From : NZ COLLEGE OF MIDWIVES (INC)
P O Box 21-106
CHRISTCHURCH

Sian BURGESS
17 Malvern Rd
Mt Albert
AUCKLAND 1003

[SUBS DUE]

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

NATIONAL NEWSLETTER

June / July 1994

Maternity Referral Criteria Project

Caesarean Sections

Section 51 Negotiations

Conference '94

AGM ~ Remits

National Midwifery Resource Centre

904-908 Colombo Street P O Box 21-106 Christchurch Tel/Fax 03-377-2732

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142 Ilam Road	Christchurch 8004	
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Nelson

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ANDREA GILKISON
43 Rangitane Street
Palmerston North

Maori Midwives Collective
LIZ ELLISON-LOSCHMAN
JOANNE RAMARI
HERENA STONE

NATIONAL COMMITTEE CONSUMER REPRESENTATIVES

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REA DAELLENBACH
8b McMillan Avenue
Christchurch

Parents Centres (NZ)
SHARON COLE
12 Elmslie Place
Rotorua

Home Birth Association
SUSAN HOLLOWAY
13 Sutton Street
Richmond Nelson

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

MEMBERSHIP APPLICATION FORM

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

Name _____

Address _____ Area Code _____

Phone _____ Home _____ Work _____ Extn

Workplace _____

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

TYPE OF MEMBERSHIP

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

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

METHOD OF PAYMENT (Please tick your choice of payment)

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

NEW	
RENEWAL	
CHANGE	

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

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☐ Automatic Payment (contact Treasurer)

NEW	
RENEWAL	
CHANGE	

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

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Invercargill

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Beryl Davis
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Wellington

WANGANUI/TARANAKI

Sheryl Ross
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Flat 1 Hawera Hospital
Hawera

WAIKATO/BOP
Heather MacFarlane
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3 Frederick Drive
Hamilton

NELSON
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P O Box 672
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27 Shammrock Street
Palmerston North

PLEASE ENSURE YOUR COMPLETED APPLICATION FOR MEMBERSHIP OR RENEWAL IS SENT TO YOUR
LOCAL REGIONAL TREASURER

CONTENTS

SPECIAL FEATURES

WE ARE MOVING

As of the 4th July 1994, the Midwifery Resource Centre and National Office of the NZCOMI will be located at **904-908 Colombo Street** (opp Christchurch Women's Hospital). Postal address and phone number remain unchanged at present.

NEXT NATIONAL MEETING

AGM

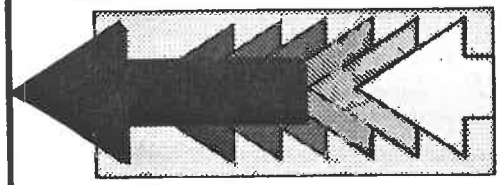
Friday 12 August 1994
Ohinemutu
Rotorua
1830 hours

Any contributions to the National Newsletter should be addressed to:
Karen Barnes
142 Ilam Road Christchurch 4

DEADLINE
for the next Newsletter is
1st August 1994
Next Newsletter will be due out late August 1994

PUBLISHING DETAILS

Editor - Karen Barnes
Typesetting by Margaret Stacey
Printing & Collating by MAS Business Services Christchurch



Editorial

Dear Members,

Welcome to another College National Newsletter. As always, there is so much to report on.

The upcoming Conference and AGM is high on the priority list for many Midwives and enclosed will be the final Conference details. We feature an article by Irihapeti Ramsden who will be a keynote speaker at Conference.

Negotiations continue on many fronts with many people spending hours working on the behalf of members. The reports presented in this issue will update you on those events. Again, we salute the hard work and long hours of those involved in these proceedings.

The "hard work" and "long hours" involved for me on the homefront have finally caught up, so this will be the last national newsletter I will be producing.

It seems most likely that Julie Richards will take on this responsibility officially after the AGM in August.

As I hand over this task to Julie, I wish to extend my thanks to all those who have helped promote and produce this newsletter over the last two years. The contributions received from around the country are always welcomed and continue to help the newsletter reflect the happenings of midwives throughout New Zealand.

My special thanks go especially to Margaret Stacey and her great band of helpers who have continued to do all the real work of producing the readable product. And lastly, thanks to the local Canterbury members who have helped in many ways to see the newsletter distributed as smoothly as possible to other regions.

Happy reading. *Karen Barnes*

..... from page 45

Home birth midwives always carry equipment for resuscitation and monitoring, the same standard of safety equipment used in the maternity wards at Lincoln and Rangiora hospitals. In the case of hospital births, most women are discharged back into the community two days after the birth, with very little follow-up care. However, home birth mothers can continue to get midwifery care for a full six weeks after the birth. During these visits, the midwife will be checking not only on the health and progress of mother and baby, but will also offer support in establishing breastfeeding.

Home birth mothers also have the support of the whole home birth network. There is a monthly magazine, a library of resource books on anything from exercises to breastfeeding, and regular coffee mornings that give the new mother an opportunity to meet other women with similar needs and experience.

A new system of support has been set up for women in extra need. A new mother can call on the help of other home birth women. Whether it's for a sympathetic ear on the other end of the phone, a cup of tea or a meal cooked, the washing hung out, or simply to hold the baby for a while.

As a nice bonus, all home birth parents can receive a free week's nappy service from Happy Nappy. The Home Birth Association is a group of mothers and their supporters who have had home births, and exists to support and foster home birth in Christchurch. It is open to anyone who believes in home birth philosophies.

The Association welcomes any parents who have had a home birth or who are contemplating a home birth. While we have closer ties with some midwives, we are not affiliated with any particular practice. If you are interested in getting in touch, you are welcome to write to the Christchurch Home Birth Association, P O Box 2806, Christchurch. ●

Assuming the doctor attends at least five courses (for example the Goodfellow Unit at an average of $25 per course), plus the cost of two RNZCUP Modules, say $100, the grand total is $5226.

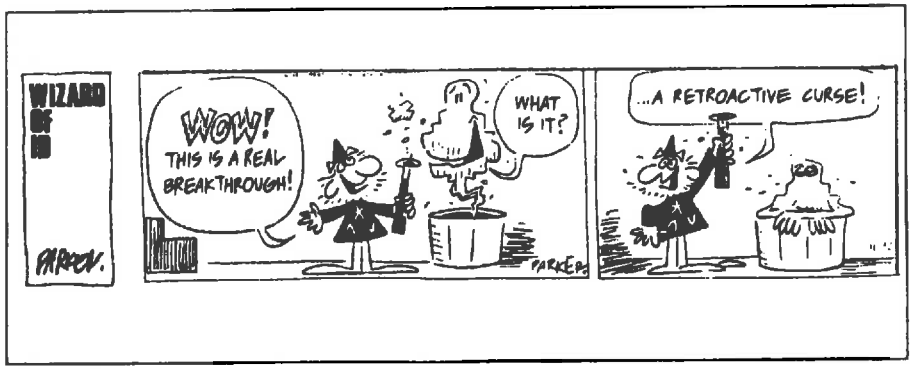
This cost is not easily recoverable, though membership of an IPA may now allow the general practitioner to be reimbursed. Presumably accreditation and membership of the College or similar entity will be the criteria for subcontracting with the IPA.

Doctors not belonging to an IPA may have difficulty recovering the necessary costs associated with continuing general practice in New Zealand.

Dr Lannes Johnson, Auckland

PRESCRIPTION PADS

These pads are still available for $5.00 each.
Please contact the
Midwifery Resource Centre
P O Box 21-106
Christchurch
for your supply.
Prescription Pads come in packets of 5.



National Co-ordinator's Forum

The last few months have been extremely busy and have seen many changes in the College's organisation.

We started as a small, voluntary organisation and have grown into a thriving "business" in only four years. It has been necessary to recognise the new demands such change makes on the structure and the individuals within. We can no longer expect the College to be run predominantly on the voluntary work of individual midwives and women as that work is too constant, often complex and very time consuming. Much like midwifery itself!

Judy Henderson is the College's new (nearly) full time secretary and is already demonstrating the wholehearted commitment that seems to be a feature of the women involved in midwifery. Welcome Judy. Until now, Margaret Stacey has provided almost six years of quite exceptionally generous secretarial services to the College. In spite of having her own business, Margaret devoted endless hours to College work and never charged us for anything like the actual hours she spent. (Richard, her husband, has also been a solid supporter of midwifery, folding and stapling newsletters, sticking on labels, delivering typing for urgent distribution and moving us from building to building). Margaret has worked nights and weekends in her own time to produce newsletters and submissions which are always required by impossible time frames. She has been a large part of our success and continues to take an active interest in our wellbeing. It has been a privilege and a pleasure, Margaret, and thank you from all of us.

The Education Workshops in May were, once again, a valuable exercise. Two years ago the College held a similar workshop in Wellington and that gathering enabled the final production of the Handbook for Practice. This year over 50 midwives and consumers in Palmerston North discussed a range of topics and formulated the College's direction for the next two years. A cross section of consumers, hospital and self employed midwives, educators, women's health managers and health agencies were involved and the debates reaffirmed the direction Midwifery is taking.

Particularly rewarding was the confirmation and consensus surrounding the Midwifery Standards Review process. A new package will be available shortly which will offer clear guidelines and the documentation required for individual midwives to review their practice. It is envisaged this review process will be applicable to all midwifery practitioners wherever they work. Some CHEs have already expressed interest in the College providing midwife employees with a Standards Review.

Other topics covered by participants were:-

- Scope of practice
- Quality assurance - a framework was produced
- Midwifery knowledge - a framework for curricula
- Competencies - in preparation for competency based Practising Certificates
- Independent Practice Guidelines
- Legislation : Amendments to the Nurses Act were identified as a priority and included:
    - removal of direct entry programmes experimental status
    - revoking the 1983 amendments which disallowed already registered Direct Entry Midwives to take responsibility for childbirth in the home
    - removing obstetrics component in nursing programmes. Most programmes now focus on family health with a student nurse following a woman through her pregnancy
    - increase in Midwife representation on Nursing Council

All outcomes and position statements from the workshops will be put together in booklet form and distributed throughout the Regions for discussion. Once ratified by College members, these statements will then lead the College's policy direction.

