From : NEW ZEALAND COLLEGE OF MIDWIVES (INC)
P O Box 21-106
Christchurch New Zealand

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17 Malvern Rd
Mt Albert
AUCKLAND 1003

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

NATIONAL NEWSLETTER

August / September 1994

3rd National Conference Report

Health Privacy Code

Guidelines for Disinfection & Sterilisation

Constitutional Changes

National Midwifery Resource Centre

906-908 Colombo Street P O Box 21-106 Christchurch Tel/Fax 03-377-2732

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Wanganui/Taranaki
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15 Stokes Street
New Plymouth

Maori Midwives Collective
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HOARANGI BIDDLE
RANGIMARIE HOHAIA
KATE SALMONS

Waikato/BOP
VIOLET STOCK
c/- Tauranga Maternity
Annex Tauranga

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ANDREA GILKISON
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Palmerston North

NATIONAL COMMITTEE CONSUMER REPRESENTATIVES

Maternity Action Alliance
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8b McMillan Avenue
Christchurch

Parents Centres (NZ)
SHARON COLE
12 Elmslie Place
Rotorua

Home Birth Association
GLYNETTE GAINFORT
P O Box 729
Tauranga

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
MEMBERSHIP APPLICATION FORM

NATIONAL INFORMATION 01 May 1994 - 30 April 1995 **REGION** _____

Name _____

Address _____ Area Code _____

Phone _____ Home _____ Work _____ Extn

Workplace _____

Date of Birth _____ ARE YOU A MEMBER OF NZNO? YES/NO

TYPE OF MEMBERSHIP

- ☐ Self Employed $255.00 } Includes
- ☐ Waged $155.00 } Indemnity
- ☐ Unwaged/Students $ 50.00 } Insurance
- ☐ Associate with Indemnity $155.00 } Cover
- ☐ Associate/Affiliate $ 30.00

FOR NATIONAL USE ONLY
Date of Joining _____
Membership Number Allocated _____

METHOD OF PAYMENT (Please tick your choice of payment)

- ☐ Subscription payable to College Treasurer (Cheque enclosed)
- ☐ Subscription from Salary (please arrange with your pay office)
- ☐ Automatic Payment (contact Treasurer)

NEW	
RENEWAL	
CHANGE	

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NEW	
RENEWAL	
CHANGE	

PLEASE RETURN COMPLETED FORM TOGETHER WITH MONEY (IF APPLICABLE) TO YOUR LOCAL REGIONAL TREASURER

A WOMAN'S DAY OR A MAN'S DAY?

Somewhere in Africa

Women's Day
rises first
kindles the fire
breast-feeds baby
fixes breakfast/eats
washes and dresses the children
walks 1 kilometre to fetch water
walks 1 km home
give the livestock feed and water
washes cooking utensils, etc
walks 1 km to fetch water
walks 1 km home
washes clothing
breast-feeds baby
pounds rice
sweeps the house and compound
kindles the fire
prepares meal/eats
breast-feeds baby
walks 1 km to cotton field with food
for husband
walks 1 km back home
walks 1 km to her field
weeds field
breast-feeds baby
gathers firewood on the way home
walks 1 km home
pounds maize
walks 1 km to fetch water
walks 1 km home
kindles the fire
prepares meal/eats
breast-feed baby
put house in order
goes to bed last

Man's Day
rises when breakfast is ready
eats
walks 1 km to cotton field
works in the field
eats when wife arrives with food
works in the field
walks 1 km home
eats
rests
walks to village to visit other men
walks home
goes to bed

The woman's day does not change if she is pregnant. On one of these days she will give birth to a child. There is little spare time for visits to a medical centre, and hospitalization in case of complications is unthinkable except as a very last resort. A woman's day or a man's day? Unfortunately the woman doesn't have a choice.

NEWS REVIEW
Issue 14 March-June 1994

CONTENTS

WE HAVE MOVED

As of the 4th July 1994, the Midwifery Resource Centre and National Office of the NZ College Of Midwives (Inc) is located at 906-908 Colombo Street (opp Christchurch Women's Hospital). Postal address and phone number remain unchanged.

NEXT NATIONAL COMMITTEE MEETING

Friday 25th November at 6.00pm
Saturday 26th November 9.00am - 6.00pm

Midwifery Resource Centre, Christchurch

ALL WELCOME

Any contributions to the National Newsletter should be addressed to
Julie Richards
P O Box 21-106
Christchurch

DEADLINE
for the next Newsletter is 1st October 1994
Next Newsletter will be posted 24 October

PUBLISHING DETAILS
Editor - Julie Richards
Typesetting by Margaret Stacey
Printing & Collating by MAS Business Services, Christchurch

Editorial

Hi Everyone!

Welcome to the August/September Newsletter.

I return to the role of the Newsletter Editor with enthusiasm and some trepidation as it has grown rapidly in the hands of Beryl Davies and Karen Barnes since its conception back in 1989.

Karen, you have created a very hard act to follow and by the time this reaches people's letter boxes, I am sure I will have contacted you many times. I'll thank you in advance for your on-going assistance.

Most of the information in the newsletter is collected by Karen Guilliland as she sifts through the masses of articles and mail that passes over her desk.

As editor I arrange and organise the material and will also summarise reports when necessary.

Therefore I'll give you a brief resume so you know where I'm coming from.

My involvement in midwifery has not been long in years but has been both intensive and varied. I obtained my midwifery registration in 1987 and was voted/volunteered on as Branch Secretary of the Midwives Section of the NZNA by mid 1988. Following the 1988 Conference the New Zealand College of Midwives was born and I moved with two others from the regional committee to join Karen Guilliland, Jacqui Anderson and Kathy Anderson to become the first National Board of Management. I commenced the national newsletter during this time.

When the Board of Management moved to Wellington I was voted in as Canterbury/West Coast Chairperson and continued in this position until June this year. I have been involved with a number of national projects such as the Section 51 Negotiations.

My midwifery experience has been five years in a level three unit pre and post registration and four years as a midwife in a home birth practice.

I have wide contact with other midwives as I continue on the Canterbury/West Coast Regional Committee and am a member to the Midwifery Resource Centre Canterbury (Inc).

Video Critique

LEWIS' BIRTH
Sweet Memories Production, Dunedin
$45

I found this video hard to review. On the one hand I want to respect the makers of the video and acknowledge their birth experience, and on the other hand ..... oh dear.

For $45, this is a very amateurish production. The cassette is lettered by hand. The sound quality fluctuates alarmingly. There was insufficient light for good videoing. And the continuity is poor - it is hard to follow what is happening. The chatty voice-over peters out midway, just when the action gets going. At this point, the camera operator discovers the zoom function and utilises it to an unnecessary graphic degree and for an unnecessary long time. I felt like an intruder.

The lack of a script or coherent editing gives the video an almost nightmarish quality. We don't see any midwifery care - I presume it happened but it would have been reassuring to see the heart-rate checked (at least once), particularly as the baby was born flat. Then, in the midst of this tense and almost wordless drama, comes a garish multicoloured flashing birth announcement. Ugh!

This video is completely unsuitable as a teaching tool - any primagravida seeing it would be stampeding for an epidural. It would be a gift to any obstetrician wanting to put women off homebirth.

Anna Venczel - Consumer

NATIONAL TREASURERS / MEMBERSHIP PERSONS

SOUTHLAND
Marion Ferguson
59 Glenalmond Crescent
Invercargill

WELLINGTON
Lynley Davidson
25 Freeling Street **Island Bay**

WANGANUI/TARANAKI
Sheryl Ross
Flat 1 Hawera Hospital **Hawera**

WAIKATO/BAY OF PLENTY
Heather MacFarlane
3 Frederick Drive **Hamilton**

NELSON
Wendy Brookes
P O Box 672 **Nelson**

NORTHLAND
Betty Trenn
c/- Antenatal Clinic
Whangarei Hospital **Whangarei**

OTAGO
Catherine Lynch
7 Morton Street **NEV Dunedin**

AUCKLAND
The Treasurer
P O Box 24-403
Royal Oak **Auckland**

CANTERBURY/WEST COAST
Caroline Nye
P O Box 21-106 **Christchurch**

EASTERN/CENTRAL
Mary Mather
27 Shamrock Street
Palmerston North

"Promoting breastfeeding has been identified as a health priority by the Public Health Commission".

The Government's abdication of its responsibilities reflects the confusion of the health reforms, she says, with "a lot of people with good ideas and few with overall global vision to bring competence and integration to the health service."

In the money merry-go-round, the Government passed the buck to RHAs and PHC. However, RHAs regard their main focus as CHEs and breastfeeding as a community activity.

The Public Health Commission may fund some aspects, but has not agreed to pay all.

Worldwide trends show a reduction in breastfeeding. New Zealand Plunket's 1993 annual report show breastfeeding rates at 85.15 per cent of new mothers compared with 86.32 per cent the previous year. At three moths 70.9 per cent of babies were being breastfed, compared with 72.7 per cent last year.

So far 19 industrialised nations have set up national authorities to supervise their programmes. Most Governments have begun baby friendly campaigns, selecting influential hospitals - almost 14,000 in 125 countries - to pioneer the scheme.

The New Zealand taskforce comprises Tui Bevin a Dunedin lactation consultant, Marcia Annandale, a Christchurch lactation consultant and Harangi Biddle, a midwife, of Opotoki.

Mrs Bevin says there is a lot of work to be done. Most mothers who stop breastfeeding do so because they experience sore nipples or they believe they do not have enough milk.

"Most women believe breastfeeding is better but they face insurmountable hurdles to feed their baby and the choice can be taken away from them, even if it is just psychologically."

