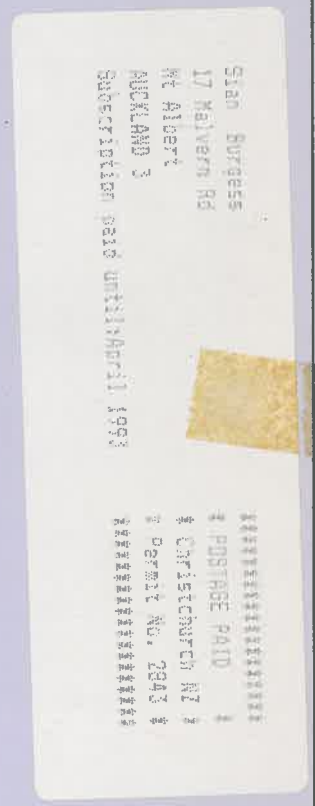
From : The New Zealand College of Midwives (Inc)
P O Box 21-106
Christchurch NEW ZEALAND



NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

SEPTEMBER/OCTOBER1992

Conference Reports

Annual Reports

VITAMIN K ISSUES

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
National Midwifery Resource Centre
1st Floor 183 Manchester Street Christchurch
Telephone 03-377-2732

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CONSUMER REPRESENTATIVES

Rea Daellenbach	Maternity Action Alliance
Anne Woodley	Parents Centres (NZ)
Debbie Stewart	Home Birth Association

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
MEMBERSHIP APPLICATION FORM

NEW	
RENEWAL	
CHANGE	

REGIONAL INFORMATION

Name _____

Address _____

Telephone _____ Home _____ Work

Workplace _____

Date of Birth _____ ARE YOU CLAIMING MATERNITY BENEFIT? YES/NO

TYPE OF MEMBERSHIP

Full Membership (Waged)	$120.00	} Includes
Full Membership (Unwaged)	$ 40.00	} Indemnity
Full Membership (Students)	$ 40.00	} Insurance
Associates & Affiliates	$ 25.00	

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)

NATIONAL INFORMATION

Name _____

Address _____

Telephone _____ Home _____ Work

Workplace _____

Date of Birth _____

TYPE OF MEMBERSHIP
Full Membership (Waged)
Full Membership (Unwaged)
Full Membership (Students)
Associates & Affiliates

ARE YOU:	
Claiming Maternity Benefit?	YES/NO
A Member of NZNA?	YES/NO
A Member of NZNU?	YES/NO

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)

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

Midwives establish own peer review committees

BY LYN HUMPHREYS

Independent New Plymouth midwives have set up their own review committee to make themselves accountable to patients and peers.

Spokesperson Trish Thompson, one of a group of four who initiated a contract with an area health board as soon as the law allowed it in 1990, cited the need for midwives to be accountable not only to themselves but to their patients.

"We feel we are accountable not only to professionals, but also to people receiving the service. And we wanted to have a good peer review, not rubber-stamping."

Called the Domino Midwives Standard Review Committee, it consists of four professionals and four consumers. (Domino is an acronym for "domiciliary midwife care in and out of hospital".)

The professionals are a hospital midwife, an independent midwife, a GP in obstetrics, the Taranaki Area Health Board women's services manager plus a co-opted paediatrician. Consumers are represented by Parent Centre and La Lêche League representatives and two women who have used the service.

"It was really exciting to have consumers there. They see things from a different point of view. It's part of the personal and professional accountability. And the DMSRC can be a forum for complaints.

"It will meet annually unless there is a complaint or a complication to look into. It is part of being open and accountable."

Ms Thompson believes the TAHB inquiry involving New Plymouth woman Susan Huta, awake in the early stages of her caesarean section because of equipment failure in February, would never have gone to the media if her complaint could have been heard.

"She would not have needed to go through the trauma ... I think this is something the medical profession hasn't done well in the past," she said.

The independent midwives began on temporary contracts with TAHB until they could take up a contract in October 1990 through the annual Obstetric Review Committee (now the Maternity Standards Review Committee).

"In the past the doctors' annual contract seems to have been fairly much an automatic procedure. When we came along, they realised they needed written criteria. There are now written area health board standards of practicefor us to follow," said Ms Thompson.

There had been trial domino schemes in Whangarei and Wellington but those midwives were employed by the boards and still worked with doctors.

"We were the first to get access to open maternity beds in our own names," she said.

The standard of practice required accountability, and therefore full statistics were kept. They have recently renewed the contract.

In their first year the four recorded 101 births - 27 home births and 74 Domino scheme (hospital) births, and assisted doctors in the birth of others.

"One of the reasons we began the scheme is that we believe in the beneficial effect of ongoing support," she explained.

Their figures bear that out, she said, even when taking into account that low-risk women use the scheme (see accompanying table).

Mrs Thompson rejected claims by the NZMA earlier this year that babies delivered by midwives cost almost twice as much as those delivered by doctors.

A Department of Health survey of 1000 births showed GP claims under the maternity benefits scheme averaged $754 per delivery. Midwife claims averaged $1316 per delivery.

Ms Thompson said independent midwives provide full services themselves while the GP figure fails to acknowledge the work done by for example the practice nurse, antenatal staff, hospital midwives, hospital cleaning staff, ward clerks, postnatal staff, district midwives and breastfeeding counsellors.

The well-established New Plymouth group holds information, education and support sessions for women and their partners each week, and the midwives themselves have fortnightly support-group meetings.

Domino midwives 1991 results

Statistics relate to 101 births managed by the four Taranaki midwives

Home births 26.73 per cent; domino births 73.26 per cent.
Midwife only care at time of birth 62.37 per cent, shared care with doctor 37.62 per cent.
Primiparas 28.71 per cent; multiparas 71.28 per cent.
Induction 4.95 per cent; spontaneous vaginal (normal) births 94.05 per cent; instrumental delivery 1.98 per cent; LSCS 3.96 per cent.
Intermediate fetal death 0.99 per cent.
Postpartum haemorrhage 3.96 per cent.
Retained placenta/GA/manual removal 0.99 per cent.
Perineal outcome: episiotomy 4.12 per cent; sutured laceration 16.49 per cent; laceration not sutured 34.02 per cent; intact perineum 45.36 per cent.
Pain relief: all those requiring drugs 19.58 per cent; gas 14.43 per cent; pethidine 10.30 per cent; epidural 0.99 per cent.
Breastfeeding at two weeks 94.05 per cent; breast plus supplement feeding 1.98 per cent; bottle (artificial) feeding 1.98 per cent (one woman left the district).

NEW ZEALAND DOCTOR 16 JULY 1992

CONTENTS

EDITORIAL

Welcome to our September newsletter. Every week seems to bring more enlightening information that relates to our practice as Midwives and it's difficult to thin it down to just the most important. Thank you for your reports on current local issues we have received.

Due to the shortage of space, some of these pieces have needed to be "edited". We endeavour to do this in such a way that the essential information is passed on and we apologise if this process has effected your piece of writing.

