way out? It appears that science, in the form of a vaccine, has negated nature's own primary line of defence. In the mid 1800s Jacque Antoine Bechamp (cited in James, 1988) wrote:

> The most serious, even fatal, disorders may be provoked by the injection of living organisms into the blood; organisms which, existing in the organs proper to them, fulfil necessary and beneficial functions - chemical and physiological - but injected into the blood, into a medium not intended for them, provoke redoubtable manifestations of the gravest morbid phenomena. (p. 70)

Is it considered ludicrous or logical to strengthen our own immune

system through healthy behaviours, so as to allow it to naturally fight infection if and when this is encountered, instead of damaging the immune system with immunizations?

It is generally accepted that every vaccine has the potential to cause adverse effects. "Apparent reactions associated with the use of vaccines must be considered with respect to their severity and frequency, as well as the likelihood that they are due to the vaccine rather than to intercurrent phenomena" (Cherry et al., 1988). For example, over the past several decades many physicians have believed that the pertussis vaccine, which is administered in Canada combined with diphtheria, tetanus, and polio, to be a cause of serious neurological illness that could result in permanent sequelae or death (Committee on Infectious Diseases, 1991). After numerous studies the debate still continues. On the one hand there is evidence that there is a causal relationship between the pertussis vaccine and acute encephalopathy with an estimated risk up to 10.5 cases per million immunizations, as reported by the National Academy of Sciences' Institute of Medicine (deClavijo & Weart, 1994). This finding is supported by the conclusion of the 1981 British National Childhood Encephalopathy Study (NCES) which stated that there was an association between the diphtheria-tetanus-pertussis (DTP) vaccine and serious acute neurologic illness (Wentz & Marcuse, 1991). In the U.S. it has been found that 1 in 100 children react with convulsions, or collapse, or have high-pitched screaming, after the DPT vaccine and 1 in 300 remain permanently damaged (James, 1988). On May 3, 1985, Edward Brandt, a physician, told the U.S. Senate Committee that every year 3500 children suffered from neurological reactions because of DTP vaccines (cited in James, 1988). On the other hand the Canadian Immunization Guide (1993) stated that additional studies have failed to demonstrate an association between pertussis vaccine and permanent neurologic sequelae. At the same time, pamphlets discussing the DTP vaccine are distributed by the Department of Health of Newfoundland and Labrador which state that serious reactions can occur but are very rare and that "The risk of complications, however, from the disease, is far greater than from the vaccine". If they can occur, even if the incidence is extremely rare, does not that imply that there is an association between the vaccine and illness? Such contradictions lead one to wonder if acting appropriately is either by continuing to routinely immunize or by discontinuing the vaccine to prevent further damage.

The DTP vaccine is only one example that could be used to illustrate the adverse events that could be associated with immunizing agents. There have been reports of adverse events involving other vaccines as well (Health and Welfare Canada, 1993a), but still proponents defend the use of immunizations. Health and Welfare Canada (1993a) stated that "the rate of occurrence of such events appears to be very low and the morbidity and mortality prevented by vaccination far outweighs this very low risk of severe adverse events" (p.176). But, what defines "very low risk" to the individual, and the family, who suffer these adverse events?

Finally, routine immunizations are deemed essential by the health care system (Canadian Immunization Guide, 1993). While the author has no estimate of the financial cost of immunizations and the hospitalization due to adverse events, the question is whether the health care system and society are rewarded by the economic impact as evidenced by control or eradication of infectious disease in Canada?

"Approximately 3000 cases of hepatitis B are reported in Canada annually, and global estimates show that 6% to 10% of adults and 50% to 90% of infants become chronic carriers with high risks of cirrhosis and liver damage" (Bentsi-Enchill, 1992, p. 49). Considering that the hepatitis B vaccine has been available in Canada since 1982, why is there such a high incidence of the disease? Perhaps the vaccine is not providing the immunity that was expected, or maybe there is a lack of immunization among those individuals at high risk of infection. In any case is the vaccine beneficial to the health care system if there are still such large numbers of infected Canadians?

Outbreaks of pertussis keep occurring in Canada, with over 3700 cases reported in 1992 and 1353 cases reported in the first six months of 1993 as compared to 1139 for the same period in 1992 (Health and Welfare Canada, 1993b). Provincially there were also fairly high reports of pertussis over the past six years. As well, reports from Disease Control and Epidemiology in Newfoundland and Labrador stated that at least four of the reported cases of measles in 1994 had previously been vaccinated against the infection (Department of Health, 1980 - 1994). Thus, these individuals received immunizations at the risk of possibly experiencing adverse events from the immunizing agents only to contract the disease. Where is the benefit for these individuals?

It is possible that the bacteria responsible for these infectious disease are developing a resistance to the vaccines and antibiotics which were at one time successful (Dambrofsky, 1995). If this is the case, are we fighting a losing battle against bacterial infectious disease? Perhaps time and money may be more worthwhile researching safer, more effective means of combat.

