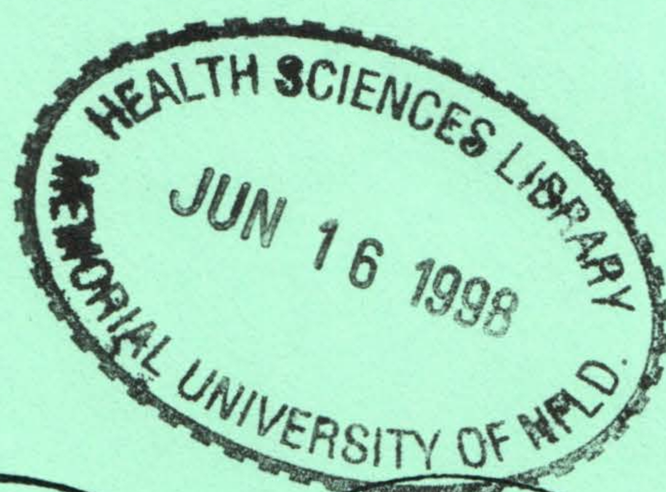
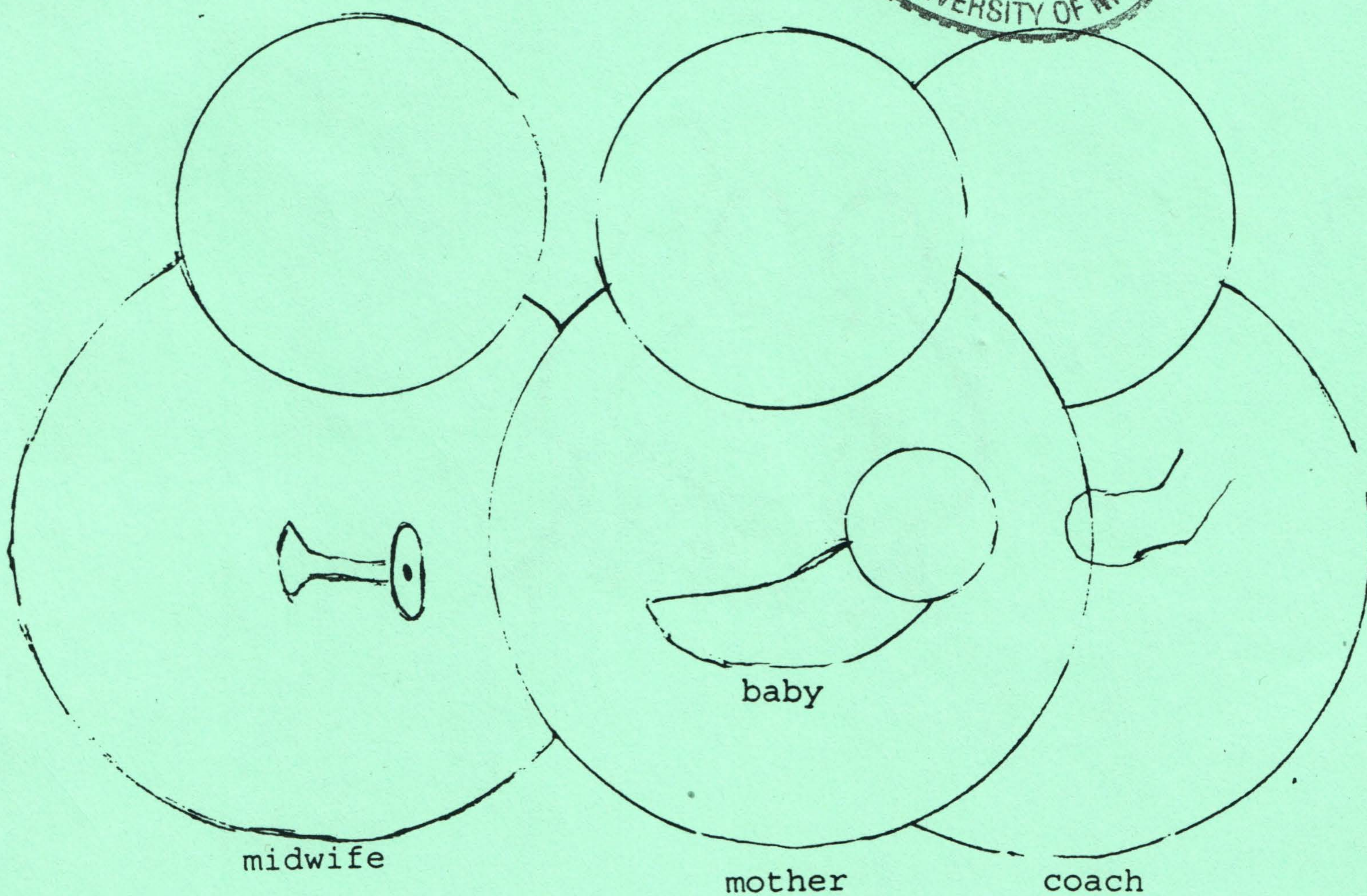
NEWFOUNDLAND & LABRADOR MIDWIVES ASSOCIATION





Newsletter No. 5, June 1998

SUGGESTION FOR A LOGO

Newfoundland and Labrador Midwives Association
(Chapters in Goose Bay and St. John's)
Newsletter 5
June 1998

This newsletter contains much detail about the meetings held in Toronto. The reports from the provinces regarding what is happening with midwifery legislation were difficult to summarise because hopefully, at some future date, this information will be of use to us. The education invitational conference also provided useful information. It so happens that I have also received an item from Rachel Munday regarding her education experiences. DeeDee Saunders has sent a report about Doulas which is very appropriate as it is relevent to our planned workshop. As you will see from the summary of the annual general meeting a workshop was requested and I am working on getting presenters. The dates fit in with a paediatric workshop which is being held the next day. We will have a key note speaker, but we will be different from other people and have her the last day instead of the first; this fits in with her travel itinerary. Please spread the word to your friends and colleagues regarding our interesting workshop.

This is the time of year where membership fees need to be renewed to avoid missing a copy of the Newsletter. If you have not done so please send your cheque to the treasurer.

Thank you to those who have submitted items for this Newsletter. Any items for the next issue should be in at the beginning of September. Items for the Newsletter are welcomed and those who submit are responsible for obtaining permission to publish in our newsletter. The Editor does not accept this responsibility. Have an enjoyable summer.

Pearl Herbert, Editor, c/o School of Nursing,
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General Meeting of the NLMA by teleconference. September 1998. In St. John's in room 2990 in the HSC. Outside of St. John's it will be the teleconference room, so arrange with your local teleconference organizer to have you booked onto the system. For the date and time watch your notice boards, and share e-mail messages; schedule will not be available until the end of July. Items for the Agenda by the middle of August .

MARK YOUR DIARY AND WATCH NOTICE BOARDS
Workshop September 21 and 22, 1998, at the Health Sciences Centre in St. John's. Date for Goose Bay not yet arranged. Topics include the natural aspects of childbearing. Bonnie Stevens, U of T, on Developmental Care. Other speakers are not yet all confirmed, so cost not yet calculated. Special rates for early booking & NLMA members.

World Breastfeeding Week, August 1 to 7, 1998
"Breastfeeding - the Best Investment"
Canada's Breastfeeding Initiative Launch and Conference
November 18 to 21, 1998, at the Bayshore Inn, Vancouver.
Abstracts for Posters by September 1, 1998
$225 for 2 1/2 days plus $125 for postconference workshops

Executive Committee
President: Pearl Herbert Secretary: Karene Tweedie
Treasurer: Pamela Browne Second Signer: Alison Craggs
Newsletter Editor: Pearl Herbert
Home page: http://www.ucs.mun.ca/~pherbert/ Newsletter: HSLibrary: WQ 160 N457n

Annual General Meeting, April 29, 1998, was held on teleconference with five members from St. John's and eight members from Labrador present. The Logo item was tabled for further suggestions.
It was decided that the cost of being able to contract to use the Association of Ontario Midwives' Emergency Skills Workshop was too expensive at $300 for every workshop plus $50 for each participant. This was passed onto the AOM but they have not made a counter-offer. The smaller Associations do not appear to be considering using the ESW. The Advanced Labour Support in Obstetrics programme from the College of Family Practice of Canada has not been received but locally it is also considered to be expensive.
As an Association we are still solvent after paying the CCM membership of $7 per midwife, bills for printing and mailing newsletters and agreeing to pay the travel expenses for the President to attend the annual general meeting of the Canadian Confederation of Midwives in Toronto on May 30, 1998. Following the CCM meeting, on May 31, 1998, the Ontario Midwifery Education Programme has organized a workshop for Midwifery Preceptors at which Lesley Page (UK), Sally Pairman (NZ), and Therese Charvet (US) will be speakers. The AOM annual conference is June 1 and 2, 1998, followed by the Emergency Skills workshop on June 3, 1998. (There was no March CCM teleconference this year).
The Constitution and Bylaws need revising, there is no mission statement and we have to decide if the objectives are applicable and suitable for our present priorities. These are provided to new members upon joining the Association, but if you do not have copies please advise either Pearl Herbert or Pamela Browne. Also contact either Pearl or Pamela regarding any suggestions to improve and update our Constitution and Bylaws. It was agreed that the executive committee serve for another year as according to the Constitution.
There is an expressed need in the St. John's area for labour support. Robyn Beaudry and Kay Matthews cannot cope with the demand. It has been suggested that a labour support group be established which would involve midwives and other interested people. It is proposed that a workshop be facilitated for this purpose in the Fall. It was suggested that Kay goes to Goose Bay and Pamela comes to St. John's. Pearl will also contact Jean Trend and others to see if they will offer to present. (Plane fares will need to be taken into consideration when calculating the registration fee).
The Provincial Perinatal Programme in partnership with the Department of Health had arranged a workshop regarding Postpartum Depression on May 11, 1998. Pearl Herbert and Alison Craggs were attending, and it was very interesting.
The Canadian Institute of Child Health has sent the NLMA a copy of the *National Breastfeeding Guidelines for Health Care Providers* (1996) and the *Postpartum Parent Support Program (PPSP) Reference Manual* (1993). Karene Tweedie will have these and they can be accessed by contacting Karene at 709-754-3870.

The Community Directory has been received, and Pearl has paid for it. The paragraph that was submitted regarding the objectives of the NLMA was not reproduced and we are listed just as lobbying for midwifery legislation.
The guest speaker was Kay Matthews who presented an update on the Safe Motherhood project which she is involved with in South East Nigeria. She spoke of her experience facilitating workshops for nurse-midwives and the tremendous interest and response in these. One topic which was addressed was the manual removal of the placenta. As Kay intimated, it was a learning experience for all as many of these midwives have a great wealth of experience from which to draw.

President's Report (April 29, 1998)
It was a year ago that the Newfoundland and Labrador Midwives Association (NLMA) started on a changed path. Probably one of the reasons why the NLMA survives is because of the willingness to adapt to fit the current situation.
Historically one notes that in 1920 a Midwives Club was formed to provide education to both practicing and aspiring midwives (Nevitt, 1978, p. 125) but this Club does not appear to have survived the colony's health care reforms of the 1930s and 1940s.
In the 1970s, with the renewed interest in midwifery across Canada regional midwives associations were formed including the Atlantic Midwives Association in 1974. Perhaps the Atlantic Midwives Association is best remembered for the annual workshops with well known people such as Margaret Myles, Dr. Murray Enkin, Peggy Anne Field, Valmai Elkins. By 1980 most of the members from the Maritimes had joined other organizations such as NAACOG, and so in 1983 the remaining midwives formed the Newfoundland and Labrador Midwives Association. An Alliance was formed consisting of the Midwives Association and the Maternity and Neonatal Nurses Association, to provide sufficient members to survive and to campaign for changes in maternity care. At this time all monies were placed with the Alliance. The NLMA did however retain its identity and had one or two meetings a year. When the Canadian Confederation of Midwives (CCM) was formed in 1987 the NLMA became a member. The coordinator of the CCM during 1993 to 1997 was from the NLMA.
The Alliance had a periodic Newsletter, but from 1992 it became a quarterly Newsletter. In 1994 there was an extra Newsletter to report the proceedings of the national midwives conference which was held that year in St. John's.
In 1994 the members of the NLMA accepted a Constitution and Bylaws for the Association.
In January 1997 it was announced that the Alliance had ceased as from December 31, 1996, so the NLMA was now completely independent. An executive committee was quickly formed according to the 1994 Constitution, and there were sufficient members to have Chapters in St. John's and Goose Bay. The members wished to continue to receive a Newsletter. In January 1997 the last Alliance Newsletter was circulated, in March 1997 a Newsletter was sent to all past members of the Alliance and to current members of the NLMA advising of the changes. The first NLMA Newsletter was issued in June 1997, and subsequent ones in September 1997, January

and March 1998[1]. Copies of these Newsletters are placed in a ring binder in the reference section of the Health Sciences Library in St. John's (WQ 160 N457n). Information about the NLMA and about the national midwifery situation is available on the internet at
http://www.ucs.mun.ca/~pherbert/
Membership has grown and by the end of 1997 there were 29 members (24 (83%) midwives and 5 (17%) associate members. Of the 29 members there were 2 midwives who were outside of Canada, and 3 midwives who were retired. In addition, 1 student had joined prior to April 1998, and is not counted in the 29[2]. The NLMA membership fees stayed the same as for the Alliance for those who are unemployed/retired/students ($10) and for associate members ($15); full members ($30) increased by $10 to cover the extra costs for the CCM, and out of country members ($40) increased by $10 to cover the extra postage, when compared to the 1996 Alliance membership fees.
Meetings have been held. The St. John's Chapter of the NLMA had a meeting on May 12, 1997. The other meetings have been by teleconference to include members around the province. These were held on September 2, 1997 and January 7, 1998.
The NLMA has continued to communicate with the Friends of Midwifery, the consumer/ lobby group formed in June 1994. As a group, the members of the Friends of Midwifery decided against becoming associate members with a separate committee within the NLMA.
Where we go this year depends on the decisions made at this annual general meeting.

Safer Childbirth by Marjorie Tew. In *Midwifery Matters, Issue 77,* Summer 1998, page 36, there is an item headed Censorship? Marjorie Tew had written a letter stating:

> At the end of 1996 Chapman and Hall informed me that they had sold their Nursing and Allied Health list to Stanley Thornes (Publishers) Ltd., Cheltenham. I learned, unofficially, that potential purchasers were being told by their suppliers that the book was out of print, without there having been any consultation with me. In January 1998 I received my first communication from them [Stanley Thornes] announcing that they had indeed withdrawn my book from publication.

Marjorie Tew has found another publisher and is hoping to bring out a third and final edition bringing the history up to date.
(See the section on Lesley Page's talk in Toronto and her report about the *Sunday Times*. It is not only in Canada that there are problems about home births and midwifery care).

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[1]The cost of these Newsletters has been $53.85 ($1.19 a copy) for June 1997; $42.54 ($1.22 a copy) for September 1997; $35.79 ($0.94 a copy) for January 1998; and $70.65 ($1.77 a copy) for March 1998 (these figures include postage). This has been $5.12 from the annual fee paid by each individual member. The average number of pages (including cover) per issue was 26. For comparison the 1996 figures were $8 from annual fee and an average of 42 pages.