My congratulations to the Conference Committee on a marvellous effort. I'm sure I'm not the only one who appreciated the opportunity to attend such a well run event and to be challenged by the views of many.

The **next newsletter** will be planned for the **start of November** and therefore the deadline for the information for that newsletter will be the **20th October**. Remember, the deadline for the material for the **Journal** is the **31st October**.

There are many reports here and information and views on the current Vit K issue.

Enjoy your reading.

Karen Barnes

NEXT NATIONAL COMMITTEE MEETING
Midwifery Resource Centre
1st Floor 183 Manchester Street
Christchurch

Friday 27th & Saturday 28th November 1992

Commences 6pm Friday and 9am Saturday

NATIONAL CO-ORDINATOR'S FORUM

CONFERENCE REPORT 1992

- Karen Guilliland -

August 1992 saw the 2nd National Conference for the New Zealand College of Midwives come and go with excitement and warmth. A wonderfully well organised conference with lots of laughter, debate and challenge. Considering how new we are as an organisation it is a tribute to the enthusiasm and commitment of the women and midwives involved that we had a variety of speakers which covered philosophy, ethics, practice and education and the organisers had ensured a good mix of presentations which kept interest alive.

The great debate, "Are Midwives a Real Choice or an Expensive Luxury?" was hilarious and spirit lifting. Midwives Bronwyn Pelvin for the "negative" and Steve Chadwick for the affirmative could have brilliant careers ahead in the performance ring if they ever wanted to start new careers! Journalists Gail Woods and Sue Kedgley stirred the faint hearted with their fighting talk and politicians Helen Clark and Joy McLauchlan gave very clear evidence that you don't have to lose your sense of humour to survive politics. David Lange as chairperson and the only man in the room, coped by declaring a draw!

All sessions were valuable and ranged from Midwives who had never presented a paper or workshop before to seasoned conference goers. Hopefully these Midwives have encouraged other Midwives to think about presenting their work next conference such was the warmth of reception the presentations enjoyed. Simon Upton opened Conference with a generalised review of the health reforms so far, urging Midwives to take an active part. Midwifery students and their tutors gave us some food for thought with their research on management of third stage. Consumer Glenys Parton's paper on the loss of identity some women endure during their childbirth experience contrasted vividly with the strong women of the Tauranga Home Birth Association who have just tendered and won the first contract with an Area Health Board for home birth services. Bronwyn Pelvin also cemented her position in Midwifery's history as a philosopher and mentor with her paper on ethics. Keynote speaker Sean Burgess (Auckland) and Alice Coyle (London) complimented each others discussions on how independent practice worked in both countries. Marion Hunter's paper on active management of labour at Middlemore sparked much discussion, and Mary Anne Rivers' workshop on arbitration methods between hospital and community practitioners provided common ground for Midwives to search for solutions to current problems.

Mina Timu Timu's presentation with her whanau (including mokopuna) depicting creation according to Maori legend was a delight to watch. Her words and wisdom about Maori culture and birth were of great value for those of us with so much to learn.

GOOD NEWS! ESTABLISHMENT OF OBSTETRIC STANDARDS REVIEW COMMITTEE - PALMERSTON NORTH -

- Ruth Martis -

The Manawatu-Wanganui Area Health Board has established an Obstetric Standards Review Committee at Palmerston North Hospital.

The Committee consists of :

1 Paediatrician
1 Obstetrician
1 Women's Health Manager (Chairperson)
1 Manager of Hospital Administration
4 General Practitioners
4 Midwives

The Committee has worked hard and enthusiastically to establish an acceptable contract (not perfect) and guidelines of experience for midwives and general practitioners.

Midwives have expressed how well they have been accepted and recognised for their expertise. One draw back is that consumers are not invited on to the committee as yet, but are greatly encouraged to write in or present a verbal report of any concerns they might have as regards to their maternity care received in the hospital.

It certainly seems a positive beginning.

Our average hospital stay is 5 days but we have had mothers and babies for up to 13 days. Breast feeding is encouraged and our breast feeding rate is 88% of all women.

The midwife will visit in the mother's home after discharge if the need is there, but most often, the mother is referred to the Plunket Nurse.
We have a close liaison with our local GP who has joined us for discussion groups on obstetric topics, management and patient care.

The community has been supportive in assisting with gardening and working bees. The CWI provide home made biscuits and hand-knitted booties on a regular basis. Other generous donations of produce have been received.

We have just completed out first two years under the Tuatapere Hospital Trust which has been challenging but most rewarding. During this time we have care for 94 mothers and 94 babies within our allocated budget. This has been the result of a unique team effort.

We look forward to the next 12 months of our extended contract before we may once again need to negotiate for rural maternity services.

"A VIEW ON DOMINO'S EQUIPMENT"

- Ruth Martis -

Midwifery is at an exciting stage. Since autonomy our professional self-esteem is being restored and women are able to have greater choices as regards to their maternity care. Of course, with any new change there are teething problems and I would like to address one of these.

Recently, two planned hospital births occurred 'accidentally' at home. In each case a different Domino Midwife was in attendance.

Although 'happy endings' occurred in these cases it concerns me greatly that some midwives appear to be practising without emergency equipment. It is inappropriate to believe that women who have chosen the Domino option will never birth at home.

By experience these women will labour longer at home. They usually only want to have the actual birth in the hospital setting. And what if the woman decides at the last moment to birth at home after all? Does she have a variable choice?
I am discussing a professional standard approach to midwifery practice here not exceptional situations that do occur at times.

I would like the NZCOM to consider this issue seriously. It is mandatory that women are able to retain their choices and that all midwives have a sound professional standard of practice which incorporates the above points.

The Domino Service is a relatively new concept and it might be appropriate for the NZCOM to establish some guidelines for midwives that are starting up as a Domino.

It is impossible to acknowledge every session but the proceedings are still available from the Midwifery Resource Centre, P O Box 21-106, Christchurch at the cost of $15.00.

The new President, Sally Pairman, closed Conference, encouraging Midwives to continue to have active participation in the health reforms and to value the collective strength of Midwives and consumers in ensuring a quality maternity service.

REMITS

The Annual General Meeting on the 28th August 1992 passed the following Remits:

GENERAL:

1 That NZCOMI develops a standardised system of client evaluation.

2. That NZCOMI establish a system for the collection of standardised national Midwifery statistics.

3. That NZCOMI develop a standardised system for Midwifery Standards review.

4. That NZCOMI supports the abolition of user part charges for babies born pre-term.

5. That NZCOMI supports the call for contraception to be available free of pre-scription charges.

6. That NZCOMI supports the establishment or re-establishment of human milk banks in New Zealand.

CONSTITUTIONAL:

Rule 7.7.3 Members shall receive a copy of the constitution of the College on request.

Rule 8 At least one consumer representative shall be from the same region as the current Board of Management.

Rule 14.2 Decisions at AGMs and SGMs is by consensus. Voting shall take place when consensus is not possible and shall be by simple majority at regional level.

