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

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NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

June / July 1995

- Midwifery Practice Organisations -

- Immunisation Symposium Report -

- Nurses & Midwives Bill -

NEW ZEALAND COLEGE OF MIDWIVES (INC)

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Christchurch	Rotorua	Tauranga

THE WAIKATO POLYTECHNIC

Te Kuratini o Waikato

It is proposed for 1996 that The Waikato Polytechnic Nursing and Health Studies Department will offer a Midwifery Knowledge paper via Distance Education. The one year paper will be offered to Registered Midwives and will be a direct credit for the Bachelor of Midwifery at the Waikato Polytechnic. The Waikato Polytechnic also offers by Distance Education a Research Paper. A Cultural Safety Paper is proposed for 1996. These papers will be credited towards the degree.

Please could Registered Midwives indicate their interest by filling out the form below and send it to:

Denise Irvine Distance Education Co-ordinator
Nursing & Health Studies
The Waikato Polytechnic
Private Bag 3036 HAMILTON

I am interested, a Registered Midwife and I wish to register my interest for the Bachelor of Midwifery

NAME: _____

PAPER: _____

ADDRESS: _____

PH NO. _____

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from page 46

Dr Durham did acknowledge that, cyclical epidemics have continued, especially for measles and pertussis, and blamed this on inadequate vaccination coverage.

(Report by Carolyn Crawford) Please Note: *The above is a brief summary of some of the views presented at the conference, it does not necessarily reflect my own, or other midwives opinions. It is an attempt to share the content of the conference with those unable to attend and especially with those who may be facing the decision of whether to vaccinate or not. It does not represent the 'complete picture' however and obviously further study/information would be necessary for people attempting to make an 'informed decision' regarding vaccination. Words in italics are my own comments.*

New rules on birth referrals welcomed

CH CH PRESS 5/6/95

WELLINGTON — A new lobby group for parents whose babies suffered preventable brain damage at birth yesterday welcomed tighter rules on when specialists should be called in.

The rules have been spelled out by regional health authorities as part of a new maternity-care package.

The package also includes provision for pregnant women to nominate a lead carer — doctor, midwife, or specialist — to co-ordinate all aspects of care.

However, doctors and midwives expressed surprise that the package had been announced because they said consultation on many aspects, including the criteria determining when specialists should be called in, was still going on.

The package is the RHAs' response to continuing control problems between doctors and midwives following changes to the Nurses Act which gave midwives practising autonomy.

Since then there have been several incidents in which parents have complained that their babies have been damaged because of failure to recognise that difficulties in birthing required specialist help. Some of those parents have formed a lobby group, Parents for Safe Births.

Spokeswoman Lisa Mannion said that had a specialist been called early in her daughter Maria's delivery she would have been healthy and alive today.

Maria, born six years ago, died at the age of two as a consequence of a massive brain injury suffered at birth.

A medical disciplinary inquiry found the injury followed substantial departures from accepted medical practice.

Medical Association spokesman Philip Rushmer has warned that significant safety issues are still to be resolved, including guidelines to when a woman should be referred to a specialist.—NZPA

Early vaccination fears held

CH CH STAR 19/4/95

Parents should delay the vaccination of babies until they are nine months old, says the Open Forum For Health Information.

The forum has voiced several concerns about mass immunisation at an early age.

The forum said New Zealand vaccination programmes for babies started at birth, at a time when their immune systems were exceedingly immature. Many other countries did not start vaccination programmes until the baby was at least two months old.

Forum spokesperson Jacqueline Steincamp said conscientious parents faced a dilemma when contemplating vaccination for their babies.

The forum recommended parents not have immunisation done if the child was unwell or had a cold. Preferably, vaccination should be preceded by a short course of nutritional supplements, which should include vitamins C and A, and zinc.

Babies who were breastfed were better protected, provided the mother's vitamin C and general nutritional status was good.

Parents should make sure the doctor or nurse knew the family history, and consider the possible side effects against any possible illnesses such as eczema, asthma, allergies and epilepsy.

Parents should also ask to be given the name of the vaccine, the manufacturer, the lot number, the batch number, the time and date of administration, and verification that the vaccine was at all times stored correctly. The person administering the shot should sign the information in the presence of a parent.

If the child had an instant reaction, parents should ask that the nature of the vaccination and the treatment given be recorded on official letterhead with a signature.

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NATIONAL COMMITTEE MEETING CALENDAR 1995

25th and 26th August
(and AGM)
17th and 18th November

ADVERTISING

Advertising in the National Newsletter is FREE to affiliated non-profit making organisations with maternity related issues, i.e. NZCOMI Regions, Home Birth Association, etc. For advertising rates and more information, please contact:

Julie Richards
NZCOMI
P O Box 21-106
Christchurch
Phone/Fax (03) 377-2732

DEADLINE

for the next Newsletter is
1st August 1995
Posted
26th August 1995

Any contributions to the National Newsletter should be addressed to:

Julie Richards
P O Box 21-106
Christchurch

PUBLISHING DETAILS

Editor - Julie Richards
Typesetting - Marita Perini & Judy Henderson
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Folding - IHC Shirley Rd, Chch

DISCLAIMER

EDITORIAL

Again much has happened in the last 2 months - no time to hibernate over winter.

We were all shocked to hear about Joan Donley's accident and incredibly impressed by the speed of her recovery. It goes to show what herbs, homeopathy, masses of support, nurturing and years of healthy living can do for you.

There have been a number of theories regarding the political motivation of the incident but it has been revealed as a genuine accident!

We're sorry for what Joan has had to go through but also know that on the positive side another sector of the medical and nursing profession have been exposed to the wisdom and teachings of our Joan.

We hope to see you at the AGM.

Establishment of Midwifery Practice Organisations (MPO) continues with reports from National and Auckland included.

A new addition to the newsletter is a summary of the quarterly National Committee meetings. This will ensure you are aware of issues being discussed nationally and then attend your regional meetings to have your say.

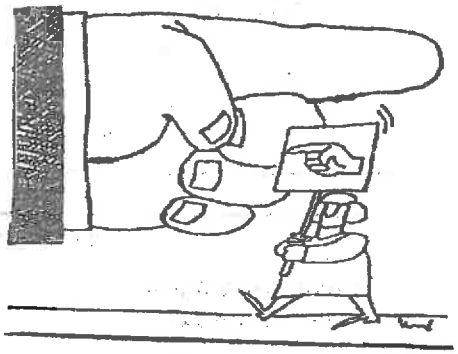
Between newsletters I attended the recent American College of Nurse-Midwives Annual Meeting in Texas - I've written a short report on my impressions. I'm very glad to be a midwife in New Zealand and proceeded to tell everyone why. Consequently there's quite a number of American midwives wanting to emigrate. Not quite the consequence I anticipated!!

Look out for the travel package organised for the ICM Congress in Oslo.

Thanks for the feedback regarding the undersized print in the last issue - there's no point in printing it, if you can't read it.

Enjoy!

Julie Richards



Guidelines' release 'premature'

Otago Daily Times 16/1/95

By Rachel Benn

Much work was still needed on the latest maternity proposals before they could be classed as final guidelines, the College of Midwives cautioned yesterday.

College president Sally Pairman, of Dunedin, said the Regional Health Authority's release of the draft guidelines on Wednesday was premature.

This sentiment was echoed by the New Zealand Medical Association, which said the announcement made it look as if the guidelines were "signed and sealed".

"We are left wondering about the haste. We wonder if it isn't another attempt on behalf of the health bureaucrats to bulldoze health professionals, or are they simply looking for some good news," the association said.

Both groups said they were unhappy about a number of issues, such as the referral criteria, which were yet to be resolved.

Joint RHA maternity project spokeswoman Sam Denny defended the announcement as an attempt to keep women informed about progress, but admitted nothing had been finalised.

The latest guidelines were the fourth draft of changes planned for the maternity system, in an attempt to control rising costs.

The guidelines laid down one set of criteria for both doctors and midwives about when births must be referred to specialist care.

Mrs Denny said it was an attempt to solve historic differences between the two groups — started five years ago when midwives were allowed to manage births by themselves — which have tended to blame each other for birth tragedies.

For the first time, home help will be paid for, providing women leave hospital within 48 hours of a normal birth, or five days after a complex birth attended by a specialist.

A main feature of the guidelines, due to come into effect in October, is that women will appoint a lead health professional who will coordinate their entire maternity care.

Health authorities say the changes have been widely discussed. Ms Pairman felt there had still been a lack of consultation with women.

Medical Association maternity services committee chairman Dr Philip Rushmer said the referral criteria did not take into account the differing skill levels of doctors.

Changes were needed to the criteria, which should be written as guidelines rather than rules, particularly if payment was linked to following the criteria.

Mrs Denny said doctors and midwives would be informed of the new funding for maternity next week.

Ms Pairman

Home Birth services receive $30,000

Evening Standard 16/1/95

HOME BIRTH services for Manawatu women have received a windfall of $30,000 in the Government's "transitional assistance" scheme. In August last year Health Minister Jenny Shipley announced a one-off funding injection of $20 million to develop new health services throughout the country. Seven organisations in the Central Regional Health Authority area have benefited from $1 million of this money. The grants to groups in the *Evening Standard*'s circulation district are:

- $29,943 to Community Birth Services, Manawatu, to set up a trust to provide home birth services, including maternity care, home help and group antenatal education.
- $183,525 to Progressive Health to help 29 Wanganui GPs set up information and management systems.
- $194,775 to the Central Independent Practitioners Organisation to help set up independent GP associations in the central region.
- $15,468 to the Nurses Organisation to help develop a diploma and degree course for GP practice nurses.

THE number of babies with birth defects caused by their mother's drinking habits during pregnancy has risen more than six-fold since 1979, a group of American researchers has found. In 1979 foetal alcohol syndrome occurred at a rate of one case per 10,000 live births. Latest figures from the US Government's Centres for Disease Control and Prevention show 6.7 children per 10,000 live births.

Dominion 15/1/95

Midwives Day celebrated

Jo Plimmer (left) with son Jack, midwife Tricia Thompson and Dianne Helme (right) with daughter Caitlin celebrated International Midwives Day recently with a posy of flowers.

College of midwives regional chairperson, Mrs Thompson says members of the college also prepared four baskets of goodies for mothers and babies to celebrate last Friday's event.

These were presented to the first baby born in each maternity unit - at New Plymouth, Stratford and Hawera, and to any mother who celebrated a home birth during the day.

All other mothers in any of the three hospital wards received a posy of flowers.

"International Midwives Day is a special chance each year to celebrate midwives and the work they do, and to educate the public about midwifery," says Mrs Thompson.

"Midwifery is a profession concerned with the promotion of womens' health through the life cycle. Every culture and every society in the world has midwives."

She says the World Health Organisations (WHO) definition of a midwife says a midwife is able to give the necessary supervision, care and advice to women prior to and during pregnancy, labour and the postpartum period, to conduct deliveries, and to care for the newborn and the infant.

She says there are about 40 midwives in Taranaki who practice in a variety of settings including the home, hospital and the community. "Most of these midwives are employed by the hospital to work in the maternity units, or in the community following up new mothers after their discharge from hospital.

"In Taranaki there are also 10 midwives who are independent or self-employed. They contract with women and their families directly, to provide all of the care for pregnancy and birth whether for hospital or home birth."

NATIONAL CO-ORDIANTOR'S FORUM

- Linda Collier

As Karen is on study leave at present the task of producing the National Co-ordinators Forum has been handed on to me.

I decided that this was an ideal opportunity to introduce myself to everyone and offer some insight into life at the National Office.

I'm Linda Collier, I completed my Diploma in Midwifery at Christchurch Polytechnic in 1992 and following this spent 15 months providing a postnatal service in the Christchurch area. In 1994 I was mentored by the Christchurch Home Birth Midwives. At the beginning of this year, Jean Peters (a graduate of the Otago Direct Entry Midwifery Programme) and I established our own practice.

My position as Assistant Co-ordinator, at the NZCOM National Office is for a 12 month period undertaking special project work and relieving Karen while she is away on study leave. I am also the National Treasurer and as you are aware, we are making some major changes to the membership system at present. I can assure you the learning curve is very steep but I am enjoying the challenge.

