om:

New Zealand College
f Midwives
P O Box 7063
Wellington

TO:

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New Zealand College of Midwives [Inc]

NEWSLETTER

Volume 3, Number 3 : February 1991

NEW ZEALAND COLLEGE OF MIDWIVES INC.

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New Zealand College of Midwives
Membership Form

Regional Information

Name _____

Address _____

Telephone _____ Home _____ Work

Place of work _____

Type of membership

Full member (Registered Midwife Full or Part Time)	$52.00
Full member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	$26.00
Associate Member (Other Interested Individual)	$52.00
Associate Member (Unwaged Interested Individual)	$26.00
Affiliated Member (Other Groups eg. Parent Centre, La Leche League etc)	$26.00

Method of Payment
Please tick your choice of payment method.

☐ Subscription payable to College Treasurer (Please enclose cheque or money order).

☐ Deduction from Salary (Please arrange with your Pay Office).

National Information

Name _____

Address _____

Telephone _____ Home _____ Work

Date of Birth _____ NZNA member Yes / No

Type of membership

Full :Waged ☐ :Unwaged ☐ Associate :Waged ☐ :Unwaged ☐ Affiliate ☐

Place of Work _____

Please return completed form (together with money, if applicable) to your local Treasurer

whether the Nursing Council is the appropriate body to govern midwifery.

As yet I have seen no evidence to persuade me that direct entry is neither feasible nor desirable. In the absence of such evidence it is my intention as Minister of Health to promote it in the context of the review of the Act. The objections appear to me to be doctrinally and not empirically based.

This Conference meets at an exciting time for the profession. I especially want to pay tribute to the College for your dedication to improving women's choices in childbirth. I know that you operate thanks largely to volunteers. You have worked untiringly in marshalling support for the Bill, responding to the concerns which have been expressed, and liaising with area health boards over the future direction of maternity services. That is all vitally important work. I also know that many of you have made considerable sacrifices to come to this conference. There are no pharmaceutical companies paying your airfares!

The challenge to the profession now is to make autonomy work. I know that you will see legal autonomy as the first step, and not the last, in increasing the choices and the quality of care offered to women in childbirth.

Thank you for the opportunity to address the conference.

NEWS & VIEWS

Contracts

Throughout New Zealand there is a wide range of differences between regions and some confusion about what contracts are. There are four types of contracts:

1. *Domiciliary Midwives Contracts:* (formerly made with the Minister of Health, now not strictly necessary as midwives can claim the Maternity Benefit);

2. *Domino Contracts:* a contract with the Area Health Boards to allow midwives to take women into Board hospitals (midwives formally paid by the Board for the delivery - the rest of the care paid by other benefits);

3. *Individual Contracts* with the Area Health Boards to meet specific needs or service provision, e.g. birthing centre staffing (midwife paid and employed by the Area Health Board);

4. *Contract to use the Area Health Board's facilities (open beds):* the practitioner is permitted to use the Board's facilities, as GPs and obstetricians do. Midwives may work alone or with a doctor. They are paid from the Maternity Benefit.

The contracts with the Area Health Boards (4.) are the ones being referred to.

Obtaining Contracts:

Some Boards have set up new Obstetric Standards Review Committees. Other Boards are still discussing the name for the Committee, and others declining to take any action because no-one else has!!

Taranaki and Wellington have both granted contracts. I will relate the Wellington experience. The Obstetric Standards Review Committee approves contracts.

The Committee is comprised of:

3 advisors - midwife, paediatrician, obstetrician
2 general practitioners
3 obstetricians
4 practising midwives (one from the College)
Chaired by a chief advisor (no vote)

The absence of consumers has been acknowledged and is to be addressed after the Committee has got itself organised.

Midwives and doctors have the same contract.

Seven midwives have been granted contracts. The only hold-up has been waiting for references.

Maternity Benefits

Since the Nurses Amendment Act 1990, midwives have been able to claim the Maternity Benefit (under the Social Security Act 1964).

There has been a lot of confusion over this, some midwives claiming the prolonged labour fee after 1.5 hours, others the prolonged labour fee after 6 hours (as spelt out in the Domiciliary Contract).

Over the last couple of weeks some midwives have been told that two practitioners could not claim and one must return the benefit. Now it seems some payment is being withheld.

The College has a legal right to be involved with negotiations on the Maternity Benefit. Consequently, meetings are being set up as soon as possible (19th February).

It would seem a number of midwives have been given inaccurate information. Liaison with Karen Guilliland (Board of Management) or committee members may be more useful.

I see midwives as a very important part of our primary health care services. The primary care initiatives which I announced last month recognise the central importance of primary care in our overall health policies. Midwives can have a special relationship with mother and child. You are in the ideal position to convey important primary health care messages, such as the importance of vaccination. You should be part of developing strategies with area health boards which can lower the incidence of low birth weight and premature babies.

Let me turn to briefly to the question of training for midwifery.

The issue of direct entry midwifery is receiving considerable attention both here and overseas. Currently midwifery training is offered only on a post graduate basis. A prospective midwife must first complete a general training course.

I am supportive of direct entry midwifery as a means of increasing midwifery training here in New Zealand and also as a means of encouraging women who would not otherwise be attracted to the nursing profession to consider midwifery training.

I acknowledge the issues are not simple. It is clear from the review of the Nurses Act that the broader nursing profession is divided on the issue. That debate should be constructive not destructive.

I know that there is interest in the polytechnics in running pilot direct entry midwifery courses. A recent application along those lines to the Nursing Council has had no joy. If the Nursing Council is inhibited by existing legislation, that can be changed. But I have to say that I would be concerned if legislative barriers were removed and still no tolerance for an experimental programme followed by full registration was shown. Certainly that opens up to question

ces. Carpets, pictures, pot plants, and bean bags are not
ommon. Although the bean bags and the pot plants have not
aged to hide the ward clocks that continue to tick away!

the past, clocks have often limited the support a midwife
ld offer the perinatal mother. During an extremely
essful time, when continuity of care and support is
haps the most important, changes in shifts have meant a
her may have contact with two or three different midwives
a day. And because the contact with that midwife is
ited to a hospital setting, it has left little opportunity
a relationship to develop prior to labour.
erstandably that can be quite disorientating and
tressing to women.

that reason I do see potential in the domino schemes some
rds are establishing. The domino option has a simple
losophy. If women can get to know their midwife before
y go into labour, there are likely to be fewer ante natal
issions, women will feel more in control of their labour,
d less narcotic analgesia, and less medical intervention
labour and in birth. The continuity of the midwifery
port into the post natal period decreases the multiplicity
advice and increases successful breast feeding patterns.
also means that women can return to the familiarity of
e as soon as that is practical after birth.

thland Area Health Board is one which has experienced this
ion. In the year just completed there were 70 domino
ths. 65 were normal deliveries, three were vetouse
isted, and only two were by caesarian sections. The three
cent rate for caesarians compares very favourably with a
ional average of nine per cent and a hospital average of
per cent.

a profession I believe you have a very important role to
f in educating the public about the increasing choices
en have in childbirth and how midwives can make a
ference.