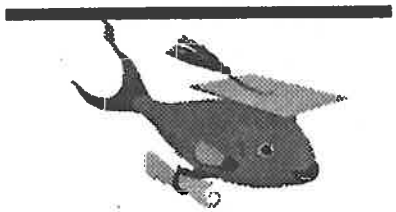
Also, she says, a lot of people believe bottle feeding is just as good if it is done properly and there is clean water.

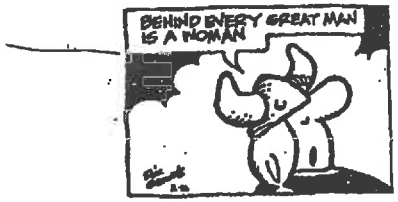
"It is not as simple as that . You can't say bottle feeding is only bad in Third World countries.

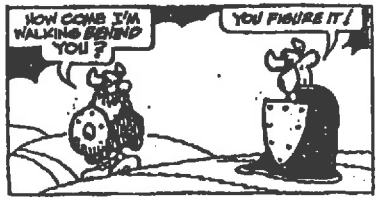
"Some women in New Zealand live in Third World conditions. A lot can't read English and most (bottle feeding) labelling is in English."

NZ Doctor News

Report by GLENYS HOPKINSON







I am passionate about midwifery as I believe it celebrates women. I endeavour to provide you with an informative and balanced newsletter and I eagerly invite information and feedback for publication.

The deadlines and postal dates for the newsletter for the next year are included.

Regards *Julie Richards*

NATIONAL NEWSLETTER DATES 1994-95

Deadline:	01 October	Deadline:	01 April
Posted:	24 October	Posted:	24 April
Deadline:	01 December	Deadline:	01 June
Posted:	19 December	Posted:	28 June
Deadline:	01 February	Deadline:	01 August
Posted:	20 February	Posted:	28 August

Artemis and Apollo

Adapted from Jeannie Parvati Baker's Preface in Artemis Speaks; Koehler, Nan 1985, California

The story of Artemis and Apollo. Long ago we find the beautiful immortal Leto in process of giving birth to divinely sired twins, Artemis and Apollo. As legend has it, two midwives attended that birth, flying to it in the forms of white doves.

They assist Leto in the deliverance of her first-born twin, Artemis, who immediately receives Her Brother, Apollo, acting as newborn midwife. From here the divine twins grow into the patrons of healing, each in their own unique ways. Artemis is known as the wild herbalist and universal midwife, healing and soothing all mothers in giving birth, be they human or animal. Apollo goes on to become the father of the archetypal medical doctor of our times, Asclepius.

Where Apollo approaches healing as a medical science, disecting through analysis, Artemis heals through ecstatic dance with language and the plant familiars as Her allies. Science and Art have at their source the same mother.

It is interesting that a group of GP/ Obstetricians in Auckland call themselves the "Artemis Group". They don't appear to have read the myth.

National Co-ordinator's Forum

It is a week since the Conference in Rotorua and all the warmth and laughter, tears and even sometimes despair. The overwhelmingly positive aspects from the gathering together of 450 women and midwives on the Marae will sustain my energy for the never ending battle to have women's voice not only heard but actioned within the maternity services bureaucracy.

Midwifery's gratitude must go to the Rotorua Hospital Midwives and Lakeland Women's Health Management, Te Papaiouru and the Home Birth Association who organised and supported the holding of the Conference. It was a wonderful effort and the evaluations by participants were overwhelmingly positive Congratulations Rotorua. Julie Richards summary on page 8 gives those of you who were unable to attend an idea of the range of events.

And so back to business.....
The Section 51 negotiations are in exactly the same place as they were reported in the last newsletter. We are still waiting for theRHA's second draft of their position on modules, lead professional, prices etc. Apparently the draft is expected out within two weeks with a meeting planned for the end of September beginning of October. We will see. Once we receive the document it will be sent out to all regions via Chairpersons so if you are interested in commenting please attend your local regional meetings. This document effects all midwives both CHE employed and self employed as service specifications for Primary Health Services will be the same (or very similar) for all maternity providers in primary health (normal birth)! CHE midwives need to be very clear that how their employer defines "lead professional" could have major consequences on midwives ability to practice independently within the hospital setting. Do not accept that all normal birth services must have a doctor as lead professional. These must be provision in CHE services for midwives as lead professionals with their own caseloads.

Speaking of caseloads.....
The College recommends a caseload for total midwifery care to be within 50-70 women per annum (for some 50 may be too high). A caseload above this figure of 70 is causing unmanageable stress for some midwives and risks burn out. An overworked stressed midwife also fails to meet both women's and the professions expectations of midwifery care. The result can be an unacceptably stressful partnership for both midwife and women.

Mrs Guilliland said it is unlikely the changes will be in place by 1 October as discussions are not yet in a final stage. But she points out GPs already have arrangements with midwives, and there is no reason why these cannot continue without a great deal of difficulty.

"GPs cannot provide continuity of care without a midwife and midwifery rely on GP referrals, so both parties are going to have to get together and work it out. In that respect it may be quite good for both professions." she said.

However, Mrs Guilliland said it remains to be seen who will be the lead professional in terms of funding and she said GPs may well have some concerns about this aspect of the change.

Wellington GP Helen Rodenburg who is a member of the NZMA maternity working party, agrees the October deadline is unrealistic.

She said there needs to be more definite information from the RHAs and considerable consultation with members.

Dr Rodenburg agrees the situation in Wellington is more complex than in other centres.

She has no doubts midwives and GPs will continue to work together but she said the areas of responsibility and methods of payment will have to be spelt out quite clearly.

"In the short term the RHAs will have to have a fee for service within their module so midwives and GPs will not be arguing over money. This is one point that is still not clear in the discussions we have had."

Dr Rodenburg thinks it is unlikely GPs are stopping referrals to midwives and said increased competition and fewer births are the reasons for any falling workload. ■

- NZ Doctor NEWS 23/6/94

MINISTRY DENIES FUNDS FOR BREASTFEEDING CODE

A task force set up to encourage breastfeeding in hospitals in New Zealand has been told to go out and find its own funding.

The Government has shrugged off paying for the taskforce it set up after signing an international code on WHO and Unicef initiatives to promote breastfeeding.

The code outlines 10 goals which maternity services should achieve in order to be labelled "baby friendly".

But the taskforce is now applying for funds from charities and various organisations.

A Spokesperson for Health Minister Jenny Shipley has confirmed that the Ministry would not provide ongoing funding in order to achieve the aims of the code.

The Government decision has drawn fire from a number of sources, including the New Zealand College of Midwives.

The WHO-Unicef Innocenti Declaration on infant feeding says it is a Government's responsibility. The goal is for babies to be exclusively breastfed in the first four to six months.

National coordinator of the College of Midwives, Karen Guilliland, says: "New Zealand signed a deal that it believes breastfeeding is an important issue. I can't see any way out of it for the Government.

"Referral and transfer of care by listing is quite inappropriate and there is no scientific basis to such a proposal. It will have the effect dragging referral down to the lowest common denominator," she said.

Meanwhile midwives feel they are being pilloried by some medical practitioners over the Hutt Valley case.

College of Midwives president Sally Pairman said the case was an isolated incident three years ago but the whole midwifery profession is being thrown into disrepute because of inadequate care by one group of people.

The College recommends members carefully document all cases and that they practise to college standards.

Ms Pairman agrees that the RHA guidelines do not have any bearing on the problems raised in the Disciplinary Committee's report, and said, midwives already refer to specialists under the sort of criteria raised.

"Blindly following protocols can absolve practitioners of responsibility and may not be in the interests of patients. We also want to know if the guidelines override the wishes of women, and what happens in these circumstances," she said.

RHA maternity project spokesperson Gillian Bishop said that practitioners do not want constraints on their professional autonomy, but the RHAs are interested in assuring safety for women and babies and establishing a consistent approach nationally.

She believes it will be difficult to get agreement among the professional groups and "at the end of the day the RHAs will have to put a stake in the ground and put a list into practice".

- NZ Doctor NEWS (7/7/94)

GPs CONSIDER QUITTING OVER OBSTETRIC MOVES

Proposed changes to the maternity schedule are such a nightmare, according to some GPs, that they are seriously considering getting out of obstetrics.

Wellington GP Carol Shand said there has been one change after another and the situation is now so stressful she feels many older GPs may just decide they have had enough.

One of the key changes involves one provider holding a budget for all perinatal care and this proposal will have a large impact in Wellington where there is a high proportion of GPs working in conjunction with midwives.

Dr Shand said most GPs have different working arrangements with each midwife and it is going to be difficult to sort out something reasonable at short notice.

"Midwives have been earning more than doctors in recent times and if GPs become the primary care givers, they may end up working for nothing just to pay the midwives."

Meanwhile some midwives report a drop in the number of referrals from GPs and they question whether it is a response to concern about the changes .

And the national coordinator of the New Zealand College of Midwives Karen Guilliland said the college has received several complaints from women who have been told by GPs they cannot have a midwife if they also want care from that doctor.

Cont.. next page

Accompanying problems are missed appointments, poor documentation, feelings of powerlessness for all and a loss of reputation for the individual and the profession.

Midwives must learn to say no and balance their work and personal lives or the opportunity to provide a midwifery service which is unique and respected is undermined.

The College advises all midwives to update their documentation skills. In today's climate of competition and the subsequent lessening of co-operation within the health sector it is essential that women have written evidence on which to make informed decisions and midwives record the process of those mutually negotiated decisions.

In an increasingly litigenous society midwives must be able to prove their practice is competent and meets professional standards. Reflect on your work and measure your records against the Standards for Practice. Ensure your documentation presents a comprehensive picture of events.