Despite the fact that I have always attended Regional College meetings and tried to keep myself informed and up to date on issues relating to Midwifery, it is taking me some time to ôget up to speedò with everything that is happening within the National Office. It was not until I became involved in the day to day activities that I really began to comprehend the hugh volume of work that goes through this office. Submissions, drafts of documents/policies, Section 51 Negotiations, access agreements, IPO Formation meetings, development of NZCOM consensus statements, Midwifery caseload management guidelines, enquiries from midwives, students and consumers, National Committee meetings, editorials, budget, membership enquiries, subscriptions - the list goes on and on.

This information is forwarded to you as members via the regional chairpersons for discussion at the Regional Meetings. Attending these meetings will enable you to keep updated with the activities of the College and provide you the opportunity to comment and have input into these areas. The regional chairperson also provides updates following National Committee Meetings.

I'm sure that the learning curve is not going to change very much over the next 12 months as the continuing health reforms and the nature of our profession ensures that there will always be new challenges and changes.

NZCOMI - ANNUAL GENERAL MEETING

Friday 25th August 1995
CHRISTCHURCH

NOMINATIONS FOR NATIONAL COMMITTEE
CONSUMER REPRESENTATIVES

Parents Centre has pleasure in nominating Diane Matsas as a consumer representative on the National Committee.

Diane was formerly President of Christchurch Parents Centre and is currently a member of the National Executive, representing the Canterbury Region. She is also a PCNZ representative on the Advisory Committee to the Aoraki Polytechnic/PCNZ Certificate in Childbirth Education.

Diane is married to Nigel, has 3 primary school-aged children and was an occupational therapist before leaving the paid workforce to have children. Since then, she has trained and worked as a childbirth educator in Christchurch and now at Lincoln.

Parents Centre is confident that Diane, with her experience and knowledge as a childbirth educator and her extensive involvement with Parents Centre at central, regional and national level, will be an excellent consumer representative on the National Committee.

Maternity Action Alliance, Christchurch has renominated Rea Daellenbach to continue as a consumer representative on the National Committee.

Midwives' access case under study

NZ Herald 15/6/95

By FIONA BARBER

A complaint over some independent midwives' lack of access to National Women's Hospital has been lodged with the Commerce Commission.

The chief investigator for the Commerce Act division of the commission, Mr Trevor Cameron, confirmed yesterday that a preliminary assessment was being done.

The move follows claims that hospital management is blocking some independent midwives from practising by failing to approve their access agreements.

The College of Midwives has complained to the Government.

The move has also reportedly affected some general practitioners.

Yesterday the chief executive of the Auckland central crown health enterprise, Mr Dennis Pickup, said the enterprise could not allow more general practitioners and independent midwives to work at National Women's.

He said the hospital was unable to cope with more, and quality and safety would become issues.

"We're not in the situation of opening up the gateway when we are inadequately resourced to meet demands," he said.

"By the nature of their [independent practitioners'] work, they are demanding of our staff, equipment and facilities," he said.

Mr Pickup, who is acting general manager of the hospital, said National Women's was catering for access holders from Kumeu to Pukekohe when there were facilities in north, west and south Auckland.

One doctor, he said, had referred a woman from Huntly.

"It's hoped that common sense will prevail and that they will be encouraged to go to neighbouring crown health enterprises."

Mr Pickup said the hospital had been working on a new access agreement and it was now in the hands of the northern regional health authority and the midwives' college and that of the gynaecologists and obstetricians.

Existing access agreements had been rolled over until the end of the year. No new agreements had been granted unless there had been a previous undertaking to do so.

Midwives say they know of practitioners who have, however, been recently granted rights of access to the hospital.

Yesterday the co-ordinator for the Maternity Services Consumer Council, Lynda Williams, said the longer the situation prevailed, the more it restricted women's choice.

"Women have the right to choose their midwife or general practitioner and no hospital should be involved in actions that curtail that freedom."

SRHA pushes maternity pilot past protesters

Southland Correspondent

The fallout from the Southern RHA's controversial maternity care pilots continues but the authority is confident it will get support from enough providers to go ahead.

The NZMA and the College of Midwives have criticised the lead professional pilots in rural Southland and metropolitan Dunedin. They have labelled them counter-productive to the national negotiations and have urged their members to have nothing to do with them.

But RHA maternity services communications manager Vivienne Allan said the criticism is at odds with what individual providers have said.

"That will be proved when the people who have already expressed an interest in the scheme send in their proposals," she said.

Mrs Allan said the pilots will proceed even if just a few providers take up contracts.

Southland midwife Terryll Muir said the swing to pay providers more for level of responsibility than actual care seemed ludicrous.

By her reckoning GPs will earn twice as much for five hours' work than midwives will earn for 25 hours' work.

Mrs Muir is also concerned the scheme will cause some "major conflicts" between GPs and midwives.

But those claims are disputed by SRHA health needs general manager Winston McKean.

"Because it will be the woman's choice whom she wants, the issue of whether a GP or a midwife spends a certain number of hours with the woman and over what period of time will be part of the care plan, decided upon between the woman and her lead professional."

While the RHA is anxious to see improved relationships between GPs and midwives that is an issue for providers themselves, he said.

"The concerns of the authority are to ensure that any conflict is not reflected in service to women."

Dr McKean said providers should remember the RHA is not dictating what they should do and there was no compulsion on any providers to take part in the pilots. The RHA hopes to have contracts in place by the end of this month.

BACHELOR OF MIDWIFERY

Hands-on experience

by Rachel Forde

Traditional midwifery training is the three-year general nursing course plus a year of specialised training.

When Ms Crabtree graduates she hopes to practice in Manawatu.

College of Midwives regional spokeswoman Ruth Martis said the Bachelor of Midwifery course made good sense, as it allowed students to specialise in midwifery right from the beginning. The course would also help to establish midwifery as a separate profession from nursing — nurses were geared towards caring for sick people, whereas midwives were focused on helping healthy women go through the natural process of childbirth.

Friday, May 5 was World Midwives Day, and midwives in New Zealand needed to raise public awareness of the options open to women.

Many people still didn't know that midwives were legally able to care for women during their pregnancy, labour and birth, without necessarily having a doctor involved. This applied to normal hospital births as well as home births.

SUE CRABTREE (left) with the Palmerston North baby she helped deliver earlier this month. Baby Tuawhiorangi is held by sister Tani, with mum Jane Elliott and dad Wally Wharewera behind.

Vaccine link to disease

Guardian Weekly 7/5/95

Chris Mihill

THE MEASLES vaccine may play a role in triggering two long-term bowel diseases, researchers say.

However, scientists from the Royal Free Hospital, London, say in the Lancet magazine that there should be no change in vaccination policy as the research is still preliminary.

They found evidence both in the laboratory and in the population of a link between the measles virus and the development of Crohn's disease and ulcerative colitis.

They argue that vaccination is more likely than exposure to the virus to be involved in the link. Babies, who are vaccinated at around 18 months, are more vulnerable than when they are four or five, the age at which they tend to meet the natural virus. Last week the Department of Health said measles had been all but wiped out after a vaccination drive in November.

The Royal Free researchers, headed by Andrew Wakefield, compared 3,500 people who had the measles vaccine in 1964 with 11,000 people born in 1958 who encountered measles naturally. The vaccinated group were three times more likely to develop Crohn's disease, at a rate of seven per 1,000, than the unvaccinated group, with a rate of 2.5 per 1,000. The vaccinated group were 2.5 times more likely to get ulcerative colitis.

Dr Wakefield said an association between measles and Crohn's did not mean that vaccination caused the latter. He said that there should be no change in policy until stronger evidence was available.

REMIT FOR AGM

Waikato & Taranaki Region

To increase the N.Z.C.O.M. (INC) annual subscription fees substantially.

(There was much discussion over the amount to increase the fees and it was agreed to not include an amount in the remit. Some felt to at least double the amount and others thought a minimum of $100 would be appropriate.)

Rationale for Remit

- To recognise midwives have a professional body that needs appropriate financial backing, to ensure growth within the college and profession.
- To have enough money on national and regional levels to fund existing services and to pursue creativity eg. education, research, professional support and to fund midwifery positions as required. To have regional paid spokespeople commenting on political issues etc.
- To recognise and respect our professional body in line with other professions. (eg lawyers pay around $2000 and dentists pay around $1400).
- Women have a history of working for no payment and it is time we value the work we do by paying for it.

I will prepare a report for discussion at the AGM.

It will look at the proposed budget and estimate the income required to provide sufficient funds to continue and improve existing services and also allow for further expansion as required. This may help to provide some guidance regarding the amount the subscriptions will need to increase.

Linda Collier
National Treasurer

SUMMARY OF THE NZCOM NATIONAL COMMITTEE MEETING HELD ON 20 MAY 1995 AT CHRISTCHURCH

BUSINESS ARISING

Section 51

Draft 4 of Section 51 finally arrived in the mail last week but included no prices. Draft 4 contains sections that neither the NZCOM or the NZMA agreed to at the last Section 51 meeting as well as previously undiscussed proposals. Both the NZCOM and the NZMA have both sent letters voicing their disapproval. In the College's letter to Sam Denny we advised that we are unwilling/unable to discuss Draft 4 until prices are attached. The discrepancies were:

- 28 days postnatal care was understood to have been the minimum time allowed but instead it has been changed to 28 days maximum care.
- States that rural practitioners are not necessarily included in Section 51 but subject to separate contracts.
- Induction included in the labour and birth module.
- Referral criteria were guidelines not requirements. This draft has shifted to imply criteria are mandatory.
- Access agreements unclear again when it had been previously agreed that it was a RHA responsibility, and not a CHE's.
- Budget holding by Lead Maternity Carer (LMC). This issue was discussed at length where it is up to the Lead Maternity Carer (LMC) to pay other carers, whether it be the midwife/doctor/CHE. It was acknowledged that it was a process many were having difficulty with and it was even harder to discuss when there are no prices put forward.

Following discussion the meeting reaffirmed that continuity of care should continue to be promoted and the fees should reflect that decision with the Section 51 Negotiating Committee basing all decisions on it.

In shared care arrangements the MPO will protect the midwife, therefore it is very important to have our MPO in place before the LMC modules take effect.

Proposed Structure of MPO

NZCOM
Indemnity/Standards Review/Education/ Accreditation/QA

↓↑

MPO (*separate legal entity from College*)
NZCOM Members/Regional Members
Separate objectives & Constitution

↓

Regional Advisory Committees
↓
Northern
Central
Midland
Southern

Executive Director
↓
Typist/Receptionist
MIS
Legal/accounts
(sub-contracts)
Quality Assurance
(NZCOM)

→Northern Regional Officer
→Central Regional Officer
→Midland Regional Officer
→Southern Regional Officer

Graduate Ruth Martis with her children, Hannah (11), Solveig (3), Benjamin (9) and Annie (5). Photo by Graeme Brown.

Extra challenges for extramural

by Shani Naylor

EXTRAMURAL study can be especially difficult for women with children and a career, as Palmerston North midwife Ruth Martis can confirm.

She also faced an extra challenge when she spent three years in Denmark during her decade of studying toward a bachelor of arts, majoring in nursing. She graduated yesterday.

The years in Denmark were challenging, she said, as she was also learning to speak Danish. "When it came time to sit (Massey) exams, I had to twist the arm of the local school master (to supervise)."

Mrs Martis grew up in Germany, did her nursing training there, and came to New Zealand 1978. She doesn't believe she could have done her degree there. There were no nursing degrees, no extramural courses and mothers with young children tended not to study, she said.

"Extramural suited me very well," she said, especially with the arrival of four children.

When her fourth baby, Solveig, was born, Mrs Martis was even able to take her to lectures she was attending for a women's health studies paper.

Study also had its lighter moments, such as when one assignment got lost when it was taken on the lecturer's honeymoon. English was also a challenge at times, and she recalls once using the word "bosom" instead of "lap" — much to a colleague's embarrassment.

Mrs Martis was a foundation tutor for the comprehensive nursing course established at the Palmerston North Technical Institute (now Manawatu Polytechnic) in 1980.

She qualified as a midwife in 1982 and is a foundation member of the New Zealand College of Midwives. For the last eight years she has specialised in homebirths.

She's now considering starting a masters degree in midwifery in 1996.