Educator Appointed

Karen Guilliland has been appointed as the Educator. There is already strong interest in having her to talk to groups in various regions.

Congratulations! It will be a busy year.

Direct Entry Midwives

The Wellington (Hutt) midwives who had their domiciliary contracts stopped because they are not registered nurses have at last had a decision. They can do antenatal and postnatal in the community but must attend "childbirth" in an institution.

Advertising Professional Services

Midwives are allowed to advertise their services. However, they must not say they are the best (or better than anyone else), nor use the College logo. They may say they are a member of the College of Midwives.

International Midwives Day will be 5th May - let us know if anyone has any inspired ideas.

Proceedings from the National Conference, August 1990, have arrived at last. Items will be included in the Newsletters as space allows.

National Planning Forum

Vision 2000 Project 1991

Remember it is important to have lots of midwives in Auckland. Auckland Region will help with billetting.

Details later in Newsletter. Please ensure you include your name and address.

Midwifery Research

The College has funding for a Midwifery Education Research Project.

Summary of Proposal
To undertake research in midwifery education needs for primary practice in specific areas, as selected by the New Zealand College of Midwives National Committee in consultation with consumer groups.

Aims and Objectives
(a) To identify the educational needs of specific areas.
(b) To identify educational needs of midwifery practitioners in these areas.

Description
A researcher employed on short term contract to the New Zealand College of Midwives would devise and distribute a questionnaire to midwives and Area Health Boards. The researcher would report on the information gained.

Expected Outcome
Information on which to base future midwifery courses based on geographical need.

Budget and Resources

Researcher	$10,000
Research costs	$4,200

Length of Project
13 weeks approximately

Anyone interested apply to Beryl Davies with details of experience, knowledge, ideas, before 18th March 1991.

Beryl Davies
PO Box 7063
Wellington South
Wellington

Let me comment briefly on the birthing services our hospitals provide. I think there need to be planned improvements in the accommodation offered. From time to time I receive letters from women who have been deeply stressed after the birth of their baby by being placed in a room with other mothers and babies in which it is impossible to rest.

Frankly I am surprised there are not more complaints. Women may well be stoic, but I think we deserve better. Surely when boards plan maternity wards in future, more single room accommodation could be provided? Perhaps women architects would help?

A number of area health boards are now exploring new ways of delivering their maternity services. I know there is often suspicion that change of any kind in our health services is motivated purely by financial considerations. That is not so. I must say that wasted resources do place a strain on the whole system. Certainly, limited financial and staff resources are wasted if medical staff repeat procedures which could have been carried out by midwives qualified to do so. The Nurses Amendment Bill discourages duplication of staff resources and should lead to more cost effective childbirth services. That is not a clever sleight of hand to take money away from the perinatal services. Far from it. The more effective use of staff and financial resources is good news for women because it enables more resources to be freed up for the care of the mother and the child. Perhaps then we can have some of those single rooms and more post natal services.

The amendment will also facilitate changes already planned by boards which want to make their services more flexible and consumer-responsive. And it should help boards to keep maternity services in smaller communities.

Thanks to the efforts of organisations like your college, some hospital maternity wards are becoming much more pleasant

itions to give full effect to the principles of the ient Bill.

ible midwives to provide a comprehensive service and to the safety of the mother and child, midwives need to e to prescribe medicines commonly used in low risk ancy and childbirth, to call for routine diagnostic tory tests and to claim the associated social security ts, and to transfer patients to an obstetrician or to a al.

mmittee has also recommended that midwives should have me access to clients whom they have referred to als as doctors have to their clients similarly ed.

up amendments to that effect which were then further ed by the select committee, and further evidence was I am confident that we now have before Parliament a amendments which meet the objectives of restoring my in principle and in practice.

ll now awaits its second reading in Parliament. I that it will be passed into law before the House rises ee weeks time.

ealistic enough to acknowledge that legislative change own does not work miracles. What is also required is ge in attitude on the part of health consumers and health professionals, and a willingness on the part of ealth boards to explore new ways of delivering es.

e foreseeable future most women are likely to continue for hospital as opposed to home births. I am ally strongly supportive of the home birth option. I hat in our hospitals we will also see more development asant, low risk birthing facilities with a homely here.

BOOK REVIEW

"BEST FEEDING : Getting Breastfeeding Right for You".
Renfrew, M, Fisher, C, Arms, S. Berkeley, Celestial Arts, 1990.

Everything you want to know about breastfeeding but were too afraid to ask! Pardon the cliché but this clear and simple guide to breastfeeding (don't you just love the title) is a must for mothers and midwives. It's a refreshing look at breastfeeding from a woman's perspective, and who better to tell all.

The authors (who, they tell us, have a total of 70 years experience between them) have pooled their collective wisdom from a variety of settings. Mary Renfrew is a midwife with a Doctorate in Breastfeeding from the University of Edinburgh. She is currently working as a researcher at the National Perinatal Epidemiology Unit in Oxford. She has endeavoured to blend together the best of clinical research and practice in the context of women's needs. She travels extensively throughout the world sharing her knowledge and experience.

Chloe Fisher is currently Senior Midwife for Community Midwifery Services in Oxford. She has longstanding experience in the community, working with mothers and babies and is an advisor to the International Lactation Consultant Association.

The third author is Suzanne Arms, whose sensitive photography adds clarity for the reader. As an author her repetoire includes: Immaculate Deception : a New Look at Women and Childbirth, To Love and Let go; Adoption; A Handfull of Hope. As a a film-maker she created Five Women, Five Births, a film about choice. Suzanne has been actively involved in setting up consumer organizations in California with the view to empowering women to actively participate in their care. She is an advocate for home birth.

Suzanne's photography and the text are complemented by Maggie Conroy's drawings. Maggie began her vocation in life as an art therapist. Her art work clearly illustrates what is required for those of us who need a little extra validation.

The contents of the book centre on the advantages of breastfeeding, how to get it right, and how to deal with problems that arise. It offers specific advice about babies in special care units, breastfeeding an adopted baby, and restarting breastfeeding after a period of stopping. (Of particular importance

to those who have been ill-advised to stop and wish to relactate.) Apropos of the whys and wherefores these 'sage femmes' have included a potpouri of gems such as: a comprehensive bibliography for further study (to back up what we already know); an index of commonly asked questions; a glossary of terms; a directory of breastfeeding help centres around the world (yes, New Zealand is included); case histories of personal experiences reflecting differing solutions to problems; and a section exposing modern myths.

Given that it is not a perfect world, one disadvantage of the book, as with all exotic material, is that it lacks certain New Zealand flavour in that it is not home grown. The readers, however, are invited to send their comments to the authors if they feel that they may improve future additions.

Jeanie Douché

MORNING SICKNESS

Being sick during pregnancy is horrible, but it seems that it may have its compensations after all!

