ASSOCIATION of MIDWIVES of NEWFOUNDLAND & LABRADOR

Newsletter No. 24, January 2003

Association of Midwives of Newfoundland and Labrador
(Chapters in Goose Bay and St. John's)
Newsletter 24
January 2003

MISSION STATEMENT

To provide professional information for midwives, and to promote the recognition of the role of midwives, and the need for appropriate legislation so that midwives in Newfoundland and Labrador are publicly funded to legally provide research-based, total midwifery care as a choice for childbearing families in this province.

This Newsletter includes the report of our January meeting, the letter received from the Minister, and important information regarding the Canadian Association of Midwives (CAM). Members are being asked to vote on whether or not we should stay as members of CAM, especially if this involves an increase in our membership fees. Please submit your vote to our secretary, Karene Tweedie, before the end of February as we have to let CAM know what we decide (see pages 2-5).

Membership fees for 2003 are now being collected. The fees were due January 1, so if you have not yet paid, please send your fees to our Treasurer by the end of the month. A membership form is at the end of the Newsletter. We urgently need new members, both full and associate, so please spread the word about the AMNL.

This Newsletter is the method by which members are kept informed about midwifery and other maternity matters. Let the Editor know what you would like to see in the Newsletter.

Pearl Herbert, Editor, c/o School of Nursing,
Memorial University of Newfoundland, St. John's, NF, A1B 3V6 (Fax: 709-777-7037)

AMNL Annual General Meeting, Tuesday, April 15, 2003, 4:00 p.m. (Island time).
Members on the Labrador Coast advise Telemedicine prior to the meeting

Nominations for the Executive Committee
The present executive may serve for another term
Nominations Officer is Kay Matthews and send Nominations before ~~the end of~~ February 21, 2003
E-mail: matthews@mun.ca Fax: 709-777-7037

The Future of AMNL and CAM
Submit your vote before February 21, 2003

Executive Committee

President: Ann Chaulk, Labrador Health Centre, HV-GB, Labrador, A0P 1E0 (Fax: 896-5130)
Treasurer: Jean Hunt Secretary: Karene Tweedie
Past President: Pearl Herbert Newsletter Editor: Pearl Herbert
Home page: http://www.ucs.mun.ca/~pherbert/ Newsletter in HSLibrary: WQ 160 N457n

General Meeting, Tuesday, January 14, 2003

There were eight members present from St. John's and HVGB. The letter received from the Minister of Health and Community Services was discussed, and a copy is included in this Newsletter. CBC TV aired the segment on midwifery at Christmas but neither Karen nor Karene, who had been interviewed for this item, were advised of the time beforehand. The subject was on the lack of choices in this province, whereas in other provinces mothers may choose to have a midwife provide care and attend the birth.

A report from the informal meeting of the St. John's Chapter included the plans to commence providing midwifery services to the women in the St. John's region. Karen is looking for a midwife to work with her in the community. Women are asking for prenatal classes and suggestions were offered as to where there may be rent-free space. There is a plan to have a video made of home births to use to publicize present day midwifery to the public and professional health providers. (Cost estimated as between $300 and $700). This is the only Canadian province where a self-employed midwife is unable to take the Neonatal Resuscitation Programme - only those employed by the Health Corporations are allowed to take the programme.

The chapter in Happy Valley Goose Bay had a coffee table to raise money to give to the President towards her expenses for the Canadian Association of Midwives (CAM) annual general meeting and conference in Vancouver last October.

The AMNL had received Christmas greetings from the Board of Directors, Management and Staff of the Health and Community Services, St. John's Region. [Following this meeting it was found that a card had also been received from the American College of Nurse-Midwives].

Nominations for an Executive are needed for 2003/2005. Kay Matthews had agreed to Chair the Nominations and Election Committee. CAM is wanting elections to be held with effect from October to September, but as this Constitution and Bylaw change needs to be approved at the AMNL annual general meeting, it will not be possible this year even if the members are in agreement. The AMNL annual general meeting is tentatively set for April 15, 2003.

There was much talk about the CAM request for increased fees, a subscription for all Association members (not individuals) for the midwifery research journey, and the increased number of conference calls per year which are also getting longer. With the number of AMNL members which we currently have this would only be possible by doubling the membership fee. Therefore, we have to carefully study our priorities for spending money and how much we spend on our own Association.

Our Financial Problems and Belonging to CAM - What Do AMNL Members Want?

Our National Membership

The Association of Midwives of Newfoundland and Labrador (AMNL) is currently a member of the Canadian Association of Midwives (CAM). To refresh readers' memories, originally there were regional midwives' associations. In this province midwives could join the Atlantic Region Midwives Association (1974-1980). Gradually these associations ceased to exist, and one of the reasons stated by those in the west of the country, was so that members could form a provincial association and work toward legislation in their own province. Then in 1987 a national organization was formed to enable midwives easier communication between each association, so they could also assist each other in working towards legislation. This organization was the Canadian Confederation of Midwives (CCM).

The Cost of Our National Membership

Our provincial midwives association has always been a member of the national association, and paid the required fee per member. Originally the annual fee was $5.00 per midwife, but then it increased to $15.00. In 2000 the board of the CCM voted to become the Canadian Association of Midwives (CAM), and in 2001 the annual fee increased to $35.00 per member. Now CAM has proposed another increase to $50.00 per member for unfunded provinces, to include $10.00 per member for the midwifery research journal. (There are no individual subscriptions for this journal as this would involve additional administrative costs). There is an option whereby AMNL could continue paying $35.00 per member as CAM has said that "if the recommended reduced rate cannot be paid, then we would accept the rate that group would be willing to pay (not less than last years rate) in order to ensure they remain within CAM". So our CAM membership fee per midwife would be $35.00 + $10.00 = $45.00 (includes the journal). This money goes directly to CAM and is not used by AMNL.

The fee per member is not the only money which we pay CAM. We pay the connecting charges for telephone conference calls which average approximately $50.00 per call. The AMNL refunds the long distance telephone charge to the President, which currently averages $20.00 per call. So, for each conference call we spend about $70.00. CAM has had about three of these meetings a year, but now they are proposing to increase these to every alternative month, resulting in five conference calls a year. This could cost AMNL about $350.00 per year. In addition to this, AMNL also pays the President, who represents us at the CAM annual general meeting, $500.00 towards travelling expenses. (AMNL Bylaws V.A.3).

The Advantages of Belonging to CAM from the CAM Bylaws:

The Canadian Association of Midwives will promote, protect and enhance the profession of midwifery and support midwives by, among other things:

- representing midwifery in Canada;
- promoting and protecting midwifery as an integral part of the health care system in Canada;
- promoting the inclusion of midwifery as a funded and self-regulating health profession in all provinces and territories in Canada;
- promoting and facilitating inter-provincial/territorial reciprocity for registered midwives in Canada;
- coordinating communication among professional midwifery associations and midwives across Canada;
- providing information about midwifery to the public, governments and other health professionals;
- participating in the regular review of Canadian midwifery education programmes;
- promoting and/or providing opportunities for continuing education;
- developing clinical practice guidelines which are evidence-based;
- promoting and supporting research in midwifery; and
- representing Canadian midwifery in the international midwifery community.

The Canadian Association of Midwives will advocate for high quality maternity and newborn services in Canada by:

- promoting universal access to midwifery care for all women in Canada;
- promoting continuity of care, informed choice, choice of birthplace;

- developing policies and position statements for midwifery, and maternal and newborn care in Canada; and
- reviewing policies and position statements developed by Canadian and international organizations for maternal and newborn care. Benefits of Membership. Individual members of CAM have voting privileges at CAM annual members meetings. Members receive the CAM Newsletter, are welcomed to submit articles for publication in the newsletter, are entitled to subscribe to CAM's email list-serve, will be invited to attend each annual members meeting, and are represented on the CAM Board of Directors by a selected member of their professional association

4.2 (b) Associate Membership: CAM may issue associate memberships to individual midwives who reside in a province or territory where no provincial or territorial midwifery association is in existence.

On the open section of the web site it states: "If you are a practising midwife, please contact your provincial/territorial midwifery association's representative to CAM for information on your membership in CAM." [Therefore, midwives in a province where there is a midwives' association are not entitled to belong to CAM as individuals].

A Midwives Association that is a CAM member is also expected to have a representative attend meetings, such as conference calls and face-to-face meetings.
5.17 A Board membership shall be deemed vacant:
on missing two consecutive Board meetings without good reason.

(Http://members.rogers.com/canadianmidwives/about/bylaws.html for a summary of the Bylaws).

<u>Our Present Position</u>

Once all the midwives associations were striving for midwifery legislation, but now this has been obtained by half of the provinces, and as they are developing they are looking for more benefits and memberships, such as in the International Confederation of Midwives (ICM). This is an added expense for CAM. The other half of the provincial associations, and the territories, are still striving to pass the legislation hurdle and the original expectations from a national organization (whether a confederation or an association) are unchanged.