Rule 3.9 To promote biculturalism in Midwifery by recognising the Maori people as

Tangata Whenua of Aotearoa. The Midwifery profession in New Zealand honours the principles of partnership, protection and participation as affirmation to the Treaty of Waitangi.

Rule 4 Midwifery care takes place in partnership with women; continuity of Midwifery care enhances and protects the normal process of childbirth.

Rule 18 The region proposing change shall submit a copy in writing to the Board of Management not less than two (2) months prior to the AGM.

Karen Guilliland, retiring President, was made an Honourary Life Member.

NEW ZEALAND COLLEGE OF MIDWIVES ANNUAL REPORT

AUGUST 1991-AUGUST 1992

- Karen Guilliland -

The National Committee has met quarterly in Wellington. An evening workshop precedes the General Business day. Workshop topics have included restructuring, education and contract tendering for Midwifery Services.

It is my pleasure to present the Annual Report for the year August 1991 to August 1992.

The end of the last financial year (April 30th 1992) saw the change over from the Wellington Board of Management to Christchurch and the new administrative structure. The National Committee were conscious that it was only one term since the Canterbury/West Coast Region had held the same office but in the absence of offers from other regions and coupled with the new Co-ordinator living in Christchurch, it was felt to be a practical proposition.

On behalf of College Members I would like to record our grateful thanks to the outgoing Board of Management - Lynley Davidson, Beryl Davies, Jeanie Douche, Chris Griffiths and Marjorie Morgan. All these Midwives provided hundreds of hours of voluntary time whilst juggling their own very busy practices, personal and family commitments. Midwifery is indebted to them all.

The increase in workload over the last two years became such that it was clear the College could no longer expect such a burdensome time-commitment from volunteers.

The Special General Meeting on 14th February made the Constitutional changes necessary to change the administrative structure of the College. The new Board of

NEWS & VIEWS

Babies are FUN! Have One,
Help Save TUATAPERE MATERNITY Home

- Isobel Fraser -
Midwife Manager

In 1989 the Government health cuts resulted in Hospital Boards having less funds available. As an economy measure Tuatapere Maternity Hospital was high on the list of institutions to close and it in fact closed on October 12, 1989.

Meanwhile a group of interested people from the local Health Committee put forward a submission to the SAHB outlining a local proposal to maintain Maternity services in our area.

The SAHB were supportive of our proposal and accepted it. As a result the Tuatapere Hospital Trust was formed with six trustees. They were then put under contract by the SAHB to provide Maternity Services for a trial period of two years.

After many months of negotiating and signing contracts, the maternity hospital reopened on April 10, 1990. The contract is for $1,500 per delivery.

There have been three major changes:

1] Efficient use of resources: The use the available space was examined to make the hospital as efficiently as possible. Now we use only the maternity side of the building which is one third of the total floor area. (The old nurses home is now the doctors surgery). This saves significantly on heating, cleaning etc.
2] We are closed when there are no patients. This further reduces heating costs and keeps wages to an efficient minimum.
3] A meals on wheels system is used for the patients main meal of the day. This is very nicely provided by the Waiau Hotel at an economical price. A microwave has been provided by the trust which helps staff prepare breakfast and lunch etc.

STAFFING : The staff consist of three midwives, two obstetric nurses and three nurse aides.

A midwife is on call 14 days prior to the next delivery. Contact is usually by phone diversion. The mother phones the hospital number which is diverted to the midwife's phone. The hospital is warm and operational very quickly.

ANTE-NATAL : Fortnightly antenatal classes are run which include videos on labour and delivery, discussions, exercises and occasionally a guest speaker.
A midwife books in the woman, attends antenatal clinics with the GP and after delivery, visits mother and baby daily while they are in hospital, advising when necessary. Plans for a midwife only care is currently being considered.

3/9/92. PAEDIATRICS NZ DOC

Possible increased risk of childhood cancer with IM vitamin K

Two epidemiological studies, one published in 1990 and the other this year, suggest a doubling of the risk of cancer among children given intramuscular vitamin K. A British Professor of Child Health says it may be time to consider changing to oral vitamin K, provided it is as effective as the parenteral formulation in preventing haemorrhagic disease of the newborn.

Though epidemiological associations such as this do not prove cause and effect, if it is confirmed in other studies the association has major implications. Simply withdrawing vitamin K prophylaxis by injection could halve the childhood cancer rate.

The association may be the result of a dose effect since after IM injection peak blood concentrations of vitamin K_1 range from 350-1900ng/ml in newborns compared with 20-330ng/ml four hours after an oral dose. However, vitamin K given orally is not as effective at preventing late onset haemorrhagic disease of the newborn (occurring between one week and six months of age) which, though rare (5 cases/100,000), results in death or severe brain damage in up to one-half.

Bottle-fed infants are less likely to experience bleeding from vitamin K deficiency since infant formulas are fortified with the vitamin. These infants receive about 10 times as much vitamin K in the first month of life as breast fed infants. There is no evidence suggesting they are at any greater risk of developing childhood cancer than breast fed babies.

In the meantime, "it seems reasonable to develop a programme of oral [vitamin K] administration for all infants at birth...". Vitamin K supplementation may need to be continued for breast-fed infants. If the oral formulation is not available an alternative might be a small dose of vitamin K (100µg) given parenterally.

Professor Hull concluded that the increased risk of childhood cancer in relation to parenteral vitamin K prophylaxis is not yet certain, and that before changing to an oral vitamin K-based prophylactic programme it is essential to determine whether this is as effective as parenteral vitamin K.

Hull D. BMJ 305:326-327, 8 Aug 1992

Management consists of Kathy Anderson, Karen Barnes and myself as Co-ordinator in a part-time paid position. Margaret Stacey provides secretarial assistance to the Board and Russell Foster is the Board Accountant.

The new structure, with its office base, will allow for a responsive professional service to members and an effective resource promotion body for Midwifery. It is also in a position to administer the Professional Indemnity Insurance now offered to members.

NATIONAL COMMITTEE ACTIVITIES

a] **Education Workshops**

These three days attended by National Committee and a wide cross section of Midwives and consumers was dynamic and exciting. It reaffirmed for the participants (in spite of their different places and scope of practice) how united Midwifery was in its women centred philosophy. The workshop produced enough material to enable the collation of a Midwives Handbook for Practice. It includes a NZ Code of Ethics, Guidelines for Practice and Referral, Standards of Practice, a complaints mechanism and a framework for Midwifery Education.

b] **International Midwives Day** (1st May)

A lower key approach to this day this year as many regions felt they tended to promote Midwifery publicly on many more days than one in a year and that it was important to continue to do so. Regions had a variety of promotional exercises ranging from open days at maternity units/hospitals/rooms, marking births on that day with a gift and radio and newspaper coverage.

c] **Publications**

We continue to produce a newsletter approximately 6-weekly - 2-monthly. With the change over in May and the low ebb in finances it was decided not to produce the April/May issue. We hope this will not be necessary again although continuing financial restrictions mean we will have to examine the number of issues produced. It is planned that the newsletter's function from now on will be the "workings" of the College e.g. reports, minutes as appropriate, news updates, snippets of interest and politics. The Journal's main role will be to publish original work/papers on Midwifery issues, both in practice and education.