The author has attempted to present a rational argument against the widespread use of routine immunizations on the basis of the associated risks. However, the decision to receive immunization should be left to the individuals after they have been fully informed and are aware of associated risk factors which will enable them to make informed decisions.

Impact on Nursing

Any nurse who administers immunizations has the responsibility to become knowledgeable, both about the vaccine and about the controversy which exists regarding immunizations. The nurse must ensure that the individual is aware of all possible risk factors, no matter how large or small their magnitude, so that the person is an informed consumer of health care. Nurses also have the responsibility to report any adverse events to the appropriate source and to advocate on behalf of the community for the use of the safest and most effective means of control and/or prevention of

infectious disease. Also, nurses who are at increased risk of the hepatitis B infection, must also weigh the benefits against the risks of becoming immunized against hepatitis B. As direct care givers they must also prevent the spread of infectious diseases through proper nursing techniques such as hand-washing.

Summary

In a sense, immunizations may also fail when they are successful (Hinman et al., 1992). While they have eradicated the incidence of smallpox and controlled other infectious disease, immunizations are rarely 100% effective nor are they without shortcomings.

The issues surroundings immunizations are complex and have a direct impact on nursing and the health care system. Thus, as future health care professionals, it is important that we become fully aware of the issue and recognize the implications to society.

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Conference Calendar

Up to $500 is available annually to a member, whose Alliance registration fees are paid up-to-date, to help pay the cost of attending a conference which is in keeping with the Alliance objectives of care to women and babies. So that members are aware of the conferences being offered it has been suggested that we list those which may be of interest. Just because a conference is listed does not mean that it necessarily meets the Alliance objectives. (The next money available is for 1996). If you know of any conferences, meetings, etc. which could be of interest to members please forward the information to the editor for inclusion in the Newsletter. For International Conferences the call for Abstracts is usually one year or more before the conference date. (Readers are responsible for checking the information of the conferences listed. As the information comes from a variety of sources the Editor accepts no responsibility for any misinformation).

Note: As from April 16, 1995, when telephoning the U.K. a 1 is needed before the area code number e.g. 959 will become 1959.

1995

July 3-28. "Breastfeeding: Practice and Policy" certificate course, London, England. Directors of the course are Felicity Savage and Gabrielle Palmer.
Cost: £1450.00 includes essential reference material and books but does not cover accommodation, meals or transport.
Contact: Continuing Education Office, Institute of Child Health, 30 Guildford Street, London WC1N 1EH, England. (Fax: 011-44-171-831-0488 or 011-44-171-404-2062) (e-mail: cich@uch.bpmf.ac.uk)

July 8-11. "Nurturing the World's Future", Chicago. 14th International Conference of the Le Leche League International.
Contact: LLLI Conference, Dept. B, P.O. Box 4079, Schaumburg, Illinois 60168-4079. (Telephone: 1-708-519-7730).

July 13-16. "Birth of a Profession: ILCA Ten Years Later", Scottsdale, Arizona.
Contact: International Lactation Consultant Association, 201 Brown Avenue, Evanston, IL 60202-3601.

July 17-21. "Lactation Educator Training Program", Phoenix, Arizona
Contact: Dept. of Health Sciences, UCLA Extension, 10995 Le Comte Avenue, Room 614, Los Angeles, CA 90024 (Telephone: 1-310-825-9187)

July 18-21. Annual Conference and Professional Day. 50th Anniversary of the Royal College of Midwives. Northern Ireland.
Membership fee: £55.00 (includes Midwives). Liability insurance is only available for those working in the NHS.
Contact: RCM, 15 Mansfield Street, London W1M 0BE, England.
(Fax: 0171-436-3951).

July 20-23. ICEA International Convention, Phoenix, AZ.
Contact: ICEA, PO Box 20048, Minneapolis, Minnesota 55420
(Fax: 612-854-8772).

July 20-23. "20th National Primary Care Nurse Practitioner Symposium", Keystone, CO. An international track to support the development of primary health care nurse practitioners through sharing of ideas and networking. Themes of areas of practice, professional development, education, research, but not limited to these areas.
Contact: Ellen Lemberg, UCHSC School of Nursing, 4200 E 9th Avenue, Box C 287, Denver, CO 80262. (Fax: 303-270-3198).

July 23 - 27. "Medinfo 8th World Congress on Medical Informatics. Medical information Towards the 21st Century. From Theory to Practice", Vancouver, BC.
Contact: Medinfo 95, Suite 216, 10458 Mayfield Road, Edmonton, AB, T5P 4P4.

August 1-7. **World Breastfeeding Week**
"Breastfeeding: Empowering Women".
August 4-5. The 3rd International Conference on Nurse Practitioner Practice, London, U.K.
Contact: Nicola Fulton, Conference and Exhibition Unit, Nursing Standard, Viking House, 17-19 Peterborough Road, Harrow, Middlesex HA1 2AX (Fax: 011-44-181-423-4302)

August 17-20. "Celebrating 35 years of Commitment to Women and Families", ASPO/Lamaze 1995 Annual Conference, Washington, DC.
Contact: ASPO/Lamaze, 1101 Connecticut Avenue, NW, Suite 700, Washington, DC (Telephone: 1-800-368-4404 or 1-202-857-1128).