A study of over 900 Californian women found that mothers-to-be with morning sickness were up to seven times less likely to miscarry than those who didn't suffer from it. But just *feeling* sick isn't enough! Women who suffered from nausea only were found to have the same chance of miscarrying as everybone else.

Mothering, Spring 1990

NAUSEA

★ **(Sweet) Basil:** Bruised aromatic leaves of sweet basil act as a powerful tonic and will help reduce nausea.

★ **Ginger:** Add a pinch of ginger to other teas to help reduce nausea - ginger compress on the head (made with the mild tea) will help relieve headache due to nausea.

★ **Goldenseal:** Drink a mild tea of Goldenseal and honey immediately upon rising to offset the nausea of pregnancy. Preparing the tea with a pinch of goldenseal powder in a cup of just boiled water; add a small amount of honey to it to overcome the bitter taste.

★ **Peppermint:** Reduce a feeling of nausea with a cup of hot aromatic peppermint tea. A pinch of basil and/or ginger may also be added. I also like a pinch of bruised cloves and/or some cinnamon.

midwife as the only birth attendant and there is no doctor in the room.

Other studies indicate that midwifery care in pregnancy has been shown to lead to higher birth-weight babies - the primary indication of wellbeing - and fewer complications in labour.

Another issue which figured prominently in the Select Committee discussions was accountability. I have already mentioned the work your College has done in developing training and peer review systems. For the time being the Nursing Council remains the disciplinary body for midwives, although the suitability of that should be examined during the review of the Nurses Act which is currently taking place.

The key accountability issues are far broader than just who should have responsibility for deliveries. A number of factors are involved. Are women satisfied with their professional care? What are the intervention and complication rates? How do these compare nationally? Were resources used appropriately?

Area health boards will need to develop perinatal information systems which monitor these factors. An important aspect of board accountability is the board contract. I am looking to see that the contracts include performance indicators which indicate the level of choices available to women in childbirth.

It became clear to me earlier this year that while the simple two clause Bill I had introduced was sufficient to bring about autonomy in principle, in practice further acts and regulations would need to be amended if real autonomy was to result. The Select Committee also became aware that more needed to be done.

Accordingly it recommended that there be further amendments to the Nurses Act and to four other acts and five sets of

is certainly my view that the safety of the woman and
ild are of paramount interest. I know that that view is
rongly shared by the College of Midwives. Nothing in the
oposed changes is detrimental to mother and child. Indeed
e converse may well be argued.

dwives are educated to recognise the problems which may
ise in a pregnancy. Any midwife worth her salt is able to
tect deviations from the norm and knows when to refer her
ients on to the medical services.

a profession I know that you are committed to providing
re and support of the highest quality. You have national
andards for midwifery practice, service, and education.
going midwifery training is being promoted. I understand
at the College, in conjunction with the Domiciliary
dwives Society, has developed a peer review concept. The
ciety has a scheme to monitor midwifery standards and the
miciliary Midwives Standards Review Committee reviews every
actising domiciliary midwife annually. The inclusion of
nsumers on that Committee ensures that the profession
mains accountable to those it seeks to serve. I understand
at the College intends to extend that monitoring system
to area health boards.

e international statistics bear out my confidence that if
ything the quality of care given to the women and her child
ll increase from the changes the Bill makes. Two
dicators of the quality of midwifery care are the perinatal
rtality rate and the child's birth weight.

recent WHO survey commented:

> "The midwife is the preferred birth attendant at uncomplicated births. Those countries in the world which have the lowest perinatal mortality rates - the Scandinavian countries and the Netherlands - have the

No benefit in treating essential hypertension in early pregnancy

Researchers from Stobhill General Hospital, Glasgow, have shown that atenolol given from the end of the first trimester to pregnant women with mild essential hypertension is associated with intrauterine growth retardation. The authors suggest there is no apparent advantage to treating mild essential hypertension in pregnancy and recommend avoiding the use of a ß-blocker in early pregnancy.

It is unclear whether mild to moderate essential hypertension should be treated during pregnancy. One study showed a benefit in pregnancy outcome among patients treated with methyldopa so a study was undertaken to assess whether BP lowering per se was responsible for improved outcome. Atenolol reduces perinatal mortality among women who develop hypertension in the third trimester. This agent was compared with placebo in 29 eligible pregnant women with mild essential hypertension.

Fifteen patients were randomised to double-blind treatment with atenolol to a maximum of 200mg daily and 14 to placebo. BP dropped from around 145/86 to 136/81 mm Hg in the placebo group and to 132/74 mm Hg in the actively treated group (significant for diastolic BP only in the atenolol-treated group).

Babies of atenolol-treated mothers weighed significantly less than those of placebo-treated mothers (2620 versus 3530g). Ten in the former group were below the tenth centile for weight while only one baby in the placebo-treated group was below the twenty-fifth centile. By the time infants were one year old growth differences had resolved.

Placental weights were also significantly less in the actively treated group (442 versus 635g). No explanation for these differences was forthcoming. There was one stillbirth which occurred in an atenolol-treated patient. The woman had previously had a stillbirth.

Early studies implicated beta-blockers in intrauterine growth retardation but prospective studies showed no such association, until this study. It is possible that BP was excessively lowered in the group treated with atenolol since their baseline BP was only slightly elevated. This may have impaired fetal perfusion. However, women in other studies started off with similar BPs and had similar reductions without affecting the fetus, which suggests either the long duration of treatment or atenolol was the cause of growth retardation.

Butters L, et al. BMJ 301:587-589, 22 Sep 1990

QUOTES

* Society is a mule, not a car ... if pressed too hard, it will kick and throw off its rider.
* Any time things appear to be going better, you have overlooked something.
* Don't care if you are rich or not, as long as you can live comfortably and have everything that you want.
* The probability of anything happening is in inverse ratio to its desirability.
* Everything put together falls apart sooner or later.

THE HUTT DISTRICT BIRTHING UNIT

The Hutt District Birthing Unit, sited in part of the former Elderslea Maternity Hospital building in Upper Hutt, was officially opened on 3 December 1990.

The Birthing Unit provides an innovative, out of hospital, birth setting. *It offers women another choice* for their childbirth experience.

The Birthing Unit is specifically for those women not wishing to go to hospital, *where it is anticipated an uncomplicated pregnancy will be followed by a normal delivery and who have adequate home support* to enable them to return home very soon after delivery.

Length of stay after a woman has delivered is a few hours only. If she delivers during the night, she stays until morning etc. She goes home once the midwife assesses her to be well enough.

An advantage of using the Birthing Unit is the *continuity of care*. I visit women at home antenatally to ensure they meet the established criteria for acceptance to deliver at the Unit. I then visit them several times throughout their antenatal period, building up a relationship between us. Once labour commences, I either go to the woman's home or meet her at the Unit, depending on how her labour is progressing. I support the woman during her labour and delivery in partnership with her GP, and discharge her home afterwards. I have also applied for an access contract to enable me to care for women independently. Several home visits are made during the early postnatal period.