Smoking blamed for miscarriages

Press 2/5/96

by John Schwartz

Smoking may cause as many as 7.5 per cent of all miscarriages — most of them occurring before the woman knows that she is pregnant, according to American researchers.

Between 19,000 and 141,000 miscarriages in America can annually be linked to smoking, and as many as 26,000 newborn babies are admitted to intensive-care units each year because of low birthweight caused by smoking, the researchers estimated. In addition, as many as 2200 cases of Sudden Infant Death Syndrome (SIDS) may be caused by maternal tobacco use, the researchers said.

The evidence of smoking's heavy toll "is a poignant reminder that use of tobacco products affects many innocent individuals who have not chosen to assume the risks involved", wrote researchers Joseph R. DiFranza and Robert A. Lew in the last issue of the "Journal of Family Practice".

The article provides a "meta-analysis" of about 100 studies related to smoking and prenatal and neonatal health. In a meta-analysis, researchers review all available studies on a particular topic and try to draw over-all conclusions.

Tobacco use during pregnancy has long been associated with miscarriage, low birthweight, and other complications in newborns. In this case, the researchers went a step further than many meta-analyses by attempting to estimate the number of miscarriages, infant, deaths, and life-threatening complications that could be attributed to smoking.

Meta-analysis is sometimes controversial because it attempts to draw comparisons between studies of differing designs. The report is "an outstanding article" that is the first to bring together so many threads of research on the subject, said Michael Siegel, epidemiologist with the Smoking and Health Office at the Centre for Disease Control and Prevention in Atlanta.

"Clearly, women have to take responsibility for the life that they are carrying," said DiFranza, a doctor at the University of Massachusetts.

DiFranza added that since nicotine is highly addictive, many women find it difficult to quit. When polled, some 39 per cent of smokers who became pregnant say they quit during their pregnancies, but studies that subjected the women to blood tests found that just 14 per cent of women offered a variety of cessation aids actually quit.

From these studies, the Massachusetts researchers estimated that between 18.4 per cent and 27 per cent of pregnant women smoke. The study concluded that any attempt to reduce the number of deaths due to tobacco use during pregnancy "should focus on preventing nicotine addiction among teenage girls".

Spokeswoman Brennan Dawson for the tobacco industry did not dispute the findings. "Women should seek doctor's advice. That's been our long-standing counsel on smoking while pregnant."

The wide range of estimates for miscarriage in the DiFranza report can be attributed to different considerations used in arriving at the low and high figures.

Studies have found that between 20 per cent and 62 per cent of pregnancies end in spontaneous abortion, with most miscarriages occurring before a woman knows she is pregnant.

The researchers' "best-case" estimate of 19,000 tobacco-induced miscarriages uses the lowest estimate of the proportion of pregnant women who smoke, and includes only those pregnancies and miscarriages that are recognized by women and their doctors.

The "worst-case" figure of 141,000 uses the highest estimate of smoking prevalence, and includes miscarriages that occur before a woman realises she is pregnant.

The researchers also found evidence from many studies that smoking elevated the risk of stillbirths, deaths among newborns, and Sudden Infant Death Syndrome (SIDS).

"The most dramatic effect of maternal smoking is on the risk of SIDS, which is tripled" when mothers smoke, they reported. Two-thirds of SIDS deaths among children of women who smoke during pregnancy can be attributed to smoking, the researchers said.

DiFranza and Lew concluded that the number of pre-natal and infant deaths caused by smoking dwarfs the figures for homicide and child abuse: "While deliberate violence and abuse are very serious concerns, cigarettes kill many more children."

—Washington Post

Direct Entry Taskforce for Students

A document was tabled giving a background, guidelines and actual application forms for Education Funds for Direct Entry Students which could be specifically used for fees, textbooks or clinical training fees. To be discussed regionally.

Midwifery Data Base

The National Committee gratefully accepted Clive Martis's offer to help with the database. Clive is Assistant Director of Information Services at Massey University and will work with Karen to develop a programme to enable the Midwifery Standards Review data to be analysed nationally.

Guidelines for Midwifery Caseload Management

The draft "Guidelines for Midwifery Caseload Management" document was tabled and suggestions were called for to make any changes or improvements. Among the sections that were discussed were the role of the mentor, access and definition. It was agreed that the word "independent" should be phased out and in its place autonomous be used throughout the document so that both self employed and employed midwives can both use it for a resource. The draft will be circulated and discussed amongst the regions and comments returned to the National Office for collation.

Proposal for the WHO International Code for the Marketing of Breastmilk Substitutes in NZ

A request has been received by the College from the Public Health Commission to send a proposal to assist in monitoring the application in NZ of the WHO International Code of Marketing of Breastmilk substitutes. Marcia Annandale, lactation consultation was invited to give her impressions of how the monitoring would best be accomplished. Marcia suggested the establishment of an advisory panel consisting of the following:

- An independent chairperson (someone in child health promotion
- A community and other groups member (community focus breastfeeding advocate)
- A Maori member (close to health promotion and its impact on Maori families
- An industry member (some who represents the biggest market share in NZ.

Panel support from the MOH who have links with the RHAs as well as secretarial support. Those present gave approval for Marcia to prepare a full proposal which is due by Friday 26th May.

Report back from Hui

The Maori Midwives reported back about their 2 day Hui in Wellington. 100 women attended, half of them were students or potential students. Recommendations from the Hui:

- The role required of Maori Midwives.
- Support for Whangai-U have had a Hui since.
- Will be a further Hui next year in Taranaki.
- One of main jobs is to support students.

Feel it is important to share what they are doing with the College.
Sorting out priorities for bi-cultural project but no firm plans as yet.

Prescribing

The Waikato Region reported prescriptions for antibiotics and contraceptives were being returned from pharmacists. Midwives have the right as per legislation to prescribe for normal pregnancy, birth and up to 6 weeks after the birth. Karen had written to John Marwick re position of the Ministry and the reply indicated they felt it was a matter for the Nursing Council to define midwifery competencies. Discussion ensued re the appropriateness of prescribing antibiotics.

Discussion reaffirmed the midwife as the appropriate decision maker regarding client need for prescription and the profession as the appropriate body to define a midwife's scope of practice. This position to be reinforced with the Ministry of Health.

Test Review Group
The SRHA has formed a committee re Laboratory Testing Schedule comprising of 4 pathologists, 1 SRHA representative as Chairman, 2 GPs and 1 specialist physician. This group will determine what tests can be ordered and who can order them. There is no midwifery representative. The Canterbury/West Coast Region has written a submission to the SRHA but has had no response. Karen indicated that this may happen in other regions so to be aware and act promptly with a submission.

Media Advertising
Karen reported an increasing number of requests to National Office for editorials from newspapers etc, often offering to also sell advertising space around this and thought perhaps this could come out of the media budget. The College is also occasionally approached nationally by regional newspapers and Karen wasn't always able to meet these needs and thought it would be a good idea to have a North Island and a South Island representative to deal with these requests. Bronwen Pelvin volunteered to be the South Island representative and Ruth Martis volunteered to be the North Island representative.

Staff
Increasing expectations of members, Government departments, RHAs, CHEs and consumers have meant the workload in the National Office has become overwhelming. The National Committee acknowledged the extra work Judy Henderson and Marita Perini have taken on without pay and agreed it is not acceptable to a good employer for this to continue. More hours and glide time arrangements were considered appropriate.

Letters:
Le Leche League
The Le Leche have written to the Ministry of Health expressing concerns regarding the lack of Government action to meet the Innocenti Declaration agreements. The Le Leche League are very keen to maintain links with the College for exchange of information, support etc. Anne Heritage is now the Director

RNGCOG
A letter has been received from Tony Baird in response to the College's initiative to have a meeting between NZCOM and RNZCOG. The RNZCOG meets on 29 May and will include our letter on the agenda.

Treasurer's Report
Regional Guidelines
The Treasurers Guidelines was tabled and discussed as a way of increasing efficiency between National Treasurer and Regional Treasurers to ensure standards, protocols for dealing with transfers, resignations etc. Chairpersons to take guidelines back to their regional treasurers for discussion and comment.

Also tabled were the proposed regional guidelines which are broad regional objectives to clarify for regions what their role involves. Gill Down (Consumer member Canterbury) donated a morning's work to help write these guidelines. The Committee gave a vote of thanks to Gill. The

MEDIA WATCH

Otago Daily Times 23/6/95

Doctors 'should advise'

Nelson (PA). — Doctors should ensure parents know about the option of giving babies a vitamin K injection at birth, Nelson coroner Ian Smith has recommended.

His recommendation was made in the Nelson Coroner's Court on Wednesday, following an inquest earlier this month into the death of Nelson baby Jasmin Eggers.

He also recommended the doctor should be "team leader" at the birth, responsible for liaising with the midwife.

Mr Smith found Jasmin died as the result of accidentally not receiving a vitamin K injection at birth, resulting in a fatal cerebral haemorrhage.

The recommendations are intended to prevent a repeat of a breakdown in communication which resulted in Jasmin not receiving the injection.

Mr Smith said Nelson-Marlborough Health Services had put protocols in place to prevent such a tragedy happening again.

He recommended that where there was no doctor attending a pregnant mother, the onus should be on the midwife to advise the parents before the birth of the option of giving their baby a vitamin K injection.

He recommended the attending doctor should be "team leader" to liaise with the midwife. They should complete and sign a checklist on all matters relating to the birth, from the time the mother was admitted to the time of discharge.

In his submission to the coroner, Dr Riley disputed Mr Smith's recommendations that the doctor should be team leader and tell the parents about the vitamin K option. He said the mother had a right to choose her care-giver and from whom she received antenatal advice.

He said the doctor and midwife involved in the case were on an equal professional footing.

Editor's Comment: This baby died of HDN. It is still an assumption that vit K would have prevented it. In this case the doctor was the 'team leader'!!

Birth deal labours on

NZ Doctor - 23/6/95

The protracted discussions over future maternity services are set to continue, despite the RHAs finally agreeing on the new schedule.

Both midwives and doctors claim that the concerns they have raised about the scheme have not been acknowledged, and they may now look to contracts with RHAs to negotiate different terms or rates of payment.

The "lead professional" responsible for antenatal care, labour and delivery will be allocated a budget to include all visits, tests and scans as well as payments to any other professionals involved.

Some suggest that budget may be in the region of $2000, which could be too little to cover the cost of complicated pregnancies and deliveries.

Fears have been raised that the system could mean that first time mothers or those with a complex obstetric history could be turned away from the lead professionals they choose. There are also concerns that inflexible budgets and additional paperwork will drive more GPs out of obstetrics, reducing choice for mothers.

The RHAs stress that the new maternity package will benefit mothers by facilitating more home support and formal care plans.

But they acknowledge that the terms may be no more than a baseline from which IPAs and independent midwives can negotiate.

North Health maternity manager Sam Denny said the modular system of payment would result in "swings and roundabouts" so professionals would not be financially disadvantaged overall.

But, she said, individuals who could demonstrate particular skills and experience would always be free to discuss separate contracts with the RHAs.

MT

IN LABOUR : Women and Power in the Birthpiace

Barbara Katz Rothman $25.95 PB0563

The first systematic feminist analysis not only on how childbirth is managed but also on why it is managed this way: addresses central questions of women's identity and autonomy. USA 1991

Recreating Motherhood

Barbara Katz Rothman

Katz Rothman challenges the way we perceive many issues involving motherhood by drawing our attention to the pervasive ideologies of patriarchy, technology, and capitalism, and how these ideologies influence our attitudes towards pregnancy and childrearing.
A profound work; truly mind-expanding.

regions main priority should now be education. Each region needs to look at guidelines and breakdown on a regional level and assign roles and responsibilities within regional committees.

GENERAL BUSINESS

Competencies and Nursing Council

The Nursing Council is intending to link competencies to Practicing Certificate. The College has written to difference groups for advice re competencies for midwives/nurses. A workshop has been organised to discuss and establish competencies for newly registered midwives. Bronwen Pelvin (Timaru), Ruth Martis (Palmerston North), Beryl Davies (Wellington), Sally Pairman and Karen Guilliland were nominated as representatives to the Nursing Council's Workshop.