[2]This compares with recent membership figures for the Alliance of: 1992 - 29 (8 (27.6%) midwives); 1993 - 40 (24 (60%) midwives; 1994 - 45 (25 (55%) midwives); 1995 - 39 (22 (56.5% midwives); 1996 - 40 (21 (52%) midwives)

Midwifery in Canada, May 1998 (Some of the items referred to in this report were included in the March Newsletter).

British Columbia. On January 1, 1998, after 18 years of striving towards having midwives recognized in BC, legislation for autonomous midwifery came into effect and midwives now have to be licensed to be able to practice. Midwives are members of both the College of Midwives of BC (CMBC) and the Midwives Association of BC (MABC). At present there are 34 registered midwives; 20 with an initial certificate and 13 with a conditional certificate. An *initial certificate* indicates a registrant has passed the written and practical examinations and met all the clinical requirements as set out in the CMBC bylaws. The midwife is then eligible to set up practice as un independent practitioner anywhere in BC and to supervise registrants with a conditional certificate. A *conditional certificate* indicates a registrant has passed the written and practical examination and met most of the clinical requirements as set out in the CMBC bylaws. To practice, the midwife must practice with a midwife with an initial certificate and follow an approved supervision plan. A registrant with a conditional certificate is eligible for initial certificate when the supervision requirements are completed. The CMBC supervision and registration approval panels meet monthly.
Candidates for registration attended the CMBC orientation in November/December 1997. There were 60 candidates and approximately two-thirds are eligible for registration with a conditional certificate, but they have to have an approved supervision plan to be able to register. To meet the needs of the many women who want midwifery care the CMBC developed a policy on inter-provincial registration reciprocity and supervision. Any interested registered midwives from Alberta, Ontario and Quebec who wish to assist their BC colleagues for a specified period, should contact the CMBC for further information.
The CMBC's Registration Committee plans to have applications ready to go out for the second cycle of assessment in October 1998. The next application deadline is April 2, 1999.
Many hospitals have midwifery implementation committees. The BC Children's and Women's Hospital has the first Midwifery Department in Canada. Victoria General Hospital is following suit. Registered midwives are required to apply for hospital privileges at the hospital in their area and to notify their professional organization of any challenges. The CMBC, the MABC, the Minister of Health, and the consumer Midwifery Task Force (MTF) continue to work towards the integration of regulated midwifery.
On December 19, 1997, the government formally announced the introduction of regulated, publicly funded midwifery services. Some doctors have protested more about the issue of money than the services provided, as doctors are feeling overworked and underpaid, and are presently engaged in contract negotiations with the government. Many physicians, nurses and administrators have contributed towards midwifery being regulated, but unfortunately the media has been providing inaccurate, inflammatory coverage which does not provide a true picture.
The MABC holds through Marsh and McLennon the mandatory malpractice insurance policy. Midwives pay commences at the level of a senior nurses pay. Midwives receive approximately $2,250 per full course of care (equal to approximately $46.87 per hour) up to a maximum of $90,000 per year. Out of this the midwife must pay for all the costs associated with independent practice including $4,500 per year liability insurance, $2,000 per year professional fees,

disability insurance and any other benefits required. The government estimates that a midwife who works full time will have a before tax income of around $55,000 per year. Approximately what an experienced obstetrical nurse receives. A general practitioner receives approximately $80 to $100 per hour, and if full time the physician has a before tax income of approximately $80,000 or more per year. (Also see the newspaper cutting in the NLMA March Newsletter).
The North American Registry of Midwives (NARM) examinations were used for the initial assessment. However, the NARM owners did not keep to their original contract, the cost of using this examination kept increasing, and the promise that measurements would be translated from imperial to metric never occurred. At the end there was no clear way of explaining the raw score and the final results. There were 95% of the candidates who passed and said that it was very easy. When studied it was found that although the examination had been developed by questioning non-nurse midwives in the United States, the answers given were obtained from popular books and not professional textbooks which may contain researched materials. After these experiences it has been decided that there will be no future contracts with NARM. The assessment charge of $2,000 per candidate did not cover costs.
To apply for licensure in BC the applicant needs to have carried out 60 births; 40 as primary midwife, at least 5 in a hospital, continuity of care to 30 women, and at least 15 in the last three years. Preparation now includes watching specific video films, writing and passing a BC examination, and agreeing to practice under supervision wherever a midwife is needed. This may take at least two months.
At present there is no firm commitment from the government for a midwifery education program. Each week there are many inquiries from people wishing to become midwives. The MABC and the CMBC education committees are collaborating on a joint document that will address the principles of midwifery education.

Alberta. In the summer of 1997 the Ministry of Health sent out a call for proposals to the 17 regional health authorities for funding and implementation of midwifery. The Ministry had an implementation fund of $800,000 that the regions could apply to access if they would agree to fund midwifery from their existing budgets for a minimum of three years. In November 1997 it was learned that all 17 regions declined this opportunity. All claimed that they had no ability to fund midwifery from their budgets. Five regions have since expressed some interest in implementing midwifery without funding, but there has been no activity to actually implement. The interested regions are considering implementation plans but there is no coordination or consultation with midwives and therefore how midwives practice may be severely limited and vary much from region to region.
The Ministry will give the Alberta Association of Midwives (AAM) $200,000 to pay for the first year of liability insurance for midwives and the Association. A further $200,000 will be used to hire two implementation coordinators for the north and south regions of the province. The remaining $400,000 is designated for use for implementation, however, no clear plans for its use have been identified. The AAM has contacted private insurance plans regarding coverage for midwifery care. Only the Alberta Teacher's Association will pay for prenatal care and care during birth up to $700 (and not for postpartum care).
The Consumer Association has been advised by lobbyists that there is no chance of funding

under the current Minister of Health. The next consumer action is to lobby for a change of Minister (they may join forces with other health care interest groups such as the Friends of Medicare).
.A regulatory body, the Midwifery Committee (under the Health Disciplines Board) was appointed in December 1997. There are 5 midwife members, 1 consumer, 1 physician, 1 RN, and 1 representative of the Regional Health Authorities. The registrar is an employee of the Ministry of Labour. It is likely that this body will evolve into a College of Midwives in the next year, although the government has said that there is no money to support or subsidize the College structure. The Midwifery Committee needs to develop criteria for determining which midwives need supervision and what this might entail.
The NARM written and clinical examinations were bought for the initial assessment, but it has been decided that they will not be used again.
An education proposal for a four year baccalaureate programme at the University of Alberta (based on the Ontario curriculum) was approved in principle by both the university and the government. However, the plans to begin the programme are on hold because there is no funding for midwifery practice.
Examinations were held in 1996 and 34 midwives were found eligible for registration. However, morale is low and midwives are moving to other provinces, so only about 20 to 24 have indicated that they may consider registering, for one year as long as there is a subsidy for the liability insurance. Part of the regulation is that to be registered a midwife must have approved liability insurance for at least $7 million, which requires a premium of $4,500 plus tax per year. Approximately another $2,000 per year will be needed for the College of Midwives for annual licensure, and to the Association of Alberta Midwives for ongoing professional development. At present mothers pay $1,200 for care from early pregnancy, birth, and postpartum, of which 50% goes towards supplies, and parents do not want to see this amount increasing.
In a last ditch effort to discredit midwifery Coroner's Inquests have begun. About six of the infant deaths occurred years ago and for the most part are being done against the wishes of the families involved. The focus seems to be on homebirth, VBAC, and lack of fetal monitoring. The midwife's lawyer is unable to call witnesses and may only ask questions. The coroner calls the witnesses. For the most part the information given by the witnesses has been pure opinion and it has not been clear that there is evidence that refutes those opinions; research regarding the safety of home births is not considered. The Medical Association maintains all records, and figures for out of hospital deaths are given including those births which were planned to be in a hospital but occurred prior to arrival and had not even been anything to do with midwifery care. The AAM and the Consumer groups have been writing letters to the newspapers in an attempt to provide a less biased report of midwifery and planned homebirth. The AAM is establishing a legal aid fund to support the legal costs of these midwives.

Saskatchewan. The Provincial Midwifery Implementation Working Group (MIWG) has been meeting since July 1997. The original intent was to have legislation ready to introduce in the Legislature in 1998, but it will now hopefully be ready for the 1999 sitting. Last January the decision was made to pursue a combination of government and self-regulation until there are sufficient numbers of midwives in the province to take over full responsibility. There is

motivation to have as much work done on bylaws and regulations as possible before the act gets through the Legislature, to reduce the workload of the transitional council and make it possible for midwives to work in a legal environment with minimal delay. A few Saskatchewan midwives have expressed interest in participating in assessment in neighbouring provinces, so that piece of the picture can also be in place for some midwives before legislation is completed.
The funding mechanism will not be in place as quickly as the regulation mechanism. This may mean that midwives who are interested in practicing but are currently employed in other capacities will decide to wait until there is funding before moving to midwifery.
The Friends of the Midwives consumer group continues to be a source of support and motivation to midwives, and they also carry out public education and lobbying.
Practicing midwives are separated by several hours travel which makes it difficult to get to quick births as backup, but when labours are long or interrupted, or a decision is made to transfer to hospital, the backup midwife ends up making unnecessary trips. There are also requests for homebirths from parts of the province without nearby maternity care backup. Originally, in many communities in this province there were borning homes or nursing homes (similar to present day birth centres). This kind of facility is now needed in Regina for rural women to come into the city but still be able to control their environment. The use of executive suites are being explored for this purpose.

Manitoba. The Midwifery and Consequential Amendments Act was unanimously passed on June 28, 1997. The Midwifery Implementation Council (MIC) will soon be named the Interim Council of the College of Midwives. The Legislation committee of the MIC will send the draft Regulation to the Act out for comment by the end of the month. The Practice committee is meeting with Hospital, Public Health, and Emergency Services working groups to lay the groundwork for midwifery practice. For the first 3 years following the legislation being implemented licensed midwives may choose to practice in all settings, or in a hospital, or in the community. At the end of the 3 years all midwives will be required to practice in all settings. There are also meetings with the Winnipeg Hospital Authority about Bylaws for midwives and writing standards. The Education committee is preparing to have the initial registration package for potential registrants ready by June 9, 1998.
Manitoba will be using the North American Registry of Midwives (NARM) examinations (written and clinical) as part of the Assessment and Upgrading (A/U) programme to assess potential midwives for registration, starting Fall 1998. There is assurance of funding to assess and upgrade a total of 50 midwives over the next 2 ½ years (2 A/U programmes a year). These will be people who are already midwives; this is not an education programme.
Both a university education program and a planned apprenticeship program are being considered. Those graduating from either of these programs would be required to write the same examinations.
Of interest is the proposed plan for midwifery education. The University of Manitoba Faculty of Nursing is developing a proposal for a School of Midwifery for direct-entry midwives. The University of Manitoba already provides distance delivery into northern and rural Manitoba and has offered the use of that technology to make midwifery education accessible throughout the province.

The Equity/Access committee is continuing to reach out to immigrant, rural and aboriginal groups to involve them in the registration process. The MIC Aboriginal Standing Committee is working to reintroduce midwifery into First Nations communities.
The Midwives Association of Manitoba was formed in December 1997, and brings together representatives from the Manitoba Traditional Midwives Collective, the Filipino Midwives Association (which has emerged since legislation has been discussed), the Association of Manitoba Midwives, and other non-allied midwives. The Bylaws are being developed with the help of those developed by Ontario and BC.

Ontario. Midwifery legislation was implemented on January 1, 1994. The Lebel Midwifery Care Organization (LMCO) which was the central Transfer Payment Agency (TPA) established by the Ministry of Health in 1993 to provide funding to midwifery practices for the first five years of regulated midwifery, ceased its operation March 31, 1998. Every midwifery practice in the province is in the process of establishing a new funding relationship with more local TPAs such as Community Health Centres, Hospitals, Victoria Order of Nurses. There are currently 11 such agencies in dialogue with the 35 midwifery practices. In many cases where there are several midwifery practices in one area they are working together with one TPA. As part of this process of devolution a new funding agreement in the form of a new contract is being developed by the Ministry. This new contract will not affect the current compensation levels for midwives but it will affect the way in which those funds flow. As the new contract is not yet ready the Ministry is flowing funds to practices through an interim mechanism. Two midwives attend a birth, one as the primary midwife and the second as her assistant. To be considered working full-time the midwives have to provide care as the primary midwife to at least 40 women per year and as the second midwife to 40 women per year; a total of care provided to at least 80 women per year. (Care is from early pregnancy to 6 weeks after the birth for both mother and baby and the minimal number of visits is stated).
Ontario does not have regional health boards. There are regions and the four regions with midwifery representatives reporting to the Association of Ontario Midwives (AOM) Board will be strengthened by changing the representatives to coordinators responsible for regional development of midwifery.
At present there are 120 practicing midwives, 26 students who will soon be graduating from the Midwifery Education Programme, and 40 potential midwives completing the Prior Learning and Experience Assessment (PLEA).
The NARM examination was originally used for assessing the first midwives to be licensed. Now the AOM is developing an examination bank. An apprenticeship program for aboriginal midwives is being considered, but further education may also be required.
The AOM has Fact Sheets, for example: In a survey of several midwifery practices in Ontario, 6% of women attended by midwives were delivered by cesarean, compared with 20% of physician assisted births; 8% of women attended by midwives received episiotomies compared to nearly 50% of physician-assisted births; 95% of women attended by midwives were found to be successfully breastfeeding at six weeks ; 5% of women attended by midwives use epidural anaesthetic for pain relief compared with 30% of physician attended births; 40% of midwife-assisted births take place in the home representing the lowest cost option for healthy births. At

present for every woman accepted for midwifery care there is another woman who is not accepted because of an insufficient number of midwives.
The AOM responded to both the SOGC Statement on Midwifery and the SOGC article on home births. (See the NLMA March Newsletter for copies of these letters). The SOGC had taken the unusual step of breaching professional etiquette and writing a policy statement about another profession; not how SOGC interacts with that profession but how that other profession should practice; including medical education, place of birth; level of education etc. This Policy Statement (No. 66, *Journal of the SOGC*, September 1997, pp. 1097-1098) appears to have been written in response to the salaries being paid to midwives and the displeasure by the SOGC members about their own "reimbursement issues". The SOGC recommends that midwives join their Society but then immediately nearly triples the 1998 membership fee for midwives when compared to previous years. They have also stated that the SOGC ALARM course (for emergency birth measures) is only available to physicians. The president of the SOGC, Dr. Andre Lalonde, and the AOM had a teleconference meeting in early May, at which time it was clearly stated that Ontario midwives do not represent midwives in Canada. The AOM suggested that a province-wide committee of obstetricians and midwives be established to deal with any concerns particular to Ontario and that the SOGC and the CCM might consider ways in which to work more closely together. Dr. Lalonde contacted Karyn Kaufman, of the midwifery program at Mcmaster University, and invited her to submit an article to the *Journal of the SOGC* in response to this matter.
After much discussion at the May 1998 CCM meeting it was agreed that each Midwives Association have at least one midwife become a SOGC midwife member to provide their other members with information. The SOGC does not have group membership. Also, each Midwives Association to write a challenge to the SOGC statement.