Another major vote of thanks must again go to Helen Manoharan, as the Journal Editor, who continues to produce issues which get better and better. Helen's organisational skills and flair for presentation are a valued contribution to the documentation of Midwifery's history, and all done in a voluntary capacity. Several articles have been reproduced in overseas Midwifery and consumer publications - congratulations to

those authors responsible.

The Breastfeeding Handbook has finally come to fruition this Conference. From small beginnings it became clear that this would be a major publication to be viewed by many and it was important that we produce a quality research based document. Publishers say it invariably takes two years for a book to see the light of day and it is almost two years to the day that we welcome the Breastfeeding Handbook. Many thanks to all the Midwives and consumers who contributed to its pages.

It is thanks to Marcia Annandale's dogged commitment that the project has come about so successfully. She and the Handbook Committee (Chrissy Fellows, Lynda Bailey and Gail Warwick) have spent thousands of hours in collating, researching, letter writing and telephone conversations making sure this was a reliable resource for anyone reading it. It has been an expensive exercise however and regions will need to fund raise in order to cover costs. Meanwhile we have applied to several funding agencies for grants.

d] **Liaison with Government Departments and Ministers**

We were frequent visitors to the Department of Health and its officers last year with varied results. I believe we have established a good relationship within the Department and have been consulted often and in as much depth as appears possible in this climate of unprecedented change. (This is not to say we have agreed with these changes but we are forced to respond within these limitations). We have not always achieved the ideal but given the extreme positions of some groups the department has been generally fair with its recommendations.

Glenda Stimpson (Auckland), Beryl Davies (Wellington) and myself attended a meeting in October called and chaired by Associate Minister of Health, Katherine O'Regan, in order to discuss with us and the NZ Medical Association and Association of GPs, protocols and guidelines for practice in the Maternity Services. It was not a particularly successful meeting as it became clear the NZMA position was entrenched in the opinion that Midwives should not be paid as much as themselves. We did agree to further discussions based on the Department of Health's document "Care in Pregnancy and Childbirth". No further meetings however have been arranged.

In November, Beryl Davies (BOM) and myself met with Acting Principal Nursing Advisor, Elizabeth Lee and Nurse Advisor Sue Scobie. We discussed the Role of the Midwife.
In December, Carey Virtue, Bronwyn Pelvin, Julie Richards and myself met with Teenah Handiside and Gillian Bishop (Ernst & Young) to discuss the Maternity Benefit Schedule. Discussions have been ongoing with the Department mainly by telephone.
In February Bronwyn Pelvin, Carey Virtue, Julie Richards and myself met with Simon Upton and Katherine O'Regan. Sheryl Smaill, Principal Nurse Advisor, was also

...AND THE VITAMIN K INJECTION

The British Department of Health is setting up a working party which will examine whether the Vitamin K injection routinely given to newborn babies might increase their risk of developing cancer. A study by Professor Jean Golding of the Institute of Child Health in Bristol suggests that Vitamin K injections may double the chances of leukemia. As well as a statistical link between cancer and the vitamin K treatment, a link between childhood cancer and mothers treated with pethidine has also been noted.

Roche, the company that manufactures vitamin K, gave Professor Golding funding for a follow-up investigation. In this latest study no link with pethidine was seen but there was a two-fold risk of leukemia in children who had received injections of vitamin K, but not those who received it orally.

Taken from the MATERNITY ALLIANCE ACTION Newsletter of July/August 1992

with frequent mistakes, misunderstandings and mis-diagnosis. Of the 27 cases, 19 had not been given Vitamin K and six had recived an oral dose. 17 cases were of the late type and ten of these developed intra-cranial haemorrhage. Two of these died and there was concern about the future mental health of the others. The two doctors concluded that all babies should receive Vitamin K preferably by inkection, or if orally, by repeated doses as a preventative measure. Extra vigilance and investigation are essential after warning bleeds from the nose, mouth, rectum, umbilicus, Guthrie test or spontaneous bruising.

The third article is a discussion and summary by two paediatricians. They discuss the variability of policy around Britain, where some units give Vitamin K by injection to all babies, others give it orally to most and injection to a selected few, whilst others only give Vitamin K to a select few. They also refer to modifications over the years, and the tendency to increase coverage and the injection method. They mention the danger of giving the wrong injection, which could be a fatal mistake and the considerable variation of dosages used in different units. They also mention the worries of some groups that Vitamin K might have adverse, delayed or long-term effects.

I must add some further comments. These three articles are by doctors and for doctors with no consideration of parents' views. I believe it was my skill in evaluating and trusting the intuition of the parents that was the key to my success in homebirth practice, and I remain confident in supporting their refusal to let their new born baby be injected. More progress could be achieved by open discussion and listening to interested and thoughtful parents, than by statistical surveys and decision-making behind closed doors. I feel sure that intensive dietary

As most of these cases occurred in the spring and summer, it seems obvious that the mother contracted a viral infection during the winter which crossed the placenta. Because viruses have a predilection for the liver and mucous membranes, they can affectintestinal absorption and liver function. It is unusual for a virus to persist for months but it can happen and this is a rare disease. A persistant virus infection weakens resistance and stamina. I feel confident that babies affected in this way would be listless, irritable and slow to thrive. Such babies should be watched carefully for warning bleeds or spontaneous bruising.

NATURAL SOURCES OF VITAMIN K

As a baby has an immediate need for Vitamin K following birth Queensland researchers have advised women to ensure they include Vitamin K in their diet, particularly in the latter stages of pregnancy. The major food sources of Vitamin K are green leafy vegetables and soya beans.

present. It was a liaison and promotion exercise where we discussed the role and practice of the Midwife, relationships within the health system and the Maternity Benefit structure. We felt we were well heard. Earlier in the day we met with the Manager and Advisor of the Medical Benefits Department to discuss the Midwives position within the Benefit Structure.

In June the Minister of Health announced he was taking up the NZMA's call for a Tribunal to hear the Maternity Benefits issues. The College had been urging tripartite negotiations since the Nurses Amendment Act in August 1990 to no avail. The NZMA would not negotiate with Midwives. Their objection was based on the belief there should be two schedules - one for doctors and one for Midwives. We argued that we provide the same maternity service (albeit in different ways) therefore the one schedule was appropriate.

The recognition by Government that work of equal value (the maternity service) should be recognised as worthy of equal pay, was New Zealand women's only successful pay equity legislation. It is imperative we protect that right. We believe, however, the Tribunal to be a serious threat given the historical and financial inequity between the College, the NZMA and the Government. We have urged the Minister to acknowledge these inequities in his selection of Tribunal members hearing the submissions.