August 18-20. Third Annual Birth Gazette Conference, Summertown, TN
Contact: 42 The Farm, Summertown, TN 38483
(Telephone: 615-964-3798).

August 19-20. "Breastfeeding: An International Scientific Conference", Melbourne, Australia.
Contact: Victorian Medical Postgraduate Foundation Inc., P.O. Box 27, Parkville, Victoria 3052. (Telephone: Australia 03-347-9633).

September ? Precertification program for foreign trained midwives. Successful completion qualifies student to take ACNM certification exam.
Contact: Diana Simopietri, Ramsey Clinic, St. Paul, MN
(Telephone: 612-221-3820).

September 4-5. "4th UN World Conference on Women", Beijing, China. WABA, IBFAN, Wellstart, are requesting lobbying of national delegates to get breastfeeding issues introduced via governments.
Contact: Madeleine Gilchrist, Beijing Coordinating Committee of Canada, c/o Canadian Research Institute for the Advancement of Women, 151 Slater Street, Suite 408, Ottawa, ON, K1V 9H1.
(Fax: 613-563-0682)

September 5-7. "6th Annual International Participative Conference for Teachers of Nurses, Midwives, Health Visitors, & Other Health Professionals", Durham, England.
Contact: Conference Administration, Graham Burn, Sets Ltd., Suffolk College, Rope Walk, Ipswich, Suffolk 1P4 4LT (Fax: 011-44-1473-216416).

September 6-8. "The Challenges and Solutions in Midwifery Education and Practice", Canterbury, Kent, England. For clinicians and midwifery teachers focusing on midwifery education, amalgamation with higher education, and the future of midwifery education. Speakers include Meryl Thomas and Betty Sweet.
Cost: £210 (residential), £120 (non-residential)
Contact: Mrs. P. Fewings, Head of Midwifery Education, Canterbury Christ Church College, North Holmes Road, Canterbury, Kent CT1 1QU England (Telephone: 011-44-1227-767700 ext. 294)

September 7-9. "Nursing in the New Millennium. Beyond Tomorrow: Building Nursing Skills for the Future", Winnipeg. Innovation in nursing and nursing care delivery. Keynote speakers: Tim Porter-O'Grady and Angela Barron McBride.
Contact: Communication Dept., Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg, MN R3C 0X2. (Fax: 204-775-6052).

September 15-16. "Breasts, Bottles and Babies - Unveiling the Myths", Hershey, PA. Speakers include Jack Newman.
Contact: Breastfeeding Support Consultants, 228 Park Lane, Chalfont, PA 18914 (Fax: 215-997-7879)

September 14-16. "Redesigning Perinatal Care: Survival in the 21st Century", Falls Church, VA. Presenters include Lisa Myers, Celeste Phillips, Carl Hammerschlag, Cynthia Evans. (Organized by the Phillips+Fenwick Institute).
Cost: $315 US before August 4; $335 US after August 4; $336 US after September 1. Discounts for three or more participants from an institution. Includes breakfast, breaks, reception, materials.
Contact: Teri Noble, Perinatal Conference Series, c/o Hill-Rom, P.O. Box 95504, Chicago, IL 60694 (Fax: 812-934-8071)

September 20-22. "Looking Beyond the Horizon - Choice, Change, Creativity and Caring", Toronto. AWHONN District Conference.
Contact: Kim Dart. (Telephone: 416-243-4266).

September 20-23. "The Fetus and Newborn: State-of-the-art care", San Diego. Eleventh annual conference.
Contact: Contemporary Forums, 11900 Silvergate Drive, Suite A, Dublin, CA 94568 (Telephone: 510-828-7100 ext. 0)

September 21-22. "Perinatal Crisis Management: A Closer Look", Rancho Mirage, CA.
Contact: Michael Holland (Telephone: 909-824-4359).

September 25-26. "Hot Topics", Sheffield, U.K.
Cost: £60 MIDIRS subscribers; £80 non-subscribers.
Contact: MIDIRS, 9 Elmdale Road, Clifton, Bristol BS8 1SL (Fax: 011-44-117-925-1792).

September 27-30. "Ambulatory OB/GYN Nursing Conference", New Orleans. Ninth annual conference for office, clinic and advanced practice nurses.
Contact: Contemporary Forums, 11900 Silvergate Drive, Suite A, Dublin, CA 94568 (Telephone: 510-828-7100 ext. 0)

September 28-30. "Women, Children and Youth HIV/AIDS Conference", Vancouver.
Contact: Continuing Education in the Health Sciences, Room 105-2194 Health Sciences Mall, University of British Columbia, Vancouver, BC V6T 1Z3 (Fax: 604-822-4835).