Quebec. In 1990 Bill 4, an Act respecting the practice of midwifery within the framework of pilot projects, was passed. Midwives had to pass government examinations to become qualified to practice within the project, but there was no licensing, "midwife" was not a protected title, and home births continued. Eight birth centres were established, although lack of midwives resulted in one of them being closed before the end of the project. At the end of 5 years an evaluation was undertaken, as was required by Bill 4, to recommend whether or not it was advisable to allow the practice of midwifery. In December 1997 the final report of the "Conseil d'Evaluation des Projects-Pilots Sages-Femmes" was released. (This was reported at the Canadian Public Health Association's annual meeting held June 1998 in Montreal). The major recommendations were that midwives be recognized as autonomous front line professionals, integrated into the perinatal team; that a transitional professional Order be established, with the intention of creating a specific Order of Midwives (similar to a College); that midwives be permitted to assist births in a variety of locations such as birthing centres, hospitals, homes, and that administratively they remain under the jurisdiction of the local community health centres; that the educational preparation for midwives in Quebec be a university bachelor's degree. In April 1998 the Ministry of Health released its recommendations based on this report, accepting most of the recommendations but requiring that the future order establish safety standards for home births and have these standards approved by the government before participation at home

births be permitted. Legislation is expected to be in place for September 1999, and in the meantime the current law for the pilot projects is being extended for one year. (Also see: Sages-femmes: Le Quebec legalisera la pratique en 1999. *Canadian Nurse, 94*(5), 21, 1998; Positive report on midwifery care in Quebec. *Internationao Midwifery Matters*, March 1998, p. 9). The midwives will continue to receive a salary from the government, and funding has been guaranteed for at least 5 years.
In February 1998 the Quebec obstetricians stopped accepting new patients and threatened to go on strike. Many more women then became aware of midwifery. There has been considerable opposition from the obstetricians but since the Minister announced that the profession will be legalized the obstetricians have expressed an interest in working with the midwives, but they are opposed to births being outside of the hospital. The obstetricians have also submitted a proposal for providing midwifery education.
In 1997 there were 60 accredited midwives in Quebec of whom 43 were practicing in the birth centres. The "Conseil d'admission" has been holding regular examinations for midwives with diplomas from other countries and 17 have been accredited and are being integrated into the birthing centres. Midwives with diplomas will be able to apply for accreditation until 2002.
A decision has been made to follow the Ontario Midwifery Model with some modification to accommodate Quebec participants. The Quebec Ministry of Education has invited the Quebec universities to submit tenders for a baccalaureate midwifery degree program to commence in the Fall of 1999.

Nova Scotia. In September 1997 the Reproductive Care Program of Nova Scotia released its report *The Potential of Midwifery in Nova Scotia*. There are 23 recommendations, 12 supporting midwifery, and the remaining ones are a mix of other items for nursing and physician care. (The report was on the internet at: http://www.gov.ns.ca/heal/). Following the release of this report the Minister of Health announced that a working group on midwifery would be set up. The first meeting of the Interdisciplinary Working Group on Midwifery Regulation was on May 20, 1998. Following lobbying efforts and support from the CCM it was agreed that three midwives would be included, plus 1 member from the Midwifery Coalition of NS, 2 physicians, 1 RN, 1 from the Dept. Of Health, 4 to 6 Regional Representatives, and Mary Jane Hampton of the Dept. Of Health is the Chairperson.

Prince Edward Island. There is one inquiry a month about midwifery services and there are a few home births. For births in hospital there is labour support, often requested by families who have had midwifery care in the past and then find that it is not available in hospitals in this province. Inquiries are also being received from women who would like to enter a midwifery education programme.

New Brunswick. Home births are usually attended by midwives from Nova Scotia. There is no interest in midwifery from the government or from other professional associations.

North West Territories. The Rankin Inlet Birth Centre has been evaluated as being acceptable. (This was reported at the Canadian Public Health Association's annual meeting held June 1998 in Montreal). The 1996 NWT regulation permits health boards to hire practicing midwives who are licensed by a provincial College of Midwives.

Committees reports - from those representing CCM on committees of other organizations.
College of Family Physicians of Canada (Karyn Kaufman). The Maternity Care Committee is chaired by Michael Klein, and has met in June and November 1997, and May 1998. The SOGC statement on midwifery has been discussed and Larry Reynolds responded in the June issue of *Accoucheur*. *Accoucheur* journal is published four times a year and costs $25. For details contact reynolds@julian.uwo.ca Data is being collected to demonstrate who provides care to mothers and babies, and a national conference is being arranged. There may be a paper drafted to discuss the relationship between family physicians and midwives. (Larry Reynolds, of the University of Western Ontario, has a web page).

The Third UKCC International Conference on the Regulation of Nursing and Midwifery was held at the time of the ICN conference in Vancouver. Peggy-Anne Field represented CCM at this meeting. Margaret Risk of the College of Nurses of Ontario represents North America and the Caribbean. She is not a midwife and does not automatically provide midwives with reports. These have been requested.

Alcohol and Pregnancy Joint Statement (Pearl Herbert). There had been no meetings during this past year and hence nothing to report.

Breastfeeding Committee for Canada (Pearl Herbert). Materials were sent in the March issue of the NLMA Newsletter but if you missed the conference information e-mail: bfc@istar.ca
Fax: 604-875-3747, Telephone: 604-875-3737
New information includes: *Nutrition for Healthy Term Infants* from Health Canada, may be obtained from http://www.hc-sc.gc.ca/hppb/cny/infantnutrition/ A copy may also be obtained from: Publications, Health Canada, Ottawa, Ontario, K1A 0K9 (Telephone: 613-954-5995; fax: 613-941-5366). (See: *Canadian Nurse, 94*(6), 25, 1998).
If you are interested in Dr. Jack Newman's articles some of them are reproduced on: http://www.erols.com/cindyrn/drjack0.htm Cindy RN, IBCLC, has placed them on this web page. There is an article by Dr. Newman which has been submitted for the Newsletter but I do not expect to have room to include it in this issue. Dr. Newman has given his consent for it to be printed.

Canadian Coalition for the Prevention of Developmental Disabilities (Betty-Anne Daviss). There was nothing new to report.

Consensus Conference on Infected Health Care Workers: Risk for Transmission of Blood borne Pathogens The Midwives Association of Saskatchewan has a copy which they will send to me.

Revision of the Family Centred Maternity and Newborn Care National Guidelines (Charlene MacClellan). There was nothing new to report regarding the revision of these guidelines.

Fetal Health Surveillance Steering Committee (Pearl Herbert). The curriculum committee has been working on designing a course to match the SOGC guidelines as written in the *Journal of the SOGC, 17*(9), 859-903. This material has now been sent to the steering committee members for their comments to be submitted by April 20, 1998. The curriculum committee (on which Eileen Hutton represents CCM) has done much work in preparing this document.

National Neonatal Resuscitation Group The next meeting will be in Hamilton and the Association of Ontario Midwives will locate a midwife from the Hamilton area to represent the CCM.

Canadian Perinatal Surveillance System steering committee (Pearl Herbert). A meeting was held in Ottawa on April 16 and 17, 1998. Absent were Dawn Fowler, co-chair, who is still in Europe with the WHO; Arne Ohlsson (now working in Texas) who has osteomylitis from where he fractured his leg before Christmas; Jamie Blanchard (MB), Judith Lumley (Aus), Raine McKay (BC), and a representative from SOGC.

A report was given regarding the November meeting held by LCDC with potential suppliers. There are a very limited number of the CPSS variables at present being collected by most jurisdictions who do collect data. In view of this a pilot project was suggested involving a few jurisdictions, but not individual hospitals, and no comparisons made between the suppliers, to enable the CPSS to assess how to get from their present objectives to future goals.

There was a discussion on the variables which can be easily collected from documents such as birth certificates. There is still a difference in the ways in which provinces/territories define "live birth", "stillbirth", how "birth weights" are recorded (some as stated and some are rounded up), and how much information is actually recorded, e.g. Quebec shows educational level for the mother whereas this is not shown by other provinces/territories.

With the new International Code of Diseases #10 (ICD10) there may be changes in the Canadian Institute for Health Information (CIHI) data collection and ICD10 could be on the agenda at the Registrars of Vital Statistics annual conference next month. At present an incident during a surgical procedure may not be reported to/by CIHI, just the procedure itself is noted (a ruptured uterus during a cesarean section may not be reported, just the cesarean section). The total numbers shown on the data files do not always make sense; there may be more of a procedure than there were births.

Fact sheets are in the process of being placed on the web page: http://www.hc-sc.gc.ca/hpb.lcdc/brch/reprod (lcdc is LCDC). The annual report has been delayed as Dawn has been away.

Papers of interest include:

Graham, I.D., & Fowler Graham, D. (1997). Episiotomy counts: Trends and prevalence in Canada, 1981/1982 to 1993/1994. *Birth*, *24*, 141-147.

Lei, H., & Wen, S.W. (In press). Ultrasonographic examination of intrauterine growth for multiple fetal dimensions in a Chinese population. *American Journal of Obstetrics & Gynecology*.

Lei, H., & Wen, S.W. (In press). Normal amniotic fluid index by gestation week in a Chinese population. *Obstetrics & Gynecology*.

Kenney, N., & MacFarlane, A. (1997). The use of computerised information systems in maternity units in England and Wales. *Midwives, 110*(1315), 204-206.

Turner, L. A., & McCourt, C. (1998). Folic acid fortification: What does it mean for patients and physicians. *Canadian Medical Association Journal, 158*, 773-774.

Wang, Z, & Sauve, R. (1998). Assessment of postneonatal growth in VLBW infants: Selection of growth references and age adjustment for prematurity. *Canadian Journal of Public Health, 89*(2), 109-114.

Wen, S. W. (1997). Survey inference for subpopulations [letter to the editor]. *American Journal of Epidemiology, 145*, 569.

Wen, S. W., & Kramer, M. S. (1997). A comparison of perinatal mortality between ethnic Chinese and ethnic whites: Why the Chinese rate was lower. *Ethnicity and Health, 2*, 177-182.

Wen, S. W., Liu, S., & Fowler, D. (1998). Trends and variations of neonatal length of in-hospital stay in Canada. *Canadian Journal of Public Health, 89*(2), 115-119.

Wen, S. W., Liu, S., Marcoux, S., & Fowler, D. (1997). Uses and limitations of routine hospital admission/separation records for perinatal surveillance. *Chronic Disease in Canada, 18*, 113-118.

Wen, S. W., Liu, S. Marcoux, S., & Fowler, D. (1998). Trends and variations of maternal length of in-hospital stay in Canada. *Canadian Medical Association Journal, 158*, 875-880

Another article of interest but not from the CPSS.

MacDorman, M. F., & Singh, G. K. (1998). Midwifery care, social and medical risk factors, and birth outcomes in the USA. *Journal of Epidemiology and Community Health, 52*(5), 310-317.

Interprovincial Midwifery Registration Reciprocity.

Robin Kilpatrick of the College of Midwives of Ontario is studying this issue, and presented at this afternoon session. Provincial midwifery regulatory bodies had representatives present (BC, AB, MB, ON, PQ).

Currently all regulatory bodies and midwives associations consider that autonomous midwifery and the level of education required for the beginning midwife to be a baccalaureate degree in midwifery (not baccalaureate equivalency), to be important for reciprocity.

For credibility there needs to be education which is equivalent to other practitioners in the country. Beginning midwives need to be able to practice as primary care providers. Primary care is the first point of entry to the health system, in the hospital and in the community. Continuity of care is where the midwives are known to the woman, and not more than four midwives in a Practice. These midwives then provide care from early pregnancy to six weeks postpartum (the provinces have a minimum requirement of visits during these months).

The Midwives Association of North America (MANA) is a non-regulatory body and so has no need to protect people. It just promotes midwifery. In the United States two States recognize the MARN examination (a branch of MANA) as credentials for non-nurse midwives. These non-nurse midwives are not allowed to practice in hospitals. As already mentioned, the answers to the examination questions are based on popular midwifery books. A psychometric evaluation in multiple choice questions is concrete and the marker cannot be sued if a person fails the exam, but midwives need to demonstrate higher levels of thought.

At present Quebec is accepting midwives licensed in Ontario and British Columbia is agreeable to accept midwives who have passed the examinations in Alberta, Ontario and Quebec. (These would usually be midwives trained elsewhere who have passed the prelicensure examinations).

Midwife Preceptors - Partners in Education. (A whole day invitational workshop on the Sunday arranged by the Midwifery Education Program, and the initial plenary session on the Monday, first day of the Association of Ontario Midwives annual conference). The guests were Therese Charvet (Seattle Midwifery School, MANA President(?)); Lesley Page (Thames Valley University, England); Sally Pairman, past President of the New Zealand College of Midwives (Otagoa Technical College, Dunedin, New Zealand).

In the United States there are four classifications of midwives. The American College of Nurse-Midwives (ACNM) graduates midwives who are eligible for licensure in all of the States. The ACNM also wants to provide accreditation to midwifery schools accepting direct-entry midwives and provide certificates to these midwives, but this has not yet been accepted. (Accreditation is approval of a school; certification is approval of an individual). There are also direct-entry midwives licensed by the States, and lay midwives. Each of the 50 States has its own legislation regarding midwives.

The ACNM views midwives as providing primary care and it is this component which places midwives in direct conflict with nurses and physicians.

MANA is a non-regulatory body and has no restrictions as to who may join as they want to attract and promote midwives as quality health providers to the managed care corporations. With managed care the corporations buy up health care facilities and sell services to consumers and so midwives have to be attached to corporations.

NARM is the examination process of MANA, which establishes a national certification process for direct-entry midwives. Recertification is every 3 years showing 25 contact hours plus 5 hours in a peer review workshop or 5 hours participating in peer reviews. There are several acceptable modules including workshops, home study programmes, documented research, etc. This compares to the ACNM which requires 50 contact hours in 5 years, and workshops, home study, approved by the ACNM. The ACNM approved courses are advertised in their *Journal of Nurse-Midwifery*.

At the Seattle Midwifery School the curriculum is 3/4 clinical and 1/4 classroom. Classroom courses include professional issues, research, writing papers, etc. Students cannot obtain funding for the programme as midwifery is seen as being a marginal profession. The students do not have liability insurance and so may only watch when they are in a hospital. As midwives in a Practice usually only have 20 to 30 home births in a year students have to be creative as to how they obtain the required number of births (100 of which 50 may be observed). The clinical experience is obtained all over the world. There is no funding with which to pay preceptors, so the quality of care provided by the preceptors vary and some preceptors may not be as educated as the students. The programme faculty counsel and educate the preceptors and provide clinical training workshops. There are clear policies about supervision and about what a preceptor can and cannot allow a student to do. Preceptors sign a contract. Students are to be treated as an adult learner. As students have different learning styles compatibility between the preceptor and student. The student and preceptor have weekly contracts on what the student wants to do, whether the student wants to be an observer or an assistant to the preceptor, and whether the preceptor should be a mentor or an evaluator for a particular skill or during a particular week. Feedback is required otherwise the student becomes tense.

Evaluation of students during their basic and advanced practicum is by a faculty committee. The committee reviews the preceptors reports and makes the final decision about passing or failing.