Funding a Midwifery Tutor Meeting

The aim was to co-ordinate tutors and other midwives and consumers to meet to discuss issues on course content and future direction. Midwifery students competing with medical students and nursing students are experiencing increasing difficulty in gaining quality clinical experience. Need to look at CHE relationship as there is an expectation for them to provide adequate clinical experience for student midwives. We must ensure courses continue to produce midwives who are autonomous and competent to practice.

It was also decided to approach the Women's Health Managers Network to look at joint arrangements with CHEs for registered midwives who wish to update skills.

Remits for AGM

Reminder to regions to forward any remits for AGM by the end of June.

Nominations for President

Sally Pairman is standing for re-election. If there are any other nominations then need a regional vote. If this cannot be done at a regional meeting or at region's AGM then a Special General Meeting is required to be called.

MSRC Assistance and Co-ordination of Training/Finance

Each MSRC is responsible for itself and is responsible for its own training and ongoing education. The MSRC Workshop has decided that if regions are without a MSRC the College can offer seeding funds to initiate a Committee. Marjet Pots is available to facilitate these meetings as required. Regions need to write to the College with a budget proposal then regions may organise themselves with Marjet. As midwives are reviewed money can be recouped and repaid to College.

Feedback was requested from other regions re their Complaints Committee formation.

It was emphasised that the complaints procedure is separate from the MSRC but related to the College as the professional body. Auckland has different committees for different types of complaints, who makes complaint and what would be helpful to support this complainant. Their Complaints Committee comprises of a midwife, consumer and facilitator. It was felt the name Complaints Committee maybe an inappropriate name - perhaps Resolutions Committee. Complaints Committee members need to be different from those involved in MSRC. It worked well to send a letter to the complainant offering contact with either the midwife or the consumer committee member to discuss the complaint further. The complainant can then choose to contact who they feel is appropriate for them.

Cot Death Research
Auckland reported on a recent meeting at the Auckland Medical School where Robert Scragg told of research which shows baby sharing room with parents/adults has a protective effect against cot deaths. This effect is greatest for European children.

Water Birth Information Book
It was advised that the Water Birth Information Book is $US16 and is available from Global Maternal/Child Health Association Inc, Post Office Box 366, West Linn, or 97068 USA. Apparently once you buy this book you are sent updated articles as they come to hand.

Another good resource book is the Water Birth Handbook by Dr Roger Lichy & Eileen Herzberg, Gateway Books UK 1993 ISBN 09 46551707.

Otago Region
It was reported that a number of postnatal beds have been removed without consultation and the CHE is now trying to make 48 hours as discharge policy and wanted to know the College's view of this. The College believes that this is acceptable as an option when women choose it and home support is available, but not as policy. The RHAs are required to consult with the public on policy changes but haven't done so.

Obstetric Records
It is planned to format "obstetric records" at a national level in an effort to standardise data collection and reduce duplication. It could be used to collect data that we require for IPOs and MSRC etc and also meets objectives for data collection for the RHAs. Otago has already done some work on this area and maybe could finalise a draft and circulate to regions for comment and then to National Office for the final draft.

Concern was expressed by some regions re the standard of documentation and/or lack of documentation by midwives as it appears to be an increasing problem. It has legal consequences especially with regard to indemnity insurance claims and ACC. Midwives and women need concise and accurate documentation to defend or inform themselves. It also has implications for HBL audit. Midwives need to be made aware of importance of documentation.

HBL Audit
The first random audit has occurred in Christchurch and HBL have employed a practice nurse to do it. Concern was expressed that a practice nurse has been employed, the general consensus being it should be a midwife. Some issues have arisen for these midwives which Karen will take up with HBL. The College has informed HBL it is available on a consultation basis for advice, interpretation of claims and considers a midwife is the appropriate person to give this advice. Midwives who have been audited might like to write to the National Office outlining their experience of an audit and how satisfactory or otherwise it was.

Bounty Books
Further concern was expressed re the content of these despite being reviewed and changes recommended and needs to be looked at again.

The next meeting of the National Committee is on 26 August with the AGM on Friday 25 August.

BOOK REVIEWS

The following reviews are of books written by Barbara Katz Rothman. Barbara is to be the keynote speaker at the 1996 NZCOMI Conference.

The tentative pregnancy:
amniocentesis and the sexual politics of motherhood. Revised edition.

Barbara Katz Rothman. London: Pandora, 1994. 282 pages. £8.99. ISBN 0044409125.

The tentative pregnancy is relevant to all of us: to any woman who has ever had, or considered, or is likely to consider prenatal testing for fetal abnormalities; and to any health professionals who offer testing.

At one level, this book is about how a particular reproductive technology - amniocentesis - changes women's experiences of pregnancy. At another, it is about the ways such a technology fundamentally affects the ways all of us think about pregnancy and motherhood.

The author is a sociologist, and the book is the result of research she did with four groups of women: those who accepted amniocentesis; those who declined it; those who underwent a termination following prenatal diagnosis; and a group of genetic counsellors who regularly explained prenatal diagnosis to women. The pregnant women in Rothman's study contacted her in response to an advertisement and an article she placed in two American journals. Although her sample is not representative of all women who face and make choices in relation to amniocentesis, we can learn a great deal about the many ways women think about the issues.

The book's contents are organised around women's responses to the existence and consequences of prenatal diagnosis: how they perceived the choices; how they made decisions; how they received bad news and lived with the uncertainty of ambiguous diagnoses; how they grieved the "genetic defect" and the loss of a wanted pregnancy. Like many other qualitative researchers Rothman uses a lot of quotations from the women themselves. Their voices are powerful and often painful to hear. Although the professionals in this study are genetic counsellors, their experiences, concerns and strategies for presenting information to women will be very familiar to midwives.

The author's analysis is grounded in women's accounts. Women (in developed countries) may have more reproductive choices than they have ever had before, but the choices are socially constructed and mediated by dominant values about, eg motherhood, family planning, "perfect" babies, the nature of childbirth. Furthermore, these choices exist in societies that both devalue the lives of people with disabilities, and place the burden of their care on women. In such a context, prenatal testing is difficult to refuse. Rothman's arguments are not against reproductive technologies per se but in the ways they are used.

The author has written an introduction to this second edition and two new appendices - one on maternal serum screening for Down's syndrome, the other on guidelines for personal decision-making. The book is otherwise unchanged. Anyone reading it for the first time will quickly realise why no changes were necessary. Rothman's prophecies and concerns have been more than justified over the years.

The book is accessible and easy to read. The women's stories about prenatal diagnosis and Rothman's durable analysis make this an important book for midwives.

Reviewed by Jane Grant, midwife teacher.

Available from *Birth and beyond*, MIDIRS book and video service

tistics are provided
• anything that might have a genetic or infectious nature is established
• public health concerns can be addressed.

She quoted Giovanni Morgagni, "the father of autopsy", as saying in the seventeenth century, "Autopsy is a gift the dead person can give the living-by providing an understanding of the disease.

"Those who don't do it are floating in a cloud of uncontrolled optimism [about their medical skills]."

Auckland district coroner Stephen Osborne said he does not know what constitutes a culturally appropriate autopsy, but is adamant that there should not be different laws for different racial or religious groups.

He said, however, that Section 8 of the Coroners Act directs the coroner in considering whether or not to authorise a post mortem examination "to have regard to the desirability of minimising the causing of offence to persons who by reason of their ethnic origins, social attitudes, or customs or spiritual beliefs, find the post-mortem examination of bodies offensive".

The coroner is also directed to listen if family members believe an autopsy should not be done. However, he or she is not dependent on having permission of the family, he said.

Mr Osborne said, in fulfilling his role to determine the cause and circumstances of death, he "is unconvinced that there is any real and effective substitute for autopsy ...and that the lack of such quality evidence can pervert the course of justice in other courts where criminal culpability is an issue".

He believes the final decision about whether an autopsy is necessary should always be in the hands of the coroner.

"In a civilised society-however polyglot-any law which seeks to inhibit or restrict the power of the coroner to establish, as accurately as possible, the causes of death of its citizens who die under certain circumstances, is a bad law."

Mr Osborne said a concerted effort is made at the Auckland mortuary to reduce the delay in releasing the body, to avoid the retention of body parts, and to let families know what is happening and why, in order to reduce the impact of the autopsy.

Allow for feelings of the minority

Auckland Law School lecturer David Williams said, "If the ways of the majority are to override a minority - and here the tangata whenua is a minority in their own land - then there's a heavy duty to ensure that there is good reason for it."

Mr Williams said there are times when a postmortem must be done, but there also has to be some sensitivity towards people whose beliefs are different.

"The coroner has to balance the need to find out how someone died with minimising the offence to people who for spiritual or cultural reasons want the early release of a body."

He said that Maori believe there is a holistic connection between all things in the universe, and, just as the human placenta is returned to the ground as a symbol of the person's link with the land and the ancestors, so the whole body should be returned to the earth at death, to complete that connection.

He said Maori custom is changing as is European law.

"There has been a lot of grief about the return of bodies with parts removed but there is also a change of attitude about the use of body parts for donors.

"Some Maori are willing to donate parts, but the cultural preference is for the body to remain whole so that it can be returned to the land," he said. ■

Midwives versus consultant led delivery; a controlled trial

There has been vigorous debate in the UK about where delivery should occur as maternity services have moved from community care to consultant maternity units. It has been argued that hospital delivery is safer for mother and baby although not all agree. In Aberdeen a midwives maternity unit has been developed to offer choice in the participation and control of labour.

The subjects were randomised on a 2:1 ratio to the midwives unit or the hospital labour ward. The 2844 women were defined as low risk by the booking criteria for general practitioner units in the Grampians. 1900 women were assigned to the midwives unit and 944 to the labour ward.

Of the women randomised to the midwives unit 34% were transferred to the labour ward antepartum, 16% intrapartum and 4% lost to follow up. In the event 46% were delivered in the midwives unit. Primagravid women were much more likely to be transferred to the labour ward than multigravid women.

There were no differences in the mode of delivery or fetal outcome between the two groups. There were important differences between the two units in monitoring, fetal distress, analgesia, mobility and the use of episiotomy, but no increase in neonatal morbidity. However, half the women identified as low risk at booking became high risk during pregnancy or labour.

Midwives care was as safe as consultant led care but the high rate of intrapartum transfer to consultant led care needed to be considered if stand alone midwives units were being planned.

Hundley VA, Cruickshank FM, Lang GD, et al. Midwife managed delivery unit: a randomised controlled comparison with consultant led care. BMJ 1994; 309: 1400-4.

NZ. Medical Journal 14/6/95.

These prices are proposed only. The next meeting to negotiate these prices along with the NZMA and the Combined RHAs is the 21st July. We welcome any responses including figures you see as appropriate before the 19th July. These can be faxed directly to National Office Fax 03-365-2789 or feed responses back to your chairperson. Thank you to all those who have supplied copies of their claim forms.

STOP PRESS

Proposed Payment Schedule

MATERNITY PAYMENT SCHEDULE
PROPOSED SCHEDULE OF FEES

The Proposed Schedule of Fees is to be read in conjunction with Draft 4 of the Joint RHA Contract Strategy Paper.
(All fees are GST inclusive)

FEES/MODULE DESCRIPTION	PAYMENT TYPE	CLAIMANT	AMOUNT
○ Pregnancy Care	Fee for Service	Midwife, GP, Obstetrician	$25 per visit
○ Pregnancy Care Urgent and Out of Hours	Fee for Service	Midwife, GP, Obstetrician	$45 per visit
○ Threatened Miscarriage Services	Fee for Service	Midwife, GP, Obstetrician	$45 per attendance
○ Services for Miscarriage	Fee for Service	Midwife, GP, Obstetrician	$75 per miscarriage
○ Information re Options of Care	Fee for Service	Midwife, GP, Obstetrician	$10 per woman
○ Lead Maternity Care Registration Care Plan Fee	Fee for Service	Lead Maternity Carer	$75 per woman
○ Pregnancy, Second Trimester	Module	Lead Maternity Carer	$165 per module
○ Pregnancy, Third Trimester	Module	Lead Maternity Carer	$230 per module
○ Labour and Birth Services	Module	Lead Maternity Carer	$750 per module

FEE/MODULE DESCRIPTION	PAYMENT TYPE	CLAIMANT	AMOUNT
• Supplies for Home Births	Fee for Service	Lead Maternity Carer	$60.00 per delivery
• Services Following Birth	Module	Lead Maternity Carer	$350.00 per module
• Home Care Supplement	Module	Lead Maternity Carer	$80.00 per module
• Specialist Consultation Services (Obstetricians)	Fee For Service	Obstetricians	$108.00 per consultation
• Specialist Consultation Services (Paediatricians)	Fee for Service	Paediatricians	$70.00 per consultation
• Specialist Secondary Labour and Birth Services	Fee for Service	Obstetricians	$425.00 per delivery
• Anaesthetic/Epidural Services	Fee for Service	Anaesthetists	$28.20 per unit under the existing Relative Value Guide system
• Ultrasound	Fee for Service	Radiologists	$83.80 per ultrasound

NZ DOCTOR

28/04/95

Autopsy creates clash of culture and science

Lynne Laracy

There is no such thing as a culturally appropriate autopsy, Auckland Medical School lecturer in Maori Health David Tipene Leach told NZMA conference goers.