Another exciting development within Midwifery has been the initiatives taken by Maori midwives to network amongst themselves nationwide in order to improve access to maternity services for Maori women. We welcome their representation on National Committee and look forward to achieving our common goals. Anyone interested in becoming part of the Maori Midwives network, please contact Becky Fox, Tutor, Nursing & Midwifery Department, Waikato Polytechnic, Hamilton.

who planned out-of-hospital birth (including the small proportion of women who were transferred to hospital because of risk factors that appeared). It may be that prevention of problems is just as effective as cure.

I completely agree with Dr Newhouse that women must have the right to a free choice of caregiver and place of birth, based on full knowledge of the risks, benefits, and costs of each alternative. But the information that they are given must be complete, and based on the best available evidence, rather than on anecdote or prejudice.

Murray W Enkin MD FRCSC(C)
Professor Emeritus
Dept of Obstetrics and Gynaecology
Clinical Epidemiology and Biostatistics
McMaster University
22/5/94

Wondering about your subscription for the College of Midwives? Consider this.....

LETTER TO THE EDITOR OF NZ DOCTOR

Paying fees to keep in practice

Membership fees for the various societies and associations have been rising steadily over the year. It is now salutary to add up the cost of belonging to the Royal College of General Practitioners in New Zealand.

Membership of the Medical Association of New Zealand is $632 and added to this is the membership and various levies associated with the Royal College totally $369.

Re-accreditation imposes its own cost by way of prime commitment and often definitive costs of attending courses. On the assumption that 50 points per year represents 50 hours involvement the cost for a general practitioner at $80 an hour is $4,000.

Since the present standard of care is birthing in hospital, birthing centre delivery should be considered experimental until it has been demonstrated that it is as safe for mother and infant as in-hospital deliveries (Canada currently has one of the lowest neonatal mortality rates in the world).

Women should therefore provide written informed consent after they have been provided with all the relevant information regarding the risk/benefit of out-of-hospital birthing and have been made aware that safe, modern anaesthesia (eg epidurals) will not be available to them in birthing centres.

M T Newhouse, MD
Clinical Professor of Medicine
McMaster University Faculty of Health Sciences, Hamilton

The Globe and the Mail,
Monday May 16, 1994

To the Editor,

I was most gratified to learn of the happy results for Dr Newhouse's new grandson, assisted by the expertise of highly skilled specialists in a first rate obstetrical department. He will also, no doubt, be pleased to learn of the safe arrival of my new granddaughter, in her own home, assisted by the expertise of two highly skilled midwives.

The midwives's skill was in the care of normal pregnancy, the prompt recognition of deviations from normal, and the institution of preventative care to avert near-disasters, as well as in infant resuscitation in emergency situations.

But as a scientist, Dr Newhouse knows that personal anecdotes, whether of horror stories or of happy outcomes, can never establish the relative safety of various birth settings for women without identified risk factors. Many doctors believe that hospital is safer for all women; many women believe that home or out-of-hospital birth centres are safer, and which actually is safest can only be answered by looking at the data.

Several large cohort studies of carefully matched low-risk women have shown no difference in the outcomes for babies born to women planning birth at home, in out-of-hospital birth centres, or in hospital. The women who planned hospital births, on the other hand, experienced more forceps deliveries and Caesarean sections, with their inherent risk to both mother and baby, than did the women

Professor Murray Enkin had a very successful tour around New Zealand and was very positive and encouraging about Midwifery's achievements. Murray was able to talk to both the RHA and Ministry of Health representatives and believes the Midwifery Model of Care to be held in respect by both bodies. He was impressed with New Zealand's efforts to be consumer based and in the main found the level of debate surrounding research based care to be insightful and valuable. The purpose of his tour was to encourage co-operation and discussion between all maternity care providers over the issues which face us all. It is a measure of his style and presentation, together with the help of his wife, Eleanor, that he was able to achieve this so pleasantly. He challenged all of us to reflect on how we practice and to make changes according to evidence available rather than anecdote or custom.

For those who would like to research their practice further, Murray tells me his new 2nd edition "*Guide to effective care in pregnancy and childbirth*" has just been published and will be available in medical bookstores shortly.

The Midwifery Resource Centre was also recently visited by a Professor of Nursing from America and she too was very impressed with midwifery in this country. She was able to take back the video "Active Birthing" to her maternity nurse students (no midwifery school in her large base hospital and only four certified midwives practising). She wrote to me on returning home and I quote "*I also want to thank you for the birth film. Such a treasure! I have had it retaped so I can use it on an American VCR in my classes. I have shared it with both of my classes who were very eager to hear about the visit. So I could tell the students that there is a place where every day women receive high quality sensitive care. Both classes, the undergraduates and the graduate classes loved the film. After it was over they sort of sat quietly so I asked what they thought. Their comments were so positive. Some of the graduate nurses who work in labour and delivery had never seen an unassisted birth and were amazed by it. They too said to say thank you for the film.*

Some of my younger undergraduate students said that the film encouraged them to seek midwifery care should they have children in the future. So the reactions were very positive."

Another letter from the South African Independent Midwife Association congratulated us on the *"fantastic initiative taken in order to reinstate midwifery as an autonomous profession."*

Yesterday, a South Australian Senator wrote, acknowledging our achievements and requesting the College's help with information on strategies which could give Australian women greater choices in childbirth, reduce their intervention rates and allow midwives to practice autonomously.

It is disappointing then that while the outside world is full of praise and admiration for New Zealand midwives achievements, some of our own colleagues are still unable to accept midwifery as a profession in its own right. There is still a small but persistent mindset amongst some Women's Health managers and even some midwives that insists women must be "protected" from midwife only care. It is, I believe, a measure of their own fear of birth from a medicalised perspective, coupled with a lack of trust in the ability of women to be responsible for their own choices that motivates this unwarranted distrust of midwifery practice. There is no evidence that midwifery care is unsafe - on the contrary, midwifery care produces outcomes that are significantly more favourable than the national averages.

A retrospective chart analysis of midwife only care attended births in Canterbury and Auckland show an 80-85% normal birth experience for the women who chose Midwifery only care. The Canterbury study showed Caesarean Section rates were 7% and induction rates 8%. These results in a region where the Caesarean rate is 23% and induction rate is 20%.

The following is the breakdown of normal birth rate according to care givers at Delivery Unit One National Women's Hospital (July 1993-April 1994)

I think it unlikely that more than a very small subgroup of women with even a modest understanding of the additional risks of childbirth to both mother and infant would choose such a medieval way of birthing unless forced to do so.

I use "forced" advisedly because I think it likely that birthing centre deliveries will cease to be optional after obstetrical beds have been reduced to a minimum as a "cost-cutting" measure.

Birthing centres, even with the best trained midwives, will be unable to cope rapidly with unexpected complications that are difficult to deal with effectively even under the most ideal conditions of modern obstetrics.

The sad outcome of the current approach to birthing espoused by our scientifically naive and theologically socialist Ontario Ministry of Health will be maternal and infant deaths as well as life-long tragedies such as cerebral palsy due to prolonged oxygen deficiency while infants are transported by ambulance to hospitals. Further delay will result from the need to assemble an appropriate team of hopefully on-call obstetricians, nenatologists, nurses and technicians.

The women of Ontario should be told that modern and safe anaesthetics such as epidurals will not be available to them in these birthing centres. Assurances that such centres have proved successful in other countries should be examined critically, since in the United Kingdom increasing numbers of women are again choosing the hospital rather than the birth centre option.

As an additional bonus for mothers-to-be, this potentially hazardous obstetrical care comes at an additional cost to the taxpayer, since already established and paid for hospital facilities, skilled obstetric nurses and properly trained medical specialists will still need to be available for emergencies.

Has the present government of Ontario totally lost touch with reality, or is it simply pandering to the demands of yet another small but noisy minority? This question could be settled rapidly by a poll to determine just what percentage of Ontario women have a preference for out-of-hospital birthing.

NEWSLETTER OF THE MIDWIVES ASSOCIATION OF BRITISH COLUMBIA *APRIL 1994. VOL. 1 NO. 1*

WHICH IS WITCH - MIDWIFE/OBSTETRICIAN

Midwives are coming. It would be naive to suggest that there has not been a certain amount of resistance to this notion. As resisters we are rank beginners. A text published in 1484 by two German Dominican monks, "The hammer of witches", stated quite categorically, "The greatest injuries to the Faith are done by midwives; and this is made clearer than daylight itself by the confessions of some who were afterwards burnt". I am not advocating the same positions by obstetricians, I just wish that I could shake the nagging feeling when I hear the public pronouncements of some of the more radical proponents of midwifery that they do not have something similar in mind for us.

Journal SOGC November 1993 reprint
Patrick J Taylor, MD FRCSC
Department of Obstetrics and Gynaecology, University of BC

The battle continues .... in Canada

LETTER TO THE EDITOR
The Globe & The Mail

Expensive freestanding birthing centres and overpaid midwives are simply another nail in the coffin of a once-proud health care system.

I am writing this letter because only the prompt and highly skilled response of knowledgeable specialists in a first-rate obstetrical department prevented a neonatal disaster when my grandson was born recently. He inhaled meconium, which caused lung injury and a problem with oxygenation. Because of prompt resuscitation efforts he could be liberated from the infant ventilator in about three days, and at age two months is just fine.

NATIONAL WOMEN'S HOSPITAL - AUCKLAND
Delivery Unit One - Experience July 93 - April 94

Normal birth rate according to care giver

Month	Independent Midwifery Care	Shared Care
July	75%	66%
August	80%	60%
September	81%	61%
November	71.4%	72.7%
December	89.4%	62.5%
January	87.5%	60.5%
February	68.4%*	56.8%*
March	77.7%	71.7%
April	82.5%	70.8%

* Holiday period and change in primary care giver

These observational studies need to be balanced by a controlled study, however they do indicate that midwife only care is as safe as any other care option available to women. In fact they show midwife only care provides a higher incidence of normal outcomes.