In England there has been much in the media about home births. An obstetrician provided the *Sunday Times*, January 25, 1998, with some incorrect research using poor statistics. Although the editors have been advised that there is a problem with the research results they are reluctant to print these letters.
Changing Childbirth government document calls for women-centred care, greater autonomy for midwives, and fundamental changes in practice to a case load practice so that women know their midwife. There has been a reluctance by some midwives to change from regular shifts to being on call and independent in the community. The managers (supervisors) often do not have confidence in the recommended changes.
Midwifery education for new midwives has moved from the National Health Service sites to an university. Administration is time consuming and the students may be obtaining clinical practice in a number of different locations. There is a heavy classroom teaching load plus involvement in clinical practice, and university meetings. Conflict of teaching/research/practice. [Just like here!] Faculty need confidence to deal with older, experienced midwives, but rely on qualified midwives to help with clinical teaching. There is often a gap in education between mentors and students as the midwives may not be as academically qualified as the students. Mentors need to be able to assess a student and not state at the end that the student is not suitable for midwifery. There is a need to help mentors upgrade their academic qualifications. Practice needs to be valued as a scholarly activity. Midwifery is often considered to be a vocation but practice is the pivot and research is required to attract money and to develop new knowledge to improve practice.
Midwives are encouraged to take refresher courses to stay up to date, and they have to complete portfolios to stay licensed.. Some midwives have difficulty in managing their time so that they are not working all the time every day. Time management courses are needed.
Thames Valley University, St. Mary's Road, Ealing, London W5 5RF, provides a MA in Midwifery Management (two 15 week semesters with a dissertation in the third semester); and a MA in Midwifery Practice (two 15 week semesters with a dissertation in the third semester). If the applicant does not have a bachelor degree they may be admitted to the programmes by showing potential for working at a Master's level, through a portfolio and qualifying essay. The Thames Valley University has previously had students from Canada.

New Zealand has a population of 3 ½ million and 5200 births per year. In 1904 a Midwives Act was passed for autonomous midwifery but with a gradual increase in medicalisation and hospitalization by 1938 free medical care was available for women during childbirth. In the 1950s consumer groups were formed and in the 1980s midwives also started lobbying so that in 1990 an amendment to the 1977 Nurses Act was passed restoring autonomy to midwives. Independent means that they work in a partnership providing continuity of care, prescribing and requisitioning of tests; a way of practicing not of how they are employed. These changes were helped by having a labour government in power, people being interested in women's issues, and the *Cartwright Report* which recommended controlling one's own care. Most hospitals only have a few midwives working there because midwives come in from the community with the women. 88% of women know their midwife and 50% of women choose a midwife to be their main carer, 53% of midwives are primary practitioners. The consumer is considered to be equal to the midwife at every level.

In 1989 the New Zealand College of Midwives was formed.
There are five schools which provide a 3 year bachelor of midwifery degree. Maori women have been attracted into programmes. Although many of those entering the programmes are direct-entry each school provides recognition for nurses. Prior learning is recognized and there is national post-registration midwifery education. There is a process to enable midwives to complete modules up to a PhD degree.
The third year is an apprenticeship model. The students negotiate partnerships with both the women and the midwives. Midwifery educators and midwifery practitioners have different but complementary roles and have developed a different partnership. An orientation package is given to the midwives as the practitioners need to know the curriculum. The educator provides support, helps with assessments, documentation. Educators are maintaining practice. At present there is no requirement for numbers of procedures but this may be required in the future as it will help the midwifery students when they are competing with medical students for births.
Each year a committee of two midwives and two consumers review a midwife applying to be able to practice for another year. If a midwife is out of practice for 5 years then a refresher course is required.

Panel Discussions It has been found by the Ontario Midwifery Education Programme faculty that support is needed to preceptors when they assess clinical competency. There is a lack of resources and so are developing a *Guide for Teaching and Assessing* for preceptors, and a copy has been requested. The levels are introductory competency, intermediate competency, and entry to practice. The types of skills are listed for each level, the learning opportunities, where the student should be at each level and teaching suggestions for each competency. Preceptors are viewed as partners sharing in the education of midwives. All midwives in Ontario are required to be preceptors after they have finished a clerkship year of practice. In Ontario "midwife" is a protected title and all midwives have to be licensed to practice by the College of Midwives of Ontario. Midwives work in a Practice based in the community from which they practice in both the community and hospitals. For clinical experience the students are placed in a Practice where there may usually be between 2 and 4 midwives. There may be a beginning midwifery student and a senior midwifery student with the same Practice. The midwives in the practice decide who will be a preceptor (as they know each others case-load, vacation times, etc). The students do not have a choice as to which Practice they will be placed in as the decision is made by the Faculty; prevents a popularity contest. Preceptors/Practices are paid the same amount of money as physicians receive for having a medical student; $500 per month per student. Liability insurance and workers compensation insurance are paid by Ontario universities for all of their students in off campus agencies. Midwives and students are required to receive hepatitis B and rubella immunizations, and Tb tests, plus any other immunizations and tests required by specific hospitals where they have admitting privileges (also required by students who are placed with the midwives coming to the hospitals).
The differences found by midwives who used to have apprentices and now have students was described as: Preceptorship versus apprenticeship; potluck who you get versus choice; no responsibility for complete education versus responsible for complete education.
Students gave similar feedback as to those we have heard from nursing students including; lack of respect, lack of time for academic work, having to attend team meetings at the Practice when not applicable, the need for constructive feedback and debriefing, and the feeling of insecurity

and fear that they will finish one course without having completed all of the assignments. Students do not receive mileage payments so often travel in the midwife's car but then do not like to be delayed if the midwife makes a personal stop on the way back to the Practice. When they reach the clerkship year the students consider that there should be a way of introducing them differently than as a student.

Information has been received about a conference being arranged by Douglas College, New Westminster, BC, and the Seattle Midwifery School. July 6-8, 1998. Professional Issues Seminar for Midwives and Midwifery Students. Includes setting up a private practice in midwifery; General business skills and information; Collaborative Relationship: the politics of obtaining hospital privileges, hospital back-up and physician consultation. Cost: $225. Contact: Continuing Education, Douglas College, Box 2503, New Westminster, BC, V3L 5B2 (Fax: 604-527-5155)

AOM Conference Concurrent Sessions. I went to one on Homeopathy, about which I know nothing. It sounded interesting but I was rather lost especially with the way of measuring these ingredients (not in mg or ml). Listening and letting the history unfold was the main message. As there is difficulty in obtaining permission to prescribe medications the majority of midwives use homeopathic remedies. The AOM has handouts for midwives.
The College of Midwives of Ontario is developing a detailed position statement and a short discussion paper for when the federal government considers prescription/prescribing by midwives. The federal government has always stated that it would not consider midwives prescribing narcotics and other drugs controlled by them until the majority of provinces have midwifery legislation implemented. It will then be interesting to see if midwives continue to prescribe homeopathic remedies.

I went to the Healthy Babies, Healthy Children session given by a person from the Ministry of Health. I had read about the programme in the *Communique* newsletter of the College of Nurses of Ontario. The Office of Integrated Services started in April 1997 and the programme is to be universal across the province so the families do not fall between the "cracks" when they relocate. The Parkyn's assessment scale is being used followed by a more complete assessment for mothers scoring over 9. It is estimated that every year 9,000 babies will be in the programme, and by 2001 this will be a $15 million per annum programme. The money added to the programme is expected to save money being spent on welfare payments. This is a mandatory programme for every health department in the province. As midwives know the women to whom they provide care they will be completing the first two assessments, on forms obtained from the Public Health Department in their region. This resulted in much discussion regarding providing confidential information to another department, even though it was pointed out that lawyers had said that this was quite legal. (I do not know what kind of consent is completed by the mothers when they receive midwifery care in Ontario and if it is all encompassing like hospitals consent forms often are).

The AOM conference finished with the Consumer group showing slides of many of the midwives in the province and reading a sentence from an evaluation about that midwife. Apparently all mothers complete an evaluation for the Consumer group after they have finished receiving midwifery care.

AOM Emergency Skills Workshop.The conference was followed by a day of the Emergency Skills Workshop; a 1 ½ hour written examination - a mixture of multiple choice and short answers - and six stations with simulated emergency situations such as shoulder dystocia, unexpected twins, unexpected breach presentation, haemorrhage, cord prolapse, fetal distress. The experience was good although I had never worked with an assistant so kept forgetting to include her and usually being a 1000 miles away from medical help I had never been able to call 911! (e.g. I would do a manual removal of a placenta if the woman was bleeding instead of waiting for the doctor, which is what midwives in Ontario have to do as they are not permitted to do manual removals). It would have been easier if one was practicing. The examination consisted of 54 questions and many had several parts, so there was really no time to stop and think. Some of the questions referred directly to the AOM regulations so had to guess the answers. The manual which we received a few weeks beforehand was not very clear and needed revising.
I have passed on the NLMA's decision from our last meeting that we could not afford to purchase the right to use this examination. The AOM has not made a counter-offer. I am ready to work with anyone who wishes to develop a program for our Association to use.

Birth Assistant? Doula? Labour Support? Montrice? from *Midwifery Now*, Newsletter of the Midwifery Coalition of Nova Scotia, Spring 1998, p. 4.

What do these terms really mean?
Doula is a Greek word meaning woman's servant. She is a companion to a labouring woman and may be professionally trained to provide labour support. She performs no clinical tasks, such as dilation checks or fetal heart monitoring. Doula can also refer to a lay woman trained and experienced in postpartum care, cooking, cleaning and breastfeeding.
Montrice is a French word. Used by Ferdinand Lamaze to describe a specially trained nurse who provides nursing care and assessment as well as support. She is hired by a couple to help with labour at home and in hospital.
Lay Labour Support Person is much like a doula or may refer to an inexperienced friend or relative who accompanies the woman in labour.
Birth Assistant or Labour Assistant refers to lay women who are trained in midwifery skills. They can do vaginal exams, fetal heart monitoring and take blood pressure, as well as providing labour support. They can do follow up support for breastfeeding and maternal health.

What is Labour Support? Hodnett (1989) describes professional labour support as involving the following:

1. Emotional support such as encouragement and reassurance;
2. Information support, such as instructions and advice;
3. Physical support, and comfort measures, such as massage and compresses;
4. Advocacy; interpreting her wishes to hospital staff and acting on her behalf.

<u>Becoming a Doula</u> submitted by DeeDee Saunders, a recent graduate from the BN program who is working as a casual nurse with the Melville Hospital, and is "happy to be back home again".

Since September 1997 I have been working toward certification as a doula with an organization called Doulas of North America (DONA). A doula is a person who provides emotional and physical support to the woman and her partner before, during, and after labour and delivery. The doula does not replace the midwife, as a doula is not permitted to perform activities such as monitoring or examining the client, education regarding family planning, breastfeeding etc, and delivery of the child. The doula also does not replace the woman's partner, and some partners have commented that they found the birth experience to be better than previous experiences because of the doula's presence.

It is interesting to note that the benefits of having a doula present during labour and delivery are similar to the benefits of having a midwife present. It has been found that there is a 50% reduction in the caesarean section rate; 25% shorter labour; 60% reduction in epidural requests; 40% reduction in oxytocin augmentation; 30% reduction in analgesia use; 40% reduction in forceps delivery (Klaus, Kennell, & Klaus, 1993, *Mothering the Mother*).

Imagine what a great experience it would be to have BOTH a doula and a midwife present for labour and delivery!

DONA is based in the United States of America and is an International Association of doulas trained to provide the highest quality of labour support to birthing women and their families. Through conversations and correspondence with nursing students worldwide, I have discovered that certification as a doula is the first step many students take as aspiring midwives anticipating future enrollment in an approved School of Midwifery. As a senior student of Memorial University of Newfoundland School of Nursing, and as an aspiring midwife awaiting the formation of the MUN Post-RN Baccalaureate Degree in Midwifery, I decided that I would use my time wisely and begin working toward certification with DONA.

The first step I took was accessing the website for DONA, which is: http://www.dona.com This site offers all the information necessary to begin working toward certification as well as useful addresses and links to other sources that may be helpful. The steps toward certification include:

5. Become a member of DONA ($40 annual feed in US currency);
6. Read four books from the approved reading list (this list includes books geared to the public which have information on alternatives for birth as well as comfort measures for the woman. One of these books is by Penny Simkins, *The Birth Partner*.
7. Complete one of the following:
   a. Training in childbirth education;
   b. Midwifery;
   c. RN with work experience in labour and delivery;
   d. Observe a childbirth preparation series (not as an expectant parent).
8. Attend the DONA approved doula training course (14+ hours) which includes education on the following:
   a. Emotional and psychological processes of labour and birth;
   b. Anatomy and physiology of reproduction, labour and birth;
   c. Comfort measures and pain management;

  d. Appropriate topics for pre- and post-birth discussion with clients;
  e. Discussion of ethics and standards of practice for the doula;
  f. Referral sources for clients whose needs exceed the scope of practice for a doula;
  g. Communication skills and values clarification.

9. After the workshop obtain and provide copies of good evaluations from:
  a. At least three clients, plus
  b. Three nurses and two physicians <u>or</u> three midwives
10. Provide copies of documentation (by the doula) from three births where the doula provided continuous labour support. To be obtained after the workshop.
11. A written essay (500 - 1000 words) on the purpose and value of labour support for the woman.
12. Sign the DONA Code of Ethics and Standards of Practice.

Unfortunately, the DONA workshops in Eastern Canada are far and few between, so I will have to wait until the New Year before the opportunity arises that I can participate in the course. In the meantime, I will complete the books from the reading list and learn what I can from other avenues, particularly from the midwives at Melville Hospital.

This certification process will require a lot of time, effort, and money on my part but I feel it is worthwhile as I wait to begin a midwifery program, and I look forward to learning everything I can. I learned from my summer preceptor experience in the maternity ward at Melville Hospital, with midwife Ann Chaulk, that I am capable of being a good support person to the labouring woman and her partner, so I feel that I will do well with this.

Any questions about certification with DONA can be forwarded to them at: Certification Chair, Connie Sultana (206-324-5440; or e-mail: momswann@aol.com) Or: askdona@aol.com

The Nova Scotia branch: Doulas on Call, P.O. Box 44027, RPO Bedford, Bedford , NS, B4A 3X5 (Telephone: 902-861-1318)

[Also see: Perez, P. G., & Herrick, L. M. (1998). Doulas: Exploring their roles with parents, hospitals, and nurses. *AWHONN Lifelines, 2*(2), 54-55].

<u>Pre and Postnatal News</u>. To receive complimentary copies send you name and address, type of institution, and that you consult/educate, to: Mack Rogers, Today's Parent Group, 269 Richmond Street West, Toronto, ON, M5V 1X1 (This is not a recommendation but just a sharing of information).

<u>Call for Abstracts</u> on nausea and vomiting in pregnancy. E-mail address for information: momrisk@total.net (From: *Canadian Family Physician*, May 1998, p. 1182).

<u>1998 CNA Publications Catalogue</u> available free. Telephone: 1-800-385-5881.