At a debate entitled "Culturally Appropriate. Autopsies" held on Whaiora Marae, Otara, he said that the procedure violates both Maori custom and the Treaty of Waitangi.

"A body is a treasure [a taonga] and as such is guaranteed by the Treaty which says Maori should have control over their treasures."

Dr Tipene Leach said Maori do not like postmortems because they dislike disfigurement of the body; because there is no precedent in the culture for such procedures; and because of their beliefs on death.

"Maori believe that, when a person dies, the spirit essence leaves the body and, for the next few days, completes things of importance - seeing old friends, needling old foes and generally completing its business.

"For people who believe that it is their job to look after the body because the spirit is not there, delays which have in the past been too long, have wrought terrible pain on families and tribes."

While there has been some improvement in procedures which have lessened the trauma, the reasons for carrying out autopsies must be carefully looked at.

"Maori people are not interested in research that comes out of dead bodies. And if you want to use bodies for the sake of clinical audit do it on those who don't mind," he said. "Everybody minds but there are some groups who mind more than others."

Maori family grief: a body is a treasure to be returned to the land

He said, however, that Maori people understand the need for postmortem for forensic reasons and this is considered acceptable.

SIDS autopsies double the pain

Dr Tipene Leach, who is also coordinator for the National Maori SIDS Programme, particularly questions the need or desirability of postmortem in the case of cot death.

He said the procedure doubles the pain of the loss for families and yet yields no useful data.

"Talking to pathologists and coroners, I am told that there are positive findings in only a small percentage of cases.

"If we are going to inflict this sort of pain, we must ask ourselves 'will it make a difference?' and, at the moment, the answer is 'no' - so why are we doing it?"

Dr Tipene Leach said that the main reason given by pathologists for carrying out such autopsies is to exclude the possibility of non-accidental death.

He suggested, as a wero, or challenge, that as 90 per cent of SIDS deaths are in Maori, that there is a suspicion that "Maori are knocking off their kids".

He suggested that another reason is that coroners are unhappy about having SIDS on the death certificate.

"I believe we should rethink that whole issue. There is a tension between the need for a diagnosis and the need for some humanity. The law might have to change," he said.

This view was refuted by Middlemore histopathologist Mary Miller. She argues that, although there are no concrete findings at present, it may - as in the case of myocardial infarction - take years of documented autopsies to find the cause.

"Eventually it is to be hoped that some bright young pathologist will find out what causes SIDS. And, in the meantime, we need to know why people die," she said.

She believes all cultures need to take part, because what is true for one, pathologically, is not necessarily true for others.

"What is more, it is Maori who will benefit most from the findings of the research into many of these diseases."

Clear benefits for some

Dr Miller said through an autopsy:

- an accurate cause of death is established
- clinical audit can be carried out
- other factors contributing to death are established
- ongoing education is provided
- an insight into how a disease affects the body, and therefore how to treat it, is gained
- more accurate health sta-

Vaccination answers

Dear Editor

Re: the questions raised by Dr Godfrey (*GP Weekly* 3 May 1995).

Clean water, sewerage systems and improvements in living conditions have played an important role in the decline of communicable disease, but they have not eradicated any diseases. Immunisation has. Through the organised efforts of the World Health Organization, smallpox was eradicated from the world in 1977.

Unlike many other communicable diseases, the incidence of polio had been increasing since the 1920s to reach a peak in the 1950s, when the disease was dramatically controlled by immunisation. It is likely to be the second disease eradicated from the world by immunisation in five years time.

The recent dramatic 80 percent decline in cases of *Haemophilus influenzae* type b (Hib) disease following introduction of the vaccine last year is another example of the effectiveness of immunisation. Unfortunately, some cases are still occurring because not sufficient children under the age of five years have been immunised. Of seven cases whose immunisation status was known, only one was immunised. Assuming 80 percent coverage, this would suggest vaccine efficacy of 96 percent (if coverage is in fact higher, so is the efficacy).

The accumulated scientific evidence also shows that any risks of the vaccine are considerably less than those of the disease. Now to answer Dr Godfrey's 10 questions.

1. It is not well accepted that pertussis vaccine is a neurotoxic. Several large studies have failed to demonstrate a causal link between the vaccine and brain damage. If the vaccine does cause brain damage it occurs so infrequently that it cannot be accurately measured.
   A review of notified cases of pertussis in the US between 1980 and 1989 found that 0.7 percent developed encephalopathy and 2.2 percent seizures.[1] A Canadian review of hospitalised cases found that 0.2 percent experienced neurological complications.[2] In Sweden, following the cessation of pertussis immunisation, neurological complications developed in four percent of hospitalised cases and encephalopathy in 0.5 percent.[3] There are other serious complications of the disease, but even without complications, the disease has a high impact on families.[4] In an unimmunised population, behavioural changes were noted for 84 percent of non-hospitalised cases.[5]
   Erythromycin reduces infectivity of pertussis but has limited impact on clinical illness. This is to be expected since it is the toxin which causes disease, and antibiotics cannot reverse the damage to the respiratory epithelium.

   Although immunisation does not seem to have altered the three- to five-yearly cycles of pertussis epidemics, it has had a major impact on the number of cases. The vaccine seems to be better at protecting against disease, especially serious disease, than infection. Another good example of the effectiveness of vaccines is the increase in cases in the UK following low uptakes of vaccine in the 1970s.
2. Outbreaks of diphtheria have occurred in other developed countries with the waning of the adult population's immunity.[6,7] Although no cases that meet the case definition have been reported since 1980, the organism continues to be isolated. While the risk of diphtheria is low, it should not be ignored.
3. The Institute of Medicine, in their authoritative review of adverse events, concluded that the risk of thrombocytopaenic purpura is of the order of one per 30,000 to 40,000 vaccine which is about six times the background rate.[8] This complication is mentioned in the Immunisation Handbook as a possible rare complication.
4. The prevention of the congenital rubella syndrome can be more effectively achieved by preventing the circulation of virus in the community as well as ensuring personal protection. This is the reason for immunising both boys and girls. If sufficient children are immunised rubella could be eradicated.[9]
5. Prevention of orchitis is not the reason for controlling mumps. Mumps is the commonest cause of viral meningitis and very rarely can have serious complications. Both men and women can suffer gonadal inflammation. Mumps is also considered eradicable.[9]
6. Immunisation is not 100 percent effective. The pool of susceptible children includes those with primary or secondary immunisation failure and the unimmunised who have not yet developed natural immunity. The congregation of children in school/early childhood centres allows the rapid spread of communicable disease. Excluding susceptible children prevents this. Children with natural immunity need not be excluded.
7. Various combinations of co-administration of the vaccines in our schedule have been found not to compromise safety or effectiveness.[10, 11, 12, 13]
8. I would be interested in seeing the literature on the use of either vitamin A or C for the treatment of vaccine-preventable disease. Their effectiveness, however, would not reduce the value of immunisation. If you can prevent it, why get it?
9. The proposed Immunisation Certificate will have an option for those parents who choose not to immunise their child.
10. Delaying the start of the immunisation programme would reduce its benefit since the diseases such as pertussis and Hib are most severe in those under the age of one year. There is no evidence to suggest that vaccine reactions are more likely in the younger infant.

The comparison of the health of immunised versus unimmunised children would indeed be a worthwhile study. Such a study would ideally be randomised, but this is unlikely to gain ethical approval. Any other comparison of the health of immunised versus unimmunised children needs to be carefully controlled for confounding factors. Another point to remember in any comparison is that the risk of getting the disease has been substantially reduced for the unimmunised by the fact that most children are immunised.

Dr Ossi Mansoor
Professional Advisor (Public Health Medicine)
Policy & Planning

25.5.95

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MIDWIFERY PRACTICE ORGANISATION (MPO)

This report summarises work done by the New Zealand College of Midwives Steering Committee on the formation of Midwifery Practice Organisations (or contracting agencies to eventually replace Section 51) since formal applications were made for Feasibility Study funding assistance to the four RHAs earlier this year.

To date, funding was approved by the Northern RHA in late May and Southern and Midland in late June. These monies will be paid out against reported evidence of work on the MPO's structure, services, relationships and benefits.

Brian Hopkins of Hopkins Consultancy Ltd has produced a series of potential IPO structures looking at issues such as taxation and legal structures. The initial work is transferable to all four RHA areas

Following a recent meeting in Auckland, a Steering Committee of four midwives and two consumers has been set up to undertake and complete a feasibility study on the IPO potential in the Northern RHA Region. Sian Burgess (Project Manager) has included a report in the Newsletter to keep everyone updated on their activities.

In Christchurch there have been positive discussions with the Pegasus Medical Group about a joint working relationship to determine the way forward for independent GP/midwife maternity care arrangements in the Christchurch/Canterbury area.

Discussions have reached a stage where the SRHA has agreed to fund a "consortium" approach to gathering maternity information that can be used as a basis for the future development of a rational and understood contracting methodology.

Our next step is to organise Steering Committees for Midland and Southern Regions to plan their studies. All local chairpersons will be discussing this at their regional meetings.

The NZCOM Steering Committee is currently working on applications to each of the RHAs for Establishment Funding to assist in the actual setting up of these Regional MPOs. The closing date for applications for Transitional Assistance has been extended to 19 August 1995.

Considerable progress has been made over the past few months and we look forward to keeping everyone informed of developments.

MPO Steering Committee

Jacqui Anderson
Karen Guilliland
Linda Collier
Julie Richards

MPO FEASIBILITY STUDY REPORT

24 June 1995

Progress to date:

1] At a meeting in Auckland on 4th May 1995 a steering committee consisting of four midwives and two consumers was set up to undertake and complete a feasibility study on the MPO potential in the Northern RHA region.

2] Budget planned for remainder of project.

3] Brochure developed and sent to all NZCOM members in North Health Area.

4] Meetings organised in region to give all midwives an opportunity to talk with project manager about the MPO and the implications for their region. Very useful in terms of identifying areas where MPO could negotiate directly on behalf of member midwives eg.

- a) Midwives in Warkworth are interested in running and maintaining the CHE facility themselves - as they are currently operating it anyway.
- b) To transfer women from Mangawhai to Whangarei takes three separate ambulances!
- c) In Auckland the Access Agreement issues are perennially difficult at National Women's Hospital, with the CHE unable to separate it's employer responsibilities from that of facility provider.

5] Meeting with RHA to set up ongoing relationship and reporting structure.

6] Meeting with Auckland Central Medical IPA to look at joint venture similar to that set up with the Pegasus Group in Canterbury. At the first meeting our proposal was received very favourably.

7] Attendance at Managed Care Conference in Auckland. This served to highlight that there is a market opportunity which Midwives must fill if women are to be able to receive good quality midwifery care, where midwives and women work in a midwifery partnership rather than a medical relationship in which the midwife works for the doctor or specialist in his/her role as lead provider.

8] Meeting with business consultant Pat Snedden to identify areas in which the committee might require consultancy input.

In summary, the learning curve has been steep and it has been heartening to see how positively the MPO concept has been received by midwives.