Access to Maternity Services.....
Women who choose midwife or GP care are coming under increasing pressure from some CHE management and/or obstetricians to book with their secondary care services. Some of this is about controlling competition but some is about controlling women's ability to choose. Fear inspired decision making is becoming a problem for many women as they are caught between extremes of opinion. The RHA maternity services referral criteria seems to have been the trigger for what often amounts to co-ercion of women when deciding their care giver and/or place of birth. A recent example is of a women who wanted to have a home birth after an elective caesarian section for prolonged pregnancy. Her wishes included religious beliefs. Her midwives had agreed to attend her and had ensured the woman had every piece of information she needed to make an informed decision. The midwife's provision was she make a booking at the local base hospital. As a result of the request for back up booking the women was sent a letter fro m the hospital obstetrician saying he "was sure she was aware of the potential risk of a rupture of the scar and associated maternal mortality if such a situation arises" and that the midwife "was breaking the law" in attending her at home.

Regardless of how a practitioner feels about birth at home following caesarian section this attitude and approach is unacceptable.

It ignores women's ability and right to make their own choices, it ignores the principles of informed consent demonstrating co-ercion and unbalanced opinion and finally it gives incorrect information from a position of authority which disempowers the womens ability to make decisions based on fact.

The RNZ General Practitioners Association is also very concerned by the current moves by RHAs to set criteria and protocols which deny access to the primary health provider. We hope to meet with them shortly to discuss strategies which support womens choice. We also will be meeting with the RNZ College of Obstetricians and Gynaecologists to discuss the maternity service and trust some useful discussion and co-operative measures will ensue. A further meeting is arranged between the Nursing Council, the Medical Council and the College to discuss matters of discipline which we will attend with interest. College representatives together with the Heads of Polytechnic Midwifery Schools will also be meeting with Jenny Shipley, Katherine O'Regan and the Ministry of Education to discuss Midwifery educations future especially in relation to direct entry and the time frame for the removal of its experimental status.

As you can see another busy month and perhaps one which will see progress!

SITUATION VACANT

The New Zealand College of Midwives National Committee is pleased to invite applicants for the following vacancy

JOB DESCRIPTION

Position: QUALITY ASSURANCE CO-ORDINATOR

General Description:
The Quality Assurance Co-ordinator is a paid employee whose role is to develop and co-ordinate quality assurance systems and programmes that advance and promote Midwifery Standards of Practice within the New Zealand College of Midwives (Inc). She works with the National Co-ordinator to ensure NZCOM policies, programmes and projects are implemented. She has a key role in providing resources and support to Midwifery Standards Review Committees and Education Research Council. She will organise and co-ordinate the Midwifery Resolutions Committees.

BAN SOUGHT ON PROMOTION OF BABY-FEEDING BOTTLE PRODUCTS

A breastfeeding support group wants the Government to ban the promotion of baby-feeding bottle products.

The La Leche League says the International Code of Marketing of Breast Milk Substitutes, adopted by the World Health Assembly in 1981, should be implemented to allow mothers to make an informed choice.

The code provides for a ban on promoting bottle-feeding products and for product labels to state the hazards of bottle-feeding.

In New Zealand, compliance with the marketing code remained voluntary, a league member and former branch leader, Bernice Williams said.

Families who need them will still be able to get the products if advertising stops; they could even become cheaper.

Marketing practices in the past had promoted bottle-feeding without mentioning the advantages or benefits of breastfeeding.

New Zealand had become a bottle-feeding culture, she said.

Mrs Williams and Wellington West group leader Judith Forbes, of Karori, presented the Wellington Hospital antenatal clinic with posters and pamphlets last week to mark World Breastfeeding Week.

- Christchurch Press, 8/8/94

RHA RULES UNLIKELY TO SOLVE MATERNITY MUDDLE

New RHA guidelines to regulate maternity services are unlikely to solve problems highlighted in the recent Hutt Valley case where a baby was left severely brain damaged, according to medical and midwifery groups.

The Medical Practitioners Disciplinary Committee censured a Hutt Valley doctor over the case, and stressed that this is the second case where babies have been brain damaged as a result of difficulties in communication or identifying areas of professional responsibility between doctors and independent midwives.

The committee called for these issues to be dealt with urgently.

However, midwives and the RNZCGP do not think the Maternity Project guidelines, which are due to be released shortly, will solve these difficulties.

The guidelines set out specific criteria for referral to a specialist under three categories - may refer; must refer; transfer care.

RNZCGP chairperson Tessa Turnbull said the Hutt Valley case related to difficulties between public hospital and independent midwives and the problem of so-called private patients being treated in public hospitals.

"Some of the problems, such as areas of responsibility, have been sorted out and are historical, but tensions in maternity care should have been sorted out a long time ago. However, the drawing up of lists will not solve these problems."

She said the college opposes aspects of the guidelines and if they are not changed substantially, it may have to recommend GPs do not include the regulations in any contracts with RHAs.

Cont.. next page

Hospital's teaching status at risk (cont'd ...)

Mr Foley said changes to the Nurses Act 1990, which enabled midwives to operate and gave more flexibility over who could provide care at births, had led to a surge in independent midwifery cover.

At a minimum, the four registrars needed to handle 1200 births between them, and for a healthy margin, needed about 1500.

"It brings into question one facet of our accreditation and that is the Wellington campus, because we are a teaching school," Mr Foley said.

"The School of Medicine run here by the University of Otago is at the Wellington Hospital campus. So we have got two institutions working here."

Between the two there were several joint positions, and there were accreditation processes in place to make sure registrars became suitably qualified.

The requirement regarding number of births handled was part of that. ■

Editor's note: As an alternative to blaming the midwives, they could review the way they train their medical staff. I've heard continuity of care is quite popular.

PRIVATE HOSPITAL NEGOTIATING TO PROVIDE PUBLIC MATERNITY CARE

St George's Hospital in Christchurch could provide public maternity care by the end of the year if it gains a contract with the Southern Regional Health Authority.

The general manager of St George's, Tony Hunter, said the plan was at the negotiating stage.

He did not know yet if the hospital would provide the service.

However, the authority said it wanted to buy primary maternity services from St George's. Primary maternity services were those for a normal birth.

The parties had been negotiating for some months. It was hoped talks would be complete by September.

The hospital had set a figure of 900 deliveries a year for the service, although its facilities were capable of 1200 to 1500. Public maternity care at St George's would provide women with another option, Mr Hunter said.

The authority has signalled it does not want to buy maternity services at Rangiora and Lincoln hospitals because of their closeness to Christchurch.

The authority said it was up to the present provider, Healthlink South, whether it wanted to continue maternity services at the two hospitals.

Mr Hunter said St George's had been committed for many years to providing an alternative obstetric service.

It had continued despite running at a loss for the last four to five years and was the last remaining private service in New Zealand.

- CHRISTCHURCH PRESS
July 7, 1994

Key Skills:
Knowledge and understanding of midwifery practice.
Understands the principles of adult education.
Has experience in mediation processes and conflict resolution techniques.
Understands group processes.
Can identify ethical frameworks for audit.
Has knowledge of appropriate legislation in relation to privacy, confidentiality, consent, human rights, the Nurses Act and its amendments.
Excellent communication skills - written or oral.
Experienced in working with people.
Ability to research and analyse.

Key Responsibilities:
Develops, co-ordinates and organises Midwifery Resolutions Committees.
Receives and actions complaints in relation to Midwifery Standards of Practice.
Resources, supports and liaises with Midwifery Standards Review Committees.
Oversees annual statistical data base from Midwifery Standards Review Committees.
Liaises and consults with consumer groups when developing, maintaining and promoting quality assurance programmes.
Liaises and works with the Education and Research Council in matters affecting quality assurance.
Develops and maintains quality assurance programmes for ongoing midwifery education.

Attributes:
Interest in women's health.
Demonstrates an understanding of cultural awareness and partnership.
Is able to establish networks with consumer organisations.
Able to work independently and in a team.
Initiative with the ability to manage and resolve conflict.
Effective listener and communicator.
Friendly, co-operative and positive personality.
Favours and facilitates consensus.

Conditions of Employment:

Hours:	24 hours per week (flexitime) with potential to increase. The position necessitates travel throughout NZ.
Annual Leave:	3 weeks plus statutory holidays.
Sick Leave:	6 days per annum.
Salary:	$24,000.00

3rd National NZCOMI Conference

Te Papai-o-uru Marae, Rotorua 12, 13, 14 August
- Report by Julie Richards

Its hard to know what to say. This conference was very special in so many ways - the atmosphere, the venue, the hospitality, the weather, the organisation, the scenic views, the participants, the babies and children, the hot pools and on and on.

Being able to have our conference on the Te Papaiouru Marae gave many attending the opportunity to develop insight, awareness and respect for Maori culture that would have been difficult to achieve in any other way. Thank you to Denise Anderson and her whanau for enabling us to be at Te Papaiouru.

The atmosphere was one of unity with a growing understanding of what we are working towards. As a number of speakers addressed, practising partnership has been more difficult than talking about it. As was said, 'you have to walk the talk' - I believe we are getting there.

The Conference commenced on Friday morning with a Powhiri and we were invited to enjoy all the marae had to offer over the next three days.

The theme of the Conference was to explore the culture of midwifery in the International Year of the Family. There were many views from many perspectives.

Sally Pairman's opening address welcomed the speakers and participants and acknowledged how the conference would be enhanced with the concurrent running of the National Home Birth Association Conference. Sally also acknowledged the opponents of the midwifery profession and encouraged us to nurture and guide the new direct entry graduates as they will make a real difference to our maternity service.