I can be contacted over 24 hours/7 days a week via the *Hutt Hospital operator (666-999); telepage*. If I am absent for any reason, a replacement midwife will be available through the same process.

Once a woman expresses a desire to deliver at the Unit, she either contacts me directly or is referred on by her GP. I then visit her at home to book her in and discuss the Birthing Unit concept.

The first baby was delivered at the Unit early in January. All went very well and mother and baby went home 5 hours following the birth.

Christine R Griffiths, RGON, RM, ADN
Charge Midwife
Hutt District Birthing Unit

are in essence anti-competitive, there is certainly a strong argument to be mounted against the monopoly of registered medical practitioners in taking full responsibility for the supervision of childbirth.

My Labour colleagues agreed with me that the case for restoring the autonomy of midwifery was strong. With their support I introduced to Parliament last November a simple two clause bill, the Nurses Amendment Bill, which aimed to enable midwives to take responsibility for the care of women throughout their pregnancies, childbirths, and the post natal period.

At the time of its introduction I said:

> "In recent years there has been a consistent message from various groups and organisations that childbirth is a natural process, and that a woman should be able to choose to have a midwife deliver her baby without the need for a woman to also be under the care of a medical practitioner."

The Bill was given its first reading and referred to the Social Services Select Committee. It received 96 submissions, and they were generally supportive. Many stressed the importance for women of having birth choices; the importance of recognising that birth is a natural process; the advantages to rural women which enhanced midwifery services could offer; and the improvements which could be made generally in birthing services if midwives were allowed to operate autonomously.

Some submissions while professing support for autonomy raised the question of whether the safety of the mother and the child could be guaranteed by the change in the law. Others expressed reservations about the adequacy of midwifery training and accountability. While those concerns would merit serious attention if they were well based, it is my judgement that they are not.

Since that time midwives in New Zealand have been
to undertake responsibility for delivery without the
rision of a medical practitioner.

a firm believer that childbirth is a normal and natural
is for most women. Having a baby is not an illness. It
normal physiological process which for centuries was
l as such. I know it is the experience of many women
hile childbirth was not necessarily an easy time,
eless it was one of the most empowering, wonderful, and
.ling experiences of their lives.

sad but true that the advent of modern technology and
:ccompanying trend towards institutional care in
)irth has led to pregnancy and labour being treated as
y were illnesses. The inevitable result is more
ention in the management of a normal pregnancy. For
omen, rather than feeling empowered, they and their
rs have felt that their choices in childbirth have been
ly limited. For most women there has been little real
about the kind of birthing option open to them.

rstand that 85 per cent of births are regarded as
.. They do not require medical intervention as a matter
rse. As midwives you are educated to give the
ary supervision, care, and advice to women prior to,
ring pregnancy, labour, and the post natal period, to
t deliveries, and to care for the new born and the
. You should be able to take full responsibility for
rk for which you are educated.

became Minister of Health last year I had the
unity to do something about the injustice which I
er the loss of autonomy for midwifery to be. I began
estigate how a change to the law might be made. I
ered surprising allies. Even the Treasury could see
in increased autonomy. And if we look at the problem
he perspective of those officials who have been charged
ernment with reviewing restrictions on practice which

FUTURE EVENTS

14, 15, 16 March: *Vision 2000, Project 1991*
National Planning Forum for Nursing and Midwifery Education

13 & 14 April: *Midwifery Workshop; Manuatu Workshop*
Palmerston North

April/May: *Sheila Kitzinger*
The world's most renowned author and speaker on childbirth issues will be touring Australia in April/May 1991. Plan now to attend events featuring this exciting and charismatic woman.

Itinerary:

	Public Lectures	Workshops
Perth	Friday 26 April	Saturday/Sunday 27/28 April
Adelaide	Monday 29 April	Tuesday 30 April
Melbourne	Friday 3 May	Wednesday/Thursday 1/2 May

(A 3-day conference will be held 3/4/5 May in Melbourne)

Brisbane	Monday 6 May	Tuesday 7 May
Sydney	Friday 10 May	Wednesday 8 May Saturday 11 May

Full details will be mailed in February 1991. If you wish to be on the mailing list please send a .43¢ postage stamp (not a stamped addressed envelope) with your name and address to: Capers, 177 Buckland Road (PO Box 567), Nundah, Qld 4012, Australia. Tel: 07-266 9573. Fax: 07-260 5009.

17, 18, 19 May: *1991 National Homebirth Meeting* (in Nelson)
Thursday pm Domiciliary Midwives Meeting.

21-25 May: *4th International Congress for Maternal and Neonatal Health.* Port-au-Prince, Haiti.
Contact: President, Professor Jean Boisrond, Mères et Enfants d'Haiti, Angle de Rues St Honoré et Monseigneur Guilloux, Port-au-Prince, Haiti. Tel: 50 91 22 760. Fax: 50 91 56 857.

15-17 July: Centre for Nursing Research Inc. (in collaboration with the Royal College of Nursing, Australia)

First International Conference - Nursing Research : Pro-active vs Reactive
St Peter's College, Adelaide, South Australia.

Enquiries to: Ms Helen Smyth, Executive Officer, Centre for Nursing Research Inc, Bedford Park, South Australia 5042, Australia. Tel: 08-275 9911 Ext 5032. Fax: 618 275 9450.

28 July - 1 August: *XIV Soroptomist International Convention*
The health workshop will be devoted to Safe Motherhood.
Contact: The Programme Liaison, c/- Soroptomist International Headquarters Office, 87 Glisson Road, Cambridge CB1 2HG. Tel: 44 223 311833. Fax: 44 223 467951.

15-20 September: *Symposium on Professional Training for Safe Motherhood at 13th World Congress of Gynaecology and Obstetrics (FIGO).*
Contact: Congress Secretariat, c/- Department of Obstetrics and Gynaecology, National University Hospital, Lower Kent Riddge Road, Singapore 0511, Republic of Singapore. Tel: 65 777 0313 or 65 775 4420. Fax: 65777 3121.

EMBARGOED UNTIL DELIVERY

SPEECH NOTES

RT HON HELEN CLARK
DEPUTY PRIME MINISTER AND MINISTER OF HEALTH

ADDRESS TO OPEN THE NEW ZEALAND COLLEGE OF MIDWIVES NATIONAL CONFERENCE

SATURDAY 18 AUGUST 1990 AT 10:30 A.M
AT KNOX COLLEGE, DUNEDIN

Thank you for the invitation to address your national conference here in Dunedin this morning.

As many of you will know I have long had an interest in midwifery. That interest has not arisen from personal experience, as by choice I have never become a mother. Rather it has arisen from my interest both in how women's occupations are valued and the status they are accorded and in the way in which the treatment model came to dominate our health services. Midwifery has had to battle for recognition not only because it offers a different philosophy and perspective on one part of our health service delivery, but also because as a female dominated occupation it suffers from the inequitable treatment common to other such occupations throughout the workforce.