In Newfoundland and Labrador we have been trying to obtain midwifery legislation for many years. The Provincial Advisory Committee for Midwifery reported in May 1994, and it was not until the Fall of 1999 that a Midwifery Implementation Committee was appointed. That committee finished its mandate in October 2001. Now midwives are told that there are not enough women who want midwifery care, when the truth of that statement has been debated the Minister has said that there are insufficient midwives in this province (on a December 2002 TV programme). We have a need to increase the size of membership of the AMNL, to communicate information about present day midwifery practice to both non-practising midwives and the general public. One of the suggestions is to make a video about midwifery in the community which of necessity will include home births as without legislation there are no hospital privileges. This will cost money. We do need to have ways of fund raising.

Can the AMNL Afford CAM Membership?

It is very important that AMNL does not run into debt. Therefore, members have to consider what is best for AMNL and what they can commit themselves to pay.

The question now is, can the AMNL afford to be a member of CAM? The $350.00 (conf nce calls) +n$500.00 (for AGM travelling) = $850.00. The minimal CAM membership fees will be $45.00 from each midwife which does not go towards AMNL costs.

The basic AMNL membership fee is $40.00 and with 10 members this would give the AMNL $400.00. This does not pay for the $850.00 needed for CAM. It would cover the conference calls without the President attending the annual general meeting. The AMNL Newsletter would have to be limited, but how much do members wish to maintain the Newsletter? However, would AMNL members want to pay another $10.00 for the midwifery research journal?

Our Options

1. To pay for all of CAM activities, including the journal, the fee would need to be raised to:
   For midwives $125.00 (includes $45.00 for CAM).
   For non-midwives $80.00.

2. If we could quickly double our membership (in the next one or two months):
   For midwives $85.00 (includes $45.00 for CAM)
   For non-midwives $40.00

3. If our CAM representative only attends conference calls and not the CAM AGM, and to notify CAM that our members do not want the research journal, but we still need extra members:
   For midwives $75.00 (includes $35.00 for CAM)
   For non-midwives $40.00

4. If our CAM representative only attends every alternative conference call, and does not go to the CAM AGM:
   For midwives $75.00 (includes $35.00 for CAM)
   For non-midwives $40.00

5. To leave CAM until we have midwifery legislation in this province. To have a drive for increasing membership and community awareness of the practice of present day midwifery care, and to keep the Newsletter as a main means of communication between members:
   For midwives $40.00
   For non-midwives $30.00

6. Any other suggestions from members.

URGENT: We have to make a decision and advise CAM of whether or not we are going to remain members. Please complete the enclosed form and indicate your choice of option. If number 6 please give details.

GOVERNMENT OF NEWFOUNDLAND AND LABRADOR

Department of Health and Community Services
Office of the Minister

October 10, 2002

Ms. Pearl Herbert, Past President
and Ms. Karene Tweedie, Secretary
Association of Midwives of Newfoundland and Labrador

Dear Ms. Herbert and Ms. Tweedie:

Thank you for your follow up letter of September 20, 2002, on the practice of midwifery in Newfoundland and Labrador. I feel that your disappointment at the delay in enacting self-regulatory legislation is certainly warranted but unavoidable given the current legislative circumstances. However, this situation is expected to be temporary.

As you have indicated in your most recent letter, the possibility of an interim solution such as amending the ARNN Act does raise numerous practical implementation issues that would (sic) very difficult to overcome. Furthermore, such an option would likely require a reassessment of the policy directives set forth by the Midwifery Implementation Committee. Upon consultation with various departmental officials, it has been decided that self-regulation of the midwifery profession will be temporarily postponed until a sufficient number of occupational groups are in a better position to make the required legislation feasible. I regrettably inform you of this decision while expressing great appreciation of your past efforts on this initiative.

I would like to stress that government still supports the self-regulation of midwives in the Province of Newfoundland and Labrador and will move ahead with the required legislation as soon as feasible. In the meantime, I would encourage the Association of Midwives of Newfoundland and Labrador to continue with its efforts of advocacy and education in the area of midwifery.

If you have any further questions, feel free to contact Mr. Reg Coates, Director of Legislative and Regulatory Affairs, Department of Health and Community Services. Mr. Coates can be reached at (709) 729-3421. Once again, I would thank you for your organization's commitment on this initiative and continued patience with this legislative process.

Sincerely,

GERALD SMITH, M.H.A.
District of Port au Port
Minister

cc: Reg Coates
Jeanette Andrews

P.O. Box 8700, West Block, Confederation Building, St. John's, Newfoundland, A1B 4J6

CAM June 6 Report from Ann Chaulk

Highlights of Canadian Association of Midwives Board Meeting held on June 6th, 2002, via telephone conferencing system. The meeting commenced at 20.05 hr. Atlantic time and lasted ap oximately 3 ½ hoursawith 11 members present representing provinces across the country and North West Territories. A change over in British Columbia has taken place with Jeanette Page now representative for that Province. Our new treasurer Eileen MacKenzie was also present as well as Fran Wertmann who recently resigned as Treasurer.

International Confederation of Midwives Meeting held in Vienna, Austria, April 2002.

Kim Campbell reported that Quebec's bid to host the ICM congress in 2008 was strong and very well presented but lost the bid to Glasgow. However Bridget Lynch of CAM was selected as America's representative for the next triennium. As a delegate to the ICM Board Meetings there were 116 agenda items discussed over 3 days and it was the highlight of her career to represent Canada at this meeting. Approximately 2500 midwives attended the ICM Congress with many areas of midwifery covered that it was often difficult to choose which presentation to listen/attend. It was noted that 7 or 8 Canadian midwives gave presentations during the Congress with Bridget Lynch giving one of the keynote addresses.

Canadian Association of Midwives Annual General Meeting.

A request had been received from British Columbia for CAM to organize a conference around the subject of Canadian Midwifery Models of Care. Although it is a little short notice, Kim thought that it would be an appropriate time to include a 2 day conference with the planned AGM in October 2002. Members were asked who wished to be part of the planning committee for the conference as well as proposed topics and speakers. It was felt that input should also be included from unregulated provinces.

Practice Guidelines

There have been many requests from the membership for CAM to develop Clinical Practice Guidelines. This is a difficult and time consuming project, but if they were set up, CAM would be in a position to provide assistance and support to members with their use. The regulated provinces require midwives to have practice guidelines or protocols but this has met with difficulty due to small practice groups, insurance problems and lack of funding. It was noted that there are pros and cons for establishing such guidelines, but individual midwives are responsible for using evidenced based and current guidelines. Once in place these guidelines/ protocols make documentation easier. SOGC review their practice guidelines every 3 years. It was agreed in principle to form a committee to review the feasibility of writing practice guidelines with a minimum of 5 members representing different areas of Canada, i.e. Atlantic, Ontario, British Columbia, Prairies and North.

Romanow Health Care Commission.

In the absence of Kim Campbell as well as the representative from Ontario, Carol Cameron gave CAM's presentation on the National Dialogue Tour in Toronto, May 31st Gisela Becker representing NWT and Nunavut also presented on Midwifery when the Commission was in the north. Mr. Romanow was very receptive to both presentations with his comments of "how can he help us" and when asked for more midwives "questioned why it wasn't thought of 10 years ago". [AMNL submitted a written brief].

Health Canada.

Jude Kornelson of the Centre for Excellence in Women's Health is writing a proposal for support from Health Canada to create, distribute and compile a data base of a Canada Midwifery Survey. The purpose of seeking this funding from Health Canada is to survey the current status

midwifery human resource in Canada so that they may plan for the future and will use it as an ongoing data base tool. It is planned to survey every member of CAM which will include those nurses working as midwives.

Other items of interest included the Presidents report where contacts and liaisons are maintained with American College of Nurse Midwives, Society of Obstetricians and Gynaecologists of Canada, Health Canada, Canadian College of Family Physicians and Rural Physicians of Canada. CAM's Budget for year 2002 was reviewed with necessary adjustments that had arisen as the year progressed. It was noted that CAM has not allocated funds in the budget to support the work of CAM's committee's and this will need to be addressed in the future. A Policy Manual has been presented to the Board to allow ongoing function of the organization on a daily basis. The design for a logo for CAM is ongoing with new ideas being put forward, which will be considered at the AGM in October. CAM is using the Consensus Model to conduct its business meetings and it was voiced that an evaluation should be held at the end of each meeting. Though many issues are discussed it is felt that participants from the Atlantic Provinces find the meeting time frame late in the day, i.e. often just before midnight before it is completed.

Some Midwifery Happenings Around the Country (a summary from CAM notes supplied by Ann Chaulk).