September 29-30. "The Ethics of Collaboration: Delivering Care in Modern Times", Toronto.
Contact: Linda Sullivan, Clinical Ethics Office, St. Joseph's Health Centre, 30 The Queensway, Room 217 SWW, Toronto, ON M6R 1B5 (Fax: 416-530-6621).

October 6-8. Conference Retreat, Chicago.
Contact: Midwifery Today, P.O. Box 2672-242, Eugene, OR 97402 (Fax: 503-344-1422) (Email: Midwifery@aol.com)

October 7-8. "Innovations in Perinatal Care: Assessing Benefits and Risks", Baltimore. Speakers include Marc Keirse, Judith Lumley, John Kennell, Ruth Lawrence, Mary Renfrew, Penny Simkin.
Contact: Diony Young, Editor, Birth, 43 Oak Street, Geneseo, NY 14454, USA. (Telephone: 1-716-243-0087)

October 11-15. "Midwifery: A Worldwide Tradition" 2nd Annual Midwifery Today East Coast Conference, New York.
Contact: Midwifery Today, P.O. Box 2672-242, Eugene, OR 97402 (Fax: 503-344-1422) (Email: Midwifery@aol.com)

October 13. "Critical Thinking Interactive Workshop", St. John's. Guest facilitators: Gaie (Rideout) Rubenfeld and Barbara Scheffer. Of interest to educators, students, counsellors, decision makers, and all health care professionals,
Cost: $50 NENL members (contact your NENL rep); $60 non-members; $25 unwaged/unemployed/retired, by September 11. $70 for everyone after September 11.
Contact: Pearl Herbert, School of Nursing, Memorial University, St. John's, NF A1B 3V6 (Fax: 709-737-7037) or the representative on the Faculty Development Committee or NENL at one of the other schools of nursing in Newfoundland.

October 13-14. "Dancing Thru Pregnancy Afterdance", New Haven, CT.
Contact: DTP. Inc., Box 3083, Stony Creek, CT 06405-1683 (Telephone: 1-203-481-2200)

October 17-19. "Teaching Skills for the Childbirth Educator", San Diego, California.
Contact: ICEA, PO Box 20048, Minneapolis, Minnesota 55420 (Fax: 612-854-8772).

October 18. "New Directions in Maternal/Child Health Care" 4th Annual Conference, Toronto. Speakers include Sheila Kitzinger.
Contact: Perinatal Nursing Research Unit, 600 University Avenue, Suite 1200, Toronto, ON M5G 1X5 (Telephone: 416-586-3180).

October 19-20. "Teaching and Learning in a Clinical Setting". A workshop in Health Sciences Education, Hamilton.
Contact: Annette F. Sciarra, Programme Administrator, Programme for Faculty Development, McMaster University, Faculty of Health Sciences, Room 3N51, 1200 Main Street W, Hamilton, ON L8N 3Z5 (Fax: 905-528-6552).

October 19-24. "Lactation Training Program", Lombard, Illinois. Five day lactation management course followed by one-day clinical case management. Home-study also available.
Contact: Breastfeeding Support Consultants, 228 Park Lane, Chalfont, PA 18914 (Fax: 215-997-7879).

October 20-22. "Teaching Skills for the Chidbirth Educator", Portland, Oregon.
Contact: ICEA, PO Box 20048, Minneapolis, Minnesota 55420 (Fax: 612-854-8772).

October 24. **The Charter of the United Nations** came into force on this date 50 years ago.

October 26-27. "First Annual Conference of the World Foundation for Medical Studies in Female Health", Carisbad, California
Contact: WFFH, Conference Registration, 405 Main Street, Port Washington, NY (Fax: 516-944-8663).

October 27-28. "7th National Nursing Conference on Violence Against Women", St. Louis, MO. Sponsored by the Nursing Network on Violence Against Women International.
Contact: Sue Dersch, AWARE Program, Barnes Hospital/Nursing Office, One Barnes Hospital Plaza, St. Louis, MO 63110 (Telephone: 314-362-9273)

October 27-28. "Baby Friendly . . . The Commitment Continues", Midland, MI
Contact: Lactation Support Services, MidMichigan Regional Medical Centre, 4005 Orchard Drive, Midland, MI 48670 (Fax: 517-839-1988).

November 6-10. Lactation Consultants Training Course, Washington.
Contact: Lactation Center and Milk Bank, Georgetown University Hospital, 3800 Reservoir Road, Washington, DC 20007 (Telephone: 1-202-784-6455).

November 10-11. "Intrapartum Nursing Practice Summit", Washington. Includes Intrapartum nursing documentation; staffing trends; fetal assessment; open forum on the current state of practice.
Cost: $225 US AWHONN members, $275 US others.
Contact: AWHONN Education, 700 14th Street, NW, Suite 600, Washington, DC 20005-2019. (Fax: 202-737-0575).