History records that midwifery is an ancient and honourable profession. Reference to it can be found in the records of ancient Greece. Socrates mother was herself a midwife. Midwives were the the primary care givers to expectant mothers until the 1700s when medicine entered the realms of midwifery. Throughout the twentieth century midwives' work has increasingly been concentrated in hospital settings, where the medical model is dominant.

The effect has been to intrude a great deal on the midwive's autonomy. The final blow came with the change to the law in

ıe next few days we will expand and reinforce our knowledge on the theories ıvern our practice. Consumerism and feminism are the corner stones to ary philosophy although many midwives would not think to label it as such.

re to the theoretical analysis of why we do what it is we do gives us an insight) resistance that we meet every day from hierarchies within the health system. empowers us to provide ways in which to change attitudes and practices which ıh women's control. Midwives and consumers from all over New Zealand and lia and Samoa and Hong Kong will be giving all of us the benefit of their nce throughout the conference and we also are privileged to welcome midwife pants from Australia, Maria Kooslak from Samoa, and Ruth Wong from the ı Hong Kong. Welcome, we are pleased that you could come and join us for hree days. Marsden Wagner, director of Maternal and Child Health for the Health Organisation, will direct and update us on international maternity s as we go into the 90s. He has only been in New Zealand for a week and the ine is already telling me he has created quite a stir. Keep it up Marsden.

ınference Committee has done us proud in their gigantic efforts to bring the ence all together. We have a programme where there is something for ıe and I am looking forward to the debate, the laughter, and the learning.

ire that you all are too.

nai, haere mai, haere mai.

5-8 November: *1st International Congress of Perinatal Medicine (ICPM)* on *Care of the Mother, Fetus and Neonate.*
Contact: Congress Secretariat, ICPM, c/- Japan Convention Services, Inc, Nippon Press Center Building, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan. Tel: 813 508 1213.

14-17 June 1992: *Reproductive Life*
10th International Congress of Psychosomatic Obstetrics and Gynaecology
Contact: Congress Secretariat, CONGREX, International Society of Psychosomatic Obstetrics and Gynaecology (ISPOG) - 92, PO Box 5619, S-114 86 Stockholm, Sweden. Tel: 46 8 32 69 00. Fax: 46 8 32 62 92.

Women & AIDS: An International Handbook

Edited by: Marge Berer

Projected publication date: September 1992 (English), January 1993 (Spanish & French)

A CALL FOR INFORMATION AND MATERIAL

You are invited to become involved in the preparation of an international handbook on women & AIDS. The handbook will be for women, women's groups and organisations, NGOs and other agencies, many of whom want and need to know more about how AIDS affects women and what women are doing about it all over the world.

The handbook will contain information on: patterns of infection among women in different regions; how women get and transmit HIV and how this can be prevented; HIV and other sexually transmitted diseases; counselling and testing of women for HIV infection; the consequences of HIV for women's sexual lives and relationships; HIV and pregnancy, birth control and abortion; women's roles as carers for themselves and others with HIV/AIDS, as health care workers and as sex workers; the many education, support, self-help, counselling and training programmes and services that exist for women; discrimination against women with HIV; and what agencies, networks and resources there are for women internationally.

Contributions of the following kinds of existing and original material for the handbook are welcome -- personal histories and experiences; leaflets, pamphlets, books, papers, research; cartoons, posters and other visuals; transcripts of taped interviews, counselling and discussion sessions; training and educational materials; guidelines for women and health care workers; descriptions of groups, projects, services, resources, networks and training programmes for women; laws and policies affecting women; and medical information about HIV/AIDS in women.

For further details and to contribute material, contact: Marge Berer, PO Box 16801, 1001 RH Amsterdam, Netherlands, tel. (31-20) 235005.

MANAWATU POLYTECHNIC
ANNUAL NATIONAL MIDWIVES WORKSHOP
12-14 April 1991

This workshop focuses on reviewing the context of present midwifery practice as well as examining and encouraging the ongoing development of midwifery. Organised by midwives for midwives, it will be relevant to both hospital-based and community-based midwives.

PROGRAMME

Friday 12 April

6.00pm - 7.00pm
Registration

7.00pm - 9.00pm
Dr Michel Odent
Internationally acclaimed
visiting obstetrician

Saturday 13 April

Commencing 9.00am
Registration

Speaker:
Karen Guilliland
President N.Z. College of Midwives

Speaker:
Hon. Katherine O'Regan
Assistant Minister of Health

Lunch provided

Saturday Afternoon and Sunday Morning 14 April

Selection of Workshops
- Essential Teaching Skills
- Clinical Midwifery Skills
- The High Risk Consumer
- Independent Practice
- Natural Approaches
- Midwifery Research
- AIDS/HIV
- Challenges in Antenatal Care
- Cultural & Consumer Perspectives

Sunday Afternoon
Report back/Future directions
Participants may choose from the variety of workshops offered. All workshops offered onSaturday afternoon will be repeated on Sunday morning.

An exhibit area will be included for the first time in association with this workshop.

Lunches, am and pm teas and evening meal on Saturday have been included in the cost of the workshop.

Annual National Midwives Workshop
12-14th August 1991

Name: _____

Address _____

Phone: (Bus) _____ (Pvt) _____

Current Position: _____

I require:

A billet	YES/NO	Air NZ/Ansett discount voucher	YES/NO
Transport to meet me at the airport	YES/NO	Discounted Motel/Hotel information	YES/NO

☐ Enclosed is my cheque for $120.00

Post to
Nursing and Health Studies Department
Manawatu Polytechnic
Private Bag,
Palmerston North Ph (063) 65030

midwife

nationally. We are aware that it is also a western world first and we should be proud of our progress. The majority of regions have consumers on their committees of management, and there are three consumers on the National Committee representing Parents Centre New Zealand, La Leché League, and Maternity Action Alliance.

Midwives in the community have also involved consumers in their Standards Reviews Committees, where there are equal numbers of consumers to health professionals. Midwives report to these committees on an annual basis and their work is reviewed. The midwives' clients can be present during the review if they so wish. The Treaty of Waitangi is based on the principles of partnership and community. The Maori define health as a state of harmony between the mental, physical, emotional, spiritual and family dimensions of the individual, the race, and the land. Midwifery is grounded in similar beliefs and midwives play a major role in providing the environment for women to realise their expectations of themselves. This partnership protects us both. It gives the woman control over her birth experience, which in turn decreases intervention in her progress. Non-intervention in a normal birth is the single most significant factor in achieving a successful outcome for both the mother and the baby, and Marsden will be talking at length about this, I should imagine.

It is a result of this partnership that we meet here today as a College. Consumer groups involved in childbirth have been lobbying for the return of the traditional midwife for years.

Groups such as the Homebirth Association, Parent Centre, Save the Midwife and Maternity Action Alliance have believed in our role even through our rough patch over the last forty years or so.

It is a tribute I believe, to the midwifery profession, which recognised their status will always principally be dependent on providing a service that women want and with which they feel safe. Status attached to degree programmes and acceptance by other health professionals is only worth persuing in the presence of this client satisfaction.