Some CHEs last year combined forces and commissioned a legal opinion on their ability to control midwives access to CHE facilities. We believe their advise to be poor and plan to challenge the medicalised approach it takes. Meanwhile however some managers (many of them nurses or ex midwives) have taken the opinion as read and proceeded to develop quite obstructive and demeaning access conditions for self employed midwives. These discriminatory measures will also have spin offs for hospital midwives who wish to practice independently within the hospital. I urge all midwives to defend their education and registration which enables them to practice independently. No midwife needs an IV certificate or standing orders to prescribe or diagnose or treat. That is your statutory right.

To not defend this right reduces a midwife's role once again to that of obstetric hand maiden. IV certification arose from the needs of the nursing profession. Epidural certificates are a delegated medical task. Midwives already have a role which is valuable and valued. It does not need or wish to have the permission of the medical profession to carry out cares that are the role of the doctor in order to gain status. It is unacceptable that women are denied their chosen midwife caregiver because that midwife does not provide a service for anaesthetists. It is unacceptable that a midwife is denied access to CHE facilities because her normal birth rate is so high she cannot gain the epidural experience necessary to gain an "epidural certificate".

The CHEs are in effect punishing the midwife (and her clients) because they are so successful at their primary role in normal birth. It is time all those involved in maternity services supported and encouraged midwifery practice rather than try to eradicate it. ■

PROFESSIONAL INDEMNITY INSURANCE

We have negotiated a new Indemnity package with the underwriters now being AMP Australia.

The new package includes
- Civil liability (previously covered)
- No overall limits to College claims (previously $5 million)
- A $250 excess on each claim (previously $500)

The cover is still for $200,000 per claim with a maximum of $400,000 in one year. We believe this cover to be adequate. Midwives who require additional cover however can do so under our policy on an individual basis with the insurance brokers. Please contact

Dean Edwards
MINET PROFESSIONAL SERVICES
P O Box 470
Auckland Phone (09) 379-0929

if you wish to take advantage of higher cover at an additional premium.

A copy of the new policy is available on request from your local Chairperson or the Midwifery Resource Centre.

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

More choosing home births

Children's writer Ged Maybury and Anna Venczel are home birth parents who enthusiastically support the practice of home birth. They explain why they are committed to encouraging parents-to-be to consider this option.

This week a home birth will happen in your neighbourhood. There will be no fanfare, no front page coverage. It is hardly news, for it is perfectly normal, and it is happening everywhere.

More and more families are choosing this option. More often, you will read in the birth noticies, "Amy, a new sister for David and Lucy, safely born at home. Thanks to the midwife and all our support team..." People who choose this option describe it as totally supportive.

"I didn't know having a baby could be this simple," said one client. "The midwives were just great." That may well be why more and more parents-to-be are choosing home birth. It is safe, normal and they know they will be getting complete, continuous care.

Their home birth midwife, a fully trained professional, will provide them with total care, from conception to six weeks after the birth. No doctor will be required, although parents-to-be can still opt to involve their family doctor, if they wish to.

Put simply, home birth midwives specialise in supporting women to give birth at home. They are available 24 hours a day. Although most antenatal care, in early pregnancy, is at the Christchurch clinic, they cheerfully do housecalls in later pregnancy, or if a woman has transport problems. No risks are taken. Out of all the births, in hospitals or at home, 80% of women can give birth naturally. Of the rest, nearly all who might need extra care or specialised services are identified early and receive appropriate monitoring and a carefully planned birth. If necessary, the care will be transferred to a specialist and home birth midwives continue to support the parents in a hospital situation.

contined on page 51

Breast-feeding at work sought

Healthlink South's Public Health Unit staff say the Year of the Family is a good time for employers to look at introducing mother-friendly workplaces.

The unit's own work area has become "mother-friendly" as an example to others of what can be achieved.

Impetus for the concept stems from the 1990 Innocenti Declaration, a World Health Organisation-UNICEF document, which promotes breast-feeding as best for the health of mothers and infants.

It declares that "obstacles of breast-feeding within the health system, the workplace and the community must be eliminated." In Christchurch Healthlink South is urging employers to:

- provide a room that can be made available as required for breast milk to be expressed or for mothers to breast-feed babies.
- make sure a refrigerator is available for storage of breast milk.
- acknowledge that women have a right to breast-feed babies, whether in the space provided, or more publicly if they so wish.

The unit's nutrition activity manager, Rosemary Hewson, said many women were interested in the idea, but employers were slow to take it up. "There's a wealth of information saying breast-feeding is good, yet women who want to, or have to return to their careers after having a child often feel they have to give up breast-feeding.

The promotion of mother-friendly workplaces is to try and get round this situation. Anyone wanting further information may call the unit on 03-364-7857.

"The surest way to make yourself happy is to make someone else happy."

Profile

JUDY HENDERSON

Having a front office/secretarial background and having lawyers, accountants and hoteliers for former employers, I am finding working for the College a far cry from any of those but nevertheless so far, a refreshing, challenging and enjoyable experience.

Born and educated in Dunedin (still very much a parochial "Otago-ite") and having travelled extensively, husband Ray and Golden Lab, Holly, are very settled in Christchurch after our shift from Alexandra some 12 months ago.

Any spare time is spent gardening, following my favourite sports and jogging. I'm very partial to all food and especially a good red wine or two.

REMITS TO AGM - NATIONAL COMMITTEE REMITS

(to be read in conjunction with other Remits on page 25)

BY LAWS

Change

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

Add

5. That each regional Treasurer/Membership representative forward on a monthly basis the standardised Membership Summary form complete with fully completed membership forms for any member who has joined or renewed their subscription that month.
6. That the regional Treasurer/Membership representative check all details on computer printout of membership list on a 3 monthly basis as issued at the time of each national committee meeting.
7. Membership must be paid in full for new members owing in the first half of the financial year. For those new members joining in the second half, fees will be worked out on a monthly percentage basis.

Section 51 Negotiations

- Sally Pairman

The repeal of the Social Security Act with the enactment of the Health and Disabilities Services Act in 1993, means that legislation surrounding the maternity benefit is now found in Section 51 of the HDS Act. The Regional Health Authorities are now responsible for managing the maternity benefit and negotiating the fees in the schedule with the New Zealand Medical Association and the New Zealand College of Midwives.

Towards the end of the 1993 we entered another negotiating round to fix the fees in the maternity benefit schedule. The NZCOM negotiating team consists of Karen Guilliland, Jo Coco, Carey Virtue and Bronwen Pelvin. Several meetings have been held between the three parties, the last being April 22. At that meeting I joined the negotiating team and we took Gill Down, an accountant and consumer from Christchurch. All of the Regional Health Authorities were represented as they are negotiating as a combined group. The NZMA is represented by varying numbers of GPs, obstetricians, anaesthetists and paediatricians.

At the last meeting we discussed the document produced by the RHAs titled 'Joint RHA maternity strategy'. This document has developed out of the Coopers and Lybrand report on maternity services and is one part of a four pronged approach by the combined RHAs to look at maternity services, or as they describe it 'the maternity project'.

The four aspects of the project are as follows:-

1. Section 51 negotiations
2. Maternity Service specifications
3. Guidelines for specialist referral
4. Qualifications and experience of practitioners

The document discussed at Section 51 negotiations sets out the RHAs plan for restructuring the maternity benefit schedule. This is the same document that Midland distributed to all practitioners and CHE's in their area. Central and Southern have also sent it to the CHE's in their areas.

RHAs promise to purchase the most independent information they can and could contract with several organisation for that.

The College of Midwives oppose the planned shift from fee for service to payment for particular modules of care, but they see it as inevitable. "Philosophically, we don't believe that compartmentalising the women's pregnancy into modules is a useful thing to do. It just reinforces that whole idea that ante-natal care is somehow separate from birth, whereas for the women it's one experience", Ms Guilliland points out.

At the moment the College is seeking clarification from the RHAs about what is considered a lead professional and a clear definition of just how many sub-contracts a lead professional can give to others.

"A lot will depend on the definitions as to whether the components will work."

However, Ms Guilliland warns it might be women themselves who could cause the downfall of the module system.

They might not let anybody know that they've changed their lead professional - one is not aware of the other [lead professional], so one doesn't get paid."

Since the 1990 Nurses Amendment Act, 25 percent of pregnant women are now choosing their own midwife.

"Midwives aren't going to go away, because women keep choosing them. Therefore, what we have to do as a profession, midwifery and GPs, is to get together and work out how best we work the system so that none of us are in conflict.

"Personally I'm just sick of fighting and if everybody could sit down and work out something we could all live with, it would be a joy", Ms Guilliland said.

"If you're headed in the right direction, each step, no matter how small, is getting you closer to your goal."

Pregnant women not seeing GP, midwife

- Vicky Tyler

Some pregnant women are missing out on care from both GPs and midwives because Government agencies are not getting information about maternity services to women, claims the New Zealand College of Midwives.

The College says some women are turning up to city hospitals in labour having never seen a doctor or a midwife during their pregnancy. It blames this on Government agencies for failing to make all women aware of the services available to them.

National Co-ordinator Karen Guilliland claims some women do not know they can go to a GP for maternity care, let alone a midwife; and it is a problem that is increasing with unemployment and changing family dynamics.

She hopes the situation will have changed by the time the new maternity service funding system is introduced, when women are expected to choose a 'lead professional' for their pregnancy care.

Ms Guilliland says relying on midwives and GPs to spell the options for pregnancy care would be naive because of the competition involved.

No other business in the world is expected to give all the opposition's advantages. It's pretty unrealistic. It's really another indicator why health shouldn't be a business.

"We would be pushing for the Public Health Commission, the Ministry of Health and the RHAs to provide the options." The Midland RHA is currently conducting an in-depth review of maternity information. RHAs plan to purchase independent information on birthing options in the 'long term'.

But as there are no organisations informing women about their options at this stage, they will be initially relying on providers to get that information across.

This distribution has given the impression that the documents will be the base line contract as is and some CHE's seem to be treating it as such. However the document is still under negotiation and changes will be made. Any comments or suggestions you would like to make are welcomed by the Negotiating Team.