November 10-11. "Dancing Thru Pregnancy Afterdance", Fort Myers, FL
Contact: DTP. Inc., Box 3083, Stony Creek, CT 06405-1683 (Telephone: 1-203-481-2200)

November 12-16. "Blending the Best of the American and Canadian Systems, an Executive Program in Management and Leadership for the Academic Health Sciences", Niagara Falls, ON.
Contact: Anne Kochmanski, Program Coordinator, Management Development Programs, Faculty of Health Sciences, McMaster University, 1200 Main Street W, Hamilton, ON L8N 3Z5 (Fax: 905-546-0800)

November 14. "Keep it Normal", London, U.K. Speakers include: Sheila Kitzinger, Nicky Leap, Jilly Rosser.
Cost: £32 MIDIRS subscribers; £42 non-subscribers.
Contact: MIDIRS, 9 Elmdale Road, Clifton, Bristol BS8 1SL (Fax: 011-44-117-925-1792).

November 14-15. "From Hospital to Community: Working Together to Support Breastfeeding", Ottawa, ON. Current trends in maternity and newborn care. Speakers include Chloe Fisher, Ruth Lawrence, Jack Newman,
Contact: Janet Bowes, Ottawa-Carlton Health Dept. (Telephone: 613-722-2281) or Debra Kaye, PO Box 72, Munster, ON K0A 3P0

November 23-December 3. "Midwifery Study Tour to Uganda - The Pearl of Africa", Kampala. The tour will combine professional and cultural visits. Will look at the work of the Safe Motherhood Initiative and will include visits to maternity hospitals, rural clinics and traditional birth attendants, the Aids Support Organisation Program, a VSO midwife volunteer, and also the Queen Elizabeth National Park (by British Journal of Midwifery)
Cost: £2195 (fully inclusive from Britain)
Contact: Master Travel, Freepost (SE 7045), London, SE24 9BR, UK (Telephone: 011-44-181-671-7521)

November 27-29. National Nursing Research Conference jointly sponsored by CAUSN, CNA, CNRG, CNF.
Contact: Canadian Nurses Association, 50 Driveway, Ottawa, ON K2P 1E2 (Fax: 613-237-3520)

December 3-6. "At the Centre of Health Care Reform". An International Community Health Centre Conference, Montreal.
Contact: CHC International Conference, P.O. Box 174, Station B, Montreal, PQ H3B 3J5 (Fax: 514-842-9973).

December 14-15. "Perinatal Home Care", New Orleans. Workshops on December 13 "Third Party Payer Relations", or "Cultural Aspects of Perinatal Home Care"; December 16 "The Dollars and Sense of High Risk Neonatal Home Care", or "Nurse Managed Perinatal Home Care".
Cost: $219 AWHONN members, $239 others; after December 1 $229/$249
Workshops: December 13 $69 US; December 16 $99 US.
Contact: Mosby, 11830 Westline Industrial Dr., P.O. Box 46908, St. Louis, MO 63146-9806. (Fax: 800-535-9935).

1996

Jan. 27-Feb. 3. "C.E.'S @ SEA" 4th Neonatal-Perinatal conference at sea. Sails from Miami to St. Thomas, St. Marten and San Juan, Puerto Rico.
Cost: From $1119 US per person includes conference/cruise and air prices. Registration limited to 100 participants.
Contact: Barbara Quinn Telephone: 1-513-395-8471.

March ? Caribbean International Conference, San Juan, Puerto Rico
Contact: Midwifery Today, P.O. Box 2672-242, Eugene, OR 97402 (Fax: 503-344-1422) (Email: Midwifery@aol.com)

May 26-31. "The Art and Science of Midwifery gives Birth to a Better Future". The 24th Triennial Congress of the International Confederation of Midwives, Oslo, Norway.
Abstracts: June 1, 1995. Completed papers in by December 1.
Main themes: Reproduction and infant health; Cultural differences in childbirth practice and midwifery; Psychological aspects of childbirth; Psychological aspects of childbirth, women's experiences; Midwifery education, research and leadership.
Cost: Before October 30 - NOK 4000; October 31 to February 28 - NOK 4900; March 1, 1996 onwards - NOK 5900.
(NOK = approx. 22 Cdn. cents)
Contact: Team Congress, P.O. Box 6, N-6860, Sandane, Norway. (Fax: 47-57-866-025).
For questions about the scientific programme contact: Norwegian Association of Midwives, Tollbugt, 35, N-0157, Oslo, Norway. (Fax: 47-2-242-2207).
Accommodation prices: Between NOK 185-1500 depending on category of hotel and if a double or single room. Price includes breakfast.

May 26-30. "Quality in Health Care", 13th International ISQua Conference, Jerusalem.
Contact: Conference Secretariat, ISAS International Seminars, P.O. Box 574, Jerusalem, Israel (Fax: 972-265-20558).

May 27-29. ARNN 42nd Annual Meeting, St. John's.
Contact: ARNN, P.O. Box 6116, St. John's, NF A1C 5X8 (Fax: 709-753-4940).