Sian Burgess (Project Manager)

GPWeekly

Letters to the Editor - 3/5/95

Vaccination questions

1. An increase in the expected incidence of seizures following the DPT vaccination has been reported. As the neuro-toxicity of the pertussis vaccine has been well recognised, and as the organism is easily treated with erythromycin (and/or vitamin C), why is the pertussis vaccine still routinely being given, especially as different organisms can produce clinical pertussis? In like manner, the vaccine does not produce permanent immunity nor provide protection against B parapertussis. To my knowledge, there has never been a published case of brain damage from the natural illness. The three-year pertussis epidemic cycle has not been changed one iota by the US compulsory vaccination programme due to over 60 percent losing their temporary and inadequate immunity within one to five years.
2. In our affluent society, diphtheria is no longer the dangerous illness of 70 years ago and is readily treatable with antibiotics (and/or vitamin C). In the 1969 Chicago epidemic, although 37 percent of cases had been immunised against diphtheria, with serological evidence of full immunity, the latter did not prevent them from becoming infected. Why is it still being given to all neonates?
3. The incidence of thrombocytopaenia following MMR has been documented as 1:50-100,000 but, as a child gets three injections, the 'true' incidence should be 1:30,000. Why are GPs and parents not warned of this adverse effect? This complication is biologically very plausible as it can occur with the wild measles virus.
4. If the only valid reason for immunising against rubella is to prevent congenital rubella, why are males exposed to a potentially hazardous vaccine?
5. If the only valid reason for immunising against mumps is to prevent orchitis, why are females exposed to a potentially hazardous vaccine?
6. If vaccination is an effective procedure, why are the children, whose parents have chosen not to vaccinate, so dangerous that they are to be sent home from school during epidemics? Is it to protect the vaccinated or themselves? The former are supposed to be immune and the latter have obtained natural immunity through an assisted healthy illness or may want the illness to obtain immunity.
7. Has any child had to simultaneously produce antibodies to measles, mumps, rubella, *H. influenzae* or diphtheria, tetanus and pertussis with polio and hepatitis B within a few weeks of each other? This is what is being expected in an uncontrolled experiment with our infants. The new round of vaccines will have five instead of seven injections with more given simultaneously and, as a vaccine against varicella has now been created, a reason will no doubt be found for including it. The vaccine manufacturers also admit that they have not researched the potential for synergistic adverse effects from the different ingredients (mercurial preservatives, animal-derived components and viral contaminants etc).
8. As there is good scientific evidence of the benefits of large doses of vitamins A and C in mitigating the severity of these illnesses, why haven't they been recommended to GPs or paediatricians? They are cheap and safe and there would be little cause for concern if the illness could be made more benign. There would then be no need for mass vaccination and we would start to get a cohort of immune humans capable of passing on healthy immunity to their offspring. As it is, we are seeing an increasingly weak population, requiring regular boosters throughout life and incapable of passing on immunity to neonates (when these illnesses are most dangerous). Paradoxically, the latter is being used to promote vaccination. Is there a common factor behind SIDS, asthma, eczema, glue ear and other signs of altered immunity that have increased to become the bread and butter of ENT and paediatric medicine?
9. Why cannot the mandatory vaccination certificate have a panel for the parents to indicate their wish for 'natural' immunity? This would comply with the requirement but would also recognise those who have taken the responsible step of nurturing their children.
10. Why cannot the vaccination programme be delayed until the child has revealed any genetic defects and is better able to indicate pain (as in Japan)? This would prevent adverse neurological effects from being passed off as 'inherited' as well as allowing them to be more accurately recorded.

Recent information from the US National Vaccine Information Center (NVIC) operated by Dissatisfied Parents Together (DPT) has shown serious misreporting of adverse reactions to DPT vaccines.

Analysis of the VAERS computer discs by the NVIC/DPT revealed that deaths and serious injuries from DPT were 1) never recorded in the VAERS system, or 2) recorded but the information was inaccurate, or 3) not adequately followed up. A similar situation apparently exists in Australia where an ADRAC official has been quoted as stating 'there is a serious problem of underreporting because most doctors don't bother reporting adverse reactions'. There is little to suggest that we are any different in New Zealand.

I have been informed that only five percent of the children attending the Steiner schools have been vaccinated. If this is so, we could have a 'control' group with which to compare quality of life. Maybe the MRC (with funding by the vaccine manufacturers) could help the anthroposophical doctors and other cooperative GPs to do a worthwhile study of all of these children who have reached the age of 12. Their immune status could be assessed as well as the incidences of natural disease and complications. This would be an honest and ethical approach. The fact that these children do not represent the nutrient-starved majority should not preclude demonstrating what can be achieved without a vaccine.

I do not think that these questions and comments are unreasonable and certainly they need to be adequately answered by those promoting mass vaccination. We otherwise risk being unquestioning puppets of a well orchestrated and highly profitable commercial business.

It is also our ethical duty to speak out when we perceive anything which could be detrimental to our patients. I have considerable misgivings concerning this uncontrolled, escalating, multiple vaccination programme. It will be far too late to acknowledge in another 20 years that 'we're sorry, but we got it wrong' and the evidence from the coerced vaccine experiments on indigent native races tends to confirm this.

Informed parents and doctors ought to be free to choose what they consider the best options without compulsory and potentially hazardous vaccination programmes.

Dr ME Godfrey,
Tauranga

-Claimed that when Japan (1975) increased the vaccination age to 2yrs+, SIDS decreased dramatically, and when in the 1980's they allowed vaccination from 3 months on, that cot death rates increased again.
-Temporal link (First 6 months is also the time of most vaccinations, including the DPT, now DPTH), ?? NZ SIDs research into this, ?? was vaccination a factor that was looked at.

6 Contamination of vaccines:
-1960s polio vaccine contaminated with animal viruses
-So called 'hot batches' / unsafe batches, still occur.

7. Homeopathic Perspective Presented at the Conference
-Post vaccine fever may cause a vaccine to be excreted, decreasing the chance of immunity AND long term negative effects. ie. May be a good sign.
-A small initial reaction may mean that the vaccine remains in the system , with an increased chance of more subtle/ chronic effects: asthma, eczema, bedwetting, behavioural changes, glue ear, anaemia.

8.Anthroposophical perspective
-Important to support children though illness with nutrition, fluids, rather than to suppress the illness.
-Fever/childhood illness have a role in
1. Killing viruses (35oC)
2. Stimulating the immune system, so that it becomes stronger and more mature, (? relevance to adult auto immune disorders)
3. Developmental/emotional psychological changes, general maturity. (David Ritchie/GP, presented drawings of his daughter through-out a fever/illness, these showed major changes in how she viewed her world, with increased maturity and link to 'reality' after the illness than before) ? link to learning disabilities, behavioural/attention deficits
4. Preventing cancer: Claimed that research has shown that adults with cancer tend to have had fewer childhood diseases/fevers

Anthroposophical doctors therefore have concerns on two levels ie. From the holistic model, of suppression not being helpful; and concerns within the biological/medical model, re inadequate information on safety and effectiveness.

Dr Gillian Durham (Chief Executive of Public Health Commission
Dr Durham was the only speaker to present a 'pro immunisation' perspective. She did not address the question of whether immunisation was either safe or effective, or desirable. Stating that " we would have to agree to differ on that question" She presented immunisation as a public health problem due to 'low coverage'. (less than 60% of children are fully immunised by 2yrs) The main question addressed was, how to increase vaccination uptake.

Along these lines, there are proposals to institute a school entry immunisation programme. This involves a vaccination certificate required by all children born after 1994, in order to enroll in school. Parents may choose NOT to immunise, however in the event of an outbreak their children may be excluded from attending school/kindergarten. This system is called 'Mandatory Choice' and it is claimed that the idea is NOT to coerce or to persuade people to immunise, JUST to make a choice, one way or the other. (Although she also stated that the aim is for 95% vaccination by the year 2000)

See BIC for conclusion

EVENTS CALENDAR

HEALTH RESEARCH COUNCIL CONSENSUS DEVELOPMENT CONFERENCE

"Whose Genes are They Anyway? The Use & Misuse of Genetic Information"

Community Meetings - 24th July 1995
Conference - 25th - 27th July 1995

Wellington - Registration Deadline : 20th July

Contact : Jenny Rankine P O Box 5541 Auckland
Phone (09) 379-8227 Extn 822 Fax (09) 377-9988

Cost : $ 80.00 Students/Unwaged - $120.00 Waged

ANTENATAL EDUCATION WORKSHOP

22nd & 23rd July 1995
Burwood Hospital Christchurch

A workshop for Childbirth Educators, Midwives, Physiotherapists and interested others.
Contact Chris Hendry, Burwood Birthing Services, Private Bag 4708, Christchurch. Ph (03) 383-6844 or (03) 383-6836.

Cost $150 + Dinner $40

WORLD BREASTFEEDING WEEK

1 - 7 August 1995

NATIONAL HOME BIRTH CONFERENCE

Home Birth - Our Choice
September 1st, 2nd and 3rd 1995
Palmerston North College of Education

Contact : Lorraine Carr P O Box 733 Palmerston North
Phone (06) 356-1204 Cost : $200

SEXUAL HEALTH UPDATE CONFERENCE

September 1st and 2nd 1995
Colquhoun Lecture Theatre, Dunedin

Topics: Herpes, HPV, Cervical Cancer, Maori Health Issues, Male Sexual Health Problems, Bacterial Vaginosis, Chlamydia, HIV, Hep C, etc

Contact : Chris Griffiths
c/- General Outpatients Dunedin Hospital

Cost : Approx $150.00

KNOWLEDGE AND WISDOM

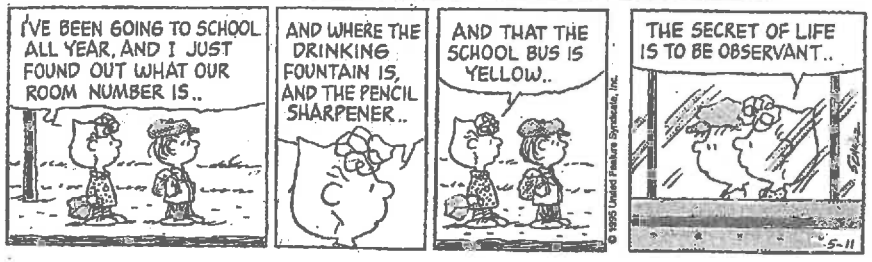
***The* KEYS TO SAFE MOTHERHOOD**

Australian College of Midwives Inc
9TH BIENNIAL CONFERENCE
Sydney Convention Centre, Darling Harbour
September 12-15, 1995

Abstracts due 28th February 1995
Completed papers will be required
by 30th June 1995

Abstracts must be submitted on official abstracts forms.
Forms available from:
Conference Secreatria
ACMI Biennial Conference
P O Box 787, Potts Point NSW 2011 Australia
Telephone (02) 357-2600
Facsimile (02) 357-2950

PEANUTS



SAFETY

Statements concerning the safety of vaccinations included:

1. Possible Harm
-Vaccines not tested as drugs are.
-Testing all done by manufacturers, who have vested interests in marketing any particular vaccine.
-No widescale testing of safety or effectiveness once introduced.

2. Lack of knowledge/research about the effects
-Synergistic Effects not known/researched.
-Numbers of vaccinations advised is increasing. Germany advises 23 vaccinations, New Zealand at present advises 25 during the first five years of life, to cover 9 diseases. 16 of these are given during the first 5 months
-In NZ the plan is to reduce the number of visits required to obtain 'full' immunisation, ie. more vaccines at each visit: ???Any research into the effect that this may have on either the safety OR effectiveness of each vaccination. *(Can the body cope with producing antibodies to several different pathogens at one time....will the 'non responder rate' increase....will there be an increase in adverse reactions due to synergistic effects of several vaccines being given at one time .... are there any plans to monitor any of these possible effects.)*

3. Short term effects of vaccinations, identified by one study
-Increase Albumin, ESR, Lipid levels
-Decreased transferrin, glucose and Se cholesterol
-Decreased immunity to other diseases/illness
-Highest grade changes follow live virus vaccination but changes do occur after most vaccinations.
-?Long term effects
-ECG changes
-Retention of various electrolytes

4 Under Reporting of Adverse Effects
-Statistics for reactions only include first 24hrs (was 72hrs,now a move to reduce to 4 hrs)
-No real attempt by health professionals to screen for possible adverse effects or to adequately inform parents of potential risks prior to vaccination. Due to attitude of vaccination being 'unquestionably' right.
-Claimed that parents presenting with their children having possible adverse reactions were too frequently brushed off, told that such an illness/ behaviour change etc was mere coincidence. Such possible reactions are often not taken seriously or investigated thoroughly.
-Egs given : high pitched crying, behavioural/sleep pattern changes, fevers, comas, convulsions, bedwetting, other infections (glue ear), asthma, eczema, etc.
-Stated that in a scientific controlled study, Odent & Kemell: discovered that the vaccinated are 5x more likely to have asthma than unvaccinated.