British Columbia. The midwifery option continues to be a safe, legal, funded alternative to medical maternity care in BC. Midwives across the province experience varying degrees of support from the medical community and are able to offer the choice of home or hospital birth to their clients. The demand for midwifery care still overcomes availability in most BC communities. Numbers continue to grow through the CMBC's PLEA Program & the federal reciprocity agreement. The new UBC Midwifery Degree program welcomed 20 new students in September. Graduates of the four-year baccalaureate program will be eligible for general registration in BC. All BC midwives are asked to enter the data from births attended since January 1, 2001 on-line as a crucial part of the MABC negotiating team's ability to negotiate a better remuneration contract with the government. The Midwifery Department at BC Women's Hospital in Vancouver is considering a follow-up to last year's working symposium "Midwifery: Building our Contribution to Maternity Care".

Alberta. Alberta continues to be the only province with a recognized and implemented midwifery profession that does not fund midwifery care as part of the health care system. The 24 registered midwives are struggling to maintain a viable profession in the province. Most of Alberta's registered midwives now have admitting privileges in at least one hospital in their area. Also, the Alberta Government has subsidized the liability insurance premiums for the second year to make them feasible for the midwives. The Alberta Government formed a Midwifery Funding Working Group over a year ago, with a mandate to study the funding issue and make a recommendation to the Minister of Health and Wellness. To date, no recommendations have come from this committee. Web Site: http://www.albertamidwives.com

Saskatchewan. Little progress has been made to regulate and fund midwifery in Saskatchewan over the past year. The Midwives Association of Saskatchewan continues to

struggle with very few members. The consumer group in support of midwifery has not been active. Many provincial multidisciplinary health committees have requested input from midwives, and a representative of the Midwives Association of Saskatchewan has participated in these meetings as much as possible. In recent communication with staff from the Department of Health regarding regulation and funding, the response has been that "the government is still committed to exploring a regulatory mechanism for midwives in Saskatchewan". There is still strong interest from women for midwifery services. There are very few practising midwives left in the province. Many women are using the services of doulas. As well, some women are choosing to have unassisted home birth.

Manitoba. It has now been over two years since regulation. There are now 27 registered midwives employed by 4 different regional health authorities and one who is working independently. There remain 6 regional health authorities who do not have any midwifery positions. Midwifery in Central region was shut down due to lack of funding. The midwifery program in the Brandon region threatened to close, but received last minute funding for one-and -a-half more positions due to consumer and midwife pressure. MAM has recently been self-recognized as a union and has ratified their constitution. They are currently in negotiations over their remuneration agreement with Manitoba Health. Midwives are leaving the province to work in other locations, such as BC. Web Site: http://www.manitobamidwives.com

Ontario. In the 2001-2002 fiscal year, midwives cared for over 7,000 women in Ontario and almost half as many as that were turned away due to inadequate numbers of midwives. There are 218 midwives in 43 midwifery practice groups working in communities and in 47 hospitals across the province this year. Caring for more women from different population groups means changes, in order to remain true to the roots of woman-centred care. There are the demands of the system which will continue to be a part of the reality: liability insurance, coroners' inquests, hospital quotas on privileging, inter-professional relationships, Ministry of Health policies.

Last Spring, promotional activities included the completion and distribution of the AOM video, "Midwifery in Ontario", and the development of a poster campaign for midwifery. They resolved 4 out of 5 key issues that were put to the Minister from *Symposium 2001: The Model of Midwifery Care in Ontario*, namely the consultation fee issue, budget approvals issue for new registrants, ongoing commitment to funding the growth of midwifery, and funding of insurance premiums. The AOM Board, staff, and volunteers have incorporated many, if not most of these recommendations into the strategic plan. They continue to advocate on the issue of compensation for midwives to the Ministry. In the Summer the renewal of the liability insurance resulted in a significant increase in their premiums. They successfully lobbied for and saw those premiums continue to be supported by the Ontario Midwifery Program (OMP) budget. An AOM Membership Reference Binder was produced and distributed to practice groups and an AOM Member Handbook was distributed to members this year with membership renewal. The AOM's guideline on the monitoring of blood pressure in pregnancy was also published and distributed to members. Emergency Skills Workshops (ESW) and ESW Instructor Training have taken place. With support from the membership, the *AOM Journal* ceased publication, and was replaced by the *Canadian Journal of Midwifery Research and Practice*. The CJMRP will continue to be subsidized by the AOM until such time as it is able to sustain itself financially. They continue to communicate with members through the monthly *AOM Informer*.
Web Page: http://www.aom.com

Quebec. Following a 6 year pilot project, midwifery in Quebec became a regulated profession in September of 1999. Although there are provisions within the law for midwives to eventually be able to assist birthing women at home or in a hospital setting, midwives are currently only able to practice in birthing centres. The "Ordre des Sages Femmes" has submitted the regulations around home births to the governmental office for approval, and it hoped that a law will be passed. There are six birthing centres in the south, and two in the north. Between forty and fifty midwives are employed in teams of three to ten per birthing centre. In a province with about 70,000 births, over 1,000 women receive midwifery care annually. (This is about 1.5%). Two of the birthing centres (in Montreal) consistently have waiting lists of clients. Therefore, the government has not actually expanded midwifery services, but it has funded two-and-a-half new positions for midwives. One new Birthing centre is scheduled to open in the fall of 2003, employing 3 midwives. There are now 46 students enrolled in the Midwifery program at the University of Quebec at Trois Rivières, and 30 of them are gaining their clinical practice in the birthing centres. The maternity centre at Inukjuak (an Inuit community of 1400 people) has just celebrated the one hundredth baby born there since it opened in 1998. Midwives are still without a contract and are now paid a lower salary than an experienced nurse with a degree.

New Brunswick. A midwifery association was established in February 2002. Attendance was low at three promotional meetings about midwifery held in different parts of the province. However, on May 5, more than 60 people attended the International Day of the Midwife celebrations. Newspaper articles, radio interviews, and speaking engagements are used to explain midwifery but politicians and health professionals are very ignorant in their knowledge of midwifery legislation across Canada, midwifery scope of practice and model of care. As consumers do not have time to attend weekend meetings, but prefer to use the Internet, a web site is being created. There are no midwives currently practicing in the province.

Nova Scotia. Two years have passed since the previous provincial government announced its commitment to bring midwifery into the health care system. The profession remains unregulated, but a small group of practising midwives continues to provide care and assistance at home and hospital births throughout the province. Informal collaborative links between midwives and other care providers who support normal “physiologic” birth are also strong. The demand for midwifery services is steady, and women’s dissatisfaction with the existing system appears once again on the rise. At the IWK-Grace hospital in Halifax, the cesarean section rate is over 25%, the number of epidurals for multiparas and primiparas is extremely high, and professional interest in “low intervention” in normal childbirth seems to be waning. There is talk of c-section as an “elective” alternative to vaginal birth. Increasingly more family physicians are dropping obstetrics from their practice, and many pregnant women in rural areas of the province are under-served, with limited options for care. The Nova Scotia Department of Health is currently engaged in efforts to develop a vision for a more community-based “family-focused and person-centred” primary health care system, and midwifery is on the agenda. Specifically, the Task Team on Existing and New Primary Care Providers, which has been meeting since May, has a mandate to develop guidelines and frameworks for increased collaboration among primary care providers. It is hoped that the recommendations will include on-the-ground models for midwifery practice.

Prince Edward Island. The local CBC radio announced a public presentation by a midwife from Ontario who had assisted a couple with a home birth. At the presentation there were about a dozen people present. The couple choosing the homebirth with the Ontario educated midwife, had her during their first pregnancy and birth in Ontario. Apparently the prenatal care for this second pregnancy was provided by a local physician who faxed reports to the midwife throughout the pregnancy. The Ontario Midwife was assisted by one of the doulas who in the past has conducted home births with the back-up of a physician from one of the rural hospitals.

NWT NU. Since incorporation of the Midwives Association in the Northwest Territories (NWT) in 2001 and in Nunavut in 2002, membership has increased to 13 members.

Currently midwifery is not regulated or publicly funded in the NWT. Legislation declaring midwifery as an autonomous profession is planned to be introduced in the Legislative Assembly in 2003. Fort Smith midwives continue to work closely with the Nik'e Niya Community Birth Centre, a community supported non-profit organization, wanting to bring birthing back to the community. Several midwives from Yellowknife, who are currently working as nurses in obstetrics and public health are looking forward to the introduction of regulated midwifery in the NWT.

In Nunavut midwifery is not funded or regulated, except for the Rankin Inlet Birthing Centre. Although midwifery practice and legislation of midwives is under discussion in Nunavut. The two new midwives in the birthing centre are registered midwives from Ontario. The Inuit maternity care worker offers childbirth education and counselling to parents and works closely with both midwives. The birthing centre provides regional birthing services to women from the Kivaliq region. The Department of Health plans to train additional Inuit maternity care workers in the communities to improve postpartum care and to enhance support for mothers and babies. Currently, the Department of Health in Nunavut supports a research project related to midwifery in Nunavut that will commence in the near future.