June 2-6. AWHONN 1996 Convention, Anaheim, California. Enhance knowledge, skills and talents to make critical choices in directing care for women and newborns.
Abstracts: August 1, 1995.
Contact: Denise Savage, AWHONN, 700 14th St., N.W., Suite 600, Washington, D.C., 20005-2019 (Fax: 202-737-0575).

June 16-19. Canadian Nurses Association annual meeting and Biennial Convention, Halifax
Contact: Canadian Nurses Association, 50 Driveway, Ottawa, ON K2P 1E2 (Fax: 613-237-3520).

June 24-27. "Research on Nursing Throughout the Life Span". Eighth Biennial Conference of the Workgroup of European Nurse Researchers, Stockholm, Sweden.
Contact: Stockholm Convention Bureau, P.O. Box 6911, S-102 39, Stockholm, Sweden. (Fax: 46-834-8441). or
Eva Szutkowska, Swedish Association of Health Officers, WENR, P.O. Box 32 60, 103 65, Stockholm, Sweden (Fax: 46-820-4096)

July 2-5. CPHA 87th Annual Conference, Vancouver.
Contact: CPHA, Suite 400, 1565 Carling Avenue, Ottawa, ON K1Z 8R1 (Fax: 613-725-9826).

October 14-18. "Breastfeeding: Science and Ethics, Theory and Practice", to be held in an Asian country. To look beyond the Innocenti Declaration by evaluating efforts since 1990, to build new commitments and to plan action in favour of breastfeeding. The forum is expected to mobilise, update, train and encourage sharing and networking.
Contact: Global Forum on Breastfeeding, c/o WABA Secretariat, P.O. Box 1200, 10850 Penang, Malaysia. (Fax: 60-4-657-2655)

1997

June 15-24. "Sharing the Health Challenge", Vancouver. 21st ICN Quadrennial Congress.
Abstracts: before January 15, 1996.
Contact: Canadian Nurses Association, 50 Driveway, Ottawa, ON K2P 1E2 (Fax: 613-237-3520)

A New Education Initiative in Nova Scotia

The Perinatal Education Partnership Project (PEPP) is an innovative, unique approach to meeting the health care needs of childbearing families in Nova Scotia through addressing the learning needs of practicing perinatal nurses. As of May 1995, 21 local site students and 10 distance students have enroled in 3 of the 5 BScN courses in the PEPP stream of the BScN (for RNs) program at Dalhousie University. The PEPP has incorporated the following three goals in its planning, implementation and evaluation strategies:
1. relevance a) to the primary health care needs of perinatal families from the antepartum through to the postpartum periods, and b) to the perceived, assessed needs for reflective practice by perinatal nurses;
2. accessibility to baccalaureate nursing education through distance delivery of university credit courses using interactive, computer-based technology as well as incorporating clinical work settings and situations into the learning experiences; and
3. partnership for the delivery of baccalaureate nursing courses to post-RN students through active cooperation, coordination and collaboration of resources between academic and service agencies - the Dalhousie University School of Nursing, the Grace Maternity Hospital, the Reproductive Care Program of Nova Scotia and the Nova Scotia Department of Health. For further information, contact the PEPP office at 1-800-PEPP.
(from COGNN Newsletter).

ASK THE EXPERTS

Q *What is the significance for nurses of the difference between "jaundice while breast-feeding" and "breast milk jaundice" in the healthy newborn?*

A Nurses who work with mothers and their newborns know that healthy breast-fed babies develop jaundice more frequently and with greater severity than their healthy bottle-fed counterparts. Nurses who are knowledgeable about the difference between this early "jaundice while breast-feeding" and the later onset "breast milk jaundice" will be able to facilitate breast-feeding success and minimize the incidence of severe jaundice, thus avoiding expensive and invasive work-ups.

"Jaundice while breast-feeding," sometimes called "exaggerated physiologic jaundice," (Brown, 1992) manifests in the newborn after 24 hours of age, peaks on the third or fourth day of life and disappears by the seventh to 10th day. Despite the common occurrence of "jaundice while breast-feeding," studies of infant characteristics or feeding patterns that affect this type of hyperbilirubinemia remain inconclusive (Brown, 1993). However, recent studies suggest that the deficient calorie intake and the low stool output of some breast-feeding newborns in the first few days of life may be significant factors contributing to hyperbilirubinemia in those newborns (De Steuben, 1992). Calories are required to sustain conjugation of bilirubin in the liver. Low stool output permits bilirubin from meconium to be reabsorbed into the circulation via the enterohepatic shunt. Thus, both deficient calorie intake and low stool output effect increase in serum bilirubin levels. If this explanation is correct, nurses should intervene and teach ways of establishing adequate breast milk volume, encouraging mothers to breast-feed their infants within two hours after birth and on demand without regard to limiting time at the breast. Supplementary feedings, especially of glucose water, may decrease breast-feeding frequency, thus increasing the risk of jaundice. One recent study concluded that "babies breast-fed on demand seem to have a low incidence of hyperbilirubinemia similar to that found in formula-fed neonates" (Rubaltelli, 1993, p. 104).