Finally however, our tribute must go to Helen Clark and I am sorry she's not here, she should be here by about 10.30. A Minister of Health with vision. It was her belief in us and her insistence on the introduction of the Amendment against a strong medical opposition which made it a reality, and when the Minister arrives this morning we will personally be able to thank her for her commitment. I think she needs some encouragement in this time, politics is fairly rough. I think it would be nice that she has the feeling of the meeting go with her.

ankfully some midwives were listening. This questioning of the stat
the beginning of this College.

rmation of the College legitimises our profession, it gives us, mi
ner alike, a focus, a place to cement ideas, to formulate plans for
e, and promote the maternity service women want and deserve.

inguishes us as a separate entity to nursing and make no mistake, t
ly way midwifery survives in a profession in its own right.

the passing of the Amendment Bill hopefully within weeks, we
ndent practice despite the nursing profession, not because of it. Mic
ccess to hospital beds, laboratory and diagnostic services, prescrib
aternity benefits. This autonomy from the medical profession is not a
. In fact, the nurses association historically, if not presently, h
t midwives moves to gain independence. One example of this recen
archives, was a letter from the Department of Health, where they p
lea that midwives could notify birth and death services as the
ately involved with that and the NZNA actively opposed that mo
ent that that was actually delegating a Doctor's duty.

ext logical move to ensure women's choices in the midwives survival i
lucation. To control one's education is a prerequisite for a profes
t afford to depend on the nursing profession for our existence. Di
fery must be our goal if we believe childbirth is a normal life process.
ts amongst us who thought they could rest, now independence is in si
t is the Minister of Health who has now challenged us. She has taker
that we are experts in normal childbirth. As you are all aware there
ense lobby by the medical profession and some nurses I might add, w
not capable of meeting this challenge.

lobbering machine is a powerful force and midwives need to be u
ent in their abilities if we are to resist. A three year women's centr
ed on pregnancy and childbirth is a powerful way to maintain our e
so got the confidence of the consumer. We must constantly remind ou
ilosophy under which this college was founded - that our power base
omen and their families. We have involved these consumers u
mental belief that we are a partnership and include the people for
le the service at policy and decision making level, both regio

Domiciliary Midwives Society of New Zealand.

Secretary: Bronwen Pelvin

Westbank Road
R.D. 1
Motueka

Phone: (0524 68) 722

Welcome to the first pages of news for domiciliary midwives (and other midwives, too!) to be included in the NZCOMI newsletter. We decided to do it this way at our annual meeting in May, 1990 and as our next meeting is almost upon us in May this year, I decided I'd better get something in print!

..... Thursday, May 10th, 1990 saw 23 domiciliary midwives from all over New Zealand meet in Whangarei prior to the Home Birth Conference. We were joined by two student midwives and one or two other interested attenders. The majority of the time was taken up with reports from all the areas represented. Midwives were continuing to have the same problems with bureaucratic obstruction in both applying for and continuing to work under their domiciliary contracts. There were continuing problems with obtaining medical cover for births and most DMs were looking forward to the change in the law although a number of midwives expressed anxiety about working "on their own." Midwives reported improving relationships with their hospital counterparts which they attributed in part to the existence of the College and working together for midwifery autonomy.

..... Strong feelings were expressed that the Domiciliary Midwives Society continue in its present form although the need for it as a body to speak on behalf of midwives was lessened by the formation of the College. It was felt that the DMS would function as a support group and lobby group for midwives involved in home birth. It would also have a role in protecting midwives attending home births as they were often isolated practitioners and more vulnerable to criticism and attack from the 'system'.

..... It was agreed that we pay Alex Gillanders for his compiling of the home birth statistics and this cost would be met by the Home Birth Associations at $5/stats form.

..... All present agreed to the value of the meeting to share our various situations and that meeting again in November would be a great idea.

..... So we did!! 18 midwives plus one student gathered at Riverside Community, Lower Moutere for a weekend of serious talking, eating, a bit of drinking and a lot of laughing. Great celebration at the change in the law. And with it, many, many problems.

..... The major ones related to the processing of claims. Seemed to be processed on the whims of the clerks in the Benefits Payments Offices. All present agreed that there needed to be a meeting of all parties - midwives, doctors etc - at Health Department level to get this sorted out. There also needed to be some acknowledgement in the benefit structure of the difference between medical attendance at childbirth and midwifery attendance. Concern was expressed over the prolonged attendance fee as this could be used to make midwives look uneconomical. There was confusion over which claim form should be used as midwives in different areas had been instructed differently. For all claims for payment after September 8th, Form H554 should be used.

..... Discussion on the idea of apprenticeship for new midwives . Most were in favour of this; wondered if the direct entry training programme would change the amount of 'unlearning' required before practising outside of an institution. Agreed that the DMS should work at putting out a booklet to help midwives in setting up to do home births. It was pointed out that all midwives needed to have a friendly lawyer as part of their support network so that they are aware of their right to practise.

..... We discussed the principles involved with decision making with our clients and the responsibility this placed on the midwife to give information and to be honest in her opinion on an any situation that arises. This included what to do when clients

Conference Proceedings

Welcome by Karen Guilliland

Haere mai, Haere mai ki runga e tena marae e te iwi tena koutou te kura tae mai rai ten e rua o ha kouru e toru toru a kune kupu kanu te mihi

Haere mai, haere mai haere mai tena koutou ta kuhe.

Welcome, welcome to this marae people greetings to you who have come today, although my words are few in Maori my greetings are very many. Welcome, welcome, welcome. Welcome everyone to the first New Zealand College of Midwives Conference. Consumerism, feminism and midwifery are the themes and we intend to examine this trilogy in detail. I have a letter from the Chief Nursing Officer and I will read that out to you as well.

> **"It seems like only yesterday that I attended the celebration that marked the establishment of the New Zealand College of Midwives. In the ensuing year the College has achieved a tremendous amount. It is a real credit to the energy, enthusiasm and skill that you and your colleagues possess. I would appreciate it if you could pass my good wishes on to the Conference, both professionally as Chief Nursing Officer in New Zealand, and personally as a new mother who has very recently received sensitive and skilled midwifery care. My very best wishes for a stimulating conference, regards Sheryl Smaill."**

In Auckland 1988 Joan Donnelly, OBE - I've been dying to say that Joan - threw out the challenge to midwives to form their own professional body and in the emotion of the moment, 52 midwives and women pledged their name and their money to the concept of a College for Midwives. A working party of both midwives and consumers was set up at that conference immediately and in April 1989 the College was officially borne.