Postpartum Depression Workshop held May 11, 1998, and organized by the Provincial Perinatal Programme and the Department of Health. Joy Maddigan and Cathie Royle chaired the main sessions. Lynn Vivian Book and Dr. MacLaughlin, a psychiatrist, presented information. Reports were received from representatives from the 9 provincial health regions. Main issues included that although postpartum depression, also known as postpartum mood disorder, is quite common, there is a lack of public awareness. In St. John's the provincial Mental Health people have been working with the public health nurses. An inservice was held last March and they have designed a bookmark which can be distributed to pregnant women. Support groups are being started to which women may either refer themselves or be referred by someone else. Both the Central and the Western Regions have also had workshops and have identified referrals as a problem. The Western Region are using the Edinburgh Postpartum Depression scale (Cox et al., 1987) to identify mothers at risk. Maranda, a MUN medical graduate student, is validating this Edinburgh Postpartum Depression Scale. Dr. MacLaughlin said that although postpartum depression starts earlier it often peaks at 3 to 6 postpartum months, affects 10% to 15% of women, but friends and relatives consider sleep disturbance, tiredness, lack of concentration, as being due to caring for a baby, not as a depression, and so it is not reported. Lynn Vivian Book spoke on identifying women at risk for a repeat episode of postpartum depression on the provincial antenatal form. At the back of the Vital Statistics Notification of a Live Birth form there is the Parkyn scale. However, if this scale is completed within 24 hours of a birth one wonders if the signs and symptoms could be missed, and the mother with a low risk score may not receive a home visit. Postpartum depression is when the mother has had signs of depression (bad after baby blues) for at least 2 weeks. Some think that postpartum depression is a depression occurring as a result of a pregnancy having finished with either the baby being born alive, or stillbirth, or spontaneous abortion. Others consider that the depression is a result of the imbalance of hormones in the postpartum period (Dalton, 1980), and this may be carried to the extent that they believe in placentophagy (Field, 1984).
For more information contact Cathie Royle, Provincial Perinatal Program, Janeway Child Health Centre, St. John's, NF, A1A 1R8 (Telephone: 709-778-4656; e-mail: hcc.royc@hccsj.nf.ca)

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Letter from Away from Rachel Munday who is studying for a MSc in Reproduction and Health at the College of Medicine, in the School of Nursing Studies, Cardiff College, University of Wales. (Rachel worked at Melville Hospital and then moved to a nursing station in western Ontario before deciding to go and further her education).

The University of Wales is a collegiate system where towns in Wales have colleges which are affiliated to the one University. Also, in recent years former polytechnics and colleges of further education have upgraded their status and become universities.

This MSc programme is intended to be multi disciplinary. Unfortunately our year only has 10 students (9 midwives and 1 gynae nurse). Modules of interest to general practitioners, obstetricians, paediatric nurses, social workers and general public members with interests in reproductive health are available. Entry requirements are age 25+ years, basic RN, RM (or more) with at least 2 years post-basic experience, but these are negotiable. All students are self-financing and about half have been given study leave, one day a week, by their National Health Services employers.

In the first year there are four taught modules. There is quite a wide choice and it is possible also to choose modules from the MSc nursing course if they are considered of relevance to a student. The Research and the Advanced Clinical in Midwifery/Obstetrics/Fertility/Paediatrics (depending on one's sphere of practice) are mandatory modules. However, the whole course is designed to be flexible to meet the needs of the mature student and negotiation on choice of modules is very possible. If there are less than four students choosing a module then it has to be self-directed learning rather than a taught module, which is quite feasible. The only requirement is that the requested written work is produced, but one does not gain so much from not attending taught sessions.

The second year is devoted to writing a dissertation which may be a literature review, with or without a research proposal attached, or it can be an actual research project. Given the time and financial restraints which limit most midwives clinical research is not often chosen, unless one has an easily attainable project of obvious relevance which does not require financial backing.

I found the Research module extremely useful. Although I had been taught to consider the research basis for all my actions in my basic RN and RM programmes, little time was spent on critiquing, appraising, and carrying out research. I now feel much more confident with research terminology and in my ability to critique and therefore use already published research in my practice. Maureen Laryea's postnatal research was often cited as one of two excellent examples of participant observation; of which there is as yet very little midwifery research. My assignment for this module was on Nutrition and Hydration in Labour. Did you know that Dr Mendelssohn's original research in 1946, on which the policy of nil by mouth (NPO) in labour is based, is totally flawed from a research perspective. It is incredible that women have been made to suffer and have had less than optimal outcomes because of his "research".

For the Advanced Clinical Midwifery module I presented a seminar on Water Birth (Labour and/or delivery and/or third stage in a pool specially used for that purpose). Now I feel quite happy to undertake water births and have indeed participated in two as an independent midwife. Other topics which were presented and discussed were Team Midwifery, Midwife-led beds, Continuity of Care and of Carer, Midwives performing Ventouse deliveries, Management of

Third Stage, Home Birth, and topics generally of interest to midwives. Each student had to review the literature and present the evidence for and against the subject. Debate on the subjects was encouraged. I have found that my experience of working in the north in a Primary Health Care setting has been of great benefit in increasing my confidence in my own abilities and in encouraging innovative practice in myself. When there is only you to do a job you have to find a way to get it done! Can midwives do ventouse deliveries? Of course they can, but should they is entirely another issue, and sparked a debate regarding midwives being the protectors of normal birth.

For my third module I chose physiology, taught by a physiologist. It was intensely interesting and of extreme relevance and importance. For example, did you know that prostaglandins and histamine play an important part in the implantation of a fertilized ovum? Should paracetamol/ acetaminophen (prostaglandin inhibitor) and over the counter cold remedies (anti-histamine) be used in very early pregnancy, especially by couples having difficulty conceiving? I have just handed in an assignment on gestational diabetes mellitus and explored glucose metabolism when non-pregnant, having a normal pregnancy, and with gestational diabetes mellitus (GDM), from a physiological point of view. I have briefly looked at outcomes; morbidity and mortality. Again the research strongly suggests that the only useful knowledge gained from knowing that a woman fulfils the as yet unstandardized criteria for GDM is her potential for future non-insulin dependent diabetes mellitus (NIDDM). Do not forget pre-existing NIDDM (type 1) and insulin dependent diabetes mellitus (IDDM) (type 2) are completely different.

The final module I chose is entitled "Influencing Change in the National Health Service (NHS)" and is taught by Sheila Drayton of "Is anyone out there still giving enemas?" fame. Although the subject matter is somewhat dry and far removed from the clinical situation, I have begun to appreciate the importance of all health care personnel being knowledgeable regarding the policies that make and shape our health service. While the system differs slightly from Canada the principles of knowing your system are the same. One day perhaps I will be a more effective/ influential midwife! This assignment is a discussion of four recent Government white papers on the subject of a Primary Care led NHS and the opportunities this affords midwives in the future.

I still have not decided on what to base my dissertation. I would like to have some sort of cultural bias or relevance to home birth. Working as an independent midwife I am of course very interested in home birth, and my various cultural immersions have given me an interest in research for the purpose of better understanding of non-white populations.

The newsletter is keeping me up to date with midwifery in Canada and I am thinking hard of what I would like to do when I return in August 1999. I would really like to get involved more directly with midwifery development and hope that my new found knowledge will be of use to some community somewhere. In the meantime I have to support myself and am putting out feelers to find my own clients for home births. I am not sure if it is lucrative enough as a first income when one has only just started in the business. I attended a really lovely home birth in April and have another lady due in August.

In England the weather has been variable, beautiful 15C in February, snow and floods at Easter. The dog has now met horses, cows and sheep. In fact yesterday he chased a horse and has a hoofprint on his ribs to prove it. He has also caught one pheasant since he came out of quarantine, so I keep him well away from anything I think he might damage.

Rachel's address is: 137 West End Road, High Whycombe, England, HP11 2QF

Health Canada Santé Canada

Canadian Perinatal Surveillance System

Infant Mortality

Over the past three years, the Bureau of Reproductive and Child Health at Health Canada's Laboratory Centre for Disease Control has been working on establishing the Canadian Perinatal Surveillance System (CPSS). The development of the CPSS is guided by a Steering Committee comprising expert representatives of health professional organizations, consumer and advocacy groups and the provincial and territorial governments, as well as Canadian and international specialists in perinatal health and epidemiology. The CPSS is part of Health Canada's efforts to strengthen Canada's national health surveillance capacity.

There are three main components to the CPSS: collection of data related to perinatal health, analysis and interpretation of these data, and response. The aim is to collect data on all recognized pregnancies, regardless of their outcome: abortion, ectopic pregnancy, stillbirth or live birth. If the pregnancy results in a live birth, information on the infant's health during the first year of life will also be collected.

The response component of the CPSS includes the development and dissemination of fact sheets about perinatal health. The objective of these fact sheets is to distribute perinatal health information to a broad audience of interested professionals and lay persons. Members of the CPSS Steering Committee review all CPSS fact sheets. This is the first of many fact sheets that will be published at regular intervals.

Introduction to Infant Mortality

Infant mortality rates are often used as an indicator of a country's state of health development. During the last century, significant decreases in infant mortality rates occurred world-wide, particularly in industrialized countries. This fact sheet examines temporal trends in, and the current state of, Canadian infant mortality. It explores differences within various Canadian subpopulations and compares Canadian rates to those of other countries belonging to the Organization for Economic Cooperation and Development (OECD). Unless referenced otherwise, infant mortality statistics are taken from the publication *Mortality – Summary List of Causes, 1995*.[1]

Definitions of Key Terms

Infant mortality – Infant mortality refers to the death of a live born infant within the first year of life. Stillbirths (also referred to as fetal deaths) are not included in infant mortality calculations.

Infant mortality rates – Infant mortality rates are usually based on the number of infant deaths per 1000 live births in any given year, but are sometimes based on the number of infant deaths per 1000 population less than one year old. It should be noted that infant mortality "rates" are actually ratios, because infants who die in the year of interest, but were born in the previous year, are counted in the numerator but not in the denominator.

Neonatal death – Neonatal death refers to the death of an infant under 28 days (4 weeks) of age.

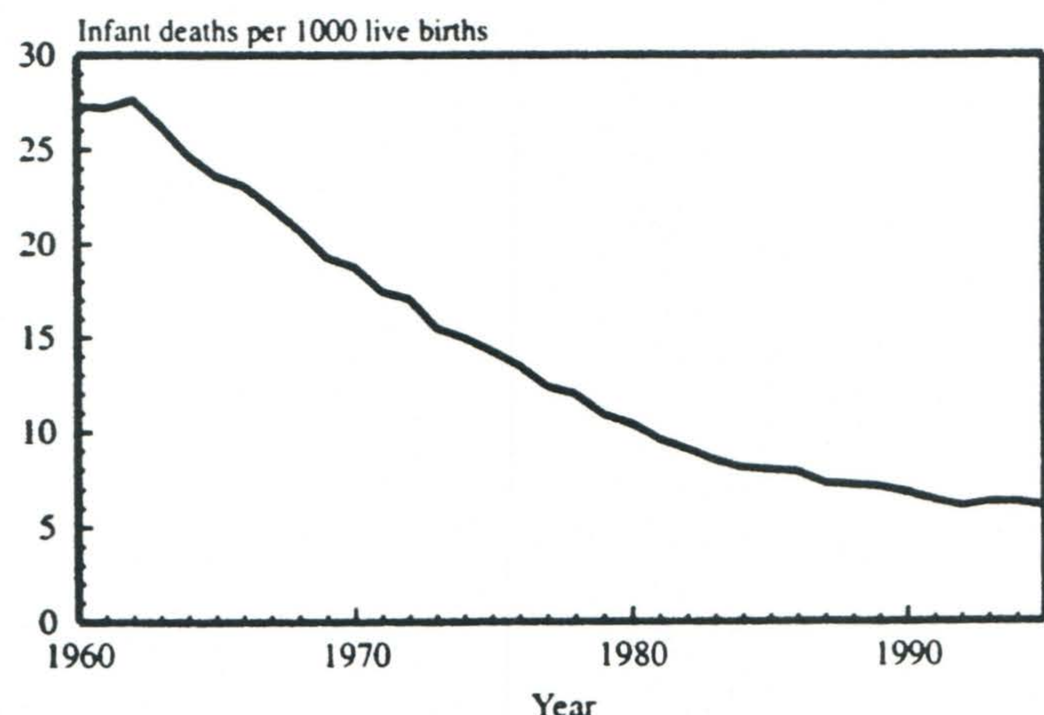
Post-neonatal death – Post-neonatal death refers to the death of an infant between 4 weeks and 1 year of age.

Infant Mortality

In 1995, 2321 infants in Canada died before their first birthday. Of these deaths, 1584 (68%) occurred in the neonatal period and 737 (32%) in the post-neonatal period. The two leading causes of neonatal death were conditions originating in the perinatal period and congenital anomalies. Conditions originating in the perinatal period, which include respiratory distress syndrome, short gestation and low birth weight, accounted for 60% of neonatal deaths. Congenital anomalies accounted for 33% of neonatal deaths. The two leading causes of post-neonatal death were sudden infant death syndrome (SIDS) and congenital anomalies, accounting for 31% and 23% of post-neonatal deaths, respectively.

With the exception of Japan, Canada has had the most dramatic decline in infant mortality rates in the past 35 years. In 1995, the infant mortality rate in Canada was 6.1 per 1000 compared to a rate of 27.3[2] per 1000 in 1960. Among OECD countries, only Japan and France had higher rates of infant mortality in 1960 (30.7 and 27.4, respectively).[3] The Canadian infant mortality rate has fallen steadily since the early 1960s, tapering off somewhat in the mid-1980s (Figure 1)[4].