We await the announcement of Tribunal members and their terms of reference with interest. Meanwhile the College urgently needs to investigate ways to raise funds in order to mount our legal argument. A cake stall perhaps?!!

Viv McEnnis, Carey Virtue and myself recently met with the Chief Executive of the Ministry of Women's Affairs, Elizabeth Rowe, to discuss the issues raised by a Tribunal Hearing and were encouraged by her understanding and support. We had met previously with the Ministry advisors last year for similar discussion.
In March Bronwyn Pelvin and I attended a confidential meeting with Katherine O'Regan and her advisors to discuss the draft changes to the new Nurses and Midwives Act. Most nursing groups were represented and also input from two consumers. We had hoped the Act changes were to be imminent however it seems more and more likely it will be some time before it is presented for submission.

Various Midwives have been consulted by the Health Reform Directorate over the last year including Sue Lennox (Wellington) on Postnatal Care Services; Sally Pairman and myself on Primary Care and related services. The selection of Midwife Consultants was by the Health reforms Directorate independently of the College.

It was with great delight the College learned of two successful funding applications for Primary Initiatives relating to Midwifery. Jilleen Cole in Auckland with a marae based Midwifery proposal and Marion Lovell and Carey Virtue with their Domino Scheme. Congratulations and appreciation to these Midwives for ensuring Midwifery is firmly in

the minds of health reformers. Every region was invited also to participate in the Health Reforms Seminars held right throughout New Zealand. Feedback from the 34 Midwives who attended ranged from "propaganda, useful background, unintelligible, alarming, interesting and a great chance to meet the decision makers in health!"

Following several hiccoughs in the Maternity Benefit claiming procedures, Julie Richards (Canterbury) and myself met with the Manager of the Regional Benefits Office. It was reconfirmed that under the Benefits legislation, Midwives and GPs receive exactly the same consideration for their services. Hopefully Midwives now will be able to receive their payments without having each claim contested.

The socialisation or acceptance of the doctors right to claim as unquestionable and the Midwife as a dependent has been difficult to shift. It also highlights however how much further Midwives need to inform people in order to have them understand and value the work of the Midwife.

After almost two years working with Quest Rapuara, the Careers Development and Transition Education Service, we now have a "Midwife" pamphlet to distribute to school students. Thanks to Wellington Midwife, Janie Scotts, whose contacts hurried the project along and Hugh McLean at Quest Rapuara who produced the leaflet after several consultations with myself and Wellington Midwives.

e] **Liaison with Other Groups**

We continue to liaise with the Nurses Association through news exchange, telephone contact and referral and have had two meetings. Viv McEnnis, Mary Claire Reilly and myself met with Gay Williams and Mary Gibb to talk about NZNA representation of hospital Midwives and the separation of Midwives from nurses in the wages negotiations. From that meeting we were invited to meet with the Socio-Economic Welfare Committee to discuss the issues.

That meeting was a good opportunity to meet and initiate discussion however the Convenor and Deputy of the Committee plus Gay Williams left after 15 minutes for another appointment. We were disappointed not to have been able to make more progress as there is marked dissatisfaction from many hospital Midwives with the lack of recognition by employers of their independent status and its accompanying responsibilities.

Our liaison also continues with the NZNU and my thanks to Steph Breen who is so accessible and a mine of information on both the industrial and professional issues that effect the Midwife members of both the College and the Union. The College has contracted to the Union for legal advise relating to Indemnity and Maternity Benefit issues.
I have had contact with a variety of consumer groups this year. Parents Centre continues to liaise at a National level as their representative, Jane Presto due to health

THE VITAMIN K CONDRUM

BY DR JOHN STEVENSON
AUSTRALIA

An old English proverb states "When Drs disagree, disciples may go free". This probably pre-dates Alexander Pope's celebrated assertion. "Doctor" in this context means not a medical practitioner but a teacher, a university graduate, and a specialist in the subject he taught. The proverb could be modernised to "When experts disagree, commoners are not bound", or "When professors cannot reach agreement, their pupils may compute their own deductions". These concepts might appear frivolous, but women will recognise their relevance; especially in relation to choosing a midwife instead of "doctors of obstetrics" who so often shift their ground.

Perhaps its most appropriate application is to the question of Vitamin K injections for the newborn. The very latest concepts amongst medical authorities are clearly set forth in three articles in the British Medical Journal, vol 303, number 6810, 2 Nov 1991. These articles indicate considerable disagreement amongst doctors, giving parents the room and the right to make an informed decision on this contentious subject. They need the most thorough information available and in comprehensible terms rather than medical jargon. They would naturally look to their midwife to supply such information.

The first article is a one-page editorial giving an historical review. Almost 100 years ago, a bleeding syndrome in newborns, not due to trauma or inherited disorder was recognised and called "haemorrhagic disease of the newborn". 50 years later, deficiency of Vitamin K was identified in the syndrome, and Vitamin K was given to mother or baby as a prophylaxis. However, doubts about its effectiveness or necessity persisted, and resulted in different policies of treatment in different nurseries throughout the British Isles.

In 1983, two types of haemorrhagic disease were identified. The so-called "classical" type affects babies in the first few days of life, whereas the "late in onset" type struck in the second or third month. It was noticed that the majority of affected babies in both groups were exclusively breast-fed. It was also

paediatrics, midwifery and an encyclopaedic medical disctionary, the only figures I found were in Townsend (one case in 400-500) and in Beischer who studied under Townsend (about two per thousand). These figures do not agree with my series in which I had no cases in approximately 500 hospital births followed by 1300 home births. So the incidence has to be substantially less than those figures, at least amongst homebirthers with their fresh vegetable diets.

The data collected also shows that late haemorrhagic disease of the newborn is relatively common, and frequently associated with intra-cranial haemorrhage. The incidence increased in the summer months (also recoded in Japan). The research had some problems

DEPARTMENT OF HEALTH
TE TARI ORA

- Ian Miller -
Gen Mgr Contract Management

FOR THE URGENT ATTENTION OF OBSTETRIC UNITS AND PAEDIATRICIANS

VITAMIN K ADMINISTRATION IN THE NEWBORN

The Fetal and Newborn Committee of the Paediatric Society of New Zealand yesterday published the attached paper on Vitamin K administration in the newborn, which contains a recommendation to change to the oral route of administration.

This paper was produced as a result of a paper presented by Dr Jean Golding at the British Paediatric Association meeting in May 1992 (Editorial BMJ 304:1264-5)

The Department of Health has provisionally accepted the recommendation that all infants should continue to receive vitamin K prophylaxis and that the oral route is the preferred route of administration.

There is no oral presentation of vitamin K available which is suitable for neonatal administration.

Some infants have been administered Konakion injection orally, but the Department of Health has no evidence demonstrating bio-availability and this is not a registered method of administration for the product. This issue is being resolved with the manufacturer. Any practitioners deciding to change to an oral regimen should note:

1. the oral dose recommended by the committee is 2 mg given at birth; 5 days and 6 weeks.
2. there is currently no documentary evidence available to support oral use of Konakion injection;
3. the Department recommends continuing the existing policy of prophylactic vitamin K for all infants, given as an intramuscular injection until the issues of effectiveness of an appropriate oral dose form have been resolved.