In contrast, "breast milk jaundice" is an uncommon diagnosis of exclusion made when jaundice is still evident in healthy breast-feeding newborns in the third week of life and no pathologic reason for the jaundice has been identified (Brown, 1993). Our understanding of the etiology of "breast milk jaundice" remains inadequate (De Steuben, 1992). "Regardless of its cause, the potential for ... breast milk jaundice to exert harmful effects on healthy term infants has not been substantiated" (Brown, 1992, p. 614). Because "breast milk jaundice" poses minimal risk to healthy infants, what, if any, intervention is needed continues to be debated among professionals. Parents who are well informed about the benefits of breast-feeding and the low risk of persistent hyperbilirubinemia at the levels observed with "breast milk jaundice" may participate with their health care providers in deciding the appropriate actions for their infant.

References

Brown, L. P. (1992). Breastfeeding and jaundice: Cause for concern? *NAACOG's Clinical Issues*, *3*(4), 613–619.

Brown, L. P., Arnold, L., Allison, D., Klein, M. E., & Jacobsen, B. (1993). Incidence and pattern of jaundice in healthy breast-fed infants during the first month of life. *Nursing Research*, *42*(2), 106–110.

De Steuben, C. (1992). Breast-feeding and jaundice. *Journal of Nurse-Midwifery*, *37*(2, Supplement), 59s–66s.

Rubaltelli, F. F. (1993). Unconjugated and conjugated bilirubin pigments during perinatal development: The influence of breast-feeding on neonatal hyperbilirubinemia. *Biology of the Neonate*, 64, 104-109.

The author of this month's "Ask the Experts" column is **Zola D. Golub, MEd, RNC, FACCE**, a corresponding member of AWHONN's Committee on Practice and neonatal intensive care unit educator at Northern Westchester Hospital Center in Mount Kisco, N.Y.

Reminder...

The next issue of the *AWHONN Voice* will be a combined June/July issue. Your copy should be arriving toward the end of June.

A subliminal message?

In many ways, parenting today would appear to be a more complicated business than ever before. Parents are faced with a plethora of choices. As health professionals we are expected to give information to enable them to make informed choices. However, our advice is only part of a whole range on offer and clients are bombarded with information from a host of sources. One of the most influential sources is from the commercial sector in the form of advertising campaigns. Advertising has a powerful influence on the decisions made by parents. Take, for example, infant feeding. Infant formula companies spend £12 million (BMAC 1993) in the UK alone on advertising each year. This figure reflects the importance that the manufacturers must place on the power of advertising. Because of the restrictions on advertising directly to parents via parenting magazines, much is aimed directly at health professionals in an attempt to influence their judgements regarding the benefits of using their particular brand of milk. However, using the midwife or health visitor as the messenger surely cannot be as lucrative as having direct contact with the client group.

These restrictions on advertising were actually enforced by the industry who operated a voluntary code to supposedly control the marketing of baby milk formula. However the code did not apply to Follow on Formulas (FOMS) which gave the industry carte blanche to advertise these products and thereby inadvertently their other infants' formula milks.

Open any parenting magazine and you are faced with a barrage of advertisements for FOMS. Examine the contents of the complimentary follow-up "bounty box" and there are free samples of SMA "Progress" or Cow and Gate "Step-Up". There have even been attempts at television advertising when Young Nutrition launched a television advertising campaign in June 1992 (BMAC Update[1]). This high profile advertising could beg the question of what is the true purpose of these products.

The fact that FOMS were not governed by the code could therefore be viewed as a loophole by the industry. This accusation has been levied by the Baby Milk Action Group, a campaigning organisation who oppose the commercial promotion of bottlefeeding. They ask if follow-on milks have been specifically created to circumvent the restrictions of the World Health Organisation International code of marketing of Breast Milk Substitutes[2]. The product designs in terms of presentation would certainly support the view that there is an element of subliminal influence, as the follow-on products are virtually indistinguishable from their infant formula counterparts – a fact that can surely be viewed with some degree of suspicion.

What are Follow-milks?

According to the WHO Codex Alimentarius Commission[3] they are:

> "a food prepared from the milk of cows or other animals/and or other constituents of animals and/or plant origin which have been proved suitable for infants from the 6th month on and for young children".

The manufacturers claim that they have developed FOMS "as an alternative to cows milk

> " and that they are "specially formulated to meet the nutritional needs of older infants".
>
> (IDFA Health Visitor, vol. 66)[4].

Do we need FOMS?

The industry claims that FOMS provide a stepping stone between breast milk or infant formula and cows milk. However, nutritionist Clare Schofield[5] says that FOMS subvert the weaning process, which is the change-over from liquid to mixed solid based diet. She maintains that the provision of so-called nutritionally complete liquid follow-on milk is pointless and may be counterproductive to the weaning process.