Lianne Dalziel, Labour spokesperson for Health, followed with a direct speech that indicated a clear understanding of the issues faced by midwives and women - very refreshing. Lianne supported our demand for women to have choices - but all women not just the educated who know the system. She also challenged us to face the threats to our profession and debate the real issues.

'Grave' staff shortage at Wgtn Women's Hospital

Christchurch Press 09/05/94

WELLINGTON — Wellington Women's Hospital services are so run down that its teaching post is under threat, and it is struggling to attract good staff, the hospital has been told.

Staff shortages, waits of up to nine months to have irregular smears seen, and an growing proportion of births done by non-hospital staff have led to a warning that the hospital's attached teaching department will lose its accreditation as a teaching post for obstetrics and gynaecology unless urgent steps are taken.

The warning has come on top of the resignation of two of the medical school's three obstetrics and gynaecology teaching staff — who also work at the hospital — in the past five months.

Professor John Hutton finished last week, and a senior lecturer, Henry Murray, has given six months notice, saying he was "totally fed up" with working 80 to 90 hours a week due to a lack of staff at Wellington Hospital. Dr Murray will take up a job in Australia soon, expressing frustration with the hospital for lack of action on staff shortages. Professor Hutton said the future of the women's health department was vital for the survival of the medical school, which in turn affected the hospital's ability to attract good staff.

The president of the Royal NZ College of Obstetricians and Gynaecologists, Tony Baird, said the college was "very concerned" at the situation in Wellington, particularly in regard to the safety of women at women's hospital, where a "grave" shortage of senior staff existed.

He had met hospital management, who shared those concerns, and he was encouraged at the steps being taken. Capital Coast Health said it was working on solutions with the school. New appointments would lift senior numbers.

But the school's remaining senior lecturer in obstetrics and gynaecology, Peter Stone, said the hospital would still have fewer staff for its workload than any other in the country. —NZPA

THE DOMINION, THURSDAY JUNE 23 1994

Hospital's teaching status at risk

by ERIN KENNEDY

WELLINGTON Women's Hospital status as a teaching hospital is at risk because more and more general practitioners and independent midwives are delivering the babies born there.

Capital Coast Health communications manager Roger Foley said the hospital would shortly be doing a "bit of a burst" on the team midwifery system at Wellington Women's.

At present the hospital worked "like a giant co-operative", with local general practitioners and independent midwives using it.

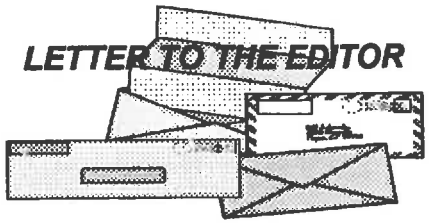
"And we are now running low on 'public babies'," Mr Foley said.

"It is starting to undermine our accreditation basis.

"We have four registrars here in the obstetrics and gynaecology area and they have to do about 300 births a year each.

About 3200 babies were born each year at the hospital but most were handled now by independent midwives and GPs, he said.

LETTER TO THE EDITOR



Sir - Recently the medical profession has made a number of attacks on independent midwifery services. I believe the transition that is occurring from doctors' control of birth to women's control over birth through the reassertion of independent midwifery has come as a response to women's growing disillusion with the dominant male profession. Women are now emphasising the right of women to experience childbirth as a natural process.

Independent midwifery is about the restoration of childbirth as a normal human experience. Though some women are what is termed "high risk", the majority of pregnant women need little medical intervention during the birth process.

It is about time doctors started listening to what women want instead of using the smokescreens of money and "safety" to cloud the real issues of the power and control they have asserted over women's bodies for the last two centuries.

FRANCINE VELLA
July 5, 1994
Chch Press 12/7/94

UK FAVOURS LOW-TECHNOLOGY BIRTHS

British Government policy urges women to give birth at home or in birth centres rather than hospitals, says midwifery professor Caroline Flint.

She was in Christchurch yesterday to visit the Avonlea Birthing Centre after speaking to the National Midwifery Conference in Rotorua as president of the British Royal College of Midwives.

Professor Flint said British research had shown that hospitalising women at delivery had done nothing to help the birthing process. Instead , it increased infection, intervention and interfered in the natural bonding of mother and child.

Birth had become more technical out of a genuine desire by governments to ensure babies were safe and grew into healthy adults.

Statistics showed, however, that one in every four children still had cerebral palsy. Rates of other infant conditions had not improved with hospitalisation.

Hospitalisation increased rates of unnecessary caesarians and epidurals. Most women giving birth were not sick. The World Health Organisation accepted that a rate of 5 per cent for caesarians was acceptable for developed countries and up to 10 per cent for developing countries.

According to the Avonlea Birth Centre, Christchurch's caesarian section rate is about 23 per cent of births a year.

"It is the unnecessary mutilation of a whole generation of women", Professor Flint Said.

- Christchurch Press, 20/08/94

Caroline Flint then stressed the need to communicate with our colleagues. For many her address gave an awareness of the unique midwifery culture of New Zealand. Caroline's suggestions are appropriate for a profession that is established and respected by all of society. As this is not yet the case for midwifery in New Zealand we must face our threats with unity and conviction if we are to survive.

Karen Guilliland and Sally Pairman presented the theory of midwifery as a partnership. They have clearly documented and illustrated the model on which we base our practice. They have created a valuable teaching tool with a theoretical framework that clearly states that without equal input from the woman you cannot practice midwifery.

The women of Tipu Ora presented the next session. Tipu Ora was created to address the health needs of Maori women and their families. The Kaitiaki of Tipu Ora provide a Maori service for Maori by Maori. They base their care on Aroha, Attitude and Approach. Their innovate service is now extending throughout New Zealand.

During the afternoon of the three days a variety of workshops catered for varying interests and needs.

Becky Fox followed the workshops with a stimulating presentation on the education journey from a Maori perspective as a midwifery tutor. Becky presented the Te Harakeke model as a tool to teach and to understand cultural safety. No one present could dispute its necessity. She clearly illustrated that Maori women need Maori midwives and how the Waikato Polytechnic direct entry programme addresses this issue.

A panel of midwife educators then outlined the courses offered pre and post graduation around the country. These included direct entry degree, Open Polytechnic units and Masters in Midwifery. Chris Hendry also discussed the role of the Education and Research Council. The College's policy is that all entry to midwifery registration is to be by direct entry degree by 1997.

This full and challenging day was followed by drinks and nibbles before launching into the National Annual General Meeting. Remits put forward to the Annual General Meeting are included in the newsletter.

Irihapeti Ramsden opened the second day with a clear and powerful analysis of the cultural safety issue in New Zealand. She sees New Zealand in the adolescent phase of our growth toward becoming safe. Cultural safety can only be assessed by the people we give our service to. Believing we are culturally appropriate or sensitive is only our personal perception, we have to change our attitudes and behaviour.

Caroline Flint followed with an informative and entertaining session on how midwives can provide continuity of care to women when employed with in a hospital. She demonstrated how to introduce case load management and the importance of selecting a team with differing skills and personalities to ensure success. A valuable session which is reiterated in her latest book "Midwifery: Teams & Caseloads".

To emulate Carolines work midwives from hospital based continuity of care schemes at National Womens, Queen Mary and Waikato Hospitals presented what has been established in their area. The hard work is paying off - Congratulations!

Following lunch Ron Patterson a Senior Lecturer in Law outlined the processes of New Zealand law and its relevance to midwives. He included examples of civil and criminal liability and indicated there was little benefit in individuals increasing their indemnity insurance cover, offered by NZCOMI.

Judi Stridd then confronted us with her view - four years post independence. She provoked us to examine our commitment to partnership with women as she saw that many midwives had *"seized the window of opportunity single handedly"*.

When the afternoon workshops concluded Bronwen Pelvin invited us to identify the universal culture of midwifery. She ensured our participation by using role plays to demonstrate the values and beliefs midwives hold.

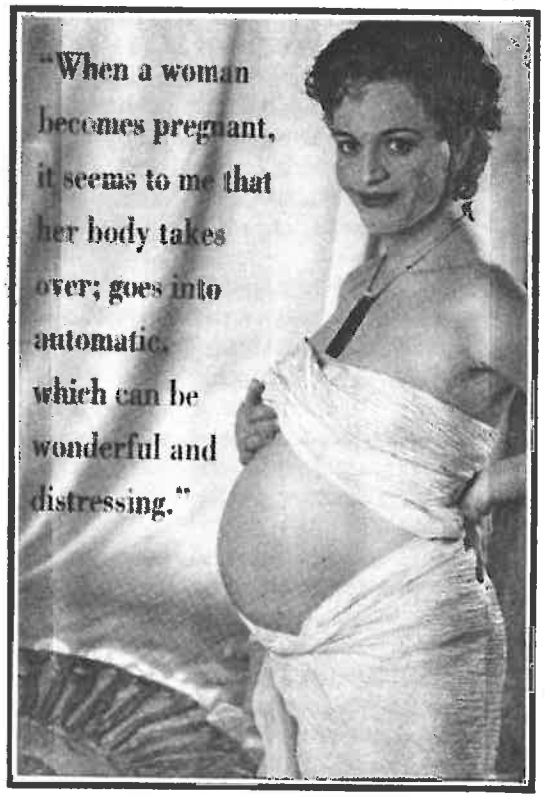
Lynlea Tucker and Glynette Gainfort concluded the day with an outline of how the Tauranga Home Birth Association contracted to provide education and support services to women planning to birth at home. Their extensive service is proactive and innovative ensuring the needs of these women and their families are not ignored.