Yukon. The health minister is working on putting together a health professions act to regulate several non-medical health professions. Midwifery may or may not be included. As for the practice of midwifery in the territory, there are two practicing midwives and one birth centre which will open officially sometime in the fall following final building inspections. The centre has evolved from a temporary residence for families travelling to Whitehorse from outlying communities to give birth to a fully equipped birth centre with suites available for longer stays. The community has worked hard to raise funds to complete the centre

Canadian Perinatal Surveillance System (CPSS) from the notes of Pearl Herbert who has been representing the Canadian Association of Midwives. The web site for further information about CPSS, the committees and fact sheets is: www.hc-sc.gc.ca/pphb-dgspsp/rhs-ssg/index.html

The Steering Committee meeting was on October 18, 2002. The new members were welcomed, and these included Beverley O'Brien (observer) who was replacing Pearl as the representative for CAM. Pearl had been representing midwives since January 1995, when the CPSS first met. Reviewing the Minutes of the April 2002 meeting there was clarification that genetic problems do not have an apostrophe, e.g. Down syndrome.

Beverley Chalmers, co-chairperson of the **Maternity Experiences Survey** group gave an update of what is happening with that committee. There had been a meeting of members on October 16. The survey has been presented to the Federal Privacy Commissioner, the Health Canada's Science Advisory Board who considers that the information obtained will be very important and such a study should be repeated at intervals, and Health Canada's Research Ethics Board who were positive in the review of the study at their first meeting on October 2.
The questionnaire will be piloted in November 2002 in BC, NB, and NT. The senior interviewers received training for the questionnaire on October 16 and 17, and then they return to their provinces and territories and train the local interviewers. The results of the pilot and needed adjustments to the questionnaire are to be finished by February 2003. The sampling frame for the main study will be constructed between February and May 2003, further interviewer training and then data collection in the Fall 2003. Suggested tables had been circulated prior to this meeting and such tables would be completed at the end of 2003, so that the micro data file would be ready for Health Canada by March 2004.
A problem is the length of time that the provinces take to send in their birth data to Statistics Canada. Ontario takes 14 months to send the details, which is a little longer than Newfoundland and Labrador. The other provinces and territories are quicker. There was a discussion as to how soon after the birth should the mothers be interviewed because this time lag may result in some late registration births being missed if the babies are too young. The committee members said that all babies must be less than 12 months old. There was also a discussion about sampling in isolated areas. This will not be done where there are only one or two births, as it would be too expensive for an interviewer to travel to such communities.
(Pearl remains on this committee as a corresponding member).

I. D. Rusen, co-chair for the **Maternal Health Study** group gave an update of the work of this committee. The corrected birth data from Ontario has not yet been received for 1999. Looking at the billing codes for women's visits to their physicians does not distinguish why women made these visits and so would not be helpful in trying to identify women with postpartum depression.
Reproductive health training studentships are available through Strategic Training Initiative in Research Reproductive Health Sciences (STIRRHS).
The Canadian Institute of Health Information (CIHI) lists do not include the poor outcomes from high risk pregnancies.
The analysis for the cesarean section study and vaginal birth after cesarean (VBAC) is being studied.
The Society of Obstetricians and Gynaecologists of Canada (SOGC) has been given information about a maternal death review project. This will be different from the UK Confidential Report. Half of the maternal deaths occur in Ontario. The ways in which provinces review deaths vary.

Alex Allen gave the report for the **Fetal and Infant Health Study** group. At the group's meeting Janet Smylie of the Family Medicine Centre, had given a report of the ethical aspects of aboriginal studies and the National Aboriginal Health Organization (NAHO). SOGC is facilitating a meeting of all aboriginal midwives and their expenses will be paid. The contact person is Kathleen McGovern at the SOGC offices, Ottawa (613-730-4092). OCAP has looked at ownership, content, access, possession and stewardship of any data from aboriginal people. There

was a regional health survey of 280 community groups of First Nations and Inuit people, but Janet was not sure if Innu Nation people were included.
The committee had looked at congenital anomaly surveillance, uniform reporting of stillbirths resulting from pregnancy termination. They are progressing with producing a birth-death file, or linking the CIHI DAD file and/or the "morbidity file" to a "birth-death" link.
The Ontario data is not yet available. They are considering the Canadian Neonatal Network Database as a source of data for surveillance.
The Canadian Fetal Growth Curves should be ready by the end of the year. A question is whether Small for Gestational Age (SGA) should be classed as a morbidity or a mortality risk.
A suggestion is that autism should be monitored. On October 18 the *Globe and Mail* had on the front page, a report by Carolyn Abraham on "Autism rates soaring in children, study finds" and there was to be a continuation article the following day. This was as a result of the release of the findings of a study from California. There had also been a report in *Time* magazine in July 2002.
Publications included:

Health Canada. 2002. *Congenital anomalies in Canada. A perinatal health report, 2002*. Ottawa: Minister of Public Works and Government Services Canada.

Kramer, M. et al. (2002). Analysis of perinatal mortality and its components: Time for a change? *American Journal of Epidemiology, 156*(6), 493-497.

Liu, S. et al. (2002). Length of hospital stay, obstetric conditions at childbirth, and maternal readmission: A population-based cohort study. *American Journal of Obstetrics and Gynecology, 187*(3), 681-687.

Wen, S. W. et al. (2002). The impact of missing birth weight in deceased versus surviving fetuses and infants in the comparison of birth-specific feto-infant mortality. *Chronic Diseases in Canada, 23*(4), 146-151.

Shiliang Liu gave a report on the folic acid study carried out in Newfoundland, in the communities of St. John's and Clarenville. Neural tube defects are higher in the Eastern provinces of Nova Scotia, Quebec, and Newfoundland. Clinical trials have found that periconceptual supplementation of folic acid is not effective as: pregnancies are unplanned; or women are unaware of the role of folic acid; or they did not follow the physician's recommendations; or they are not able to afford the supplements. To increase the intake of folic acid the government agreed to the fortification of grain. To see if this was effective the time periods between November 1997 and February 1998, and November 2000 and March 2001 were compared. There was random sampling and it was found that awareness, vitamin taking and taking the correct dosage had all increased. With the fortified grain the dietary intake of folic acid had increased, as was measured by plasma blood samples. The number of babies being born with neural tube defects had decreased.

Ruth Kohut gave an update on the Congenital Anomalies Surveillance Network. Initially there had been a national workshop in 2000. There was a support network, collaboration and research with the goal of providing information to improve the health of Canadian families. In September 2002 there had been the first annual scientific meeting "Achieving Excellence in Congenital Anomalies Surveillance in Canada". Congenital heart defects had been studied. The web site is: http://www.hc-sc.gc.ca/pphb-dgspsp/casn-rcsac . Further studies of folic acid will be carried out in Newfoundland, Prince Edward Island, Nova Scotia, Manitoba, Alberta, and British Columbia for when there was no fortification of grain 1992-1997, partial 1998-1999, and full fortification 2000-2002.

The new Chief of the Reproductive Health Section is Hajnal Molnar-Szakács. Injuries are now part of a separate section. Waiting for the report from the Romanow commission to see how prevention and health promotion are included. Financial support is moving to aboriginal health. Health Canada is holding a research forum November 17-18, 2002. The national perinatal record is being resurrected, as the person who was working on it was transferred but is returning to the Reproductive Health Section. The next CPSS meeting and committee meetings are planned for April 23-25, 2003.

Following the CPSS steering committee meeting there was a combined meeting of CPSS members and the **Canadian Perinatal Programs Coalition (CPPC)** members. An update was provided on the CPPC including past history. Most provinces/territories have perinatal data collection initiatives, and six provinces have one or more perinatal programs that operate/manage databases. The databases are in varying stages of development or renewal. There is a shortage of coders and funding is not certain. Databases need to be compatible with existing systems, coder friendly, and the ability to be reported on web sites. Ownership of data, agreements for analysis and reporting, consent, privacy and confidentiality of women/infants/populations/care providers and agencies need to be agreed and can provide challenges. There is a need to be able to link with databases to cover from pregnancy until later after birth. To be able to integrate with other regional or provincial systems. Various perinatal health issues that would benefit from further investigation were discussed, e.g. maternal smoking, alcohol consumption, breastfeeding, neonatal readmissions.

Nova Scotia uses hospital based records, checks with CIHI to see if all births are captured. The collection of data from hospitals may not be consistent across the province, as some hospitals may decide to collect one set of items and other hospitals may collect other items. A national perinatal record would help and the CPSS record is being resurrected.