Two years from conception we gather here in Dunedin, an established and creditable group of people with a membership of nearly 1,000. How did we achieve this? There is a Yiddish proverb which says, don't ask the Doctor, ask the patient, and this is what we did. Under the medicalised maternity service of the last 40 to 50 years, we often forgot the individual patient. While we were studiously caring for the special features of the disease, that is in this instance, pregnancy and childbirth, we forgot that a well woman is the expert on herself. As nurses, we asked the Doctor what they wanted instead. It was the women themselves who started questioning this approach

THE NEW ZEALAND MATERNAL DEATHS ASSESSMENT COMMITTEE
(UNDER THE MORTALITY RESEARCH ACT 1968)

Chairperson
Professor Dr Aicken
Department of Obstetrics and Gynaecology
Christchurch School of Medicine
Christchurch Women's Hospital
Private Bag
CHRISTCHURCH
Phone (03)644-638
Fax (03)644-634

Secretary
Department of Health
P O Box 5013
WELLINGTON

January 14, 1991

The Secretary
New Zealand Royal College of Midwives
P O Box 7063
Wellington South
WELLINGTON

Dear Madam

The Maternal Deaths Assessment Committee has recently been reconstituted. The notification of maternal deaths have been incomplete during the process of review, particularly the years 1989-90. Under the terms of the Maternal Mortality Research Act 1968, practitioners and pathologists are obliged to refer deaths that occur during or within three months of pregnancy. The appropriate method of notification is through the local Medical Officer of Health, who may be contacted through each area health board.

It is anticipated that a midwife will be appointed to the Committee in early 1991.

Following each assessment meeting a newsletter is produced and will be sent to midwives. The method of distribution will be discussed with your organisation at a later date.

Although midwives are not legally bound to report maternal deaths, the Committee would like to encourage midwives to do so. The Committee would appreciate you letting your members know about the reconstitution of the Maternal Deaths Assessment Committee and its work. Thank you very much.

If you have any queries please contact either myself or the Chairperson of the Committee.

Yours sincerely

Geraldine

Geraldine O'Connor
Secretary

made decisions which differ from our preferred option and the midwife's responsibility to continue midwifery care. We discussed how case loads in any area could be 'shared' among the midwives - there was some anxiety about there not being enough work to go around. The view was expressed that each time a midwife set up to do home births she gradually attracted her own clientele to home birth. We looked at ways that midwives can ensure that they get the 'energy' and nurturing that they need to continue doing such a demanding job without 'burning out'. We also discussed specific midwifery situations: water birth, lotus birth, VBAC, unexplained infertility, artificial insemination, prolonged labours, anterior lips etc, etc, etc.

.....

NEXT MEETING FOR DOMICILIARY MIDWIVES:

Prior to the Home Birth Conference
May 17th, 18th & 19th in Nelson.

At Riverside Community, Lower Moutere, NELSON.

Commencing: 8pm, Thursday, May 16th, 1991
and continuing to
4pm, Friday, May 17th, 1991
then joining with the Home Birth Conference.

Regards to all,
Bronwen

1991

NEW ZEALAND HOME BIRTH CONFERENCE

"Home Birth: Every Woman's Choice"

To be held at :

Bridge Valley Christian Ranch,
Nelson.

On : May 17th, 18th and 19th, 1991

For information and registration forms, write to:

Brenda Wraight,
Orinoco,
R.D. 1,
Motueka.
Phone: (0524 68)820.

THE TROUBLE WITH WOMEN
The Story of Parents Centres New Zealand
by Mary Dobbie

This is an absorbing account, packed with anecdote and human interest, of the Parents Centre movement throughout New Zealand.

From its beginnings in Wellington in 1952, when Helen Brew's vision and drive brought about the first antenatal classes, to the New Zealand-wide selection of parenting activities and support services which Parents Centre now offers, this is a fascinating story.

Every parent should look back to the days, less than 40 years ago, when a woman who wanted her husband's support in labour was labelled "a communist!"...To when parents were forbidden to visit their sick children in hospital for more than an hour once a week...To when babies belonged to the hospital, not to their parents...

There's humour and political action and superb vignettes from the recent past in this name-packed chronicle of Parents Centre New Zealand. With 24 pages of photos, it's an excellent gift, and a book for all parents.

The Trouble With Women, by Mary Dobbie, is published and sold by Cape Catley publishers in association with Parents Centres New Zealand.

Retail Price $25 per copy
Special Price to Parents Centre Members: $20 per copy

ORDER FORM: Return to **Cape Catley Enterprises**
P.O. Box 1
Collingwood

Please supply ..... copies of **The Trouble With Women**

By mail/freight to:

Enclosed cheque for ..... copies @ $25 $.....

Enclosed cheque for ..... copies @ $20 $.....

OUTLINE OF COURSES

COURSE ONE

Thursday 14 February 7.30 - 9.00

• THE RECONSTRUCTED FEMALE

Sandra Coney

Cosmetic surgery, liposuction and hormone replacement therapy are holding out the promise to aging women that they can stop the clock, but how ethical is this and what does it say about the way society regards older women? This session will look at the underlying meaning of the reconstruction industry and the risks of the techniques it offers.

Thursday 21 February 7.30 - 9.00

• NEW DIRECTIONS FOR MIDWIVES

Joan Donley

Midwifery is currently undergoing a renaissance in this country with the changes to the Nurses Act giving midwives the right to practice as independent practitioners and the introduction of Direct Entry Midwifery courses. This session will chart the historical precedents for these changes and outline possibilities for the future.

Thursday 28 February 7.30 - 9.00

• MAORI WOMEN'S HEALTH

Waireti Walters

The well being of Maori Women: her relationship with Papatuanuku, the earth; with Tane, and the role of man; with Uenuku, the Rainbow God, with its colours representing the services to Maori women and the choices Maori women have; with the environment, Turea - the environment of women, her relationship with the other.

Thursday 7 March 7.30 - 9.00

• ABORTION - THE FIGHT GOES ON

Ruth Hemmingsen

The right to safe legal abortion has long been a cornerstone of the women's health movement. Even though New Zealand has relatively liberal abortion laws, these cannot be taken for granted. This session will discuss the future of abortion services and the possible impact of new developments in abortion technologies such as the abortion pill, RU 486.

Thursday 14 March 7.30 - 9.00

• PREVENTING OSTEOPOROSIS - FOR WHOSE BENEFIT?

Ruth Bonnin

Thinning bones can lead to fractures as people age, especially women who lose oestrogen after the menopause. Current medical preventive strategies favour a high tech approach involving costly screening techniques and the widespread use of hormone replacement therapy. This session will discuss how big a public health problem osteoporosis is, and review the evidence for the effectiveness of proposed screening and prevention strategies.

Thursday 21 March 7.30 - 9.00

• WOMEN AND MADNESS - MENTAL

COURSE TWO

Thursday 4 April 7.30 - 9.00

• DEPO PROVERA: NEW ZEALAND'S LIVING LABORATORY

Sandra Coney

New research has once again called into question the safety of this controversial injectable contraceptive. This session will review Depo Provera's history in New Zealand and overseas, outline recent research findings, and discuss what the future might hold for the drug. The American film The Ultimate Test Animal will be shown. (Note longer session time).