During the evening we feasted on a delicious hangi and were entertained with a magnificent cultural performance. As the night wore on hidden talents were revealed as women and midwives produced a vaudeville show with Steve Chadwick as the persuasive director.

The final day of the Conference was opened by Angela Kearney - a midwife with Save the Children and presently working in war-torn Angola. Her stories of the birthing cultures experienced in the countries where she has lived left few dry eyes. These included the pain and multiation caused by female circumcision and the consequences of no caesarian section facilities. Angela's commitment to these women was greatly admired and the magnitude of their problems brought our own issues into perspective.

Media Watch

I'd like to report on what's happening in your area. Please send newspaper articles to:
Julie Richards
Midwifery Resource Centre
P O Box 21-106 Christchurch



Joanna Paul - New Zealand's answer to Demi Moore

Midwives back ban on circumcision

The College of Midwives has added its voice to support for proposed legislation to ban female circumcision.

The national co-ordinator of the College, Karen Guilliland, said in Christchurch midwives internationally had called for the elimination of female circumcision.

"More and more European and American midwives are attending women in childbirth who are severely compromised by the effects of this often mutilating practice. Continual pain and infections which effect their major abdominal organs are commonplace for these women.

Christine Fletcher (Nat, Eden) is proposing to introduce a private member's bill outlawing this practice.

Michael Laws (Nat, Hawkes Bay) entered the debate yesterday, saying if people from other cultures wanted to settle in New Zealand they should adopt the mores of our society and "not try to import some barbarism from some other society."

- Chch Press 28/6/94

FURNITURE FOR THE KIDS

The Ministry of Consumer Affairs has published a new edition of its popular nursery furniture guide. Called Furniture for Kids, the booklet is colourful, bright and full of helpful hints on buying and using nursery furniture. Furniture for Kids is the Ministry of Consumer Affairs contribution to the International Year of the Family.

There is a checklist to use when buying prams and strollers, baby walkers, high chairs, cots, change tables, bouncinettes, playpens and safety barriers. The information is given in a question-and-answer style making it easy to read and to use.

The booklet also gives some general guidance for buying secondhand furniture, as alterations made to furniture or just wear and tear over a period of use can make it unsafe.

Furniture for Kids will be distributed to parents before their babies are born - quite a task, as there are about 60 000 births every year in New Zealand!

Copies of the booklet are available from:
Consumer Affairs
PO Box 1473
WELLINGTON Phone 04-474-2750

PRESCRIPTION PADS

These pads are available for $5.80 each.

Please write to:
Canterbury/West Coast Region
New Zealand College of Midwives (Inc)
P O Box 21-106
Christchurch
for your supply

Prescription Pads come in packs of 5

The student midwife forum gave students the opportunity to share the uniqueness of their programmes. Although yet to complete their education these women eloquently expressed about being a midwife what has taken many of us years to understand. What can be said other than our maternity service appears safe with these women.

A panel discussion on the Roles and Responsibilities of care givers followed. The messages were all similar and expressed a partnership model which is no mean feat considering the panel was made up of a consumer, a paediatrician, an obstetrician and a midwife.

After lunch Majet Pot outlined the history of the Midwives Standards Review from its beginnings with the Auckland Home Birth Association through to its recent review at the Education Workshop as a nationally standardised process. Majet along with Lynda MacKay have been actively involved in this process over the years. Lynda MacKay followed with a presentation of the preliminary 1993 Home Birth Statistics. Majet and Lynda also reported from the National Home Birth Association meeting and presented their remits.

Gillian Bishop and Sam Denny of the Combined RHA Maternity Project created a strong feeling of dis-ease as they commenced their presentation. It appeared that despite our commitment to providing choice and working in partnership with women, we are destined to function in an environment that may sabotage this at each stage. The feeling of frustration was palpable.

Caroline Flint gave her final address "Vision Year 2000" following the workshops. Once again, many midwives recognised this as a vision appropriate for the maternity service in England but of minimal relevance to New Zealand.

Sally Pairman concluded our 3rd National Conference. She celebrated women as the heart of families and with the right to be attended during maternity by a midwife they know and trust. To achieve this she saw the need for women and midwives to be unified.

It was a very full and emotional 3 days. The organisation and work of the Conference Committee led by Nita van Boven was highly commended. The Mistress of Ceremonies, Steve Chadwick, was superb with her contagious enthusiasm and ability to eloquently summarise each presentation.

The Canterbury/West Coast Region has offered to host the 1996 Conference in Christchurch.

We will be unable to recreate the unique atmosphere of the Papaiouru Marae but we will do our best to apply what we have learned during that weekend and create something different.

Special thanks are extended to the Tunagata Whenua and St Faiths Church Women's group for their hospitality and guidance on the marae during the Conference.

A copy of the Conference proceedings is available from:

Violet Stock
9 Regent Street
Tauranga
Cost : $24.00 includes P&P

ANNUAL GENERAL MEETING OF THE NZ COLLEGE OF MIDWIVES (INC)
12 August 1994

REMITS TO BY LAWS

i] National Committee

Change

3. That capitation fees be paid to National Committee monthly as subscriptions are received by the regions excluding those paid by direct credit. CARRIED

Add

5. That each regional Treasurer/Membership representative forward on a monthly basis the standardised Membership Summary form complete with fully completed membership forms for any member who has joined or renewed their subscription that month. CARRIED

6. That the regional Treasurer/Membership representative check all details on computer printout of membership list on a 3-monthly basis as issued at the time of each National Committee meeting. CARRIED

7. Membership must be paid in full for new members owing in the first half of the financial year. For those new members joining in the second half, fees will be worked out on a monthly percentage basis. CARRIED

III Lying-in

In the case of a lying-in woman, when there is any abnormality or complication, such as -

(a) fits or convulsions;
(b) abdominal swellings and tenderness;
(c) offensive lochia;
(d) rigor, with raised temperature;
(e) rise of temperature above 100.4° F or quickening of pulse above 100 for more than 24 hours;
(f) unusual swelling of the breasts with local tenderness or pain;
(g) secondary post-partum haemorrhage;
(h) white leg.

NOTE : Special attention is drawn to the importance of (c).

IV General

In all cases in which a woman during pregnancy, labour, or lying-in appears to be dying or dead.

V. The Child

In the case of the child, when there is an abnormality or complication, including -

(a) injuries received during birth;
(b) any malformation or deformity in a child that seems likely to live;
(c) dangerous feebleness;
(d) inflammation of, or discharge from the navel;
(e) serious skin eruptions;
(f) inflammation about, or haemorrhage from the navel.

- With the Compliments of Val Alexander.

I wonder if the RHA would like a copy?

An Old (mid)Wives Tale

Angus was helping the midwife at the birth by holding a lamp, but quickly moved away after two babies had been born. "Here, come back with the lamp," the midwife called. "I think your wife's got another one coming."
"No way! I'm taking the lamp away," says Angus. "It's the light that's attracting them."

Extract from:

RULES AND INSTRUCTIONS FOR THE GUIDANCE OF MIDWIVES

Victoria, Queensland 1920

EMERGENCIES

23. In the case of an emergency as defined hereunder the midwife shall (where no medical practitioner engaged by or on behalf of the patient is in attendance) call in to her assistance a medical practitioner.

I Pregnancy

In the case of a pregnant woman -

(a) When abortion or miscarriage threatens or occurs;
(b) if the patient is a dwarf or deformed;
(c) when there is excessive loss of blood;
(d) when there is any abnormality or complications such as -
excessive sickness,
puffiness of hands or face,
dangerous varicose veins,
fits or convulsions,
sores of the genitals.

II Labour

In the case of a woman in labour at or near term, when there is any abnormality or complication, such as -

(a) fits or convulsions;
(b) a purulent discharge;
(c) sores of the genitals;
(d) a malpresentation;
(e) presentation other than the uncomplicated head;
(f) when no presentation can be made out;
(g) where there is excessive bleeding;
(h) where, two hours after the birth of the child, the placenta and membranes have not been completely expelled;
(i) in case of rupture of the perineum, or of other injuries of the soft parts;
(j) in cases where labour has been prolonged more than 24 hours;
(k) where general condition of the patient is unsatisfactory.

ii] Auckland Region

a) 7.9.2 The financial year shall be divided into 4 quarters to allow proportional payment by automatic payment, and for new members on first enrolment only, who join part way through the year. WITHDRAWN

b) 4. A capitation fee proportional to amount received shall be paid to Board of Management. Capitation fees as set by the National Committee are payable when received and if received by direct credit, at the end of the financial year. WITHDRAWN

iii] Board of Management Remit

a) That the New Zealand College of Midwives take such action as required to implement the following structure and positions:

NATIONAL COMMITTEE

EDUCATION & RESEARCH COUNCIL

Elected Representatives
Professional Development
Continuing Education Accreditation

ETHICS COMMITTEE

Elected Representatives
Monitors NZCOM Code of Ethics in relation to Research and Policy

SECRETARY
30+ Hours

Typing/Typesetting
Correspondence
Personal Assistance to National Co-ordinator
Telephone/Receptionist

NATIONAL CO-ORDINATOR
Full Time

Spokesperson
Public Relations
Liaison/Co-ordination
Resource person
Contracting (Self Employed)
Negotiating Committee

TREASURER
Part Time (Paid)

Membership File
Co-ordinate Regional Treasurers
Bookkeeper
Budget
Reports to National Committee
Honorarium
Accountant
Lawyer

QUALITY ASSURANCE
Part Time (Paid)

Standards Review
Competencies
Complaints
Liaison and Consultation with Women's Health & Consumer Bodies
Data Collection & Statistics Analysis

PUBLIC RELATIONS
Part Time (Paid)

Marketing
Image
Pamphlets/Advertising
(may contract out)

CARRIED

b) That the role of industrial representation of employed midwives are added to the structure of Option One.