Officer for Enquiries: Dr G R Boyd
Manager
Therapeutics Section
Phone 496-2088

reasons, was unable to participate as fully as planned. The Home Birth Association representative, Madelaine Gooda also resigned half way through the year for personal reasons. It was with regret we said goodbye to these two women but look forward to working with their successors. It is with a great deal of sadness the College also farewells Marcia Annandale from La Leche League. Marcia has been involved right through all our changes from Midwives Section to College and has contributed vast amounts of valuable information on breastfeeding throughout those years. Unfortunately her term on National Committee has expired but we are delighted she intends to keep active at regional level. We extend our grateful thanks for her years of commitment to the welfare of women.

Many Midwives continue their involvement with National Council of Women at regional level, the Southland Midwives attended their last annual conference and spoke to the Direct Entry remits which resulted in NCW's support.

I spoke at the Lionesses South Island Conference about Midwifery and was enthusiastically received and have also had several discussions with the Catholic Women's Welfare League over their submissions on a variety of issues effecting maternity services. It is very heartening to talk to these community spirited women and listen to their overwhelming support for Midwives and a return to "normal" birth practices.

We have corresponded with the Council of Maori Nurses over ways in which we can increase our contact. Mina Timu Timu continues to be an invaluable link with the Council and we look forward to finding a time to formalise these links.

I have spoken at the Registered Obstetric Nurses Conference and the Obstetrical & Gynaecological Society's Annual Conference last year. Glenda Stimpson (Auckland) and I have met with Tony Baird, President of the O&G Society.

In December I also met informally with Phillip Rushmer of the NZMA Negotiating Committee to discuss a variety of issues surrounding Maternity Benefits:
Nursing Council and my role as the member nominated by the College continues to consume large portions of my life. I believe we now have a working relationship with Council and Midwives throughout New Zealand have been consulted on a variety of educational and registration matters. Many Midwives have been involved in the audit process of Midwifery curricular and in setting Midwifery questions for the state examination.

The Midwives who have appeared before the Preliminary Proceedings Committee together with their colleagues representing them have been exceptionally professional and highly creditable. It is reassuring to hear how impressed Council members have been with the cohesive and convincing Midwifery philosophy presented by these Midwives. In these times of aggressive hostility towards Midwives from some doctors it is worth noting that if you practice according to a Midwifery philosophy and standards

supported by the profession, you have nothing to fear from an audit process. Remember too your defence centres on your Midwifery representation, not legal arguments.

This year as a member of the Professional Standards Committee of Council, I have critiqued and approved Midwifery curricula from Auckland, Carrington, Waikato, Wellington, Christchurch and Otago Polytechnics. I was also involved in the NZ Qualifications Authority approvals of Auckland, Carrington and Otago Polytechnics.

Those of you who are familiar with curricula will realise what a major time consuming task this was! Other Midwives involved in this process were Beryl Davies, Jilleen Cole, Sally Pairman, Lynley Davidson and Sheilah O'Sullivan.

The whole issue of Direct Entry curricula approval was a complex and stressful one. There were many (often hidden) agendas which were difficult to interpret and resulted in a less than satisfactory process which left many people feeling resentful and mistrusting.

To the observer with no vested interest and a penchant for free thinking it must have been difficult to see just what all the fuss was actually about. No other educational course in health's history has ever been subjected to such outrage and scrutiny. The sincerity of the commotion must be questioned. It is significant that in a profession which aligns itself to a woman's right to control her own birth experience there has been such resistance to changes which would allow this to happen.

My overall impression is that it was a fight between the Medical and Midwifery models of birth. The arguments against Direct Entry Midwifery when examined indicated a real fear of birth and the power of women. These views were expressed and acted on in a variety of ways depending on the group involved. Nurses exhibited behaviours typical of oppressed groups, managers and bureaucrats swayed according to who held their power base and doctors from an anti competition stance, and it is the women who will be losers. In this climate one has to have sympathy for Katherine O'Regan faced with making a decision no one would be happy with. On reflection, I feel that to support two courses in the face of such opposition gives credence to her stated belief in Midwifery even though we were very disappointed not to have Carrington and Wellington also approved. Nursing Council had refused to rank the courses on the grounds that if they all met the criteria to produce competent Midwives thus they all should be approved.

f] **Education**

The beginning of 1992 saw the introduction of separate Midwifery courses for registered nurses at Christchurch and Waikato Polytechnics. New Zealand no longer offers any Midwifery courses as an option within a nursing course. Wellington, Dunedin and Auckland also continue to offer separate courses.

the view of the Committee cannot be lightly disregarded. The Committee has therefore made the following recommendations.

1] All infants should have vitamin K prophylaxis.

2] For healthy term infants the preferred route of administration is oral: 2mg given at birth with the first feed. For breastfed infants repeat doses (2mg) should be given at 5 days and at 6 weeks. These repeat doses may conveniently be given at the time of the Guthrie test and with the first immunisation but should not be delayed if either of these do not take place on time.

3] For high risk infants (maternal anticonvulsant or coumarin therapy, prematurity, birth asphyxia and traumatic deliveries, known hepatic disease, or any illness in the infant which will delay feeding) the preferred route of administration is intramuscular, 0.5 to 1mg. Ordinarily only a single dose at birth is required, although repeat doses may be necessary in malabsorption states or in infants requiring parental nutrition.

POSITION STATEMENT FROM ROCHE AUSTRALIA

Re : ***KONAKION Injection Given Orally***

Further to your enquiry regarding the use of ampoules of Konakion injections as an oral route of administration, I would like to make the following comments.

* We have no clinical studies to support the use of Konakion ampoule solution being given orally.

* Our UK company, Roche Walwyn, were conducting clinical trials on a sterile, oral Vitamin K solution as seen in the attached clinical paper by Sewell & Palmer. These trials, performed in 1988, have since been abandoned and trend is now back towards the parental route of administration.

* Vitamin K injection is preserved with phenol which has been reported to be an irritant on neonatal oral mucosa.

* Vitamin K requires bile salts for absorption from the intestinal tract and variability in their production or release may cause significant variability in the absorption profile. Parenteral routes of administration are expected to give more reproducible plasma concentrations than oral dosing regimens.

For the above reasons we would not recommend the administration of Konakion ampoule solution orally to neonates.

VITAMIN K ISSUES

The major controversy surrounding the giving of Vit K to new born babies has resulted in many phone calls from women and Midwives and doctors to the Midwifery Resource Centre, asking for advise and information.

The College has no stated policy specifically related to Vit K but does have a firm commitment to informed choice and consent. It is evident therefore that Midwives are only able to offer information to parents to assist them to make their own decisions about their newborn. We have published the following to assist that process.