According to Palmer[6] there does not appear to be any reason why a non-breastfed baby should not continue with standard infant formula (if bottle fed) and leading nutritionists agree unanimously that continued breastfeeding with appropriate solid foods after six months is the best practice.

The most vociferous argument marketed by the industry in favour of FOMS is that they provide babies with protection against iron deficiency. This point is laboured in their advertisements aimed at health professionals where the copy informs us that

> "It is richer in iron ... than cows milk, making it nutritionally appropriate as a main drink'[7].

To counter this claim, Fomon[8] states that standard infant formulas, designed for young infants, are reasonably well suited to meeting needs of infants during the latter half of the first year of life, and that the level of iron fortification of standard infant formulas seem appropriate for older infants. Palmer[6] further states that cows milk is a poor vehicle of iron and the more that it carries, the less is absorbed, so onl 4-10% of iron in FOMS is used and 90-96% wasted. Furthermore in breast milk, up to 70% is absorbed which means that breastfed babies get more than double that of babies given FOMS.

In May 1994, Dr Ernesto Pollit[10] of the University of California, published a research article in Lancet questioning the assumption that it is safer to give iron of children who do not have iron deficiency. In a study in Indonesia, participants who were not initially found to be iron deficient appeared to have a deficit in their growth rate when supplemented with iron.

Duggan[9] claims that iron deficiency is a problem of poverty anyway, and that the research findings cited by the industry that "children at risk of iron deficiency come from all social backgrounds" is supported by a single review. She suggests that the prevention of iron deficiency "could be achieved by paying due attention to the progression of the weaning process".

I would suggest that the reasons for the promotion and sale of follow-on milks would appear to have little substance. At face value they offer the manufacturers the opportunity to exploit the loophole that exists and to promote the sale of formula milks.

Conclusion

In June 1994 a European Union directive was supposed to be accepted by our government to regulate effectively the sale and promotion of infant formula and FOMS. The directive was expected to become legislated in a UK law. However on January 16th 1995, the government voted against the proposals to ban the advertising of infant formula (including FOMS) in the UK.

By translating the voluntary code into law, the government had a real opportunity to promote breast feeding by strictly enforcing the advertising ban on formulas and to include FOMS in that ban. As a result of this decision, infant formula will continue to be advertised in professional health journals, and FOMS will be permitted to be advertised anywhere the manufacturers desire.

By failing to legislate, the government have put commercial interests before infant health and have denied mothers the right to informed choice on the way that they feed their babies.

Lorna Davies
March 1995

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4 The Infant and Dietetic Foods Association (1993) Misrepresenting milks: the industry responds: Health Visitor: Vol 66 No 10: October 1993, p 336-7
5 Schofield C (1991) BMAC update: Summer 1991 p.6
6 Palmer G (1993) Any Old Iron: Health Visitor: Vol 66: No 7 July 1993, p. 248-9
7 Cow and Gate Advertisement: Health Visitor: Vol 66 No 10: Oct 1993
8 Fomon S J, Sanders K D, Zeigler E E (1990) Formulas for Older Infants: Journal of Paediatrics 1990: 116: 690-96
9 Duggan M (1993) An Overbalanced Response by Industry
10 Pollitt E (1994) Too much iron in children may retard growth: Lancet: May 21 1994 p. 1252-54

Future Nursing Education Faculty Development Committee and
Nurse Educators of Newfoundland and Labrador (NENL)

REGISTRATION FORM

CRITICAL THINKING WORKSHOP

Date: Friday, October 13, 1995
Time: Registration 8 am, sessions from 8.30 am to 5 pm
Coffee/tea breaks included; Lunch not included
Place: Littledale, St. Clare's School of Nursing,
Waterford Bridge Road, St. John's
Parking: Corpus Christi Church

Of Interest to:
Educators, Students, Health Care Professionals
Counsellors and Decision Makers

Facilitators: **M. Gaie (Rideout) Rubenfeld** RN, BS, MS
Barbara K. Scheffer RN, BS, MS
both from Eastern Michigan University
Co-Authors of: Critical Thinking in Nursing: An Interactive Approach (in the Health Sciences Library at MUN). They have other publications on critical thinking, and have presented at conferences and facilitated workshops.

Registration fees: By September 11, **$60** except for:
$25 unwaged/unemployed/retired;
$50 ($30 + $20) NENL members.
After September 11, $70 for everyone.
No Refunds after September 11. Receipts given at the Workshop

Detach Detach

I enclose a cheque/money order for $_____ made out to NENL

I am an:
Educator at: _____;

Student at (and area of interest): _____;

Other Interested Person (please specify): _____

Name: _____

Address: _____

_____

Postal Code: _____

Telephone No: _____ Fax No: _____

Date: _____

Mail to: NENL, c/o School of Nursing, Memorial University of Newfoundland, St. John's, NF A1B 3V6
(or give to your local NENL representative)
Inquiries: Pearl Herbert, 737-6755.

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

APPLICATION FOR MEMBERSHIP
1995

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.
Membership for those who are unwaged is $10.00

Signed: _____ Date: _____

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