INDUSTRIAL
Full Time (Paid)

Indemnity/Personal Grievance
Employment Contracts/Negotiation
(Representation for all employed midwives)
Wages, Travel, Accommodation LOST

c) That the 1995/96 subscription rates are:

Self Employed Midwife	$350	Employed Midwife	$175
Unwaged/Student	$ 50	Associate/Affiliate	$ 30
Associate with Indemnity	$155		

CARRIED

iv] Canterbury/West Coast - Option Three (Late Remit)
That the National Committee form a working party to investigate various models of representation as outlined in (Option 2) b) and that the consequences of the New Zealand College of Midwives (Inc) taking on industrial representation be explored. The working party is to report back to National Committee by the 1995 Annual General Meeting.
CARRIED

v] **Remits - General**

i) Auckland Region
91.1.3 Individual members to vote for National President. Voting will be by postal ballot and these to be received by National Committee 14 days prior to Annual General Meeting.
LOST

ii) Life Membership - Board of Management

7.4.1 Those members who by virtue of their contribution to the New Zealand College of Midwives can be granted life membership by the National Committee.

7.4.2 Life membership shall be proposed by a region of the College and shall be subject to such criteria as the National Committee shall determine.

(b) Sterilisation by dry heat
(hot air oven, glass bead steriliser)
Appropriate for instruments that can withstand 170C. An ordinary electric household oven is satisfactory for dry heat sterilisation. The recommended operating temperature is 170C with a holding time of one hour. Additional times should be allowed as appropriate for penetration of large instruments.

For glass bead sterilisers. It is important that adequate time must be allowed for beads to reach operating temperature. Thirty (30) minutes is recommended. Instruments must be deeply inserted into the body of beads. A succession of instruments should not be sterilised one after another without allowing adequate time for bead temperature to recover. It is unwise to attempt to sterilise more than two instruments at a time. Instruments should be held in the steriliser for a minimum period of thirty (30) seconds.

(c) Boiling

A high level of disinfection is achieved when instruments are boiled for 10-30 minutes depending on the size of the instrument. This is the simplest and most reliable method for inactivation of most microbes, (including HIV and HBV) when sterilisation equipment is not available. It is important however to note:

(a) the water should be boiling vigorously at the time the instruments are added and remain boiling throughout the time.

(b) where instruments have been placed in a boiler at different times, no instrument should be removed until an appropriate time has lapsed since the last instrument was added.

(c) Duration of boiling should be sufficient to ensure that all parts of the instrument reach 100C.

Taken from : HIV/AIDS Information for Health Professionals, June 1993
Available from Ministry of Health, P O Box 5013, Wellington

the risk of acquiring HBV following a puncture with a needle contaminated by an HBV carrier ranges from 6-30%, far in excess of the estimated risk of HIV infection, which is less than 0.5%).

It is important to note that in most situations, disinfection/sterilisation procedures are directed against other potential pathogens in addition to HIV and HBV. Some may be significantly more resistant to inactivation. The following should be particularly noted:

i) **HEAT IS BEST.** Heating instruments to sterilise them is generally considered superior to chemical sterilisation.
ii) Physically clean instruments, which have been already cleaned with cold water and detergent prior to disinfection/sterilisation, require shorter disinfection times than when the instrument is contaminated with organic material.
iii) Disposable instruments should be discarded after use. No attempt should be made to sterilise such instruments by following these guidelines.

1. Reusable Medical Instruments

(1) Cleaning
Through physical cleaning is essential prior to sterilisation or disinfection. This should be performed by washing in COLD WATER and DETERGENT by personnel wearing suitable protective clothing and heavy duty gloves. All visible organic material should be removed from the instrument before proceeding further.

(2) Heat
Remember: HEAT IS BEST for those instruments capable of withstanding heat treatment (eg. most metal instruments).
(a) Sterilisation by steam
Steam Sterilisation (autoclaving) is the method of choice for most medical instruments.

Operating temperature (degrees C)	Holding time (Minutes)
121	15
126	10
134	3.5

7.4.3 A life member shall pay no subscription, but have all the rights and responsibilities of a full member.

CARRIED

TOPICS FOR DISCUSSION

That the following changes are made to the Regional Boundaries of the New Zealand College of Midwives.

BAY OF PLENTY/ EAST COAST	WAIKATO/ WEST COAST	CENTRAL
Tauranga	Hamilton	Wanganui
Gisborne (north of Wairoa)	New Plymouth	Taihape
Rotorua	Taumaranui	Napier
Opotiki	Huntly	Hastings
Waihi Beach	Taranaki	Palmerston North
Taupo		
Whakatane		

FOR FURTHER DISCUSSION

NATIONAL HOME BIRTH ASSOCIATION CONFERENCE REMITS
14 August 1994

The following remits were presented to the NZCOMI Conference by Majet Pot.

I apologise if the wording is not absolutely correct but I think I have captured the intent (I couldn't write fast enough!)

"The Home Birth Association of Aotearoa strongly urges the NZCOMI to retain an annual standards review of midwives for the first three consecutive years of independent practice prior to the review becoming three yearly.

RATIONALE
Once the midwife has met the standards of practice for three years she no longer needs to undergo a yearly review.

- to be sent to National Committee members to be discussed in their areas with responses to the next National Committee meeting.

"The Home Birth Association of Aotearoa demands that the Justice Department terminates the practice of sending copies of the RG9 Notification of Births Forms to the Plunket Society as a means of accessing clients as it contravenes the Privacy Act."

ENDORSED BY CONFERENCE

"The Home Birth Association of Aotearoa demands that the Ministry of Health directs the Regional Health Authorities to provide home based support services for all women postnatally up to 20 hours to be used at any time in the first six weeks."

ENDORSED BY CONFERENCE

Bella Beard and six month old Shayne Beard with Sally Pairman at the NZ College of Midwives Conference in Rotorua

- Kindly provided by the Daily Post, Rotorua

GUIDELINES FOR DISINFECTION AND STERILISATION OF BLOOD-BORNE VIRUSES

(Hepatitis B, HIV)
Prepared by the Medical & Scientific Sub-Committee of the National Council on AIDS. November 1989.

The Human Immunodeficiency Virus (HIV) is a blood-borne, sexually transmitted disease, epidemiologically similar to Hepatitis B virus (HBV). HBV is recognised as the major occupational health hazard in the health care setting and a model for the transmission of blood-borne pathogens. Measures to prevent HBV transmission in the health care setting have been found to be more than adequate for the prevention of HIV transmission. Information on the environmental stability of HIV and its inactivation by physical and chemical agents indicate that HIV is more readily inactivated by most means than HBV.

HIV has been isolated from blood, semen, vaginal secretions, CSF, breast milk, synovial and amniotic fluids. To date, all published reports of HIV transmission in the health care setting have resulted from exposure to BLOOD or body fluids containing blood. Transmission from other body fluids including sputum, saliva, nasal secretions, urine, faeces or tears has not been reported.

In the health care setting both HIV and HBV can be transmitted parenterally via blood contaminated sharp objects causing lacerations or penetrating injuries, from blood contamination or open wounds, or skin defects or possibly by blood contamination of mucous membranes. Developing sound work practices will include measures to reduce the frequency of needlestick lacerations in the health care setting (as these have been shown to be the principal means of HIV transmission to health care workers) and promoting awareness of skin lesions prior to commencing duties.

Like HBV, there is no evidence that HIV is transmitted by casual contact; faecal, oral or airborne routes, or by contaminated food or drinking water. Physical barriers to HBV are effective against HIV. Workers are at risk of either infection to the extent that they are directly exposed to blood and body fluids. Even in groups with high potential exposure to HIV contaminated fluids and tissues, eg family members of AIDs patients, transmission is recognised as occurring only between sexual partners or as a consequence of mucous membrane or parenteral (including open wound) exposure to blood or blood contaminated body fluids. Despite the similarities of modes of transmission, the risk of HBV infection in the health care setting far exceeds that of HIV (eg

Rule 10 **Limits on use of Health Information**

Health agency must not use for any other purpose than that for which it was obtained unless:-

- authorised by the individual
- information is publicly available
- used to protect public safety
- the information is non-identifying
- compliance is legally necessary
- where there is accident/death

Clients may veto the disclosure of any information. Individual may be asked when information is being collected if it may be used for research purposes.

Rule 11 **Limits on Disclosure of Health Information**

The Health agency that holds the information must not disclose it to any other agency or individual unless the agency believes on reasonable grounds that:-

- it was authorised by the individual
- it is publicly available
- use is necessary to protect public safety
- the information is non-identifying
- compliance is legally necessary
- it is in general terms concerning the presence and condition of the patient (with permission of the patient or representative)
- it is required for accreditation, quality assurance, legal proceedings.

Application may be made to veto information disclosure by the individual or representative.

12. Unique Identifiers

Care must be taken in using unique identifiers so that:

- identities cannot be confused
- individuals are not identifiable by others

Consider these:

- Do you have an appointed privacy officer in your practice or institution?
- If you are a self employed midwife, do you understand the implications and requirements of the code and your legal responsibilities as an automatic 'privacy officer'?
- How do you store and dispose of your client information?
- Do you discuss with your client and document what information you are collecting and who will have access to it? Do you document a client's persommission to use or possess this information?