In Ontario there is the Perinatal Partnership Program of Eastern and Southeastern Ontario (PPPESO), a regional database which was created in 1997 to provide perinatal data to PPPESO partners. The Niday Perinatal Database has been developed in collaboration with ISCIS (Healthy Babies Healthy Children) to ensure that the systems are complementary and to minimise duplication of effort. The database currently includes 42 indicators for every baby that is born in Eastern and Southeastern Ontario, including hospital births and home births attended by midwives. Hospitals and midwives enter their own data directly into the database which takes approximately 60 seconds per record. The midwives are also wanting other information and PPPESO is willing to add these items when they have been clarified.

The BC Reproductive Care Programme has a CD-ROM explaining their database.

Community Accounts website

The web site: www.communityaccounts.ca provides provincial, regional and community information for Newfoundland and Labrador and was created when the government made the commitment to measure social progress at the launching of the Strategic Social Plan in 1998. Data are taken from census reports, CIHI information, income tax returns, and local surveys. This is the only province which has the information from which one can find the median age of people in a community, economic information for each community, and other information. Community Accounts deals with aggregates if a community has a small population. Such a community is combined with another community so as to maintain privacy of the residents. [If using for research purposes, remember that this information is from secondary sources.]

Breastfeeding

Breastfeeding Challenge 2002. The 2002 Challenge took place across Canada on October 5th. This second annual challenge was expanded on the success of a BC-wide challenge in 2001. Families across the country had a great time! The Winner's Circle. Of course, all the babies were winners by getting the best breakfast possible on October 5th! The Yukon Territory contingent won the Challenge. Yukon had 1 site with 23 women participating. This gives them a score of 6.6%. (The scoring is explained below.) Newfoundland deserves a lot of recognition for being the first-runner up with 94 women participating between 8 sites. This gives them a score of 2.0%. Other Great Statistics: 816 women participated, 47 sites participated, 10 provinces or territories participated. BC had 444 women at 23 sites. Ontario had 119 women at 7 sites. Victoria, BC had the largest site in Canada with 74 women participating.

Although Quintessence promotes and coordinates the Challenge, the event's success is determined by hundreds of people across the country. Organizers from health and education groups plan, advertise and run the sites. Regional contacts coordinate sites. The media shares our success with the community. And the mothers and babies make it all possible by showing their support and joining us! It is for these mothers and babies that the event takes place.

How were the Scores Calculated? The Quintessence Challenge 2002 is based on the participant rate within a province or territory. Participants must have been breastfeeding at an official site on October 5th at 11 a.m. The rate or score is found by dividing the number of participants by the previous year's birth rate as reported by Statistics Canada.

The Future. Next year's challenge may make this year's great results seem small by comparison. Challenge 2003 will be extended to the entire US as well as Canada. This will take place on October 4th, 2003!

The Breastfeeding Committee for Canada (BCC) has received a grant of $200,000 from Population Health, Health Canada, for a two-year project - *BFI in Community Health Services: Implementation and Evaluation*. It will allow the BCC to develop outcome indicators and assessment tools, and to develop and deliver a comprehensive assessor training program (the first training tentatively scheduled for the end of February 2003).

The UK UNICEF BFI Newsletter can be read online at http://www.babyfriendly.org.uk

Breastfeeding reduced cholesterol in later life. (2002, October). *RCM News & Appointments*, p. 2. [Breastfeeding may be good for the long-term cardiovascular health of a child, according to a study published by St. George's Hospital Medical School in south London. . . . The results suggested that breastfeeding has varying effects on the cholesterol at different stages of life. Breastfeeding seems to be associated with high levels of cholesterol in infancy, but there is no relation between infant feeding and cholesterol in childhood and adolescence. However, in adults, those breast-fed appear to have lower cholesterol levels than those formula-fed. Dr. Christopher Owen, a researcher on the St. George's team, said: "The possibility that infant feeding has long-term effects on blood cholesterol levels is of considerable public health importance. Early exposure to the high cholesterol content of breast milk may improve fat metabolism in later life. In which case, there may be a strong argument for the content of formula feeds to match that of human milk". RCM midwifery advisor Janet Fyle said: "This research adds to the body of evidence we already know about the benefits of breastfeeding".]

(Your Newsletter Editor: Not new information, see: Davies, D. F. (1971) Milk protein and other food antigens in atheroma and coronary heart disease. *American Heart Journal, 81*, 289-291.

Jelliffe, D. B., & Jelliffe, E. F. P. (1978). *Human milk in the modern world* (p. 255). Toronto: Oxford University Press.

Spady, D. W. (1977). Infant nutrition. *Journal of the Canadian Dietetic Association, 38(1)*, 34-41.)

Have You Read?

Midwifery and Related Topics

- Anderson, T. (2002). Integration or disintegration: The scandal of the integration of midwifery services. *MIDIRS Midwifery Digest, 12*(4), 445-447. [In the UK midwives are now expected to work in all maternity areas of the hospital and in the community, changing from one shift to the next. No continuity of care to the women].
- Cesario, S. K. (2002). The "Christmas effect" and other biometerorologic influence on childbearing and the health of women. *JOGNN 31*(5), 526-535.
- Clinical issues. (2002). Women's risk-taking behaviors. *JOGNN, 31*(4), 454-477.
- Furgal, C., & Gosselin, P. (Eds.). (2002). Selected papers from the Quebec City consensus conference on environmental health indicators, October 2000. *Canadian Journal of Public Health, 93*(Suppl. 1), S1-S70.
- Klein, M. C., Johnson, S., & Christilaw, J. (2002). Three doctors warn of the unforeseen dangers of closing rural hospital. Health care centralization risks safe maternity care and community sustainability. *Accoucheur, 9*(2), 1-2.
- Lewis, P. (2002). Protecting the public through professional standards - an analysis of the role and responsibilities of the Nursing and Midwifery Council. *MIDIRS Midwifery Digest, 12*(4), 454-457. [On February 12, 2002, the Nursing and Midwifery Order 2001 came into effect and replaces the Nurses, Midwives and Health Visitors Act, 1997. The Nursing and Midwifery Council (NMC) now replaces the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).]

Pregnancy

- Evans, E. C. (2002). The FDA recommendation on fish intake during pregnancy. *JOGNN 31*(6), 715-720.
- Garcia, J., Bricker, L., Henderon, J., Martin, M-A., Mugford, M., Neilson, J., & Roberts, T. (2002). Women's views of pregnancy ultrasound: A systematic review. *Birth, 29*(4), 225-250.
- Moss, S. W. (2002). The power to terrify: Eclampsia in 19th-century American practice. *JOGNN 31*(5), 514-520.
- New register for epileptic mothers (2002, October). *RCM News & Appointments*, p. 2. [Midwives and GPs have been asked to encourage women to join the UK Epilepsy and Pregnancy Register, which has been established to track women through pregnancy and after birth with the aim of identifying the best drug regimes for mother and child. The register is being funded by the Epilepsy Research Foundation. . . . According to the Epilepsy Research Foundation, children born to women with epilepsy are three times more likely to have some form of physical or developmental abnormality. Drug therapy, genetic anomalies, folic acid metabolism, maternal seizures and interactions between these various factors can all play a part. However, there are no clear family planning guidelines for women with epilepsy. As a result, many women are either fearful of becoming pregnant, or unaware that their medication could harm their baby. Women taking those anti-epileptic drugs (AEDs) that reduce the effectiveness of the oral contraceptive pill, should take a higher dosage of "the pill" to avoid unwanted pregnancy. Some of these drugs have been reported as being associated with an increased incidence of spina bifida. Because of these risks, there is an increasing move to the newer anti-epileptic drugs in young women. However, such a move is based largely on the findings

of animal studies and human data regarding the safety of these drugs to the unborn child is lacking. For further details, contact the Epilepsy Research Foundation at www.erf.org.uk.]

- Sherman, J., Young, A., Sherman, M. P., Collazo, C., & Bernert, J. T. (2002). Prenatal smoking and alterations in newborn heart rate during transition. *JOGNN 31*(6), 680-687.