STATEMENT BY FETUS AND NEWBORN COMMITTEE OF PAEDIATRIC SOCIETY OF NEW ZEALAND

VITAMIN K ADMINISTRATION IN THE NEWBORN

- Brian Darlow -

Haemorrhagic disease of the newborn (HDN) is an important, but potentially preventable, cause of morbidity and mortality in newborn infants. There are three patterns of disease; early, classic and late.

Early HDN occurs in the first 24 hours of life and is usually associated with maternal anticonvulsant therapy. It is rare and can not be prevented by oral vitamin K administration in the newborn.

Classic HDN occurs between day 1 and 7 and is virtually confined to breastfed infants. The incidence with figures varying from any haemorrhage occurring in 1 in 400 births to serious haemorrhage occurring in 1 in 10,000 healthy term infants. The site of bleeding is variable and may include the skin, umbilicus, gastrointestinal tract or, rarely, intracranial: circumcision is a significant risk factor. The available evidence is that oral vitamin K can prevent most classic HDN.

Late HDN occurs beyond 1 week of age; is at least as common as classic HDN, and is accompanied by intracranial haemorrhage in 50% of cases. As with classic HDN it is confined to breastfed infants, other risk factors being administration of antibiotics and cholestatic jaundice. Late HDN is not prevented by a single oral dose of vitamin K.

Intramuscular vitamin K (phytomenadione - 0.5 to 1 mg) given at birth is of proven effectiveness in preventing all forms of HDN. A retrospective study from the UK published in 1990 unexpectedly suggested a possible association between intramuscular vitamin K and an increased incidence of childhood cancer, and a case-controlled study from the same researchers has now reached a similar conclusion. This information is preliminary, based on small numbers and needs to be confirmed but in

Direct Entry has two programmes running since the start of 1992. Auckland Institute of Technology offers a 3-year Diploma Course (although plans to convert to a degree) and Otago offers a 3-year degree course. The evaluation process will be ongoing throughout the three years over two intakes of students.

True to form and in an exercise in amazing overkill, the Department of Education & Health, NZQA, Nursing Council, Ernst & Young and myself as the only Midwife, will be responsible for protecting the public from this terrifying graduate called the Direct Entry Midwife! I wondered when I was the only one to have my name wrongly spelt (in the minutes) if this was to be an omen of the struggle ahead?!

The Education Committee, Marion Lovell (Convenor), Chris Hendry, Jilleen Cole, Beryl Davies, Jeanie Douche, Val Fleming, Andrea Gilkison, Jackie Gunn, Viv McEnnis and Liz Smyth, continue to work on the Midwifery Education framework. They have distributed questionnaires to Midwives about ongoing education needs and are planning an accreditation system for recognition of courses offered and undertaken. Several Polytechnics are proposing a variety of approaches to post graduate education of Midwives and the College hopes to keep these courses cohesive. The Education Committee is working with the Open Polytechnic to develop learning modules. Distance education is a feature of these. The Vision 2000 project has been rejected by the College as inappropriate for Midwifery.

g] **Submissions**

Submissions have been written over the last year on the following:

- Care for Pregnancy and Childbirth - DOH
- Core Health Services
- ACC Amendment Bill
- Future Direction of Plunket Society
- Review of the Maternity Benefit Schedule
- Clinical Training of Health Professionals
- Standards Protocols and Access Agreements
- Review Obstetric Regulations
- Vision 2000

h] **Funding**

The College continues to function on minimal resources and our financial security is an ongoing issue. The Board of Management has applied to J R McKenzie Trust, Lotteries and Trustbank and still await the outcome of those applications. Our submission to Women's Suffrage and the local Trustbank Committee have been declined.

I was also involved in an application to the Health Research Council for a grant to investigate costs of birth in the community which has also been declined.

i] **Media**

We have had many a headline this year throughout New Zealand. Unfortunately, in true media fashion, the emphasis has often been placed on any item which could be construed as controversial. It is interesting to note however that the majority of health reporters are women and in the main they tend to be sympathetic and understand the issues. This could not always be said about the editing of those articles. We have however, also received a great deal of supportive press especially with radio and magazine coverage. I have given several radio interviews nationally and two national television interviews. Regional Chairpersons have also been quick to respond to media interest. There is also increasing interest from companies looking for positive images to promote e.g. Telecom, Area Health Boards and Health Reformers have used Midwives to demonstrate this image.

j] **International Events**

Our profile internationally has increased markedly with the advent of independence and our stance on consumer participation in Midwifery's development. It is reaffirming to get such positive feedback from so many countries who also wish to involve women more in the decision making processes surrounding birth.

Judi Strid (consumer) and myself as delegates with Bronwyn Pelvin as observer, attended the ICM Asia Pacific Regional Meeting in Melbourne in March where consumer membership to ICM was discussed. Difficulties with language aside there were also cultural difficulties surrounding the status of women which needed to be acknowledged.

We agreed however that the region would support a two way approach. New Zealand Remits to ICM International Congress would be:

(1) ICM endorses the right of the New Zealand College of Midwives to operate in partnership with women.

(2) ICM supports this partnership with consumers on a global basis.

We will present a paper in Vancouver, May 1993, to support these remits. It is an important issue in the equity struggle to have these concepts debated widely, with Midwives being seen publically as "with women". I attended the two day pre-congress education workshop also and listening to all our Midwife neighbours, its is evident that the equity issue is a major barrier to healthy pregnancy and childbirth. Midwives worldwide need strategies to address these basic needs of women in order to fulfil their Midwifery role. New Zealand believes partnership gives strength for political and social change.

As New Zealand's nomination, the International Confederation of Midwives has appointed me as their representative to the United Nations Economic Commission (Asia Pacific Region). It is a shared position with an Australian Midwife, Pamela Hays. I am hopeful that the partnership model practised in New Zealand will serve me well in this appointment.

REA DAELLENBACH - CONSUMER REP

Rea represents the Christchurch Maternity Action Alliance and is a consumer member of the Canterbury Midwifery Standards Review Committee. She has worked as antenatal co-ordinator for the Christchurch Home Birth Association and is active within this Association since the birth of her children.

Rea is a part time tutor in Feminist Studies at the University of Canterbury. She is also a PhD student engaged in critical comment on the Government's health policy. She is focusing on how the health system reforms will affect women as clients. Her research interests come out of her long standing commitment to maternity politics.

UPCOMING EVENTS

[a] **2ND INTERNATIONAL HOMEBIRTH CONFERENCE**
4-7 October 1992
University of Sydney, Australia

Contact : Conference Secretariat
2nd International Homebirth Conference
GPO Box 2609
Sydney NSW 2001 Australia
Phone 61-2-241-1478

[b] **BIRTH IN THE 21ST CENTURY**
16-18 October 1992
Centra Hotel, Auckland, New Zealand

Contact : Box 52-065
Kingsland
Auckland 3 New Zealand

[c] **3RD NATIONAL BIENNIAL CONFERENCE OF NATIONAL ASSOCIATION OF CHILDBIRTH EDUCATORS**
1-3 October
Professional Development Centre
Barden, Brisbane, Australia

"Refresh - Renew - Revitalise"

Contact : Capers
P O Box 567
Nundah
Queensland 4012 Australia

PROFILES

SALLY PAIRMAN - PRESIDENT

Sally is the Midwifery Course Supervisor at Otago Polytechnic and is responsible for the 3-year degree course for Direct Entry Midwives.