The Essence of Midwifery

He who uttered the words "Routine Delivery"
Or hastily wrote "Normal Spontaneous Delivery" as one further procedure in
a busy day
Couldn't have really been with her
He couldn't have been
Or he would have felt her muscles as they
worked, strained, pushed
that infant into the world.
He couldn't have been,
Or he would have truly felt her perspiration weep from her body as she reached for strength deep within.
No, he couldn't have really been with her.
If he were, he would have appreciated her expression as it changed from excitement, to concentration, to fear, and to excitement and peace.
He couldn't have held her,
Whispering
"You're almost there"
"You're doing so beautifully"
"You are so strong".
Routine Delivery.
He couldn't have been there.
He couldn't have taken the time to pause in awe and wonder as that little head came slowly, ever so slowly, and the eyes opened and looked out with such trust and wisdom.
Procedure - normal spontaneous delivery.
He couldn't have been with her.
He couldn't have marvelled as she reached down, drawing her daughter to her breast
Laughing, shouting, crying - all the emotions of birth.
No, he couldn't have been with her.
For she who has been with woman knows there is no routine birth, and that delivery is not a procedure.
Being with woman is opening up,
sharing,
loving,
caring.
Being with woman is truly being a midwife.

By Linda Walsh : On Nursing : A literacy celebration

Upcoming Events

6TH NATIONAL CONFERENCE OF SANDS AUSTRALIA

"Back to Basics - Family Needs when a Baby Dies"
23-25 September 1994
Grace College, University of Queensland, Brisbane

Enquiries to: Conference Co-ordinator
SANDS Queensland P O Box 49
Royal Brisbane Hospital Queensland 4029

CALL FOR PAPER FOR CONFERENCE

LA TROBE UNIVERSITY

MIDWIFERY & THE COMMUNITY
3rd National Midwifery Forum
Friday and Saturday 28 and 29 October 1994 at the Conference Centre, Royal Exhibition Building, Melbourne.
Abstracts are invited on the following topics: midwifery and the community - in Australia and other countries; private practice in the community and in hospital; decision making in midwifery practice; domiciliary care; birthing; breast-feeding; midwifery education.

All enquiries, brochures or Call-for-Papers to: Liz Pittman
School of Nursing, La Trobe University, Bundoora 3083 IDD
Phone 61 3 418 6951 and Fax 61 3 418 6988

AUSTRALIAN COLLEGE OF MIDWIVES INC
6th Biennial Conference

Sydney 12-15 September 1995

Enquiries to:
ACMI 1995 BIENNIAL CONFERENCE
P O Box 787
Potts Point NSW 2011
Australia
Ph (02) 357-2600 Fx (02) 357-2950

- includes the right not to have their case used for teaching purposes
- give choice over who is present when information is collected
- streamline process so information is not repeatedly asked

Rule 5 **Storage and Security of Health Information**
Agency with the information must take measures against :
- loss
- access by unauthorised persons
- misuse

If no longer needed it is given to the provider/individual or disposed of in a manner to preserve privacy (this has implications for storage of clients notes after 3 years, use of faxes to transfer client information etc)

Rule 6 **Access to Health Information**
Individual is entitled to:-
- ask if information is being held
- have access to that information
- have the information corrected

No charges should be made by the health agency for this information
- unless they are a private sector agency, where they are permitted to do so in certain situations.

Rule 7 **Corrections to Health Information**
Individual has the right to have information corrected or have notice of correction attached to records. No right to physically change document.

Rule 8 **Accuracy of Health Information to be checked before use**
Individual should be the first auditor. Record source of information on file. Need to ensure information is correct, accurate, up to date, complete, not misleading.

Rule 9 **Retention of Health Information**
Health agency must not keep client records longer than lawful use, excluding that which may be needed for future health care.

Health information includes, identifiable information about:-

- past and present health
- disabilities
- use of health and disability services
- donation of body parts or bodily substance
- medical tests and examinations
- personal details collected before or during time of care

Rules Concerning Health Privacy Code

Rule 1 **Purpose of Collection of Health Information**
Can only be collected for lawful purpose and if necessary closely related purposes include 'for training and education' to assist in developing and maintaining expertise and competence.

Rule 2 **Source of Health Information**
Information must be collected from the individual concerned unless:

- they authorise someone else
- agency needs to ask from representative
- where compliance is not practical
- where there is a legal requirement to provide
- the information is publicly available

Rule 3 **Collection of Health Information from Subject**
Where information is collected the individual must:

- be told it is being collected
- be told why
- explain who will have excess
- explain who holds it and how
- be told if it is mandatory
- be told the consequences if not supplied
- explain who has right of access

Theses explanations must be made before, or as soon as possible after the information is collected.

Rule 4 **Manner of Collection of Health Information**
Information must be collected by the agency by :

- lawful means
- in circumstances that are fair and non intrusive of personal affairs

Current Issues

SUBSCRIPTIONS

There seems to be some confusion with regards to midwives who are working part time waged in a hospital setting and also working part time self employed (i.e. claiming from the Maternity Benefit).

These midwives must pay the $255 subscription rate as they are benefiting from the ongoing negotiations that the College is doing on their behalf.

If you have paid the wrong subscription rate, please see your local regional treasurer.

SUBSCRIPTIONS ARE OVERDUE

Subscriptions were due on the 1st May. If you have not yet paid, you will officially have been removed from the membership list at the end of August.

This means you will no longer:

- have indemnity insurance with the NZCOMI
- receive a two monthly newsletter and bi-annual Journal
- receive any other mailouts instigated by the College
- receive other benefits of belonging to the College

See the inside back cover for subscription form and your local treasurer's address. PLEASE ensure you fill in ALL sections of the form including your post code. Thank you.

Special Features

HEALTH PRIVACY CODE

Report of Workshop held on 16th July 1994, Christchurch
Facilitated by Chris Hendry
Reported on by Karen Barnes

What follows is a summary of the information discussed and topics that will require further organisation and action by individual midwives and the NZCOM.

- The Health Information Privacy Code 1994 is a statute that has come from the Privacy Act 1993
- The Health Privacy Code only relates to those for whom a health service is provided. It does not deal with employee information (eg. staff records) The Privacy Act 1993 covers this.
- The Code is legal document and is enforceable in its own right.
- The Code relates to information about an identifiable individual not about statistics or anonymous information.
- All "health agencies" (from institutions to an individual midwife) are required to develop internal operational procedures in order to apply the principles of the code. However in differing situations a midwife may come under the jurisdiction of different privacy officers (ie. a self employed midwife using a CHE facility while there, but be her own privacy officer for her own independent practice.)
- It is a requirement that every health agency appoint one or more persons as Privacy Officers. These Officers are required to:-
  - encourage and ensure compliance with the Code
  - deal with requests about the Code
  - work with the Privacy Commissioner in investigations with the agency about the Code
  - furnish statistics when requested about number of requests and complaints received by the agency.

THE ROLE OF ASPIRIN IN PRE-ECLAMPSIA IS CLEARER

- NZ Doctor 12/5/94

Several large studies published over the past 12 months give a better indication of the role aspirin should play in preventing pre-eclampsia.

While "results do not support the routine prophylactic or therapeutic administration of antiplatelet therapy in pregnancy to all women at increased risk of pre-eclampsia or IUGR ... they do suggest that aspirin may have a selective effect in preventing early-onset pre-eclampsia". It should be reserved for use in high-risk women identified at less than 20 weeks' gestation. The authors added that what is needed is an accurate test predicting pre-eclampsia and IUGR "suitable for routine clinical use".

Hypertensive disorders in pregnancy are the leading cause of maternal death in the UK and therefore results of large international trials of aspirin prevention have been awaited with interest.

The first of the three big trials to be published was from Italy and involved just over 1100 women at moderate risk of pre-eclampsia or IUGR. There was no difference between no treatment and aspirin 50mg daily for outcomes of pre-eclampsia, low or mean birthweight or perinatal mortality.

A US group randomised three times as many women to aspirin 60mg or placebo during the second trimester and found no difference between groups for birthweight, gestational age or perinatal mortality. Pre-eclampsia was less common in the actively treated group (4.6 versus 6.3 per cent) and this was evident in those whose systolic BP was initially higher. Placental abruption was seen significantly more often among the aspirin recipients, however. The authors did not recommend using aspirin routinely in healthy nulliparous women.

The most recent study, the Collaborative Low-dose Aspirin Study in Pregnancy (CLASP), involved over 9000 women in 213 centres and continued for five years. The authors also concluded routine use of antiplatelet therapy in pregnancy to all women at raised risk of pre-eclampsia or IUGR could not be justified, though they indicated a possible role in preventing early-onset pre-eclampsia. There was no significant increase in bleeding disorders affecting mother, foetus, or newborn infant, though maternal need for transfusion was slightly higher among aspirin recipients.

Initially promising results with aspirin some years ago may have been caused by selection of patients at greatly increased risk of pre-eclampsia and IUGR. Even so, aspirin only proved partially protective, suggesting platelet activation is only one aspect of the aetiology of the condition. Pre-eclampsia appears to result from the failure of trophoblastic invasion of the spiral arteries, causing placental ischaemia. This is thought to give rise to endothelial cell activation and symptoms in various systems which are characteristic of the disorder.

Open Polytechnic of New Zealand Nursing and Midwifery Programme

All of The Open Polytechnic midwifery courses are now available.

Many thanks are extended to members of the College of Midwives and especially Chris Hendry who has put in a great deal of time and energy to the courses to give them a New Zealand practice and philosophical perspective.

All midwifery tutorial staff are on an individual contract arranged through the College of Midwives.

Midwives interested in continuing education can undertake study in a core module and in antenatal, labour and postnatal practice papers. In addition, breast-feeding and parenting are offered for those involved in these specialities.