The RHA's are proposing to contract directly with the 'lead professional' ie. The person who at any given point of time is taking both clinical and commercial responsibility for women's care needs.

Payment will be made on a modular basis with a set fee to be negotiated by the three parties for each module. The lead professional need not provide all components of care as identified in each module (and by the service specifications) but will be expected to have in place arrangements with other providers to ensure the full range of required services is provided eg. A GP could be the lead professional and subcontract out labour care and postnatal care to a midwife. The lead professional will be paid the module fee and out of that will be responsible for paying subcontracts.

The proposed modules are as follows:-

1. **Information Module**
   Information re choice of provider (generic), general aspects of care and education, possible outcomes, other information.

This module could be provided by a health professional or consumer group and a fixed fee will be paid. Each woman is entitled to only one information module.

2. **Pregnancy Module**
   (a) Information provided after needs assessment of woman - Services offered, quality of care and performance indicators, complaints procedure, advocacy services, outcomes, possible interventions etc.

   (b) Pregnancy Care: first complete examination, all pregnancy visits, all ultrasounds, all mileage, education and advice (not antenatal classes), urgent attendances, false labour attendances.

Fixed fee paid per trimester to lead professional.
Specialist consultations paid separately.

3. **Labour and Birth Module**
   (a) Management of labour and birth: includes management, education and advice, mileage, urgent call outs, ultrasound, all care including midwifery (paid to lead professional).

   (b) Support attendance at birth: second person at birth when CHE midwifery or medical services not used and where lead professional is the only other person claiming fee. Mileage, urgent call outs, education and advice (may also be paid to CHE if self employed practitioners not used). Specialist consultants paid separately.

   (c) Miscarriage attendance: fixed fee to lead professional.

4. **Postnatal Module**
   (a) all post natal care in hospital or at home, education and advice, mileage, post natal examinations of woman, post natal examination of baby, transfer of baby to well child services. Fixed fee to lead professional.

   (b) Post miscarriage or termination care - all care necessary, education and advice, mileage, final examination.

   Fixed fee to lead professional.
   Specialist consultations paid separately.

5. **Main issues**
   (a) NZCOM is concerned about the definition of lead professional.
   How can one professional take responsibility for the clinical decisions and care of another professional? We are seeking a 'legal' opinion on this.

   (b) Need clarification on what happens when a woman transfers to secondary care.
   Midwives need to be able to continue to provide midwifery care.

The AGE, Melbourne Nov 1993

Midwives set back in bid for autonomy

By GARETH BOREHAM,
medical reporter

Victorian midwives say the State Government has caved in to pressure from doctors in deciding to not go ahead with a law that would have allowed Victorian midwives to supervise births without an obstetrician.

Midwives had successfully lobbied the Government to have the strict regulations, which apply only in Victoria, scrapped under the Nurses Bill now before Parliament.

But the Royal College of Obstetricians and Gynaecologists this week convinced the Health Minister, Mrs Tehan, to have the guidelines retained. An amendment tabled in Parliament this week will effectively retain the status quo until the clauses come up for review in 1996.

The chairwoman of the Midwives Action Goup, Ms Beverley Walker, said midwives had been been betrayed by the Government.

"If we had got it through, it would have been the most exciting moment for midwifery this century. It has just been stopped at the door and we are very, very angry," she said.

"I have had midwives on the phone to me in tears today. They just cannot believe that the Government would capitulate like this."

Ms Walker said midwives were with women throughout a birth. "The doctors just come along and demand $1000 for five minutes," she said.

Mrs Tehan said she could understand midwives being upset but the Government was not prepared to scrap the regulations without support from obstetricians.

The Australian Nurses Federation attacked the Government for heeding doctors' advice on a bill that did not concern them.

A federation officer, Ms Kelly Minogue, said the Government's reimposition of the midwifery regulations was inconsistent with its desire to deregulate the nursing industry through the new act.

"It seems to suggest that Mrs Tehan is happy to listen to professional associations that are not covered by the bill but will not consult with those that are."

But Mrs Tehan said nurses would be free to contribute to discussion of the Medical Practitioners Bill, which will be introduced into Parliament next year.

The Opposition health spokesman, Mr Roper, has condemned the legislation for its proposal to set up a ministerially appointed nursing board to replace the existing Victorian Nursing Council.

"This legislation is a dangerous and backward step, both for the safety of patients and for the future quality of the nursing profession in this state," he said.

OTAGO DAILY TIMES Friday May 6 1994

New-born baby oblivious to International Midwives Day

By Andrea Jones

Being the first baby born on International Midwives Day this year was no laughing matter for Joseph John Lawless, pictured with his mother Margaret and midwife Janice Kontoules at Dunedin Hospital's Queen Mary unit yesterday.

Joseph, weighing just over 4.3kg was born at 0.03am. As one of the babies born on International Midwives Day he received a certificate marking the occasion.

President of the New Zealand College of Midwives Sally Pairman, of Dunedin, said the aim of the day was to make women aware of their choices and realise the different options within midwifery. Ms Pairman said New Zealand began marking the day in 1985.

The idea was taken up by the International Federation of Midwives the following year and the day has been celebrated since.

Ms Pairman said there were about 80 members of the New Zealand College of Midwives in Otago and about 1500 members throughout the country.

(c) Need clarification on expectation of continuity of care and involvement of lead professional eg. could a GP who doesn't practice obstetrics be lead professional and subcontract out all care?

(d) Where is the choice of provider for woman? How easy will it be for women to change caregiver? Can women have any choice re: subcontractors? (RHA say not)

(e) The RHAs mention qualifications and experience necessary for practitioners not only to access the maternity benefit but CHE facilities - NZCOM is seeking clarification on these. Who defines experience and on what basis?

(f) The attempt to reintroduce a doctor's involvement in every birth (eg. paediatric check at 48 wks and 6 wks, maternal medical check at 6 wks) This is unacceptable and is in breach of the Nurses Amendment Act which enabled midwives to practice on their own responsibility.

Where to Now?

- The RHAs hope to implement the maternity project units entirely by October 1.
- The second draft of this document is anticipated to go out to negotiating groups shortly.
- Further detail will come from the report on referral criteria and service specifications which are expected shortly.
- NZCOM, NZMA and the combined RHA's will be meeting again shortly to look at these documents. The details of the modules will be finalised before we start talking about the fee which should be attached to each one.
- In the short term (ie. next year) practitioners will be paid on a per case basis using the modular system. Later providers may have to contract for a certain caseload for payment.

Implications for midwives

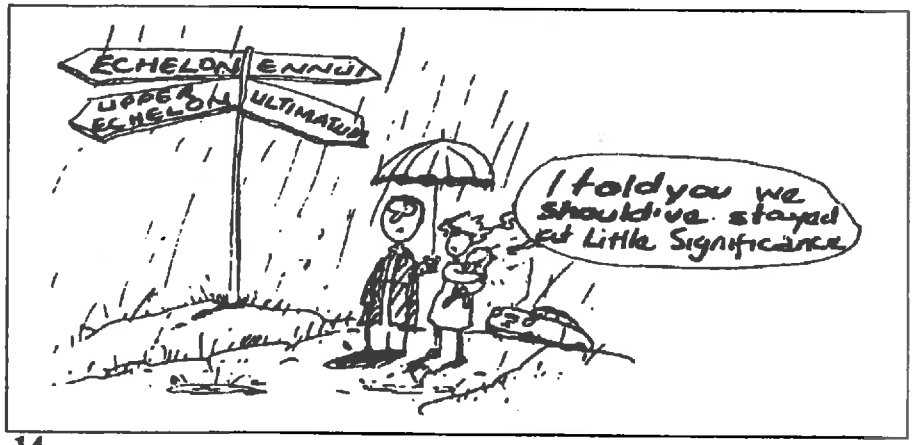
- If midwives act as lead professionals the modular system of payment will suit well.
- Midwives agreeing to be subcontracted by GPs or Obstetricians face risks regarding financial remunerations, clinical responsibility and autonomy, ability to provide continuity of care.

NB: At this stage the combined RHAs are looking for a national agreement regarding fees for the modules. It is in our best interests to work with them on this basis. Small groups of midwives or GPs seeking to contract directly with the RHAs run the risk of undermining our negotiating position which not only risks decreasing the fee for everyone but may have major effects on womens choices.

It is tempting to go down this path and try to negotiate something suitable for your own group, but this will have major implications for the maternity service.

It is our best advice that we work together to set a national fee structure and use that as a base for any local contracts which could then be negotiated above that for specific reasons (eg. specialised type of service)

We will keep you informed of progress on this and other aspects of the maternity project through your local chairpersons and the newsletter.



Media Watch

HAPPY BUNCH:
Taranaki midwives join New Zealand College of Midwives Taranaki spokesperson Tricia Thompson (right) in making up floral bouquets to give to clients today as part of the United Nations International Year of the Midwife.

The Taranaki floral arrangements were part of a nationwide gesture to highlight the campaign, said New Zealand College of Midwives Taranaki spokesperson Tricia Thompson.

The 37 Taranaki midwives will give clients their floral arrangements wherever they are - in the labour ward, ante-natal, post-natal, neo-natal or out in the community. The midwives work from New Plymouth, Stratford and Hawera.

"We believe safety in childbirth is every woman's right and that women are essential to the wellbeing of nations, primarily as mothers of the future generations of countries, and also as major contributors to the workforce", said Ms Thompson while making up the floral presentations at Taranaki Base Hospital in New Plymouth.

Midwives around the world would be urging their governments to concentrate on improving the health of women within their own country and to endorse initiatives to reduce maternal mortality and morbidity, said Ms Thompson.

Photo: DWAYNE SENIOR
Taranaki Daily News
5/5/94

ACCEPTING OTHERS FOR WHAT THEY ARE

When nurses see confusion, anger, pain and embarrassment, they must understand they are not there to pass judgement, they are there to give the best service in each situation without further demeaning people or causing them stress.