Genetics

Labour and Birth

- AWHONN Monograph. (2002). *The prevention of preterm birth: Research based practice*. Washington, DC: Author. (Cost: $17.50 US).
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- Clinical issues. (2002). Labor support. *JOGNN, 31*(6), 721-769.
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- Garland, D. (2002). Collaborative waterbirth audit - supporting practice with audit. *MIDIRS Midwifery Digest, 12*(4), 508-511.
- Gaskin, I. M. (2002). Concerns about single-layer suturing of the uterus after cesarean surgery. *MIDIRS Midwifery Digest, 12*(4), 519-522. (From (2002), *Midwifery Today*, pp. 32-34).
- Harper, B. J., (2002). Taking the plunge: Re-evaluating waterbirth temperature guidelines. *MIDIRS Midwifery Digest, 12*(4), 506-508.
- Hunter, L. P. (2002). Being with woman: A guiding concept for the care of laboring women. *JOGNN 31*(6), 650-657,
- Multiples born to older moms fare same or better. (2002/2003, December/January). *AWHONN Lifelines, 6*(6), 492-494.
- Nursing organizations caution against over-interpretation of recent labor support study. AWHONN and ACNM call for further research regarding impact of medical interventions and nursing care on laboring women. (2002/2003). *AWHONN Lifelines, 6*(6), 544-545. ["Before we started this trial, there was strong evidence that labor support was very effective in reducing cesarean rates. Our purpose in this study was to examine whether labor support was effective within the context of North American hospitals", said Dr. Ellen Hodnett . . . "And we found the answer is 'no'. However, we believe the most plausible explanation for our results is that the benefits of continuous labor support are overpowered by the effects of birth environments characterized by high rates of routine medical interventions"].
- Plumb, R. (2002). Demystifying the research on amniotomy. *MIDIRS Midwifery Digest, 12*(4), 511-515. ["Amniotomy should be treated with caution and reserved for cases where labour progress is poor or where fetal complications are suspected. It is imperative that a good working relationship is forged between women and midwives if women are to receive the informed choice they deserve." Informed consent should be obtained.]
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- Ruchala, P. L., Metheny, N., Essenpreis, H., & Borcherding, K. (2002). Current practice in oxytocin dilution and fluid administration for induction of labor. *JOGNN 31*(5), 545-550.
- Shallow, H. (2003). Should cord pH be performed routinely after normal birth? *RCM Midwives Journal, 6*(1), 28-31.
- Simkin, P. (2002). Supportive care during labor: A guide for busy nurses. *JOGNN 31*(6), 721-732. [Do you remember the report by Kip Moeller. (1999, January). PEI conference with Penny Simkin. *NLMA Newsletter, No. 8*, pp. 13-23?]

Infections

Neonatal Care

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- Geyer, J., Ellsbury, D., Kleiber, C., Litwiller, D., Hinton, A., & Yankowitz, J. (2002). An evidence-based multidisciplinary protocol for neonatal circumcision pain management. *JOGNN, 31*(4), 403-410. [Summarizes and provides conclusions for seven methods used for pain relief and provides a protocol].
- Harrison, D., Evans, C., Johnston, L., & Loughnan, P. (2002). Bedside assessment of heel lance pain in the hospitalized infant. *JOGNN 31*(5), 551-557.
- Hehir, B. (2003). Head cases: An examination of craniosacral therapy. *RCM Midwives Journal, 6*(1), 38-40. ["Craniosacral therapy may be advocated as a solution to various problems of newborn infants, but how much do we know about it?"]

Postpartum

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- Bozoky, I., & Corwin, E. (2002). Fatigue as a predictor of postpartum depression. *JOGNN, 31*(4), 436-443.
- Groer, M. W., Davis, M. W., & Hemphill, J. (2002). Postpartum stress: Current concepts and the possible protective role of breastfeeding. *JOGNN, 31*(4), 411-417.
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- Matthey, S., Morgan, M., Healey, L., Barnett, B., Kavanagh, D. J., & Howie, P. (2002). Postpartum issues for expectant mothers and fathers. *JOGNN, 31*(4), 428-435.
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- Vieira, T. (2002/2003). When joy becomes grief. Screening tools for postpartum depression. *AWHONN Lifelines, 6*(6), 506-513.

Breastfeeding

- McKeever, P., Stevens, B., Miller, K-L., MacDonnell, J. W., Gibbins, S., Guerriere, D., Dunn, M. S., & Coyte, P. C. (2002). Home versus hospital breastfeeding support for newborns: A randomized controlled trial. *Birth, 29*(4), 258-265.
- Pollock, C. A., Bustamante-Forest, R., & Giarratano, G. (2002). Men of diverse cultures: Knowledge and attitudes about breastfeeding. *JOGNN 31*(6), 673-679.

- Ripmeester, P., & Dunn, S. (2002). Against all odds: Breastfeeding a baby with harlequin ichthyosis. *JOGNN 31*(5), 521-525.

Women's Health

- Langille, D. B., Hughes, J., Murphy, G. T., & Rigby, J. (2002). Contraception among young women attending high school in rural Nova Scotia. *Canadian Journal of Public Health, 93*(6), 461-464.
- Sharp, B. A. C., Taylor, D. L., Thomas, K. K., Killeen, M. B., & Dawood, M. Y. (2002). Cyclic perimenstrual pain and discomfort: The scientific basis for practice. *JOGNN 31*(6), 637-649. [CPPD is an important health problem with distinct, although individualized, symptom clusters. It is a new concept developed by the AWHONN fifth Research-Based Practice project science team. As the nurse is reviewing the assessment with the patient, several appropriate interventions will come to mind which should be narrowed down to a workable number. If the nurse is left with more than four appropriate treatments, he or she should consider again the strength of the science supporting those interventions].

Research and Models

- Carne, V. (2002). Informed choice. A. solution to health information delivery challenges of the 21st century. *MIDIRS Midwifery Digest, 12*(4), 440-444. [Now more than ever, there is a fundamental requirement to be able to access sound, evidence-based information and that this demand continues to be fueled by clinical governance strategies, risk reduction programmes, and spiralling National Health Service (NHS) litigation].
- Cesario, S., Morin, K., & Santa-Donato, A. (2002). Evaluating the level of evidence of qualitative research. *JOGNN 31*(6), 708-714.
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- Improving children's health. How population-based research can inform policy. The Manitoba experience. (2002, November/December). *Canadian Journal of Public Health, 93*(Suppl. 2), S1-S80.
- Sakala, C., Declercq, E. R., & Corry, M. P. (2002). Listening to mothers: The first national U.S. survey of women's childbearing experiences [editorial]. *JOGNN, 31*(6), 633-634. [To read the whole report see http://www.maternitywise.org/listeningtomothers]

Conferences As this information comes from a variety of sources the editor takes no responsibility for any errors.

2003

March 6-7, 2003. "Setting the Agenda: Research on Women's Health" 6th annual Women's Health Forum, St. John's.
Contact: WHNNL, Suite 501, 2204 LeMarchant Road, St. John's, NL, A1C 2H8 (Telephone/ Fax: 777-7435; E-mail: whnmun@mun.ca; Web site: http://www.whnnl.mun.ca)

April 10-11, 2003. "Fetal Alcohol Exposure: Time to Know, Time to Act", Toronto.
Contact: 1-800-397-9567; Fax: 416-408-2122; Web site: www.beststart.org before March 15.

May 3-4, 2003. "Mothering and Work/Mothering as Work" in honour of Mother's Day and May Day, Toronto.
Contact: Association for Research on Mothering, 726 Atkinson College, York University, 4700 Keele Street, Toronto, ON, M3J 1P3 (Telephone: 416-736-2100 x 60366; E-mail: arm@yorku.ca Web site: w w .yorku.ca/crm)

May 5, 2003 International Day of the Midwife
May 12, 2003 Canada Health Day

May 14-15, 2003. "Current Issues in Perinatal Care", annual conference of the PPPESO.
Contact: Robin Vandekleut (Telephone: 613-738-3665; E-mail: rvandekleut@pppeso.on.ca)

August 1-7, 2003 International Breastfeeding Week
October 1-7, 2003 Canada Breastfeeding Week

October 16-18, 2003. "Building Brighter Futures", AWHONN Canada 14th national conference, Mississauga.
Abstracts: April 15, 2003.
Contact: Barbara Davies, AWHONN Canada Conference, c/o School of Nursing, University of Ottawa, 451 Smyth Road, Ottawa, ON, K1H 7E6 (Fax: 613-562-5443;
E-mail: bdavies@uottawa.ca)

October 24-26, 2003. "Mothering, Religion and Spirituality", 7th Annual Conference of the Association for Research on Mothering, Toronto.
Abstract: March 1, 2003.
Contact: Association for Research on Mothering, 726 Atkinson College, York University, 4700 Keele Street, Toronto, ON, M3J 1P3 (Telephone: 416-736-2100 x 60366; E-mail: arm@yorku.ca)

SOGC's ALARM Committee announces a new examination procedure for RNs in 2003

At the ALARM Committee meeting held in Winnipeg, MB, in June 2002, it was decided to modify the examination process for RNs. RNs will now be evaluated in the same manner as physicians, midwives and residents. Expectations for passing, however, will be consistent with the RNs scope of practice.

The ALARM Course offers a comprehensive examination of knowledge and skills in intrapartum care. Successful completion of this examination is necessary to receive the certificate of completion. The process consists of:

a. A written examination that requires short answers to open-ended questions.
b. A four-station (OSCE) skills test with simulation of clinical situations. These stations will consider the nurses' scope of practice.

A participant must score 70% for both the written examination and each of the four OSCE testing stations to pass the ALARM Course. Candidates who are not successful on one or more of the examination components will receive a certificate of attendance (for credits) but will not receive an ALARM certificate of completion.