Thursday 11 April 7.30 - 9.00

• PATIENT ADVOCACY

Lynda Williams

An examination of how the concept of patient advocacy at National Women's Hospital has changed over the past 18 months. Topics covered will be the response of the hospital and the Auckland Area Health Board to the service and the future of patient advocacy in New Zealand.

Thursday 18 April 7.30 - 9.00

• A CERVICAL SCREENING PROGRAMME FOR NEW ZEALAND

Ruth Bonnin and Sandra Coney

New Zealand is about to embark on a national cervical screening programme. This session will summarise the history of the programme, look at the epidemiology of cervical cancer in New Zealand, discuss unique aspects of the local scene and examine how national policy will address these issues. This will be a useful session for any nurses or others involved in providing or organising cervical screening.

Thursday 25 April 7.30 - 9.00

• THE UNFORTUNATE EXPERIMENT

Cheryl Hamilton and Lynda Williams

A review of the progress made or not made in the implementation of the Cartwright Report. How have the medical profession, AHBs and the Medical School responded? This session will look at what still needs to be done both locally and nationally. The ABC Four Corners programme The Unfortunate Experiment will be shown. (Note longer session time).

Thursday 2 May 7.30 - 9.00

• NEW VIEWS OF HYSTERECTOMY

Lynne Giddings and Lyn Porter

Lyn Porter will discuss the results of research into the most commonly performed major gynaecological surgery, including the rarely discussed problems of ovarian failure and sexual turn-off. Lynne Giddings will outline the results of the New Zealand Woman's Weekly survey of women who had hysterectomies.

REGISTRATION

I wish to register for Course One ☐ Course Two ☐

Name .....

Address .....

.....

Phone/Home ..... Work .....

Please find enclosed $ ..... ☐ VISA ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Return with payment to

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Herne Bay
Auckland

expiry date .....
signature .....

HOME BIRTH NATIONAL NEWSLETTER
Subscription 1990-1991

NOW DUE

Name(s) .....

Address .....

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Please find my subscription fee attached

☐ $12 ☐ $15 ☐ $20 ☐ Donation

Send to: *National Newsletter*, c/- Hetty Burger, 34 Nottingham St, Karori, Wellington, tel. 766-661

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or as a gift subscription for a new mother or for someone who has moved on from Home Birth but still wants to keep in touch.

INTERNATIONAL CONFEDERATION OF MIDWIVES RESEARCH CONFERENCE
The Netherlands, 13-15 March 1992

The International Confederation of Midwives are pleased to announce that their first research conference will take place at Koningshof Veldhoven, near Eindhoven in the Netherlands, in March 1992.

The scientific programme of the Conference will address the current interests and concerns in the field of Midwifery and will comprise plenary invited lectures, concurrent sessions consisting of proferred abstracts, and posters.

Key issues to be discussed are detailed below :

* Recent research in midwifery internationally
* Re use of research in midwifery practice
* Creating networks between researchers
* Communication between researchers & practitioners

The Conference will take place at Koningshof, a Congress Hotel and Meeting Centre set in 79 acres of woodland near Eindhoven in the Netherlands.

For further information regarding the Conference please return the coupon below to the Conference Secretariat, Conference Associates ICMRC, Congress House, 55 New Cavendish Street, London W1M 7RE, United Kingdom, Telephone : 071 486 0531, Telefax : 071 935 7559.

March
1992

Please send me further details regarding the International Confederation of Midwives Research Conference, 1992

Name .....

Address .....

Please forward fee and registration form to:

School of Nursing and Midwifery,
Auckland Institute of Technology,
Private Bag,
Auckland

Please make cheques payable to:

Nursing Forum

Organising Committee

Marie Burgess	Nursing Council of New Zealand
Beryl Davies	NZ College of Midwives
Ray Wootton Susan Jacobs Merian Litchfield Margaret Horsburgh	Nurse Educators in the Tertiary Sector (NETS)
Joy Bickley	NZ Nurses' Association
Sheryl Smail	Department of Health
Denise Hutchins	Chief Nurses' Association

ACCOMMODATION

BILLETS

Some billets will be available. Please tick appropriate box on the registration form if you would like a billet. Details will be forwarded to you.

AUCKLAND HOSPITAL: HUIA RESIDENCE

Those wishing to reserve accommodation should contact:

Huia Residence
Private Bag
Auckland Hospital
Auckland 1

Tel: (09) 771-345 or 771-275

- Single room - $25 per night
- Double room (2x single beds - only a limited number available) $35 per room
- Plus: $20 bond (refundable) for entrance card
- Plus: $2 breakfast - optional

NOTE: The document produced on Day Three of the conference will be forwarded to all those who attended the first two days of the conference.

VISION 2000: PROJECT 1991

A forum to develop a national framework for nursing and midwifery education with targets guidelines and strategies and to establish shared ownership of education targets.

ALL WELCOME

VENUE:
Auckland Institute of Technology
Akoranga Drive
Northcote
Auckland

DATE: Thursday 14, Friday 15, Saturday 16, March 1991
Day 1: The Issues
Day 2: Strategies
Day 3: A group of invited participants will develop a framework (for publication).

PROPOSED PROGRAMME

Day 1 - THE ISSUES

Thursday 14 March 1991

8-8:30 Registrations
Powhiri
Conference Opening: Politician

Tea

Panel: Overview from interests outside nursing

Lunch

Speakers and Workshops to address the three main forum themes.

1) Entry into nursing/enrolled nursing/ midwifery - includes the image of nursing and the needs of service.

2) The educational process; both basic and post-basic, including university education.

3) Transition from education to practice.

Tea (Time to be allocated)

Please include your name + address

PROPOSED PROGRAMME

Day 2 - STRATEGIES

Friday, 15 March 1991

Registrations
Politician
Panel 1: The need for a national framework
Department of Health
Ministry of Education
Nursing Council of New Zealand
New Zealand Qualifications Authority

Tea

Panel 2: A national perspective
NZNA
National Council of Maori Nurses
NZ College of Midwives
National Action Group

Lunch

Workshops

Tea

Plenary Session (completed by 4pm)

Day 3: THE FRAMEWORK

Saturday, 16 March 1991:

A small invited group will put together a framework reflecting the findings of the forum.

REGISTRATION FORM

Please complete and return with fee, by Monday, 4 March 1991 to (see over)

1. Please identify from the following list, your current area of interest and expertise (in order to facilitate the organisation of the conference)

EDUCATION:
- Student ☐
- Tutor ☐
- Management ☐

SERVICE:
- Midwife ☐
- Nurse ☐
- Enrolled Nurse ☐
- Management ☐

OTHER: _____

(members of the public are welcome)

2. Do you require a billet?
No ☐ Yes ☐

3. If so, which nights? _____

4. REGISTRATION FEE:
Two days $100 ☐
One day $60 ☐
(please indicate which day)_____
(fee includes lunches, morning and afternoon teas)

5. Please indicate your interest in attending a dinner on Thursday evening (cost will be no higher than $22)
No ☐ Yes ☐