4. Is cultural safety working?

There is anecdotal evidence. For instance, I discussed cultural safety with my own people in Christchurch recently and many of them said that they had noticed a change in nursing service, particularly among recent graduates. One aunt told me about our relation who took all his linen into hospital with him. When the nurse asked him why and told him that hospital linen was properly laundered and regularly changed, he replied, "Yes, but nobody's died in these!", and it is accepted. In my day that man wouldn't have had a hope of retaining his preference and cultural safety. He felt safe within that hospital environment because his cultural needs had also been attended to.

The real issue is to give people a choice of services which they consider to be safe, both technically and culturally.

Other cultures have never had a choice in health service delivery in this country. It has always been designed and delivered according to the beliefs and values of a single culture which has happened to outnumber others.

It must not be assumed that Maori people conform to stereotypes, just as it wouldn't be assumed of pakeha or Indian or any other cultural group.

Stereotypical cultural assumptions can be humiliating, demeaning and dangerous - dangerous because people will avoid the service to avoid feeling bad.

Cultural safety teaches nurses to understand themselves and the powerful position they occupy. It explains that their attitudes can deeply influence the access of people from other cultures to service.

The art of nursing involves a rich, wise and productive interaction between people. People certainly know then they do not feel physically, emotionally or culturally safe. They are very clear about telling us and at last we as a profession have begun to listen and respond.

NZ Quality Health No. 11 April 1994

NB : ***Irihapeti is a keynote speaker at the NZCOMI conference in Rotorua in August.***

The Maternity Referral Criteria Project

Joint RHAs and Core Services Committee called the NZCOM, College of O&G's, GP's and Paediatric Society to a Hearing on their proposed criteria for specialist referral document (some 248 criteria). This is the Opening statement from the NZ College of Midwives at that hearing on 22 April 1994.

NZCOMI Representatives :	Sally Pairman	Dunedin
	Judi Strid (Consumer)	Auckland
	Jacqui Anderson	Christchurch
	Jo Coco	Auckland
	Carey Virtue	Wellington

"The NZCOM wish to make the following points. These points underlie all other comments made by NZCOM today.

1. The stated objective of this project is to promote the safety of women and children by providing referral criteria for appropriate specialist care. Where is the evidence for this? We believe safety can be assessed from analysis of the outcomes of care and that it is the management which is important, not the fact that referral has been made. Referral to a specialist per se does not necessarily improve the outcome or promote safety. This project implies that once referral is made, quality standards are automatically met. What about discussion of the appropriateness of ongoing care? We are forced to assume that it is only Midwives and GPs whose practice the RHA wants to monitor. This is unacceptable given that all practitioners are accountable. There is an acceptance in this project of medically based criteria and an implication that the referral process is all one way - to the specialist. Will we see another list of predictors of normal pregnancy and birth where the specialist "must consult and transfer care" to the specialist in normal birth, the midwife?

2. Whatever the referral factor, no specialist is able to carry out the care of the mother or the baby alone. Midwifery care is required throughout. Even if the responsibility shifts for a time from the midwife to the obstetrician, the midwife must still continue to provide care. After the intervention is performed, responsibility must go back to the midwife who has a major role in assisting the woman to resume her 'normal' lifestyle in the community as soon as possible.

3. The concept of a list of indicators for referral denies that the woman is at the centre of the childbirth process. It does not recognise women as unique individuals requiring individual assessment. It does not recognise womens' choice in making decisions about care and the fact that they must give informed consent. Women will not accept this approach.

4. Informed consent is touched on. Given that this list will clearly be linked to payment structures, what will happen if the woman refuses the advice of the primary practitioner? Will she no longer be eligible for public maternity care? Will the practitioner not be paid? Will practitioners begin to make decisions and provide care on the basis of payment rather than the best interests of women and babies?

5. The original list sent to the expert panel identified the Obstetrician as the appropriate specialist to whom referral would be made. Our responses reflected this. In some cases we identified other specialists we felt more appropriate. Frequently our responses fell in the range of 1-3 because we felt links between condition, subheading, measure of severity and rationale were tenuous and unsupported by evidence. Indicating a range of 1-3 was to enable clarification. Some factors we felt should be removed. In all these cases our responses have been recorded in the second list as 1. This misrepresentation of our view has, we understand, already had negative connotations for midwifery amongst our colleagues and in the community. The collation of responses by Terranova has been arbitrary. Failure to record our qualifying comments has added to the misrepresentation. We doubt the commitment to real consultation in the way the project has been carried out so far. The form itself does not allow for discussion or diversity, the collation is faulty and the second list arrived only on Wednesday, leaving no time to adequately prepare for today.

ACCEPTING OTHERS FOR WHAT THEY ARE

Cultural safety teaches the social and historical environment around many Maori people and shows why they may not know of the custom. The issue is how to offer the placenta without humiliating the patient from whom this knowledge has been taken during the process of colonisation.

If cultural safety is well-taught nobody should feel guilty or personally responsible for the past. If it's crudely taught people respond angrily, which is understandable. It is critical to accept responsibility for future practice while understanding the impact of the past.

Nursing students do not want to learn anything which does not relate to practice. They're in the course to learn nursing - they don't want ethnology. It's hard because people want soft options. They want the lovely romantic notions - what the natives do when they're in hospital.

Well, the natives do what everybody else does - they require nurses to have excellent communication and to accept their difference as legitimate - nurses technical skills are of little use if they cannot communicate.

3. Will it improve the quality of nursing for Maori and other groups?

Nurses have to be able to work effectively in a society which is becoming increasingly diverse. It is also important to remember that many nurses never work in hospitals - they work in schools, homes, and the community, helping to keep healthy people healthy. If nurses are running programmes in the south-east Asian community about glue ear, then cross-cultural skills need to be very good. Nurses won't need to understand rituals because they will be guided through them if necessary. Nurses do need to know how to approach people in the right way, and how to modify their own language to suit the people.

The way to get useful health messages through and be a successful service provider is to understand one's own attitudes and not judge or patronise others. If a nurse is working with powerless people, those attitudes will come through - nothing is more obvious to people in powerless positions.

ACCEPTING OTHERS FOR WHAT THEY ARE

The objectives are to educate nurses and midwives to:

- examine their own cultural realities and the attitudes they bring to each new person they encounter
- be open minded in their attitudes toward people from differing cultures
- not blame the victims of historical and social processes for their plight
- be considered culturally safe to practice by consumers

2. How is cultural safety taught?

The closest different culture experienced by New Zealand nurses is tangata whenua culture and the focus has been on Maori because of that. This is the culture which has the poorest health status currently. About 10 years ago, the Department of Health became concerned and decided to do something about it.

People began to understand that many Maori do things differently and a romantic wave swept across nursing education. It was thought that one had to understand customs and traditional rituals to nurse Maori people effectively. Students were learning bits of language - one school of nursing was teaching the poi and the Lord's Prayer in Maori. People were teaching romantic information about how lovely we were, but at that time there was little examination of the delivery of service in relation to the social and historical environment of Maori people. We were teaching a version of traditional cultural knowledge, yet most Maori are highly urbanised and have been so for 45 years - romance is easier than pragmatism.

I watched student nurses' reactions to being told how lovely we were, and conversely how lovely they were not. It set up predictable anger reactions and did not translate into understanding the issues in a nursing framework. I saw that the framework needed to be broader and tighter.

An example concerns the practice of giving the placenta to mothers. Recently midwives and obstetricians, who have been taught the traditional custom, have been taught the traditional custom, have been saying that when young Maori women are offered their placentas they don't know what to do with them.

6. It is stated that the lead professional is accountable for secondary referrals as qualified by legislation and health policy. This is incorrect. The professional accountability is measured by professional standards of practice and the scope of practice. Legislation and health policy do not provide guidance and it is not appropriate that they should. This statement needs to be removed.

7. We question why the maternity service has been singled out in this way. Other areas of health care are not subject to this type of control of practice. For instance GPs are not questioned about their ability to assess and refer in their General Practice. Why then does this occur for maternity service providers?

8. Set referral indicators undermine the professional judgements of practitioners and insults the education of Midwives and Doctors. Surely the point of health professional education is to prepare practitioners to make assessments and judgements about client care. The focus should be on keeping practitioners skilled and updated rather than providing them with lists on how to practise. No risk list will make any difference if the practitioner is unable to assess and recognise the problem in the first place. Practitioners must be able to recognise their particular professional groups. The risk list may inhibit referral as much as it encourages and this could be equally detrimental to the client.

9. In our view the most effective way of promoting safety and rationalising primary and secondary maternity care services is by analysis of outcomes. Outcomes will be able to be measured and linked with practitioners. At that point this sor of discussion could occur on the basis of knowledge and real scientific evidence. In our view the development of referral criteria needs to be delayed until the database is implemented and information gathered. Rather than discussing referral criteria today, we could use this opportunity to discuss what information needs to be collected and what goes on the database.

We are now waiting for the outcome of this hearing. The RHA and Core Services have made it quite clear that the final decision regarding referral will be theirs.

Professor Murray Enkin, during his recent tour, provided supportive evidence for the College stance on "risk lists" (which is essentially what the referral criteria are). He also gave this information to the RHAs at a meeting with them in Wellington.

Editor's Note : *The high rate of Caesarean section in New Zealand is of concern to midwives. In a search of the international literature it would appear our range of 10-23% for Caesareans is higher than most and should be a cause for alarm, not only for midwives, doctors and consumers, but also for the funders of the maternity services. We would value feedback from midwives on this issue. The following articles illustrate the problems.*

Rise in Caesarean Rate in Britain

Dr Colin Francome, Reader in Medical Sociology, Middlesex University

The number of births by Caesarean section in Britain has been rising steadily. Data collected by Professor Wendy Savage and myself, over nine years, show that the *rate of increase* is also rising. During the period from 1985 to 1989, the rate rose by 0.2% each year and from 1989 to 1992, by 0.3% a year to 13%.

We now have data for 1992 from 133 hospitals, where the Caesarean rates vary between 7.9% and 21.5%. We would like to take this opportunity of gratefully acknowledging the help of the Royal College of Midwives and those of its members who are directors of midwifery services (DMSs) throughout the country.

Midwives are in a good position to be aware of Caeserean rates to evaluate the differences between obstetricians. At the same time as asking DMSs about hospital data, we also asked for their views about the rates. The question was: "Do you feel your current Caeserean rate is too high or too low?". Of 107 midwives in our sample, 97 answered this question.