Courses can be taken for interest or as part of a Diploma of Clinical Practice or a Bachelor of Health Science (Australia).
Detailed information can be obtained from The Open Polytechnic on 0800 507 333.

Professional Indemnity Insurance

Additional premiums required for College members wanting to increase their cover on an individual basis are now available.

Limit	Additional Premium
$ 500,000	$20.00
$1,000,000	$35.00

Please Contact: Dean Edwards
Minet Professional Services
PO Box 470
Auckland Ph: (09) 379-0929

Remember: If you are involved in any incident you think could result in a claim, notify the College FIRST before proceeding

NZCOMI NATIONAL CONSTITUTION

A copy of the NZCOMI National Constitution and By Laws is available to any member at any time, either from your local regional chairperson or secretary or from the:
National Office of the NZCOMI
P O Box 21-106
Christchurch

BUSINESS ADVISORY SERVICES

Within our Business Advisory Services Division, we are frequently asked to make presentations to business groups on a variety of topics which have included:

- Starting out in Business
- Staying in Business
- Tax Saving Initiatives
- Maintenance of Books and Records
- Helpful Hints for Growing Businesses
- How to Get the Best Value from your Accountant

If any members of your organisation were interested, we would be happy to hold a complimentary seminar or address one of your meetings and cover any business or tax-related topics which may be of interest to you.

We also have a variety of free publications available which might be of interest to your members.

If interested, please contact : Ms M D Rose, Business Advisory Services Division, Coopers & Lybrand, P O Box 13-244, Armagh Chch

MIDWIFE VACANCY

A Midwife is required for a busy independent practise on the West Coast of the South Island.

Workload would include full antenatal care, homebirth, domino birth and postnatal care.

A Midwife is also required as a locum during December 1994 and January 1995.

Accommodation and vehicle available. Part care or full care optional.

Ideal experience of Midwifery in an established practise.

For further information contact:

Bev Olson
20 Kaniere Tram
Hokitika
Phone 03-755-7545
(Answerphone)

MEDICAL RISK : IMPLICATING POOR WOMEN

from Reroductive Health Matters, May 1994 No. 3 Page 123-124

Since 1987 courts in the USA have increasingly relied on medical testimony to prosecute women labelled 'high risk' for failure to comply with medical advice when they miscarry, have stillbirths or infants deaths. This paper looks at the inappropriateness of judges to understand medical risk and the differences in how epidemiologists, clinicians, judges, lawyers and women themselves perceive risk.

In one California clinic, pregnant women are routinely interviewed by a nurse at the first antenatal visit, and classified as high, medium or low risk according to a long list of criteria. Depending on which category the woman is classified in, her case is modified to provide, anticipate, minimise, prevent or treat possible adverse outcomes. Her whole experience at the clinic, for the duration of the pregnancy and during labour and delivery, is affected.

Assessments of risk were not always objective, however, but appeared to be influenced by social and ideological factors. A tendency was observed to classify Asian, caucasian and Hispanic women as low risk and black women as high risk, even if they shared the same risk factor. For example, a pregnant black woman with a poor diet was classed as high risk, while an Asian woman's poor diet was attributed to cultural differences and not classed as risky. On the one hand, 'high risk' then becomes stigmatising. On the other hand, being seen as 'low risk' may mean problems are overlooked. Women may be treated as risk categories and not individually as the pregnancy progresses, especially if continuity of care is missing.

With the growth in fetal medicine, there is an increasing tendency to see the woman and her baby as separate entities. Where a high risk label has been applied, the fetus is increasingly seen as needing protection from the mother. While drug addition and other 'high risk' behaviour is seen as a health problem in middle class women, poor women of colour are increasingly viewed as criminals. Attempts to prosecute 54 women have failed to date to obtain a sustained conviction, but the thinking behind them gives cause for concern. The American Medical Association and American Public Health Association have argued against prosecuting women, because it will drive vulnerable women away from seeking care. But a survey in 1987 of directors of maternal and fetal speciality programmes found that 46 per cent thought women who refused medical advice and endangered their fetuses should be detained.

While medical professionals and law officials may see a clinic as a safe and nurturing environment, the threat of prosecution may make that clinic appear very unsafe for women who know that their health-related behaviour and/or life situation will label them high risk.

VAGINAL BIRTH AFTER MORE THAN ONE CAESAREAN SECTION

Trial of labour in patients with two or more prior caesarian deliveries is a safe and successful alternative to elective repeat caesarian delivery. This retrospective study included 170 women who underwent two or more low transverse caesarian deliveries. The study examined whether a trial of labour in women who experienced two or more low transverse caesarian sections is a safe alternative to repeat caesarian delivery. Thirty-five women attempted a trial of labour and twenty-seven (77%) experienced a successful vaginal delivery. Uterine rupture is the major concern of most patients and physicians when considering a trial of labour. There was one uterine rupture in this study, which occurred at thirty-three weeks without a trial of labour, representing 0.5% of all patients with two or more previous caesarian deliveries. No patient who laboured experienced uterine rupture.

Three groups were studied: patients who underwent repeat caesarian deliveries without a trial of labour; women who experienced a caesarian delivery after a failed trial of labour and the vaginal birth after caesarian (VBAC) group. Hospitalization averaged 4.9 days for the group of scheduled repeat caesareans, five days for those with a failed trial of labour and 2.9 days for those with a vaginal delivery. The difference between the last two groups was significant (>0.05). Apgar scores, the only indication of fetal morbidity assessed in this study, showed no statistical difference among the groups. Of the women who attempted labour after an original diagnosis of CPD and had at least two caesarian deliveries, 50% delivered vaginally. Three of these patients delivered larger infants than with their primary caesarian delivery. Of the group that underwent primary caesarian delivery for a reason other than CPD, 95% delivered vaginally. Patients experiencing a successful vaginal delivery had less febrile episodes, fewer transfusions, shorter hospital stays and less antibiotic use than the elective repeat caesarian delivery group. This study indicates that trial of labour and vaginal birth is an option that should be offered to patients with two or more prior low transverse caesarian deliveries.

Hansell, R.K. McMurray and G Huey 1990.
Vaginal birth after two or more cesarean sections: A five year experience.
Birth 17:146-150.
46/IJCE/May 1991

AUSCULTATION OF THE FOETAL HEART RATE AFTER THE ADMINISTRATION OF EPIDURAL ANAESTHETIC

A recent inquiry into the death of a baby resulted in the recommendation to auscultate the foetal heart rate after the administration of an epidural anaesthetic.

We have been requested by the Ministry of Health to reinforce this practice to midwife members as their informal inquiries nationally indicated that it may not be normal practice in some areas to do this.

The College expressed its extreme surprise to the Ministry of Health that this is not a normal practice in some CHEs and is keen to reinforce this recommendation.

CONGRATULATIONS AVONLEA

Midwifery Pilot Scheme

Recently Avonlea Midwives signed a contract with the Southern RHA to provide NZ's first midwife owned and operated birthing unit. This contract effectively established the five midwives as the budget holder for all normal birth services plus funds the Avonlea facilities.

Articles of Interest

NUMBER OF ABORTIONS HALVED AMONG SWEDISH TEENS

- Reproductive Health Matters, May 1994, No. 3 Pg 122

The municipality of Gavle in Sweden has reduced the number of teenage women having abortions by subsidising oral contraceptives for this age group. In 1992, the annual cost of the pill (about $45 per year) was reduced to about $13.50 per year. The number of teenage abortions dropped from 75 in 1989 to 38 in 1992.

A trend of an increasing number of abortions began in 1985 when a new law required that users renew prescriptions every three months instead of once a year. It was found that about 18 per cent of young women who needed an abortion between 1987 and 1989 had often post-poned renewing their prescriptions because of their financial situation. In 1992 that proportion was reduced to 2 per cent. In addition, the policy has stimulated increased use of the pill, from 32 to 39 per cent overall, with the highest increase among 19-year-olds from 42 up to 60 per cent.

After one year, the project was considered successful and the policy was adopted by 70 per cent of Swedish municipalities. The head of the project in Gavle has now recommended that 20-24 year-old women be entitled to subsidised pills.

GPA moves to increase contraceptive access

- NZ Doctor 23/06/94

A form designed to help low income women get contraception is to be made available to GPs.

GPA chief executive Lynley Smith Pilling said an application form for a supplementary contraceptive benefit, modelled on one provided by the Family Planning Association, is now available from the GPA on application.

It resembles a Section 99 application and should assist low income people who are missing out on government contraceptive help because they do not know help is available, said Mrs Smith Pilling.

Family Planning Association medical adviser Christine Roke is pleased the recent survey of women seeking termination of pregnancy at an Auckland clinic, which was published in the NZMJ, has highlighted cost barriers to contraception.

"The need is most obvious when clients are on an income equivalent to or less than the benefit."

People on low incomes can apply through their GP to the Wanganui Benefits Centre so that the part charge is waived.

That reduced the cost of a six month supply of contraceptive pills from $20.

Anyone who relies on benefits or is on $22,000 or less is able to apply for contraceptive assistance.

"I don't think a lot of people realised they could claim. The Government hasn't made any effort to advertise it," said Mrs Smith-Pilling.

After cost, the second reason for low use of contraceptives cited by those attending the Epsom Day Unit at Green Lane Hospital was a lack of knowledge.

Dr Roke said the GPs could promote contraceptive education through their practices, particularly by having nurses instruct patients.

"GPs should make totally sure that their clients know how to use the pill. The practice nurse can teach patients about it as clients are less in awe of nurses than of doctors and listen better."

The nurse can also demonstrate the use of condoms to clients, she said.