Sally has always maintained a midwifery practice and was responsible for setting up the Otago Polytechnic Independent Midwifery Service which provides Midwife care for women in Dunedin as well as clinical experience for student midwives.

Sally has been actively involved in the NZCOM since its beginnings both as a chairperson and as an individual member. Prior to this she was active in the Midwives Section of NZNA.

Sally and Michael have one son, Oscar, aged eight months.

ANNE WOODLEY - CONSUMER REP

Anne has been involved in Parents Centre New Zealand at a local committee level since 1982 in both Christchurch and Dunedin. She has been on the National Executive of PCNZ since 1990.

Anne has been actively involved in antenatal education, training in 1987 as a Childbirth Educator. She was also one of the original working party members in the setting up of the PCNZ Childbirth Education Diploma.

Anne is currently a consumer representative on the Christchurch Midwives Standards Review Committee. Anne is a primary school teacher but presently working full time at home looking after her three children.

DEBBIE STEWART - CONSUMER REP

Debbie was nominated by the delegates at the 1992 National Home Birth Conference in Auckland. Debbie is the mother of two children, one born in hospital and one born at home. Home Birth was an empowering experience for her as it initiated her demedicalisation and helped her relearn the natural process of birthing.

Debbie is a Registered Nurse and has worked as a Practice Nurse over the last five years.

She is actively involved in the Tauranga Home Birth Association and Play Centre. Debbie was one of the working party which tendered and won a contract with the Bay of Plenty Area Health Board for Home Birth Services.

k] Workforce Development Workshops/Independence

The funding as educator for the promotion of Midwifery Independence finished in May 1992. During this time I travelled extensively throughout New Zealand but the issues remained the same - power, control and money. Integral to these powerful sources of hostility and resistance to independent Midwifery practice is the status of women.

Too difficult a job for one person, I'm afraid and the 15 months did little to enhance either my sense of justice or security. The positive aspects of the workshops were the Midwives, whose excitement and enthusiasm for the opportunities the legislation gave maternity services were boundless. Hospital and independent Midwives alike saw ways they could expand their scope of practice and revitalise their work satisfaction.

My recommendation to Midwives following my workshop experiences is to not waste energy on the arguments, the knockers, the doubters and the negatives; you will hardly ever win. We must concentrate on our partnership with women. It is through knowledge about the service Midwifery has to offer that we will change societies attitudes. This is already happening. Where Midwives offer continuity, informed choice and consent, 60-80 percent of their clientele choose midwife only care and the outcomes from midwife care speak for themselves when women are looking for a caregiver.

There are issues however which need widely debating. Shared care with doctors and its over servicing and dependency problems, labour support only, postnatal care only, relationships and responsibilities between domino and hospital services. At present these issues are often discussed in a covert and destructive way. We must find ways to address these concerns openly and effectively.

The contracts for access problem doesn't go away either. We are presently seeking legal opinions on several contracts which penalise Midwifery Independence in an anticompetive way.

This is my last annual report as President and it has been through a time of tumultuous change. It has been a privilege to have been part of such history making advances. I would like to record my warmhearted thanks to all my midwife friends and colleagues who have been so supportive over the last five years that I have been in the Chairperson/President role.

It is with great pleasure I welcome the incoming President and look forward to working with her and the College to an even brighter future.

AKENEHI KEI was New Zealand's first Maori Midwife. Does anyone have any information about this interesting woman? Registered in 1909, it is thought her whanau came from Gisborne, but we are unsure of her iwi.

Anyone with any further information please write to:
Karen Guilliland
c/- Midwifery Resource Centre
183 Manchester Street, Christchurch

ADVERTISEMENT

Interested in Homeopathy? Wellington College of Homeopathy is holding a 5-day intensive Summer School course for health professionals.

The emphasis will be on practical therapeutics. The course runs in Wellington February 1st-5th 1993.

For full details, contact:
G Gibson or Karen Johnson
IC Hom 65 Oxford Street
Tawa

BREAST FEEDING HANDBOOK

The Breast Feeding Handbook was officially launched at Conference in August and this very worthwhile book is available directly from your local Chairperson or from the:
Midwifery Resource Centre,
183 Manchester Street,
Christchurch,
*at a cost of **$19.95.***

There may be a slight delay with the supply of your order but rest assured we will get your copy to you as soon as possible.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
PROPOSED BUDGET 1993/94

The following proposed budget is for the next financial year 01/05/93-30/04/94. To be able to pay a co-ordinator for 40 hours per week and cover expenses, Subscriptions have been set as follows at NZCOMI AGM on the 29 August 1992.

TYPE OF MEMBERSHIP	TOTAL SUB	Amt paid to Region	Amt to National
Full	$155.00	$40.00	$ 115.00
Unwaged & Students	$ 50.00	$15.00	$ 35.00
Associate & Affiliate	$ 30.00	$ 5.00	$ 25.00
Associate Full Members (includes Indemnity)	$155.00	$40.00	$115.00

NB : For this financial year, 01/05/92-30/04/92, our finances and proposed budget only allow us to continue paying our co-ordinator for 24 hours work per week.
Fundraising is necessary in the regions to assist with covering the capital outlay of the Breast Feeding Handbook.
If you would like a copy of the audited accounts for 1991/92, please contact your local Chairperson.

PROPOSED BUDGET 1993/94

INCOME		
Subscriptions		$89,550.00
Conference Profits		2,400.00
Interest		1,025.00
		$92,975.00
EXPENSES		
Co-ordinator's Salary (4 days per week)	32,000.00	
Secretarial Support (Salary and Costs)	10,000.00	
Co-ordinator Support	500.00	
Treasurer	1,500.00	
Accountant	600.00	
Journals (2 per year)	7,000.00	
Newsletters (5 per year)	10,250.00	
Indemnity Insurance	8,000.00	
Postage	1,200.00	
Phone/Tolls	2,000.00	
Travel (Local)	6,000.00	
ICM Capitation Fees	2,300.00	
International Conferences	4,000.00	
Computer Costs	200.00	
Photocopier Costs	300.00	
P O Box Rental	125.00	
Subs & Affiliations	600.00	
Legal Costs (Tribunal)	5,000.00	
General Expenses	200.00	
Office Rental	1,200.00	
		$92,975.00
Net Profit (Carried Forward)		NIL
Net Profit brought forward	Nil	
Less extraordinary Expenditure		
Research Project	$ 5,975.00	
Bicultural Project	14,287.00	
Pledged money to Breast Feeding Handbook production	5,000.00	
	$25,262.00	
		$25,262.00
Net Loss for Year Ended 30/04/94		($25,262.00)