While nearly three in five midwives thought the rate was about right, two in five thought it was too high; only 1% felt it was too low. Clearly a substantial number of midwives are concerned about the rates of Caeserean section births, and there is a strong case for more detailed research in this area.

This information is part of wider research on Caesarean rates that we have been conducting. One of our aims is to raise the awareness of the issue of high Caesarean rates within the medical profession - with some success when an article we wrote, published in the *British Journal of Obstetrics & Gynaecology* in May 1993, led to an editorial on the subject by the new President of the RCOG, Geoffrey Chamberlain. This month sees a publication of a book, Caesarean Birth in Britain, co-authored by Wendy Savage; Helen Churchill of Manchester Metropolitan University; Helen Lewison of the National Childbirth Trust (NCT); and myself.

ACCEPTING OTHERS FOR WHAT THEY ARE

Irihapeti Ramsden

Quality Health asked Irihapeti Ramsden to clarify the form and intent of cultural safety in nursing education.

1. What is cultural safety and why is it required?

You must define cultural safety by looking at cultural risk, which can only be defined by the people at risk. If people don't feel safe they are the only ones who know it. Putting people at cultural risk demeans in some way.

The term came up because of the Nursing Council's safety requirements for nurses. Nurses already had to be ethically, legally and clinically safe. Now the ability to be culturally safe has been added to the safety requirements to practice.

I believe that if you really understand yourself and your own culture, then you can accept others for what they are. A lot of New Zealanders say they haven't got a culture - they don't understand enough about their history to see that they do, and that what they think is normal are the pervasive norms and surroundings of their own culture.

In psychiatric nursing for example, if you understand that you come from a culture which suppresses ghosts you may better accept the experiences of patients from a culture which is full of ghosts. If someone says they're being bothered by their grandfather you think of sexual abuse - then they announce grandfather has been dead for 25 years! Nurses have to understand how powerful they can be because their own culture denies the ghosts which are fundamental to many other people's reality. Service to the culturally different person will often be flawed by the nurse's beliefs.

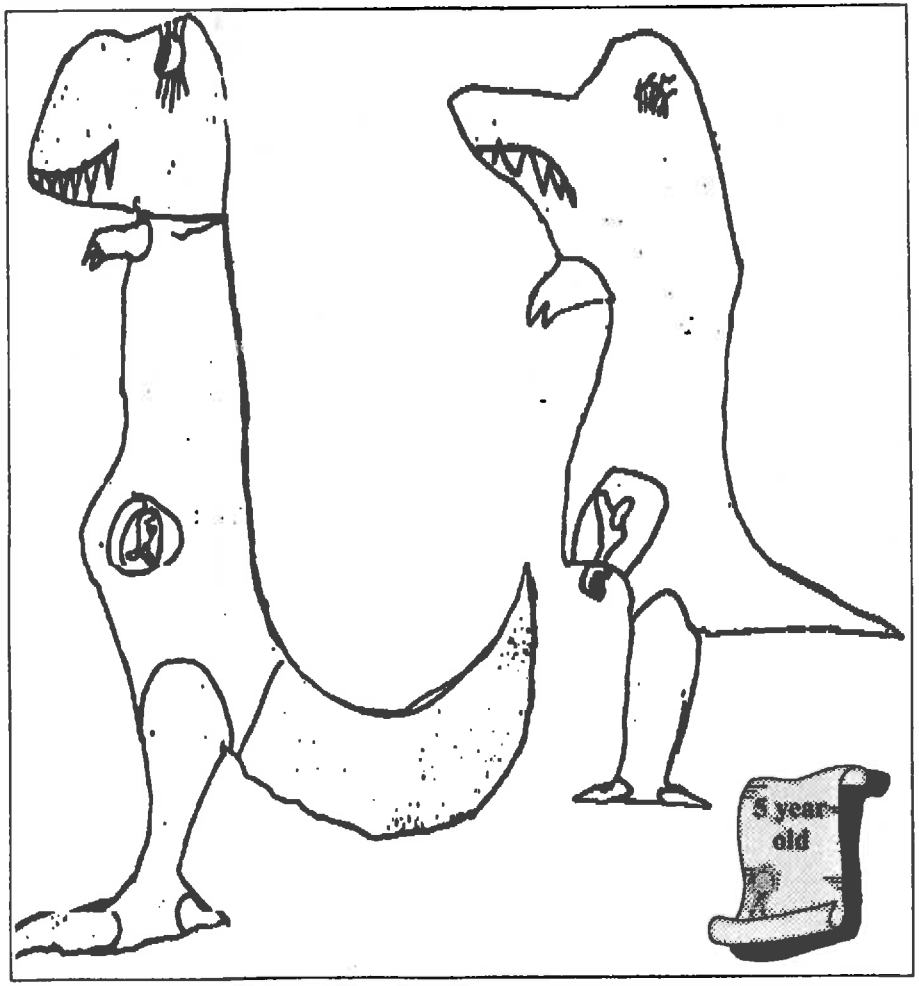
Cultural safety is really about nurses understanding themselves as culture bearers; with this understanding nurses can work with people from any culture, including the elderly or young of their own culture.

Following is a letter received from Kit James-Kuiper of Hamilton.

Dear Editor,

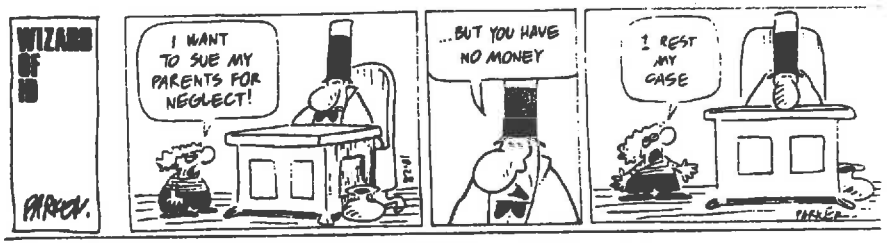
A 5 year old friend of mine drew these. I thought they were classic and wondered if they merited a spot in the next newsletter.

Kit



EXTRACT FROM CINAHL (R) 1983 - 3/94

TI : Caesarean section in Britain and the United States 12% or 24%: is either the right rate?
AU: Francome-C; Savage-W
SO: Social-Science-and-Medicine (SOC-SCI-MED) 1993 Nov; 37(10) : 1199-218 (112 ref)
SI: The rate of Caesarean section (CSR) in Great Britain (GB) and the USA, 12% in England in 1989 ascertained from a survey performed by the authors, and 24% according to official US figures, is higher than warranted by the known and agreed obstetric indications of this operation, which suggest a rate of 6-8% would be adequate. It is argued that the fall in perinatal mortality which has occurred over the period during which the CS rate has risen is not the main reason for this fall. The training of obstetricians to deal with anxiety, provision of primary maternity care by appropriately trained midwives and general or family practitioners, and changes in management protocols could cut the CSR. The number of women undergoing surgery every year in the UK could be reduced by 20,000 and in the US by 470,000 if the rate of 6% were achieved. In studies of midwifery care the CSR is even lower and it is possible that labour proceeds more efficiently if the woman knows her caregivers and labours at home, as in The Netherlands. Although CS is much safer than in the past it is still more likely to result in the death of the woman and has significant morbidity for the woman and economic costs for society.
AN: 1994178636



Extract from Chapter 17 "Anthology on Caring *p239-251 USA 1990*

Caesareans and Care

- Lynn McCreery Schimmel

In response to the threefold increase in cesarean delivery during the 1970s, from 5.5% to 15.2% by 1978, a National Institutes of Health (NIH) Consensus Development Conference was held in 1980. The report issued (NIH, 1981) recommended the use of specific management practices (such as vaginal birth after a previous cesarean and vaginal delivery of the term breech infant under certain circumstances) to help reverse the increase. Among other findings was the recommendation for future research to focus on the effects of medical training and economic, legal and ethical concerns upon the method of delivery, as these were still unexamined variables potentially associated with the problem.

Despite the findings of the Consensus Development Conference, cesarean birth rates have continued to climb not only in the United States, but in other countries as well. The rate of cesarean births in the United States had risen to 24% by 1986 (Placek, Taffel & Moien, 1988). In 1978, 510,000 women had caesareans (Placek & Taffel, 1983); in 1987, the number rose to 959,000 (National Centre for Health Statistics, 1989). Anderson and Lomas (1985) have expressed concern about Canada's rapidly increasing surgical birth rate, as have Notzon, Placek and Taffel for countries worldwide (1987). Wide variations have been noted in the procedure's incidence; for example, a rate of less than 5% was reported during 1984 in Dublin's National Maternity Hospital (O'Driscoll, Foley, MacDonald & Stronge, 1988), while the rate for Blue Shield subscribers in California during 1985 was 41% (R.W Schaffarzick, MD, personal communication, August 4 1986). Clearly, there has been a ''short-term failure'' of the 1980 Consensus Conference (Gleicher, 1984, p3273); two years later, Gleicher (1986, p563) termed the problem an ''epidemic''.

The overall justification for the continued rise in the cesarean birth rate has been a presumed causal relationship between declining perinatal morbidity and mortality rates and the incidence of cesarean birth (Bottoms, Rosen & Sokel 1980).

We wrote to the Chief Medical Officer at the Department of Health, with copies to the Chief Medical Officers in Scotland, Wales and Northern Ireland drawing attention to the study and asking if at least a study could be done here comparing children with severe speech problems with controls to see if there were differences in ultrasound exposure. We have been contacted by mothers of some children who had frequent or prolonged ultrasound exposure. It is virtually impossible now, of course to find a sample of children who have no ultrasound exposure, but at least we might look at differences in duration or frequency, where these are known.

Dr Calman at the DoH responded by pointing out further problems in the design of the study; for example the authors do not say if the researchers studying the records of both groups knew which was a problem child and which was a control. If researchers are 'blind' to which is which, there is less likelihood of unconscious bias entering the study. We had already pointed out that since we don't know why mothers had scans, these could have been used more in problem pregnancies, which are more likely to produce children with handicap.