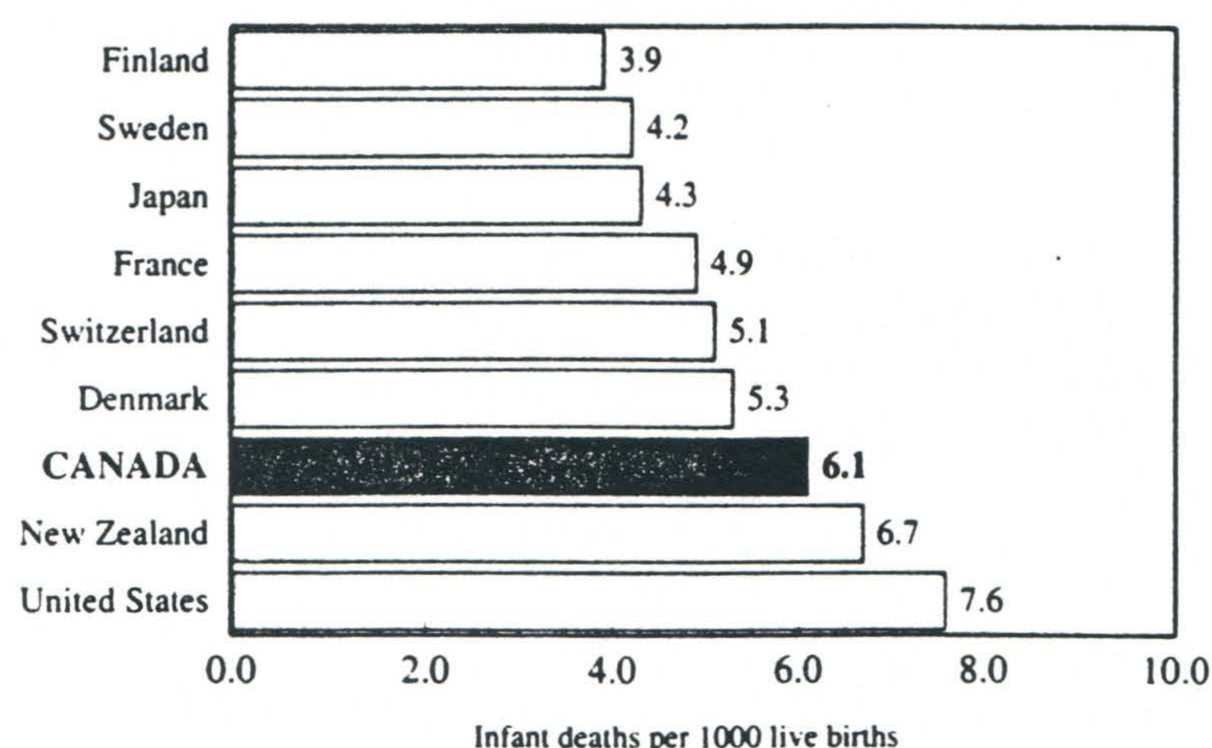
Figure 1. Infant Mortality Rate
Canada, 1960-1995



Sources: Statistics Canada, *Selected Infant Mortality Statistics, Canada, 1921-1990.* Statistics Canada, *Births and Deaths, 1995.*

International differences in infant mortality rates must be interpreted with caution, as there are significant international variations in clinical practices and the methods used to register live births.[5,6] In comparison with infant mortality rates in other OECD countries, Canada's rate of 6.1 is somewhat high. Finland, Sweden and Japan reported the lowest infant mortality rates: 3.9, 4.2 and 4.3, respectively; while New Zealand and the United States reported the highest rates: 6.7 and 7.6, respectively (Figure 2).

Figure 2. Infant Mortality Rates
Selected Countries, 1995



Source: Statistics Canada, *Births and Deaths, 1995.*

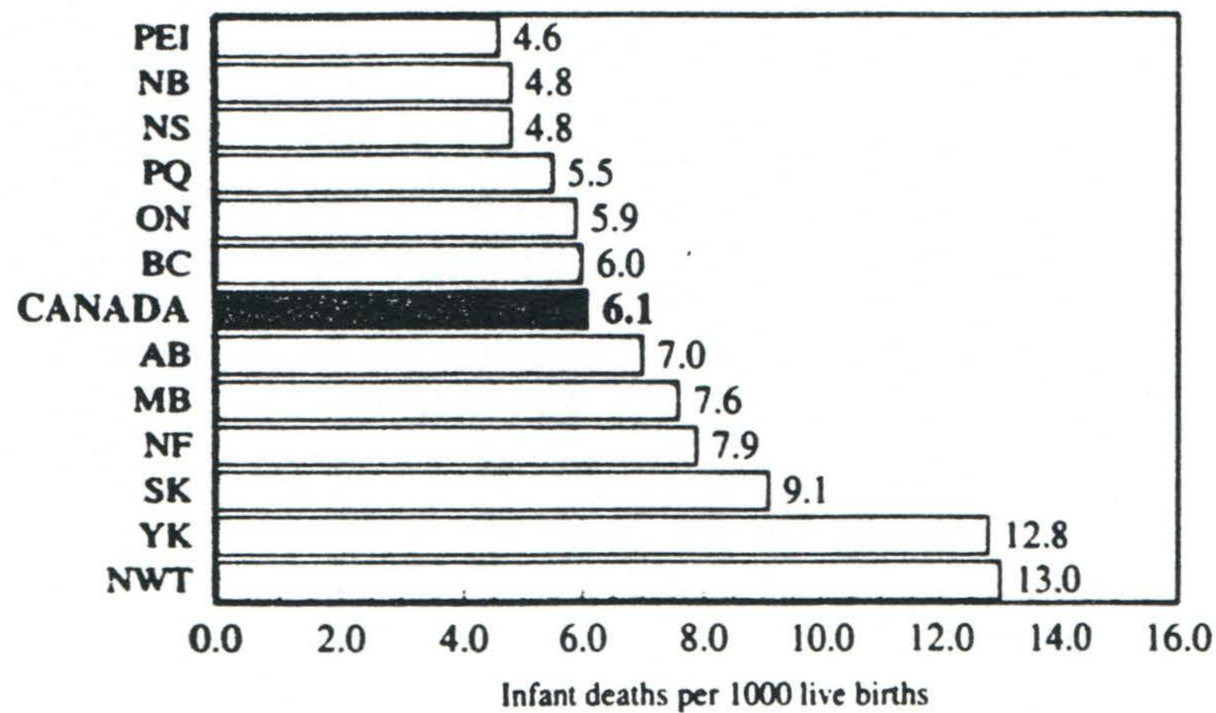
Differences within Canada

Male infants are more likely than female infants to die before their first birthday. However, the difference between the male and female infant mortality rates has decreased, from 4.8[7] per 1000 in 1971 to 1.2 per 1000 in 1995. In 1995, the male infant mortality rate was 6.7 per 1000 and the female infant mortality rate was 5.5 per 1000. Unlike the rate difference, the male to female infant mortality rate ratio has remained constant at 1.3.

Provincial/territorial differences in infant mortality rates must be interpreted with caution, as rates are unstable in provinces and territories with few infant deaths. This is particularly true for the smaller east coast provinces and the Yukon. For example, in 1994, the Yukon reported the lowest infant mortality rate in Canada (2.3) whereas in 1995 it reported one of the highest (12.8). In 1995, Prince Edward Island, Nova Scotia and New Brunswick reported the lowest

infant mortality rates, 4.6, 4.8 and 4.8, respectively; while the Yukon and the Northwest Territories reported the highest rates, 12.8 and 13.0, respectively (Figure 3).

Figure 3. Infant Mortality Rates
Provinces and Territories, Canada, 1995



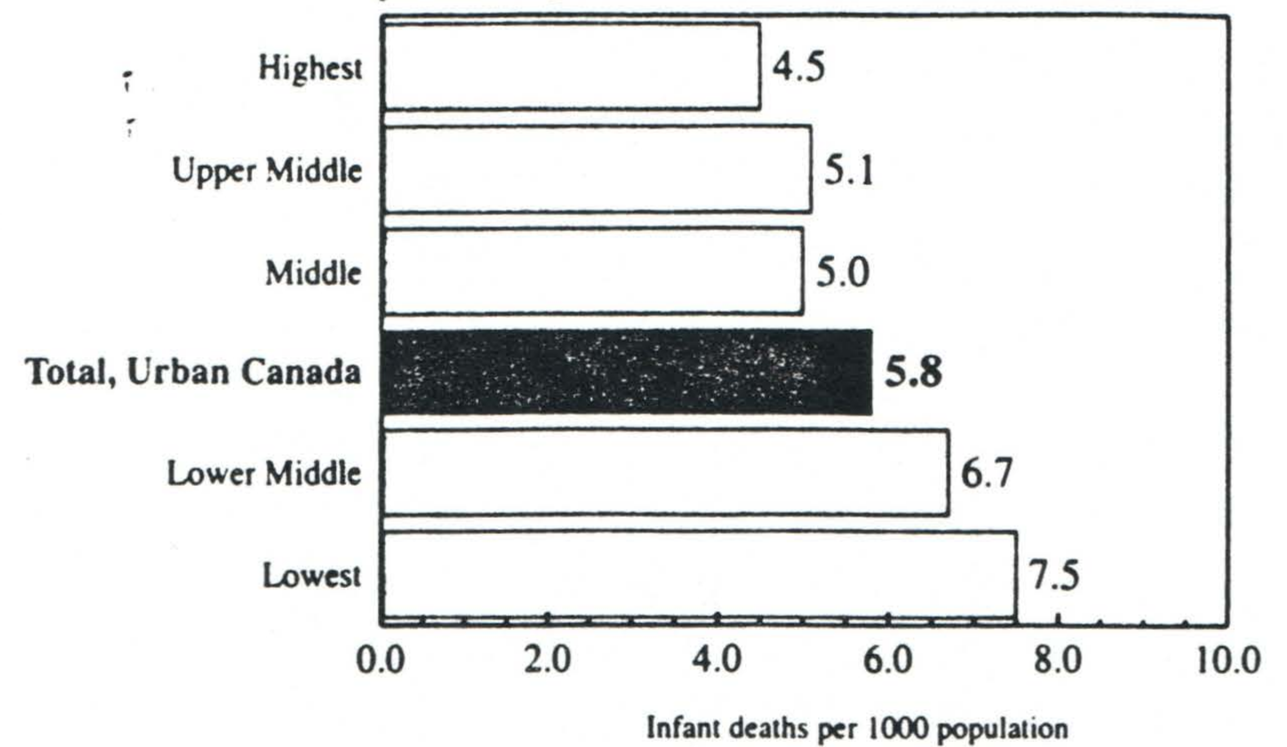
Source: Statistics Canada, *Births and Deaths, 1995.*

Differences in infant mortality rates between income groups in urban Canada are pronounced. In 1991, the overall infant mortality rate in urban Canada was 5.8 per 1000.[8] The high, upper-middle and middle income groups had infant mortality rates that fell below the Canadian average, while the lower-middle and low-income groups experienced higher than average infant mortality rates (Figure 4). Canadians in the high-income group had an infant mortality rate of 4.5 per 1000, compared with a rate of 7.5 per 1000 among Canadians in the low-income group. The rate difference between the highest and lowest income groups was 2.9 per 1000. In 1986, the difference was 4.8 per 1000 and in 1971 it was 9.8 per 1000.[9] The ratio of infant mortality rates among the lowest versus the highest income group was 1.6 in 1991, 1.8 in 1986 and 2.0 in 1971.

Data Limitations

Regional and temporal variations in the methods used to register live births weighing less than 1500g have been reported in the medical literature.[5,6,10] Comparisons of infant mortality across place and time need to be adjusted for the proportion of such births. Indeed, analyses have shown that the exclusion of live births weighing less than 500g changes the results of interprovincial comparisons and secular trends.[10,11] The data sources used in preparing this fact sheet did not permit the exclusion of such births from infant mortality statistics.

Figure 4. Infant Mortality Rates
by Income Quintile, Urban Canada, 1991



Source: Wilkins R. "Mortality by neighbourhood income in urban Canada, 1986-1991."

In the study of infant mortality by income group, rates were calculated using the census population less than one year of age rather than the total number of live births. This method leads to an underestimate of the number of births (particularly in the lower income levels), and consequently a slight over-estimate of the infant mortality rate.[9] It should also be noted that the income-related mortality study was based on the income of the neighbourhood rather than the income of an individual or a family. "However, various other Canadian studies[12-14] suggest that the pattern of disparity in socio-economic groups observed in this study is likely to be a reasonable, if somewhat conservative, reflection of what might be expected at an individual level of analysis."[9]

Summary

Since the early 1960s, reductions in infant mortality rates in Canada have been dramatic and encouraging. However, there is still room for improvement, as other OECD countries have lower infant mortality rates. Disparities between regions and income groups within Canada are pronounced and provide further evidence of the need for improvement. Unfortunately, owing to the current lack of comprehensive perinatal health information in Canada, data are not available to identify the causes of these disparities. By collecting and analysing perinatal information, it is the intent of the CPSS to identify these causes and thereby help reduce the overall rates and disparities.

For Further Information

In the upcoming months, the CPSS will publish fact sheets on other aspects of perinatal health. For more information, or to be added to our mailing list, please contact:

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Or visit our website at:
www.hc-sc.gc.ca/hpb/lcdc/brch/reprod

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This fact sheet was prepared by members of the CPSS.

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Health Santé
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Canadian Perinatal Surveillance System

Induced Abortion

Over the past three years, the Bureau of Reproductive and Child Health at Health Canada's Laboratory Centre for Disease Control has been working on establishing the Canadian Perinatal Surveillance System (CPSS). The development of the CPSS is guided by a Steering Committee comprising expert representatives of health professional organizations, consumer and advocacy groups and the provincial and territorial governments, as well as Canadian and international specialists in perinatal health and epidemiology. The CPSS is part of Health Canada's efforts to strengthen Canada's national health surveillance capacity.

There are three main components to the CPSS: collection of data related to perinatal health, analysis and interpretation of these data, and response. The aim is to collect data on all recognized pregnancies, regardless of their outcome: abortion, ectopic pregnancy, stillbirth or live birth. If the pregnancy results in a live birth, information on the infant's health during the first year of life will also be collected.

The response component of the CPSS includes the development and dissemination of fact sheets about perinatal health. The objective of these fact sheets is to distribute perinatal health information to a broad audience of interested professionals and lay persons. Members of the CPSS Steering Committee review all CPSS fact sheets.

Introduction to Abortion

In 1969, a law was passed to regulate abortion under the Criminal Code. This law permitted a qualified medical practitioner to perform an abortion, if prior approval was obtained by a Therapeutic Abortion Committee. A 1988 Supreme Court of Canada decision found this process unconstitutional. The 1969 law was rendered unenforceable and abortion was effectively decriminalized.

As of March 1998, a woman may obtain an abortion in all provinces and territories in Canada, except Prince Edward Island. However, in most hospitals and clinics, the procedure is limited to a gestational age range that is specific to that facility. In British Columbia, Alberta, Ontario, Newfoundland and most facilities in Quebec, hospital fees or clinic fees are paid by the province. In the remaining provinces and territories, only abortions performed in hospitals are funded; abortion clinics require private payment.[1] An analysis of the impact of state-level restrictions on abortion in the United States (U.S.) indicates that abortion rates are unchanged by different funding policies.[2]

This fact sheet examines recent trends in Canadian abortion statistics and compares them with those of other countries belonging to the Organization for Economic Cooperation and Development (OECD).

Unless referenced otherwise, all abortion statistics reported in this fact sheet are taken from the publication *Therapeutic Abortions, 1995*.[3]

Definitions of Key Terms

Abortion – "Abortion is the termination of pregnancy by any means before the fetus is sufficiently developed to survive."[4] In this paper, abortion refers to any abortion otherwise described as *induced* or *therapeutic*. Spontaneous abortions (miscarriages) are not included.

Abortion rates – The number of abortions per year, per 1000 females aged 15-44.