5. Relationship between cot death and DPT
-Dr Scheibner spoke of her experience using cot watch monitors, which demonstrated alarm sounding episodes post vaccination, representing 'stress breathing patterns'.
-Also found increased temperatures overnight, post vaccination and questioned the relationship between this and the 'over-heating' associated with cot-death.

3.Not necessarily Immune Once Vaccinated:
-Speakers put forward the idea that a demonstratable increase in antibody levels does not necessarily confer immunity (AIDS, HEP B, Measles)
-Eg. During the last measles epidemic in NZ, the . Dept of health quoted an 80% effectiveness of the vaccine in the Wellington area. (*Although it is unclear how this was calculated it, if we assume it means that 20% of vaccinated children will still catch the disease, it does raise further questions. eg. What is rate of the disease in the non- immunized, and so what extra protection is given by the vaccine.)*

4. Reasoning Behind Desire to Vaccinate is Faulty:
-Stated that the concept of herd immunity has never been proven and is in fact faulty. (ie.immunise a large enough proportion of the population and a disease will be eradicated, due to lack of 'vectors' to spread the disease)
-Apparently it was initially claimed that once 60% of a population was vaccinated, this would be enough to eradicate measles, now the figures have changed to 90%
-Calculations were based on the idea of natural immunity NOT artificial, (which is generally not as effective or long lasting) and vaccinated individuals CAN be vectors.
-Gave examples of;
Iman; 87-90% uptake of polio vaccine, 8 months later= epidemic
USA; 94% immunisation rate for diphtheria and still epidemics
USA; 98% measles coverage and still have epidemics

5. Unnecessary risk
-Only small numbers of a population will catch any given disease &/or be affected by it long term, so why treat all. This exposes all to (unknown/higher than quoted) risks of vaccination.

6. Rebound effects
-it may be possible to suppress the natural patterns of infections/illness with immunisation but there is a risk of rebound effects eg. atypical disease, (measles) the development of other diseases, increase in elderly or younger (ie. changing the age distribution of disease)
-eg. A. Whooping cough; Claimed that there has been an increased morbidity and no decrease in mortality since the vaccine was introduced.
Stated *an increase has occurred in whooping cough in the 1st yr of life and in the older population and that the disease is proving more serious at these ages.
*In non vaccinated population disease occurs at 3-5 yrs and is milder
*Vaccine only l lasts 3-5 yrs and whooping cough occurs in 4 yrly cycles
*35-45% of those with whooping cough are vaccinated
*That the rate in a non vaccinated population is approx 6.6:1000 (0.66%)
*Sweden stopped vaccinating and no evidence that disease increased
* Effectiveness quoted at 4-90%!!!! ie Unknown

- B. Measles; Claimed changes= increased in first yr, decreased in childhood and increased in adulthood, due to the fact that antibodies wear off after 10-15yrs. Thus no antibodies in childbearing population to pass on to fetus, plus increased morbidity in adults and adolescents.

7. No evidence of Protection
-Claim there is no evidence that vaccinated persons catch a milder form of any disease. Gave atypical measles as an example, i.e. MORE serious and ONLY develops in vaccinated children.

1995 World Women's Conference
Beijing
September 1995

Poverty, violence and women's access to education, health services and decision-making will be among the concerns of thousands of women meeting at Beijing next September for the Fourth United Nations World Conference of Women.

The conference will be attended by government delegations and non-governmental organisations which have official status with the United Nations, such as the International Federation of University Women. Parallel to the main conference, a special forum for non-governmental organisations (NGOs), Forum 95, will be held.

The Committee's address is:
New Zealand Non-Governmental
Organisations Co-ordinating Committee: Beijing 1995
P O Box 12-117
Wellington

PAEDIATRIC CONFERENCE

27th to 29th September 1995 Sheraton Hotel, Auckland

Contact : Organising Committee
1995 Paediatric Conference
P O Box 12736
Penrose, Auckland

11th Birth Conference

7 - 8 October 1995

Innovations in Perinatal Care : Assessing Benefits and Risks

Baltimore MD

Sponsored by the journal Birth & John Hopkins University

Speakers include Marc Keirse, Judith Lumley, Beverley Chalmers, John Kennell, Ruth Lawrence, Mary Renfrew, Charles Mahan, Bruce Flamm, Ellen Hodnett and Frank Oski.

Birth

43 Oak St, Genesoa

NY 14454 USA

Tel/Fax 716 243 0087

BIRTH, BABIES & BRIDGES IN THE 21ST CENTURY

October 21st, 22nd, 23rd 1995

Centra Hotel, Auckland

Issues :
- Sensitivity & Awareness of the Newborn
- Legal issues in obstetrics and paediatrics
- Maori and multi cultural birth traditions
- Sexuality and birth
- Women and power in the Birthplace

Contact : P O Box 52-065
Kingsland Auckland 3
Ph (09) 525-3437 Fax (09) 846-1801

NEW ZEALAND O&G SOCIETY BIENNIAL CONFERENCE

October 27th, 28th, 29th 1995

Palmerston North Convention Centre

Contact:
Sue Peek
P O Box 474 Palmerston North
Phone (06) 351-4469 Fax (06) 356-9841

Thus in many ways it is easier and more comfortable to vaccinate, to let others be responsible for a child's health; Not to vaccinate, takes the responsibility entirely on oneself.

Given the controversy surrounding this issue, it was pointed out that to vaccinate or not is an issue of parental choice. There ARE questions about both the safety and effectiveness of vaccines. Parents should be able to access all information, the arguments from 'both sides' and accurate rates of harm/risk associated with both vaccination and the diseases one is attempting to prevent. (*The major problem with this is the difficulty in obtaining accurate 'facts and figures', and the amount of disagreement about the validity of the 'facts' presented by each side*)

Furthermore, taking into account the difficulty facing parents who attempt to come to an informed decision, it is important to support parents in whatever choice they make. There is no place for coercion/pressure/emotive language etc.

ARGUMENTS AGAINST IMMUNISATION

The following is a brief summary of the main objections to immunisation raised by the various speakers at the conference. These objections can be broadly grouped into two main questions. Firstly are vaccines effective, i.e. do they do any good, and secondly are they safe, i.e. do they do harm.

Two general claims were repeatedly stated, that no systematic controlled trials to demonstrate either the effectiveness or safety of vaccination have been carried out and that adverse events are poorly reported. (ie. Under reported)

EFFECTIVENESS

Claims made when questioning the effectiveness of immunisation included:

1. Prior Decline of Infectious Diseases Covered by Immunisation:

-Speakers claimed that the decline of major infectious diseases was due to factors other than immunisation programmes. They stressed the importance of other disease preventing factors, eg. water supply, nutrition, sanitation, increased understanding of disease process (isolation of infectious persons), economic and social stability, decreased poverty, pollution and improved housing)

-It was suggested that diseases go through natural cycles. Scarlet Fever was given as an example, despite the absence of vaccination, this disease has largely disappeared.

-Other speakers stated that graphs showing the decline of diseases associated with vaccinations are a case of manipulation/misrepresentation of figures and presented an abundance of other statistics and data to show that diseases like measles, polio, diphtheria were already declining prior to the introduction of widespread immunisation programmes and that these programmes had little effect on the rate of this decline.

- Eg. State that 80% of whooping cough deaths had disappeared before vaccine introduced.

2.No evidence of Increased Disease when Vaccines withdrawn:

- Claimed that in countries where immunisation has been withdrawn, no difference in mortality has been shown. ie.(Sweden 1979 /whooping cough vaccination was stopped and Japan...1975, no immunisation before 2 years)

REPORT FROM THE VACCINATION DILEMMA II

An International Symposium organised by The Immunisation Awareness Society
(April 1995)

Over the two days of this conference sixteen speakers from around the world, presented a wide range of issues, concepts and data relating to vaccination. Among the speakers were several G.P.s, a sociologist/osteopath, a bacteriologist/virologist, a health activist, parents, a nutritionist, homeopaths, a naturopath, a micropalaeontologist and researchers. Immunisation was described as 'the black box' of modern medicine, the concept which in general health professionals do not think (or dare), to question. Fifteen of these sixteen speakers did just that, they questioned both the efficacy and the safety of vaccination. The following report firstly outlines the 'dilemma' (as presented at the beginning of the conference) faced by parents when approaching the question of vaccination, it then goes on to summarize the major concerns raised over the two days..

THE VACCINATION DILEMMA

Kevin Dew (Sociologist & Osteopath) Outlined one view of the dilemma faced by parents when considering whether to vaccinate or not.

Firstly, if parents **decide to vaccinate**, then they follow the more socially/medically 'acceptable route'. Three possible outcomes include:

* No reaction and the child does not catch the disease; In this case everyone is happy.
* The child has no adverse vaccination effects but still catches the disease; In this case the parent(s) may feel assured that
  - they did everything possible for their child,
  - they may be advised that the resultant illness is of a 'milder form' than if they hadn't been vaccinated (this 'fact ' was challenged by several speakers)
  - they can rest assured, in the belief that their child's illness is 'bad luck' / due to a poor vaccine batch/ a 'failure of medicine'.
* The child may suffer adverse effects from the vaccination; In this case, despite possible feelings of guilt and grief, parents do have someone to blame. They followed accepted medical advice, in doing what is widely proclaimed as 'the best' for their child, and have been let down/mislead by, doctors/nurses/medical science.

Vaccination was described as being in one sense, an act whereby the responsibility for your child's health, is handed over to someone else.

However if parents **choose NOT to vaccinate**, they are then taking the full weight of responsibility for their child's well-being onto themselves.

*Whether or not the child becomes ill, or suffers any long term adverse effects, they may well be subject to harassment by 'concerned others' (friends, family, doctors, nurses, acquaintances) The general suggestion being that they are 'irresponsible', 'uncaring', foolish, mislead, that they are putting their own and other's children at risk.

*Any illness (related to vaccination or not) may be an instance where attempts are made to make parents feel guilty/responsible for the suffering of their children.

*In the event of a 'vaccine preventable illness', with or without long-term effects, they may have...

-not only their own guilt/remorse to cope with, but also
- have no one to blame and
-have to cope with the added burden of blame from others.

1996 : MIDWIFERY TODAY INTERNATIONAL CONFERENCE

Weaving a Global Future II

29th February - 3rd March 1996
Pacific Beach Hotel Hawaii

Contact : Midwifery Today
P O Box 2672-4002
Eugene Oregon 97402
Ph (503) 344-7438 Fax (503) 344-1422

24th TRIENNIAL CONGRESS OF THE INTERNATIONAL CONFEDERATION OF MIDWIVES

26th to 31st May 1996 Oslo, Norway

Theme : *The Art & Science of Midwifery gives Birth to a Better Future*

CALL FOR ABSTRACTS
Deadline 31st March 1995. Completed papers due 4th June 1995

For more information, contact: MIDWIFERY RESOURCE CENTRE
P O Box 21-106 Christchurch
Ph 03-377-2732

ICM 24th TRIENNIAL INTERNATIONAL CONGRESS OF MIDWIVES

Oslo, May 1996
Pre-Congress Workshop, 23-26 May
(TO BE CONDUCTED IN ENGLISH)

Experienced Midwives who wish to become Consultants/Advisors, primarily in developing Countries, are invited to attend this workshop. Apply early - only 40 places are available. Registration Fee : £125
Further details from ICM Headquarters, 10 Barley Mow Passage Chiswick London W4 4PH UK

NEW ZEALAND COLLEGE OF MIDWIVE (INC)
1996 National Conference

28th August - Pre Conference Workshop
29th - 31st August - Conference

Lincoln Conference Centre, Canterbury, New Zealand

Theme : *Midwifery : The Balance of Intuition & Research*

Keynote Speaker : Barbara Katz-Rothman

Contact: Judy Henderson Phone (03) 377-2732

NATIONAL HOME BIRTH CONFERENCE 1996

28th August
Lincoln Conference Centre, Canterbury

PROPOSED CONFERENCE

Water Birth International Conference

Florida, USA

July 1997

God knows mothers need a lot of rest and that's why She created breast-feeding

At present in New York State $13,000 pa will buy you a mere $100,000 cover.