He also reiterated points AIMS has already made - the difficulty of finding unexposed controls, and the fact that different machines would have given different 'doses'.

However, a less-than-perfect study does not mean that results are untrue. The problem can still exist. Difficulties in doing further studies do not necessarily make them impossible. The only way we can find out is if researchers elsewhere take an interest in this hypothesis and see if it can be validated or disproved in other studies. The question of a possible effect on speech has already been raised and it is not going to go away.

Meanwhile we have a number of letters from women who had frequent or prolonged ultrasound in pregnancy and whose children have unusual speech or other problems of unknown origin (all boys). We would like to hear from anyone else who had numerous or long scans as to how their children are getting on; we are as anxious to hear from those who have normal children as any who have children with problems.

Jean Robinson

Campbell, James et al. Case-control study of prenatal ultrasonography exposure in children with delayed speech.
Canadian Medical Association Journal 1993: 149 (10) 1435-1440

"Be smarter than other people - just don't tell them so."

AIMS - UK

JOURNAL WINTER 1993/94

Ultrasound and Delayed Speech

A recently published Canadian study suggests that ultrasound exposure in the womb may cause development of speech in children to be delayed.

In Calgary, Alberta, a professor specialising in Ear, Nose and Throat problems, James Campbell, noticed that he was seeing more children who had not developed speech. Their hearing was normal, and they seemed to have no social or other causes which could account for their problems. He carried out a research project with a professor of Family Medicine, Wayne Elford, and a statistician, Dr Rollin Brant. Antenatal records of 72 children with delayed speech of unknown causes were compared with those of 142 controls who were similar in sex, date of birth and birth order within the family. The children were similar in social cases, birthweight and length of pregnancy. About three-quarters in both groups were boys; males are more likely to experience such problems.

The children with speech problems were twice as likely as controls to have been exposed to ultrasound in the womb. 61% of cases, and only 37% of controls, had had at least one exposure.

What is rather puzzling about the study, is that it did not seem to matter in what stage of pregnancy the ultrasound was used; the risks seemed elevated in every trimester. The authors conclude:

"If no obvious clinical indication for ultrasonography exists, physicians might be wise to caution their patients about the vulnerability of the fetus to noxious agents."

Such a case-control study does not, of course, PROVE that exposure causes speech delay, but it certainly suggests that it might. When we put this together with the Denver study (Stark et al 1981) which suggested an increase in dyslexia, and the Norwegian study (Salvesen, Kietal) which showed an increase in left handedness, and animal studies which suggest neurological damage, there is growing evidence that ultrasound exposure before birth may affect the development of the brain.

After reading the study, we sent a press release to all major newspapers and journals. Only the Daily Telegraph did a news item. Yet this could be a major problem affecting thousands of children in this country and all over the world.

Compare this with the huge front page headlines on possible dangers of water births - hitherto used by few women - following a press release based on second hand anecdotes from the RCOG!

Although this inverse relationship has been disputed (Haynes de Regt, Minkoff, Feldman & Schwarz, 1986; Myers & Gleicher, 1988; O'Driscoll & Foley, 1983; Porreco, 1985), and the significant economic, physical, and emotional costs of cesarean birth have been published, the problem persists.....

In one of the few studies employing a quasi-experimental design, investigators found a significant cesarean rate difference ($p<.001$) when comparing a stratified random sample of 800 women delivering at a nurse-midwifery birthing centre, where the cesarean rate was 7.3%, to a frequency matched sample of the same size at a tertiary teaching hospital, where the rate was 19.3% (Strombino, Baruffi, Dellinger, & Ross, 1988). Similarly, a retrospective analysis of a rural certified nurse midwife (CNM) practice, co-managed by physicians in case complications arose, had a rate of 9.9% of 730 births (Wingeier, Bloch, & Kvale, 1988). The 1989 National Birth Centre Study investigators (Rooks et al.), analyzing the outcomes of 11,815 low-risk women delivering at 84 free-standing birth centres in the United States, found a total cesarean birth rate of 4.4% and a primary rate of 9.9%. The cesarean rate of less than 5% at Dublin's National Maternity Hospital is also at a site where "the delivery suite is in the hands of a senior midwife," and each mother has one-on-one care (Garcia, MacDonald, Elbourne & Grant, 1985, p.80).....

Did you know .....

"A recent study revealed that people who did volunteer work at least once a week outlived those did none, two-and-a-half to one. That implies that doing something for other people is a powerful contributor to health and long life."

Current Issues

NZCOMI NATIONAL CONSTITUTION

A copy of the NZCOMI National Constitution and Bylaws is available to any member at any time, either from your local regional chairperson or secretary or from the :

National Office of the NZCOMI
P O Box 21-106
Christchurch

MIDWIFE VACANCY

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

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

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

For further information contact:

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

SUBSCRIPTIONS ARE NOW DUE

Any member who has not renewed her subscription by 31st July 1994 will be removed from the membership list and will no longer be covered by Indemnity Insurance, receive newsletters or journals or other benefits of belonging to the College.

Please check if you have renewed your subscription. Subscriptions are from 01 May 1994 to 30 April 1995. Ask your regional treasurer to check if you are unsure whether or not you've paid.

A membership form is printed on the inside cover of this newsletter. Please ensure you fill in ALL sections of the form, to ensure we have an accurate database. Thank you.

ULTRASOUND SCANS

Dear Editor,

The members of the Maternity Services Consumer Council were concerned to see a photograph of an ultrasound scan illustrating the [March] article on maternity services ....

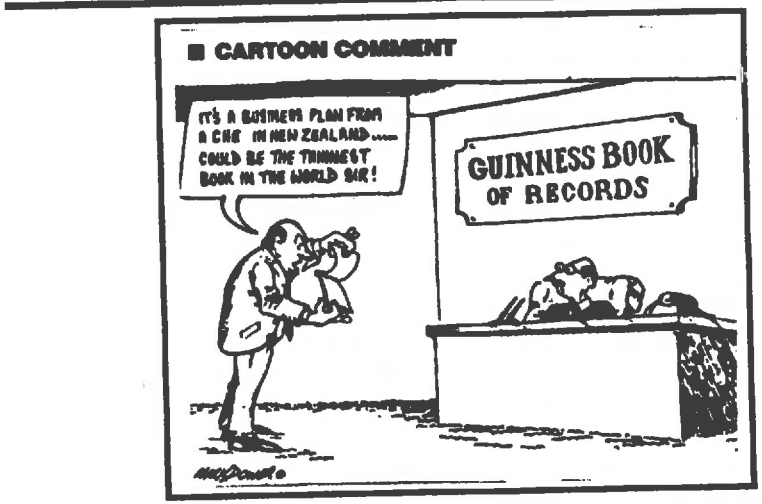
The Council believes that a large amount of maternity health dollars are spent on ultrasound scans, money which is desperately needed for other areas within maternity services such as post natal care and support.

The use of the image of an ultrasound scan when discussing maternity services just serves to reinforce the idea that scans are an essential component of *all* pregnancy care and something that *all* pregnancy women can expect to have ...

Lynda Williams
Co-ordinator

Your points are accepted. The CEO and Maternity Services Manager Sam Denny have already rapped us over the knuckles.

North Health Newsletter April 1994



Canterbury Cot Death Society Inc

ABSTRACT

Aim
To describe sleeping practices for newborn infants in maternity units.

Method
Observations were made of the sleeping environment of 348 babies in three Canterbury hospitals.

Results
Fort the 259 observation of babies weighing more than 1500g and not in incubators, there were 93% sleeping on their side. 81% swaddled and 85% in environments of 23°C or more.

Swaddled babies were less likely than unswaddled babies to have their underneath arm well forward (chi squared = 12.6 df = 2p<0.0002), more likely to have part of their face covered (chi squared = 12.6 df = 2p<0.0002), to be covered by more total bedding layers (chi squared = 44.1 df = 2p<0.0001) and to have hands not visible to the observer (chi squared =38.7 df = 2p<0.0001). There was also a tendency for swaddled babies to be further down the bed (chi squared = 6.0 df = 2p< 0.05).

Babies in sloping beds were more likely to be observed further down the bed (chi squared = 54.2 df = 2p <0.0001) and to have more of their face covered (chi squared = 10.4 df = 2p<0.0005) than babies in horizontal beds.

Conclusion
The importance of both a baby's sleeping environment, and of the modelling impact of maternity practice on parental learning, cannot be overestimated. Parents and maternity staff need to consider the total sleeping context rather than practices in isolation, when deciding the sleeping arrangements for a baby. This study suggests that the practice of firmly swaddling babies needs critical appraisal.

RECOMMENDATIONS

Protection from SIDS can be increased considerably by not placing babies to sleep on their tummies, but care is needed also to protect them from assuming this position during sleep for side sleeping babies. This needs to be done by considering all three factors of placement of the baby in the bed, the arrangement of bed covers and the firmness of wrapping.

Babies that are loosely swaddled or not swaddled, and babies that sleep in horizontal beds, are better protected from their face becoming covered during sleep and better protected from potential overheating during sleep.

- HISP Project, 24 March 1994

Upcoming Events

NZCOMI CONFERENCE 1994

The Culture of Midwifery : Celebrating Women & Family

12, 13, 14 August 1994

Te Papaiouru Marae
Ohinemutu Rotorua

Registration Form for Conference is enclosed with this newsletter

AUSTRALIAN COLLEGE OF MIDWIVES INC

9th Biennial Conference

Sydney 12-15 September 1995

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

6TH NATIONAL CONFERENCE OF SANDS AUSTRALIA

"Back to Basics - Family Needs when a Baby Dies"

23 - 25 September 1994
Grace College, University of Queensland, Brisbane

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

BIRTH ISSUES

1st Annual Conference

Choices, Decision-Making and Control

University of Melbourne - Melbourne 18 - 20 November 1994

The focus of the conference will be on :

* midwifery practice
* birth centres
* childbirth education
* research
* consumer advocacy
* support for childbearing families

International speakers :

Ruth Lubic - General Director, Maternity Centre Association, New York and ***Diony Young***, Editor of Birth Journal, author **Changing Childbirth, Bonding** and co-author of **Unnecessary Caesareans: Ways to Avoid Them**

* *

A one day conference will be held in **BRISBANE**
Wednesday 16 November 1994

* *

For more information contact:
Jan Cornfoot - CAPERS
P O Box 567 NUNDAH QLD 4012 Fax 07-260-5009 Tel 07-266-9573

CALL FOR PAPER FOR CONFERENCE

LA TROBE UNIVERSITY

Midwifery and the Community

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

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

This group of researchers had previously shown that this same thing would happen with a baby's face directly into a pillow of polystyrene beads.[5] Other surfaces slept on by babies dying of SIDS have also been shown to rebreathe by this group of researchers.[6]

We have carefully examined the main surfaces that babies sleep on in New Zealand and have shown that every soft surface we can find, whether a sheepskin or not, rebreathes to levels that can be dangerous.[7] These surfaces include soft foam, foam chip and very soft "tea-tree bark" mattresses.