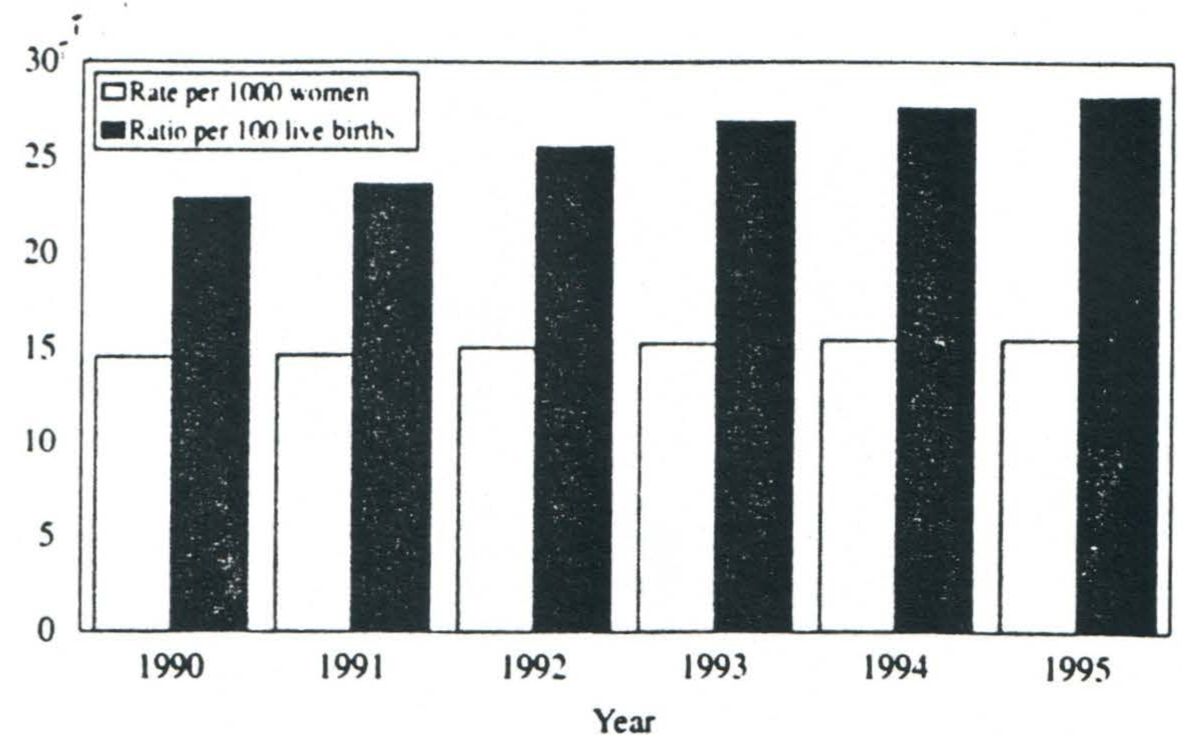
Abortion ratios – The number of abortions per year, per 100 live births.

Induced Abortion

Data on induced abortions obtained by females residing in Canada are gathered from Canadian hospitals and abortion clinics, and from voluntary reports from U.S. states. Data from all these sources are collated by the Canadian Institute for Health Information and transferred to Statistics Canada for analysis and publication. In 1995, Statistics Canada reported that 106 658 abortions were obtained by Canadian females. Of these, 459 (0.4%) were performed in the U.S. That year, there were also 378 011 live births and 2353 stillbirths;[5] making abortions approximately 22% of reported pregnancy outcomes.*

Temporal trends in induced abortion rates and ratios show increases (Figure 1). Between 1990 and 1995, the abortion rate increased from 14.6 to 15.5. The 1995 rate corresponds to one induced abortion in every 65 women 15 to 44 years old. The abortion ratio also increased between 1990 and 1995, from 22.9 to 28.2. The 1995 ratio corresponds to one abortion for every 3-4 live births. The increase in the abortion ratio is partly attributable to a decrease in the number of live births over time.

Figure 1. Abortion Rates and Ratios
Canada, 1990-1995



Source: Statistics Canada. *Therapeutic Abortions, 1995.*

Abortions are primarily performed in hospitals, but the proportion performed in clinics is increasing. In 1990, 22% of reported abortions were performed in clinics. By 1995, this proportion had risen to 34%. All clinic abortions and almost all hospital abortions (94%) are performed on an outpatient basis, with no overnight stay.

The following demographic and medical characteristics of women obtaining abortions are based on a subset of abortion records which contained more detailed information. Twenty percent of abortions, in 1995, were obtained by females less than 20 years of age; 52% by women 20-29; 26% by women 30-39 and all others by women 40 years and older. Over half (54%) of women who obtained an abortion had had a previous delivery; a third of these women had had a previous abortion.

There were no abortion-related deaths in 1995 and the rate of complications was 1.1%. This is probably attributable to the fact that most abortions are performed early and to the use of less invasive abortion procedures. Over eighty percent of abortions, in 1995, were performed during the first trimester, before 13 weeks of gestation; and almost all abortions (97%) were performed using the less invasive procedure of dilatation and suction curettage. It should be noted that most congenital anomalies are detected by ultrasound and/or genetic testing after 13 weeks of gestation. With the introduction of medically/pharmaceutically induced abortions, it is likely that abortion procedures will become even less invasive. Approximately 1500 medical abortions were performed in Canada in 1996.[6]

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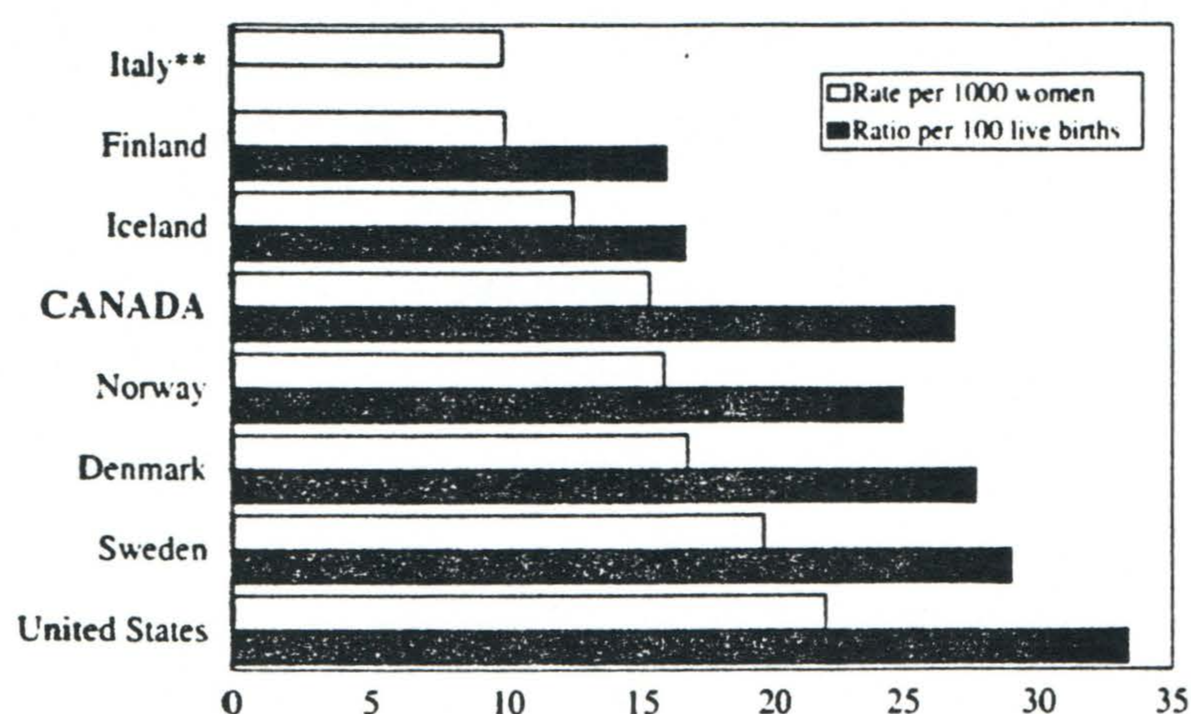
* These pregnancy outcomes do not include ectopic pregnancies and miscarriages. Also, the definition of stillbirth is not standarized across the country. The number of stillbirths reported here includes fetal deaths after 20 or more weeks of gestation and fetal deaths of unknown gestational period.

Canada's abortions rates and ratios are similar to those observed in the Nordic countries. In 1993 (the last year for which data are available for all these countries), Canadian rates were lower than those observed in the U.S. and higher than those observed in Italy, Finland and Iceland (Figure 2).

Figure 2. Abortion Rates and Ratios
Selected Countries, 1993*



*1993 is the last year for which abortion figures are available for *all* these countries.
**Italy's 1993 abortion ratio was not available.
Sources: See references 7-9.

The difference between the proportion of abortions obtained by females in different age groups should be interpreted with caution, as females in age groups with higher proportions may also have higher fertility rates. Although an approximation of all pregnancies in a certain age range may be gained from the addition of reported live births, stillbirths, ectopic pregnancies, spontaneous abortions (miscarriages) and induced abortions, it is difficult to determine accurate fertility rates, as spontaneous abortions may go unnoticed and/or unreported. Furthermore, fertility rates are usually reported for women aged 15-44, but women younger than 15 and women over the age of 44 also have abortions.

An additional data limitation is the lack of reporting of some abortions. This stems primarily from three sources: abortions provided in physicians' offices that have not been designated as abortion facilities,[10] medically/pharmaceutically induced abortions and abortions provided to Canadian women in the U.S.[3]

As stated previously, detailed analyses of demographic and medical characteristics of women who have induced abortions or analysis of clinical practices relating to induced abortions could only be carried out using a subset of records. This subset consisted of clinic records from Ontario and Alberta and 76% of hospital abortion records. Routinely available abortion data contain no information about rural versus urban differences nor any details about the reasons why Canadian women have abortions. The percentage of pregnancies terminated following prenatal detection of congenital anomalies is thus unknown.

Summary

Reported Canadian induced abortion rates and ratios increased between 1990 and 1995. The majority of these abortions were performed in hospitals; however, the proportion performed in clinics is increasing. The average woman obtaining an abortion in 1995 had had a previous delivery but had not had a previous abortion. The methods used to induce abortions are becoming less invasive due to increased use of dilatation and suction curettage and the introduction of medical/pharmaceutical abortions. Comparing abortion figures in selected OECD countries, Canada's figures are similar to those observed in the Nordic countries.

There are significant limitations in the quality and scope of induced abortion data currently available. The Canadian Perinatal Surveillance System intends to address some of these limitations by collecting and analyzing information concerning women who have induced abortions.

For Further Information

In the upcoming months, the CPSS will publish fact sheets on other aspects of perinatal health. For more information, or to be added to our mailing list, please contact:

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This fact sheet was prepared by Konia Trouton and Susie Dzakpasu.

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Name of Organization: ____________________

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NEWFOUNDLAND and LABRADOR MIDWIVES ASSOCIATION
APPLICATION FOR MEMBERSHIP
1998

Name: ____
(Print) (Surname) (First Name)

All Qualifications: ______________________________________

Full Address: ____

____

Postal code: ____________________ Telephone No. (home) ______________

Telephone No. (work) ______________________ Fax No. ______________

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: ____

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 Newfoundland and Labrador Midwives Association).

Membership for midwives is $30.00 (as this includes the Canadian Confederation of Midwives fees which the Association has to pay).
Membership for those who are not midwives is $15.00.
Membership for those who are unemployed/retired is $10.00
Membership for those who are residing outside of Canada $40 (to cover the cost of the extra postage).

Signed: ________________________ Date: ______________________

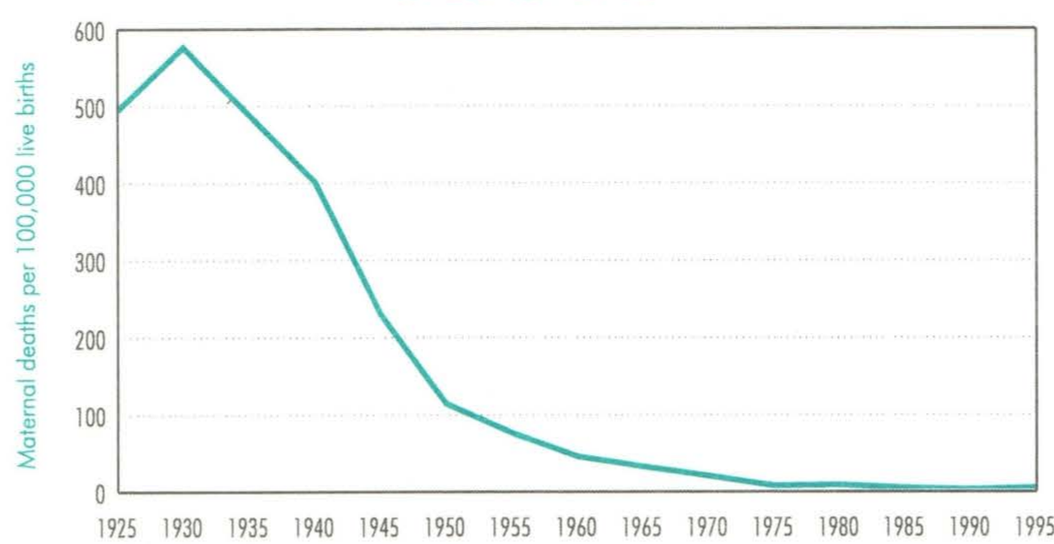
Return to: Pamela Browne, P.O. Box 112, Station A, Goose Bay, Labrador A0P 1S0

REPORT ON MATERNAL MORTALITY IN CANADA

on the occasion of World Health Day, April 7, 1998, devoted to the theme of Safe Motherhood

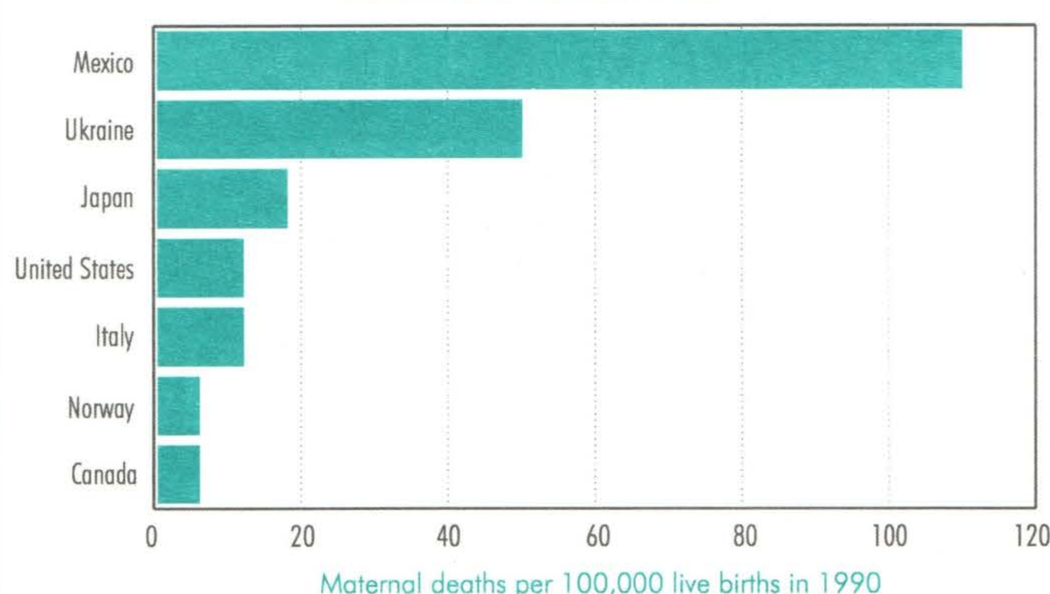
During the 20th century risks to women associated with childbirth in developed countries have been dramatically reduced as a result of many factors. These include technological advancements in obstetrical care, greater access to health services and fewer births occurring at the extremes of women's reproductive age span. The reported maternal mortality ratio in Canada has declined from approximately 500 maternal deaths per 100,000 live births in the early 1920s to less than 5 per 100,000 live births in the 1990s,[1] among the lowest reported maternal mortality ratios in the world.[2]

Maternal Mortality Ratios in Canada, 1925 to 1995



Source: Statistics Canada. *Selected mortality statistics, Canada, 1921-1990.*

Maternal Mortality Ratios in Selected Countries



Source: Unicef. *The state of the world's children 1997.*

Why is this issue important in Canada where childbirth is known to be relatively safe?