The new exam procedure will commence with the 2003 ALARM Courses. Register early as the courses are limited to 40 participants. See: http://www.sogc.org.

Midwifery Legislation in England (summarized from the RCM 100 year calendar.) This sounds similar to getting midwifery legislation passed today.

The Midwives' Institute (forerunner to the RCM) had tirelessly campaigned over the previous 12 years for legislation to govern the training and practice of midwives, and had promoted the first Midwives Bill in 1890. On February 26, 1902, the Midwives Bill had its second reading in the House of Commons proposing the transfer of powers to the Privy Council that had been previously vested in the General Medical Council. Following its journey through the House of Lords, under the able leadership of the Duke of Northumberland, the first Midwives Act received Royal Assent on July 31, 1902,

At its final stages of debate, in order to get the Bill approved, MP's debated the date from which the Midwives Act should fully operate, as there were fears that many women would have no midwife care because of insufficient numbers of registered midwives. As the Bill left the Commons to go to the House of Lords for debate, the main change was to Clause 1: "From and after the first day of January 1910, no woman shall habitually and for gain attend women in child-birth or shall after the first day of January 1905, be entitled to take or use the name or title of midwife . . . unless she is certified by this Act". The words were slightly modified in the Act and introduced fines of up to £5 for using the title "midwife" without being certified and up to £10 for attending a woman in childbirth, without certification.

Following the passing of the Midwives Act, Rosalind Paget, treasurer of the Midwives Institute, wrote to the midwives: "Trained midwives, now that you are recognised by Act of Parliament, what body of workers have you to thank that you are not by law called midwifery (nurses) or obstetric nurses. . . . that you are not bound hand and foot under those who have only too openly shown how they could "end" you if they only had the power . . . you owe all this and much more to the Council of the Midwives' Institute". In early 1902 "the opposition (doctors) had been showing its teeth in a very nasty way . . . refusing to attend women in the emergencies of labour who have employed a midwife. It is sad to see that the medical man is in such bad condition that competition with midwives will do him serious injury" (*Nursing Notes*, 1902).

In August 1903, the Central Midwives Board had drafted Midwives' Rules and these were approved by the Privy Council. The third Midwives Act of 1936 introduced a domiciliary service of salaried midwives under the control of Local Supervising Authorities to "improve maternity services and reduce maternal mortality". By 1939, all local Supervising Authorities had inaugurated domiciliary midwife services. With the organisation of domiciliary midwifery services after 1946, midwives tried various forms of transport on which to carry their penthrane, trilene and oxygen. In 1964 the RCM welcomed the proposal for midwives to be in attendance for 28 days following confinement.

In January 1902, there were over 6,000 midwives who had passed examinations with the Obstetrical Society for London. The parliamentary Standing Committee agreed that those with the Obstetrical Society of London's qualification would be certified under the new Act. From 1937 pupil midwives took midwifery training in two parts, usually in two different training schools. Part 1 concentrated on theory and practical hospital experience. Part 2 mainly covered public health issues and district midwifery. The last mention of "pupil midwife" in legislation was 1979 and from the following year "student midwife" was used. On October 29, 1903, the Central Midwives Board opened the Midwives Roll. The Central Midwives Board awarded Midwifery Certificates from 1902 until 1983, when the UKCC was established. From April 2002 the new Nursing and Midwifery Council provides regulation.

In March 1902, midwives were campaigning against the proposal to have only one representative on the Central Midwives Board who would be a medical practitioner. The British

Nurses Association continued to object to the Bill. But, despite their opposition to the Midwives Act, the British Nurses Association wanted a seat on the Central Midwives Board - and got one. In 1938 the Queen, who had shown so much interest in the Midwives Institute when Duchess of York, agreed to become Royal Patron. As Queen Elizabeth the Queen Mother, Her Majesty laid the foundation stone at the RCM Mansfield Street HQ in 1956.

It's back to the birthing pool *Daily Telegraph* (Filed: 29/10/2002)
Michel Odent's theories about natural childbirth were originally snubbed - but the research proves him right, says Thea Jourdan.

Michel Odent, the pioneer of "natural" childbirth, has spent the past 40 years helping women to have babies. In the Seventies, the French-born obstetrician thought up the concept of birthing pools, arguing that, during labour, women were more relaxed and comfortable in water. More recently, Odent, who lives in London, spoke out against the fashion for fathers being present in the delivery room, saying that anxious men cause the mothers unnecessary stress. He has also criticised the trends of elective caesarean births and artificially induced labour, which, he believes, can damage the bonds between mother and child. Odent has argued against elective caesarians, artificially induced labour and separating premature babies from their mothers by incubating them

Sixteen years ago, Odent published his first book, *Primal Health*, which contained many theories about the critical period between conception and a child's first birthday. At the time, it was a book of ideas; there was little evidence to substantiate his claims. This month, *Primal Health* is being republished for a new audience. In the intervening years, hundreds of studies have shown that Odent usually got it spot on. "I wrote the book based on my experience with women in childbirth," says Odent, who has published more than 50 scientific papers and nine other books. "I started with feelings, and predicted what would be the outcome. At that time, it was new, and many health care professionals were skeptical. What I talked about then has now been extensively researched. It is gratifying to know that a new generation of studies back me up." Odent is hoping that the second edition of *Primal Health*, with a new introduction and postscript, will be read by a wider audience. When it was originally published, it was sidelined by the medical community. "I want to broaden the debate," says Odent, who founded the Primal Health Research Centre in London in order to collect scientific studies from around the world. "Women are still uncertain about what is best for them and their baby. I want to make sure they are informed about their choices."

Odent still worries that a great deal of progress needs to be made. In Britain, about 22 per cent of women have caesarean sections, and there is a high rate of induced births. "Women do not rely on their own hormones any more, and this can have long-term health consequences," he says. He is also unhappy with the style of antenatal care in most hospitals, and believes that too much emphasis is placed on disease detection, rather than promoting health. "Pregnant women go into hospital for ultrasounds, scans and blood tests to check for abnormalities and diseases. That is not care. It is testing." Science, he points out, proves that women can take simple steps, both dietary and in the way they live, to ensure their baby's health throughout its life. "Just changing the style of prenatal care may change a great many lives. Shouldn't women be told what the experts already know?"
[Primal Health by Michel Odent (Clairview Books) is available for £10.95.]

What Michel Odent thinks mothers need to know

Oily fish for full-term births

Odent has always believed that women can eat their way to giving birth to a healthier, brighter baby. In 1996, he published a study in the journal *Obstetrics and Gynaecology*, evaluating the benefits to pregnant women of an increased consumption of sea fish. He found that women who ate more were less likely to give birth prematurely, and their babies had bigger heads at birth. Earlier this year, a Danish study, published in the *British Medical Journal*, revealed that women who eat sea fish regularly quartered their chances of giving birth to a low-weight premature baby. This is significant because babies born at term have measurably higher IQs, overall. Oily fish, such as fresh tuna, anchovies and mackerel, contains large amounts of long chain fatty acids, known as Omega 3 and Omega 6 polyunsaturates. These fats are crucial for the development of the foetal brain. Odent stresses that fish oil supplements do not have the same effect.

Born to be wild

In 1986, Odent suggested that delinquency could be linked to birth trauma. Since then, studies of long-term criminals show that birth complications and maternal rejection make it more likely that a baby will be involved in violent crime at the age of 18. A study in Copenhagen, published in *General Psychiatry* in 1994, showed that the main risk factor for becoming an adult criminal was the association of a traumatic birth, but that maternal rejection, on its own, did not increase the risk factor. A mother who smokes throughout her pregnancy may also be doing long-term psychological damage to her unborn baby. A study published in January 2002 in the *Journal of Psychiatry* concluded, "maternal prenatal smoking is related to criminal and substance abuse in male and female offspring".

'The mother can be the best incubator'

Everyone knows now that newborn babies need close contact with their mothers. In 1986, however, it was rare for women to sleep with their babies, and premature babies were routinely placed in isolating incubators. Odent was rather a lone voice when he wrote that the "human mother can be the best incubator". He pointed out that babies needed to identify the smell of their mother, and a mother separated from her baby had difficulty secreting milk. A 1988 study showed that premature babies are much more likely to survive and thrive if they have close contact with their mothers. In one Colombian study, low-weight babies were placed on their mothers' chests in slings, kangaroo style. For babies weighing less than one kilogram at birth, the survival rate rose from nought to 72 per cent. "I knew that it was wrong to keep these tiny babies in glass boxes with no movement, no stimulation and no voice of the mother," says Odent.