We now think that babies that have a mature brain and are healthy, will, if they put their face into a soft surface, rapidly respond to a "rebreathing stress" by awaking and moving their head to the side. This may explain why babies that have been stressed in the womb (small at birth, maternal smoking) are at increased risk of SIDS.1 Our continuing research (currently funded by the Health Research Council) is looking at the main influence both before and after birth that affect the ability of a baby to arouse to a rebreathing stress.

There is some preliminary evidence that even simple surfaces such as a bunched up sheet with a face into it could cause significant rebreathing and we therefore think that at present we cannot suggest that parents avoid using soft surfaces (including sheepskins) especially as it may be that lying on your back on a soft surface may be the best of all options. Further research is looking at this question, but for now our advice would be that babies sleep on the side or back and so avoid the risk of rebreathing whatever the sleeping surface.

If a baby does sleep on the front (prone) for medical or other reasons then the mattress should be very firm with a sheet stretched lightly and tucked in very firmly across it. A waterproof layer under the sheet appears also to protect from any rebreathing risk.

References :
1. Scott S, Cole T, Lucas P, Richards M. Weight gain and movement patterns of very low birth weight babies nursed on lambswool. *Lancet* 1983; 2:1014-1016
2. Mitchell EA, Taylor BJ, Ford RPK et al Four modifiable and other major risk factors for cot death: the New Zealand Study. *J Paediatr Child Health* 1992; 28 suppl 1:S3-8
3. Ponsonby A-L, Dwyer T, Gibbons LE et al SIDS: factors potentiating the adverse effect of sleeping prone during infancy. *N Engl J Med* 1993;329-377
4. Kemp JS, Tach BT. A sleep position-dependant mechanism for infant death on sheepskins. *Amer J Dis Childh* 1993;147:642-646
5. Kemp JS, Tach BJ. Sudden death in infants sleeping on polystyrene filled cushions. *New Engl J Med* 1991;324:1858-1864
6. Kemp JS, Kowalski RM, Burch PM et al. Unintentional suffocation by rebreathing: A death scene and physiological investigation of a possible cause of sudden infant death. *J Paediatr* 1993;122
7. Bolton D, Taylor B, Campbell A et al Rebreathing expired gases from bedding: a cause of cot death? Archives of Diseases in Childhood 1993;69:187

EMPOWERING WOMEN EMPOWERING MIDWIVES
75 YEARS OF GLOBAL PARTNERSHIP
INTERNATIONAL CONFEDERATION OF MIDWIVES

EXPLANATION

These changes do not increase the Regions therefore the financial implications remain as now. They do however effectively dis-establish the Wanganui/Taranaki Region which will be divided between Waikato and Central. It also creates a new Region (Bay of Plenty / East Coast) which was previously a part of the Waikato Region.

Articles of Interest

SLEEPING SURFACE OR POSITION - what is dangerous for babies?

Barry Taylor, Senior Lecturer in Paediatrics

SIDS Canterbury Issue No. 5 May 1994

In New Zealand since the early 1970s it has been commonly thought that lying on a sheepskin or soft surface would be more comfortable for babies and that they would appreciate this and perhaps sleep better. Early research on sheepskin use suggested that premature babies did in fact grow better and move around less on baby lamb-skins.[1]

Some concern did exist that sheepskins may be related to the known high rate of SIDS in New Zealand, so this was looked at in the first major study of SIDS in New Zealand - The New Zealand Cot Death Society Study [2]
Forty one percent of babies that died as well as 41% of babies that did not die, used sheepskins. This suggested that sheepskin use was not a risk factor for SIDS.

Further analysis of the information suggested however, that babies sleeping prone on sheepskins were at *higher* risk than those sleeping prone on other surfaces. Going along with this analysis was information to suggest that babies *sleeping on their sides or backs on sheepskins* were in fact at *lower* risk of SIDS. A study about this issues from the Tasmanian SIDS research group shows that tea-tree bark mattresses increase the risk of SIDS *only* if the baby is lying prone (on their front).[3]

Research from St Louis, Missouri, USA has shown clearly that if a baby puts his or her face directly into a sheepskin that the sheepskin will retain the breath of the baby and hold it to be breathed in again at the next breath - rebreathing.[4]

1994 AGM

Friday 12 August 1994
Ohinemutu Rotorua
1830 hours

REMITS FROM AUCKLAND REGION - May 1994

9.1.3 Individual members to vote for national president. Voting will be by postal ballot and these to be received by National Committee 14 days prior to AGM.

EXPLANATION
It is important that all members participate in the election of a National President. The current system of Regional voting is not adequate to elect such an important position. It is difficult to get participation of a large number of members at one time and to actively seek the opinion of most members in the larger regions would take several months if meetings are monthly, and a lot of publicity to attract members to discussion and debate.
Ballot papers could be incorporated as part of the National newsletter to reduce extra expense, and extra resource could be directed to the process of scrutineering and counting of votes. On a 2-yearly basis, this should not prove too expensive.

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

EXPLANATION
The present system for joining acts as a deterrent. Many would be members wish to join throughout the 12 month period and expect their subscription is for the year from joining. At the end of the financial year they receive notification that their subs are due for renewal. People don't consider this is always value for money. Part payment would facilitate joining part way through the year. If a member joins in the first quarter of the year, they could pay the full subs. If in the second quarter they could pay 3/4 of the subs; in the third quarter, 1/2 of the subs; and in the fourth quarter, 1/4 of the subs to bring to the end of the financial year after which time they would pay the full subs. In the event that members wish to pay by automatic payment, this quarterly breakdown could also be used for the A/P period. This would mean that four A/Ps a year would be deposited into the account, and would reduce the banking fees for this service and the work of the Treasurers on a monthly basis as they will only have to check the A/Ps quarterly instead of monthly.

BY LAWS

4. A capitation fee proportional to amount received shall be paid to BOM. Capitation fees as set by the National Committee are payable when received and if received by Direct Credit, at the end of the financial year.

EXPLANATION

To assist regions with deductions from Salaries and Automatic Payments to better manage capitation payments - not leaving them out of pocket because of the need to pay full capitation for people joining on deductions part way through the year. Also brings in line with current practices for same.

NATIONAL COMMITTEE REMITS

BY LAWS **OPTION ONE**

That the 1995/96 subscription rates are :

Self Employed Midwife	$350.00	Employed Midwife	$175.00
Unwaged/Student	$ 50.00	Associate/Affiliate	$ 30.00
Associate with Indemnity	$155.00		

EXPLANATION

These increases are essential to enable the College to expand its Education & Research, Quality Assurance and Public Relations roles. As midwifery becomes accepted as a profession in its own right, the College increases its professional responsibility to develop and monitor the professions standards and the public image of midwives. The proposed fee supports the following structure.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
PROPOSED STRUCTURE & POSITIONS

SECRETARY
30+ Hours
- Typing/Typesetting
- Correspondence
- Clerical
- Personal Assistance to National Co-ordinator
- Telephone
- Receptionist

NATIONAL CO-ORDINATOR
Full Time
- Spokesperson
- Public Relations
- Liaison/Co-ordination
- Resource Person
- Contracting (self-employed)
- Negotiating Committee
- General Administration

EDUCATION & RESEARCH COUNCIL
Elected Representatives
- Professional Development
- Continuing Education
- Accreditation

QUALITY ASSURANCE
Part Time (Paid)
- Standards Review
- Competencies
- Complaints
- Liaison and Consultation with Women's Health & Consumer Bodies
- Data Collection & Statistics
- Analysis

PUBLIC RELATIONS
Part Time (Paid)
- Marketing
- Image
- Pamphlets/Advertising (may contract out)

TREASURER
Part Time (Paid)
- Membership File
- Co-ordinate Regional Treasurers
- Bookkeeper
- Budget
- Reports to National Committee
- Honorarium
- Accountant
- Lawyer

NATIONAL COMMITTEE REMITS

BY LAWS **OPTION TWO**

That the 1995/96 subscription rates are :

Practising Midwife (both self employed and employed)	$350.00
Associate with Indemnity	$155.00
Unwaged/Student	$ 50.00
Associate/Affiliate	$ 30.00

EXPLANATION

It has been proposed several times by different regions over the last year that the College represent hospital employed midwives industrially. The College is currently distributing a questionnaire to members via the regions to gauge the feasibility of such a move. It is hoped to have these responses collated in time for presentation at the AGM. This fee reflects the increase necessary to cover the additional staff needed to provide employed midwives with this industrial service.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
PROPOSED STRUCTURE

INDUSTRIAL
Full Time (Paid)
- Indemnity / Personal Grievance
- Employment Contracts / Negotiation (Representation for all employed Midwives)
- Wages, Travel, Accommodation

NB : Proposed Full Structure requires a total Budget of $332,000.00.

BY LAWS

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

BAY OF PLENTY/ EAST COAST
- Tauranga
- Gisborne north of Wairoa
- Rotorua
- Opotiki
- Waihi Beach
- Taupo
- Whakatane

WAIKATO/ WEST COAST
- Hamilton
- New Plymouth
- Taumaranui
- Huntly

CENTRAL
- Wanganui
- Taihape
- Napier
- Hastings
- Palmerston North