Canadian women are fortunate to have universal access to health care contributing to the safety of pregnancy and childbirth. It is nevertheless important to monitor patterns of pregnancy-related mortality and serious morbidity (illness) and to be sensitive to what observed patterns or changes may tell us in order to continue to safeguard women during this critical period. Because many developed countries have found maternal deaths to be seriously underreported,[3] the monitoring process must begin with ascertainment of the accuracy of routine reporting of deaths associated with pregnancy and childbirth in Canada. The addition of the categories "late maternal deaths" and "pregnancy-related deaths" (defined below) to the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10), recognizes that deaths from any cause related to or aggravated by pregnancy may not be counted as maternal deaths because they occurred more than 42 days after the termination of the pregnancy, or because they may have been misclassified under other ICD-9 categories.

The Canadian Study of Maternal Mortality and Morbidity is being conducted under the auspices of Health Canada's Canadian Perinatal Surveillance System

The Canadian Perinatal Surveillance System (CPSS), a program of the Bureau of Reproductive and Child Health, is part of Health Canada's Public Health Intelligence initiative. The CPSS subcommittee studying maternal mortality com-

prises health professionals, epidemiologists and representatives from Statistics Canada and the Society of Obstetricians and Gynaecologists of Canada (SOGC).

What are the objectives of the Canadian Study of Maternal Mortality and Morbidity?

- To determine the extent of underreporting of maternal mortality in Canada during five target years (1988-1992) by examining the cause of death recorded for all women who died within a year of a live birth or still birth. (Deaths are identified through a record linkage process using vital records housed at Statistics Canada that originate from the provinces and territories.)
- To determine cause-specific death rates within a year of a pregnancy outcome for women whose death was not classified as a maternal death, and to compare these rates with cause-specific death rates among women not known to have been pregnant within the preceding year. This will include comparisons of rates of suicide, homicide and other traumatic causes.
- To explore approaches to defining and quantifying serious pregnancy-related morbidity in Canada nationally.
- To document trends and/or regional differences in defined indicators of serious pregnancy-related morbidity.

Definitions of maternal mortality

ICD-9 definition[4]: Maternal death is "death while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."

ICD-10 definition[5]: Maternal death as defined in ICD-9, with the addition of the following:

Late Maternal Deaths: deaths from direct or indirect obstetric causes more than 42 days but less than one year after the termination of pregnancy.

Pregnancy-related Deaths: deaths while pregnant or within 42 days of the termination of pregnancy, irrespective of the cause.

References

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3. Atrash HK, Alexander S, Berg C. *Maternal mortality in developed countries: not just a concern of the past*. Obstet Gynecol 1995;86:700-705.
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5. World Health Organization. *International statistical classification of diseases and related health problems, 10th revision*. Geneva: WHO 1992;1:1238.

Contact for further information:

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Ottawa, Ontario K1A 0L2

Tel.: (613) 957-0169

d'étudier la mortalité maternelle, comprend des professionnels de la santé, des épidémiologistes et des représentants de Statistique Canada et de la Société des obstétriciens et gynécologues du Canada (SOGC).

Quels sont les objectifs de l'Étude canadienne sur la mortalité et la morbidité maternelles?

- Déterminer l'ampleur de la sous-déclaration de la mortalité maternelle au Canada au cours de cinq années cibles (1988-1992) en examinant la cause des décès enregistrés chez toutes les femmes qui sont décédées dans l'année qui a suivi une naissance vivante ou une mort-naissance. (Les décès sont relevés au moyen d'un couplage d'enregistrements à partir des actes de l'état civil provenant des provinces et des territoires, qui sont conservés par Statistique Canada.)
- Déterminer les taux de mortalité par cause au cours de l'année qui a suivi l'issue de la grossesse chez les femmes dont le décès n'a pas été considéré comme une mort maternelle, et comparer ces taux avec les taux de mortalité par cause au cours de l'année précédente. Il s'agira entre autres de comparer les taux de suicide, d'homicide et de décès attribués à d'autres causes violentes.
- Tenter de trouver des façons de définir et de quantifier les cas de maladies graves associées à la grossesse à l'échelle du Canada.
- Noter les tendances et(ou) les différences observées entre les régions en ce qui concerne les indicateurs définis de maladies graves liées à la grossesse.

Définitions de la mortalité maternelle

Définition de la CIM-9[4] : La mort maternelle se définit comme « le décès d'une femme survenu au cours de la grossesse ou dans un délai de 42 jours après sa terminaison, quelle qu'en soit la durée ou la localisation, pour une cause quelconque déterminée ou aggravée par la grossesse ou les soins qu'elle a motivé, mais ni accidentelle ni fortuite ».

Définition de la CIM-10[5] : La définition de la mort maternelle est la même que celle donnée dans la CIM-9, sauf que deux autres catégories y sont ajoutées :

Mort maternelle tardive : se définit comme le décès d'une femme résultant de causes obstétricales directes ou indirectes survenu plus de 42 jours, mais moins d'un an, après la terminaison de la grossesse.

Mort maternelle liée à la grossesse : se définit comme le décès d'une femme survenu au cours de la grossesse ou dans un délai de 42 jours après sa terminaison, quelle que soit la cause de la mort.

Références

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2. Unicef. *La situation des enfants dans le monde, 1997*. Toronto, Ont. : Oxford University Press, 1997.
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5. Organisation mondiale de la santé. *Classification statistique internationale des maladies et des problèmes de santé connexes. 10e révision*. Genève : OMS 1992;1:1330.

Personne à contacter pour obtenir d'autres renseignements :

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Laboratoire de lutte contre la maladie
Direction générale de la protection de la santé
Santé Canada
IA 0601E2, Pré Tunney
Ottawa (Ontario) K1A 0L2

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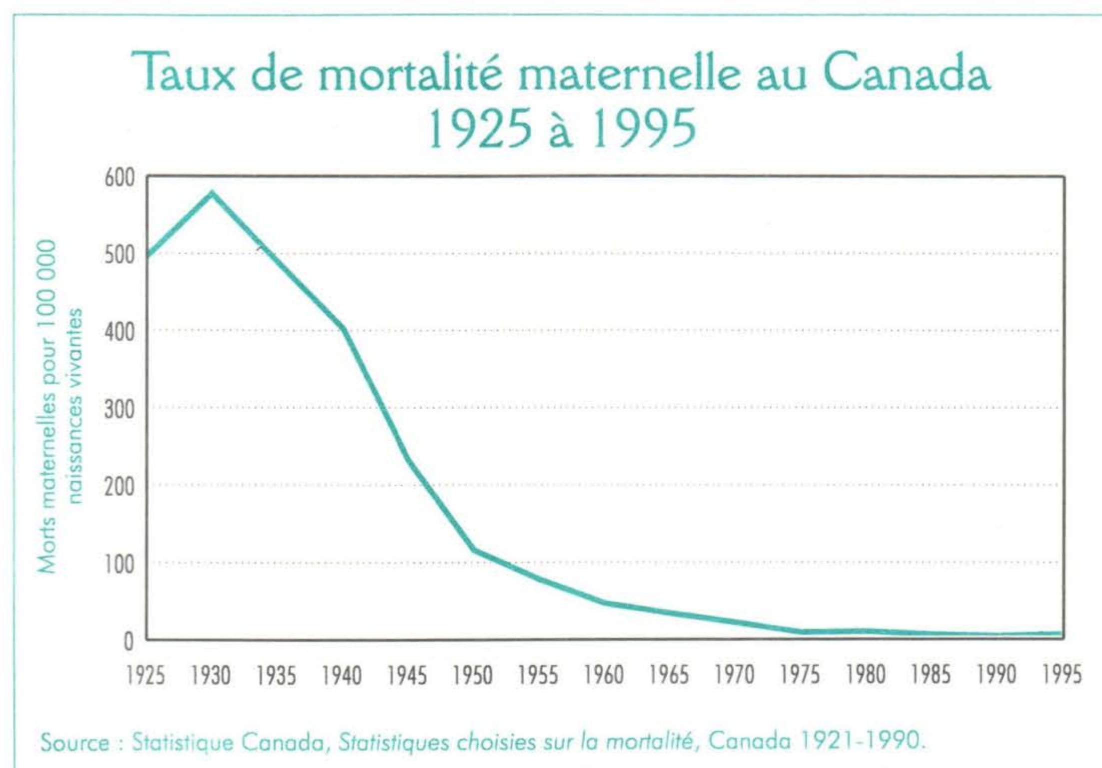
Santé Canada Health Canada

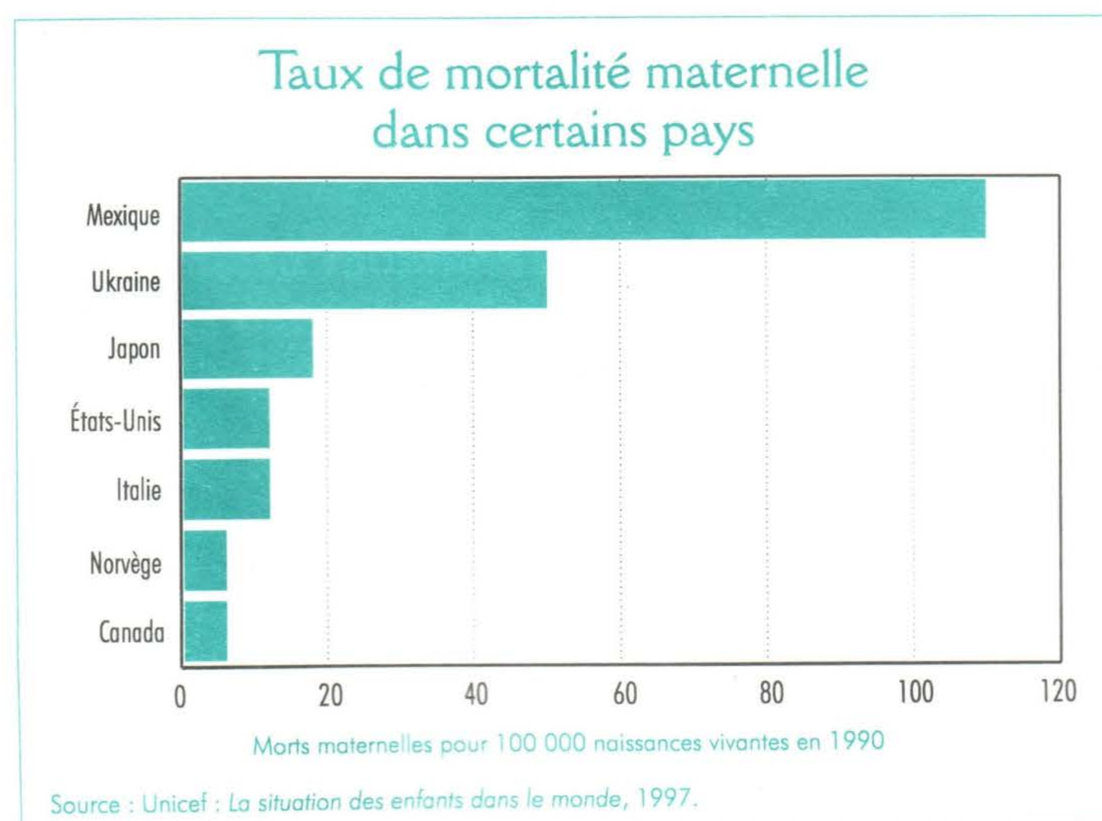
RAPPORT SUR LA MORTALITÉ MATERNELLE AU CANADA

publié à l'occasion de la Journée mondiale de la santé, le 7 avril 1998, consacrée au thème de la maternité sans risques

Au cours du XXe siècle, les risques chez la femme associés à l'accouchement ont considérablement diminué en raison de nombreux facteurs, notamment des percées technologiques dans le secteur des soins obstétriques, un accès accru aux services de santé et une diminution des naissances, aux extrémités de la fourchette de l'âge de fécondité dans la population féminine. Le taux de mortalité maternelle signalé au Canada a chuté : au début des années 20, il était d'environ 500 décès pour 100 000 naissances vivantes; au cours des années 90[1], il était tombé à moins de 5 cas pour 100 000 naissances vivantes, soit le taux le plus faible enregistré dans le monde[2].



Source : Statistique Canada, *Statistiques choisies sur la mortalité, Canada 1921-1990.*



Source : Unicef : *La situation des enfants dans le monde*, 1997.

Pourquoi cette question est-elle importante au Canada, où l'accouchement est reconnu comme relativement sûr?

Les Canadiennes ont la chance de bénéficier d'un accès universel aux soins de santé, ce qui contribue à la sûreté de la grossesse et de l'accouchement. Il est néanmoins important de surveiller les tendances relatives aux décès et aux maladies graves associés à la grossesse et de tenter d'interpréter le sens des tendances ou des changements observés si l'on veut continuer de protéger les femmes au cours de cette période critique. Comme beaucoup de pays développés ont constaté que les décès liés à la maternité ont été nettement sous-déclarés[3], il s'agit, dans un premier temps, de vérifier l'exactitude de la déclaration systématique des décès associés à la grossesse et à l'accouchement au Canada. L'inclusion des catégories «mort maternelle tardive» et «mort maternelle liée à la grossesse» (voir les définitions ci-dessous) dans la Classification statistique internationale des maladies et des problèmes de santé connexes, Dixième révision (CIM-10), confirme que les décès imputables à n'importe quelle cause déterminée ou aggravée par la grossesse ne peuvent être considérés comme des morts maternelles parce qu'ils sont survenus plus de 42 jours après la fin de la grossesse, ou parce qu'ils ont peut-être été classés par erreur dans une autre catégorie du CIM-9.

L'Étude canadienne sur la mortalité et la morbidité maternelles est réalisée sous les auspices du Système canadien de surveillance périnatale de Santé Canada

Le Système canadien de surveillance périnatale (SCSP), un programme du Bureau de la santé génésique et de la santé de l'enfant, fait partie du Réseau d'information sur la santé publique de Santé Canada. Le sous-comité du SCSP, chargé

"Great video!"
. Heather Brandon (Queen W CHC)
. Cara Scott McCron (RPU December 6th Memorial Fund)

LET THE STORIES BE TOLD...

"Let the Stories Be Told..." is a compilation of footage from women's focus group discussions and interviews with two community health workers. The focus groups were held, one with women from the Latin American community in Toronto, the other with Toronto women from the East African (Somali-speaking) community. All the women speak openly about their experiences with the health care system in Ontario during their pregnancies, births and their postpartum periods.

Discussed in this video are issues of economic, language and cultural barriers to care. As an educational resource for health care providers "Let the Stories Be Told..." hopes to contribute to the enhancement of quality cross-cultural care by exploring solutions to issues of inaccessibility. While the stories presented in this video may be common to many immigrant women, they are individual accounts and are not meant to generalize to entire communities.

You can order a copy of this video for your practice at $50 per copy. Money from sales will be used to pay outstanding costs incurred in the production of the video.

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