Like mother, like daughter

In 1986, Odent noted that the best way to determine how a woman would give birth to her child was to look at how she had been born. "From my own practice, I have learnt that there is a correlation between the way a baby girl is born and the way she will give birth to her own children," he wrote. "Observations such as these might inspire a wealth of research." A Canadian study published last year showed that maternal behavioural patterns, including birth experience, are transmitted through the generations. There is no genetic component. Instead, it seems that the inheritance is a neural mechanism which is wired into the neonatal brain. Odent believes that this finding means it is more important than ever for women to be allowed to have their babies in a non-medicalised, stress-free environment.

CHOICES MIDWIFERY CARE
INTRODUCTORY PRICES

While the government is "committed to the regulation and funding of midwifery", implementation has been delayed. Unfortunately, this means that Choices Midwifery Care must charge for its services. Fees may be based on income.

Telephone Consultation:	Free
Initial Prenatal Consult:	Free
Prenatal Home Visit:	$25
Postnatal Home Visit:	$25

Prenatal Parent Classes

SMALL GROUPS OF 4-8 COUPLES:

- Set of 5 (2 hour) classes: $75

INDIVIDUAL CLASSES

- Set of 3 (2 hour sessions): $75

COMBINED PACKAGE:

3 prenatal and 5 postnatal home visits and prenatal classes: $250

Home Birth and Water Birth Services including Prenatal, Labor, Birth and Postnatal Care*: $1500

2^{nd} baby: $1200

Contact: Karen Robb

753-3569

Choices Midwifery Care

SERVICES

SEE PRICE INSERT

PRE-NATAL HOME VISITS TO:

- Minimize pregnancy discomforts
- Prepare a birth plan
- Optimally position your baby
- Learn natural pain relief methods

POST-NATAL HOME VISITS TO:

- Assist with breastfeeding
- Minimize postnatal discomforts
- Advise on gentle baby care

PRE-NATAL PARENT EDUCATION CLASSES WHICH:

- Give a broader perspective
- Provide up-to-date information
- Use interesting teaching activities in a relaxed atmosphere.

HOME BIRTH AND WATER BIRTH SERVICES

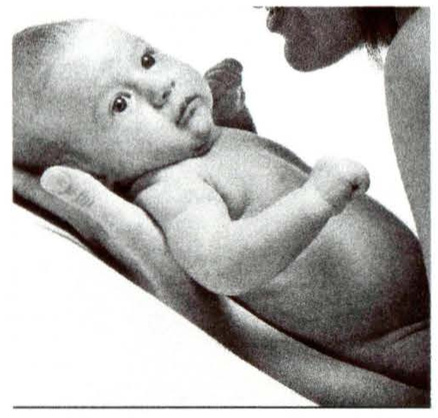
- A comprehensive package of care throughout pregnancy, labor, birth and six weeks following

WHY CHOOSE A MIDWIFE?

Midwives are the professional experts in normal pregnancy, birth and care of the newborn. Midwives have faith in women and in birth as a natural process. When communities lost their midwives, they lost the professional who best balanced ancient wisdom with technological innovation. Without midwives, intervention in birth has become "normal". Many other provinces have restored midwifery services as a result of consumer pressure to change birth practices. This reform movement has the support of current research which shows most hospital routines to be unnecessary and midwifery care and home birth to be as safe, for low risk-women, as obstetric care and hospital birth.

CHOICES MIDWIFERY CARE

FOR HELP TO MAKE INFORMED CHOICES THAT CELEBRATE NEW LIFE



CONTACT:

KAREN ROBB

753-3JOY

(709-753-3569)

CHOICES MIDWIFERY CARE

PHILOSOPHY

- Pregnancy, labor, birth and parenting are a profoundly important journey, one that can be empowering, joyous and safe.
- Childbearing couples have the right to make informed choices about their care and maternity professionals have the responsability to provide supportive, research based care.
- Babies are affected by all their experiences and a peaceful birth provides a better start to life.
- Fathers play an important role and deserve the highest level of involvement and support.
- Midwifery care **should** be regulated and funded so that it is available to families who want continuity of care, control over their experience and a choice of setting for their birth.

QUALIFICATIONS

Feb. 2000 - present
British Registered Nurse/Midwife

March 2000 – August 2002
Midwife Practitioner
St. John and Elizabeth Birth Unit
London, England

October 2001 – present
Masters of Midwifery studies
Thames Valley University
London, England

August 1998 – Feb. 2000
Diploma of Midwifery
Robert Gordon University
Aberdeen, Scotland

Sept. 1994 – June 1997
Home Birth Midwife Apprentice
Birth Wise Midwifery Care, Calgary

Sept. 1996 – Dec. 1996
Midwife Apprentice Intensive
Austin Area Birthing Center, Texas

Jan. 1994 – June 1997
Self Employed Doula, Calgary
Sept. 1993 – Sept. 19/96
Volunteer Labor Companion
Calgary Health Services

TESTIMONIALS

"You will forever be part of our lives as one of the people who helped bring Morgan into the world peacefully, safely and joyfully. You have a special gift for supporting, encouraging and being "with" women"...

Melody Williamson
Home Birth

"A tremendous thank you for your warrioress energy and focused concern throughout the labor and birth of our beautiful son. We were so lucky to have you by our side."

Jessica Smeidan
Hospital Birth

"I would like to especially thank you for helping me through the most difficult part of my labor. I will always remember how you kept me informed, gave me choices and control of my labor and the birth of our beautiful child."

Sandra McManus
Home Birth

ASSOCIATION OF MIDWIVES OF NEWFOUNDLAND and LABRADOR
APPLICATION FOR MEMBERSHIP
2003

Name: _____
(Print) (Surname) (First Name)

All Qualifications: _____

Full Address: _____

_____

Postal code: _____ Telephone No. _____
(home)

Telephone No. _____ Fax No. _____
(work)

E-mail Address: _____

Work Address: _____

_____

Area where working: _____

Retired: _____ Student: _____ Unemployed: _____

List of Organizations of which you are a member (the Association receives requests from various organizations for representatives to review articles, attend conferences, be on committees). Your name would not be forwarded without your consent.

Provincial: _____

National:_____

International: _____

Would be interested in participating in a research project if asked: Yes ____ No _____

If already pay CAM fees as a **Full** member of another Canadian Midwives Association, name of Association:

_____

I wish to be a member of the Midwives Association and I enclose a cheque/money order from the post office

for: $_____
(Cheques/money orders only (no cash) made payable to the Association of Midwives of Newfoundland and Labrador).

Full membership for **ALL** midwives is **$75.00** (as this includes the Canadian Association of Midwives fees which the Association has to pay).
Associate membership for those who are not midwives is **$40.00**
Membership for those who are unemployed/retired is **$20.00**
Membership for those who are residing outside of Canada **$85.00** (to cover the cost of the extra postage).

Signed: _____ Date: _____

Return to: Jean Hunt, Treasurer, P.O. Box 1495, Stn. B, Happy Valley-Goose Bay, Labrador, A0P 1E0

Name to verify membership _____

Can the AMNL Afford CAM Membership? (See pages 2-5 in the Newsletter)

It is very important that AMNL does not run into debt. Therefore, members have to consider what is best for AMNL and what they can commit themselves to pay.

The current cost to AMNL is $70 x 5 (conference calls) + $500 (for AGM travelling) = **$850** p.a. (The extra $35.00 which each midwife pays is not included in this - it goes directly to CAM).

The basic AMNL membership fee is $40.00 x 10 members = $400.00.
The Newsletter costs in 2002 were $244.04
Money left for AMNL use = **$155.96**

This means that AMNL is short nearly **$700**, and nothing has been spent on AMNL projects.

Circle the option which YOU consider is best for AMNL and for YOU.

1. To pay double AMNL basic membership fees and $35 + journal fee for all of CAM activities. Midwives $125, non-midwives $80 p.a.

2. To double our membership before the end of March and basic AMNL fee stays at $40.

3. Extra members recruited, our CAM representative attends every conference call and not the CAM AGM, and to notify CAM that our members do not want to pay for the journal. For midwives $75.00 (includes $35.00 for CAM). For non-midwives $40.00

4. If our CAM representative only attends every second conference call, and does not go to the CAM AGM [and so we lack much input into what is happening nationally]. For midwives $75.00 (includes $35.00 for CAM) For non-midwives $40.00

5. To leave CAM until we have midwifery legislation in this province. To have a drive for increasing membership and community awareness of the practice of present day midwifery care, and to keep the Newsletter as a main means of communication between members: For midwives $40.00. For non-midwives $30.00. For unemployed $20.00

6. Any other suggestions (please give details) _____

_____

_____

7. Do you support providing some money to produce the video to promote current day midwifery in this province? (See Minutes on page 2). Circle your choice.

No money $100 $200 $300

Send to: Karene Tweedie, Centre for Nursing Studies, Southcott Hall, 100 Forest Road, St. John's, NL, A1A 3Z9 E-mail: ktweedie@cns.nf.ca Fax: 709-777-8176

BEFORE FEBRUARY 21, 2003