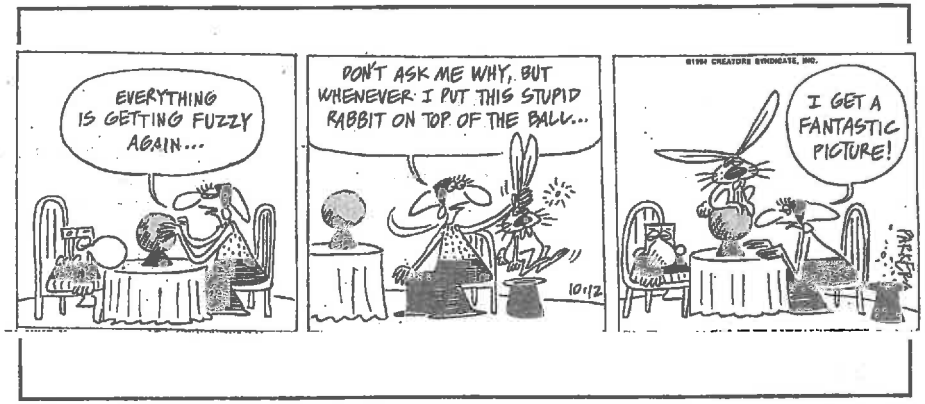
I applaud the women who practice midwifery in this climate and the women who choose midwife care against the vast majorities better judgement.

The Home Birth Networking Meeting was very encouraging for me. It was here the principles of partnership and continuity of care were clear. These women sat with tears in their eyes as I explained the scope of service available to women in New Zealand, and our breast feeding rates met with a standing ovation.

Yet even with this group there were differences in practice. Midwives appeared to only provide 2 post natal visits, at 24 hours and 2 weeks, before the 6 week check. No wonder breast feeding failure rates were high. I was curious that gynaecology was also part of many midwives practice and part of the midwifery curriculum. Whereas the academics viewed this as clearly part of a midwives scope of practice, many clinicians disagreed and stated they wouldnt offer a gynaecological service if they had enough midwifery clients.

I believe this group are the back bone of the ACNM - even if the ACNM doesn't realize it. Each year they introduce a remit to the business meeting to change the Colleges name to the American College of Midwives - this year it only marginally lost. This is major progress.

The ACNM still strongly believe it is the name ænurse that gives them credibility in American society. I strongly disagree and believe it is not until they drop the ænurse and align with women that they will gain the credibility they are seeking.



ARTICLES OF INTEREST

AMERICAN COLLEGE OF NURSE MIDWIVES

40th Annual Meeting - Dallas Texas
May 26th - June 1st 1995

Report by Julie Richards

So how does midwifery fare in a paternalistic, capitalist society? As expected it struggles. On one hand American midwives are dealing with issues that we faced 5-10 years ago, such as identifying midwifery as a separate profession. On the other hand, they are dealing with issues I sincerely hope we will never face, such as professional indemnity insurance that when you can get it, can cost half your annual income.

The Meeting ran for five days, with the 1st two days being pre meeting workshops. There are approximately 5000 midwives in the USA, of which 3000 belong to the ACNM. Around 1200 people attended the meeting including nurse-midwives, lay midwives and students. If you spread 5000 midwives over the USA you understand why the profession struggles for recognition. The output from midwifery schools is increasing but it is a long expensive academic process which is still firmly entrenched in nursing.

Probably the greatest control over midwifery is the insurance company as they hold the money. Some states have a law that demands midwifery services are reimbursed by the insurance company but many have not.

Reimbursement policies may vary between practitioners, with doctors being reimbursed at a higher percentage than midwives. Some Midwives talked of being an average of $15,000 in arrears and clients on life time payment plans.

The medical profession also maintains its control over practice as a Certified Nurse Midwife (CNM) cannot have access rights to a birthing unit or hospital without the written back up of a physician.

Managed Care Organisations (sound familiar) which is the way in which primary health care is being delivered often excludes midwives and doesnÆt recognise midwifery care.

Malpractice Insurance varied significantly in cost and availability between states and place of birth. In 1992 insurance companies refused to cover midwives practicing at home and this has only just been renegotiated in some states. The number of midwives attending homebirths at that time dropped from 189 to 127 due to financial risk to the family.

THE BEGINNERS MEDICAL DICTIONARY

Artery	*The Study of Paintings*
Bacteria	*Back door of a cafeteria*
Barium	*What doctors do when patients die*
Bowel	*A letter like A,E,I,O,U*
Caesarean Section	*Neighbourhood in Rome*
Cat Scan	*Searching for kitty*
Caurterise	*Made eye contact with her*
Coma	*A punctuation mark*
D & C	*Where Washington is*
Dilate	*To live longer*
Enema	*Not a friend*
Fester	*Quicker*
Fibula	*A small lie*
Genital	*Not a Jew*
G I Series	*A soldier ball game*
Hangnail	*Coat hook*
Impotent	*Distinguished, well known*
Labour Pain	*Getting hurt at work*
Medical Staff	*A doctor's cane*
Morbid	*A higher offer*
Nitrates	*Cheaper than day rates*
Node	*Was aware of*
Outpatient	*A person who has fainted*
Pap Smear	*A fatherhood test*
Pelvis	*A cousin of Elvis*
Recovery Room	*A place to upholster*
Rectum	*Dang near killed him*
Secretion	*Hiding something*
Seizure	*Roman Emperor*
Tablet	*A small table*
Urine	*Opposite to you're out*
Varicose	*Nearby*

CURRENT ISSUES

CONSENSUS STATEMENTS

The N.Z.C.O.M. Consensus Statements have been circulated to the Regional Chairpersons for discussion at forthcoming Regional meetings.

The National Committee have recently reviewed and updated the previous N.Z.C.O.M. Position Statements on:

- Breastfeeding
- Management of Third Stage of Labour
- Immunisation
- Ultrasound

Consensus Statements have been developed for:

- Access to Facility Agreements
- Roles & Responsibilities in the Hospital Postnatal Setting
- Gestational Diabetes in Pregnancy
- Complementary Therapies
- Alcohol and Pregnancy
- Vitamin K
- Guidelines for Prescribing
- Informed Consent
- Cervical Screening

These are all now completed in ôDRAFTö form and have been circulated for discussion and comment. These drafts will be reviewed and amended following comment from the Regions. The final consensus statements will be tabled at the N.Z.C.O.M. AGM in August 1995 for endorsement.

Once the Consensus Statements have been endorsed they will be collated in a file and distributed to the Regions as a resource file.

YOUR OPPORTUNITY TO ATTEND!

24th Triennial Triennial Congress
Oslo, Norway 26-31 May 1996

The College and Riccarton United Travel, Christchurch are presently putting together a package tour to give members the opportunity of attending the above Conference.

The draft itinerary is:

Christchurch/Auckland → Hong Kong	- 2 nights accommodation at Park Hotel, Kowloon with return transfers and 1/2 day Hong Kong Island Tour **$NZ254 per person share twin**
→ Amsterdam → Oslo	- re accommodation Oslo - the Travel Agent has advised that it would be better if you chose your own hotel as better room rates would have been negotiated by Conference personnel and personally choose the class of hotel that suits your pocket.
Oslo → Amsterdam → Singapore	- Orchard Hotel, Singapore for 2 nights with return transfers.
Return airfares = $NZ2,999	**$NZ250.00 per person share twin**

The prices are obviously approximate as there are no 1996 rates as yet, however once we know more definitely the numbers interested we can then firm up on costs for you.

It is desired that the Group travel together going to the Conference and may come home their own way, ie, via the routings of Air New Zealand/KLM.

If you wish to express an interest in attending the Conference, please fill in the details outlined below and return to The Secretary, NZCOM, P O Box 21106, Edgeware, Christchurch, so that we can gauge how many members would be interested as well as directing further correspondence to you.

Yes I am interested in attending the 24th Triennial Congress in Oslo

Name: .....

Address: .....

.....

Phone: .....

INTERNATIONAL WATER BIRTH CONFERENCE

London - April 1 & 2 1995

The following audio tapes are available:

Day 1 - Saturday 1st April 1995

Tape 1 Welcome Sheila Kitzinger Opening Address Baroness Cumberlege

Tape 2 Birth in the 21st Century - Where are we going? Dr Marsden Wagner Why do women want a water pool? Janet Balaskas Are we marine chimps? Dr Michel Odent

Tape 3 An obstetrician's experience of 1,600 water births, including breech and twin births Dr Herman Ponette Fetal & neonatal physiology during water birth Dr G Eldering, Dr K Selke

Tape 4 Labour and Birth in Water: an obstetrician's observations over a decade Dr F Haddad Panel Discussion J Balaskas, Dr M Odent, Dr G Eldering, Dr K Selke, B Lawrence Beech, Dr H Ponette, Dr F Haddad

Tape 5 NPEU Survey of the use of water in child-birth Dr Fiona Alderdice & Sally Marchant A clinical analysis of 948 water births at the Family Birthing Centre, California Dr Michael Rosenthal Waterbirth compared with conventional childbirth: a retrospective study of 501 cases Dr C Hoestermann

Tape 6 Evidence from randomised controlled trials: of the effects of water on labour and birth Prof J Hofmeyer, Cheryl Nikodem Panel Discussion Dr M Rosenthal, Dr F Alderdice, S Marchant, Dr C Hoestermann, Prof J Hofmeyer, C Nikodem

Tape 7 Parents' rights when choosing to use a birth pool Jayn Ingrey Water birth in a rural community Dr Roger Lichy Being: an emotional journey into the passion of childbirth Maria Nwobani, Ola Akanwo & baby Nkechinyere

Day 2 - Sunday 2nd April 1995

Tape 8 Is obstetrics good for your health? Beverley Lawrence Beech Assessing the effects of health technology Rosemary Jenkins

Tape 9 How does water birth affect midwifery practice? Caroline Flint Water birth and pain relief - observations of 400 water births at Hillingdon Cass Nightingale Water birth & supervision of midwifery practice Dianne Garland

Tape 10 1,000 water births: selection criteria & outcomes Dr Josie Muscat Water births: facts & philosophy Dr Michael Adam

Tape 11 Water births in a conventional French maternity unit Dr Patrick Stora Panel Discussion B Lawrence Beech, R Jenkins, C Flint, C Nightingale, D Garland, Dr Josie Muscat, Dr Michael Adam, Dr Patrick Stora

Tape 12 Water birth in Australia Athena Vassie Water birth in Italy Piera Magnolia Water birth in Denmark Anne Uller

Tape 13 Issues of safety and decision making process Dr Yehudi Gordon Water birth: surviving the onslaught of the uninformed Professor Lesley Page Closing address Sheila Kitzinger

Prices.....

Individual tapes	US$14.00
Set of 13 tapes	US$125.00

add $3.00 postage per tape in North America
$5.00 postage per tape overseas

add $6.00 postage for the set in North America
$9.00 postage for the set overseas

For ordering by mail, please add to GMCHA order form and send together with payment to : Global Material / Child Health Association Inc, Post Office Box 144, Wilsonville, Oregon 97070. Fax 503-682-3434

Report of Umbrella Group Meeting (or Nurses and Midwives Network) on proposed Nurses and Midwives Bill, May 8 1995, Wellington.

This meeting was attended by Sally Pairman and Beryl Davies on behalf of NZCOM. The Nurses and Midwives Network was established in 1994 as a way of ensuring communication between the various nursing groups and the NZCOM on matters of mutual interest. Membership consists of NZCOM, NZNO, NCNZ, NETS, Nurses, NERF, MoH, Massey and Victoria Universities, National Council of Maori Nurses and possibly one or two other groups.

A previous meeting of the Network regarding the Nurses and Midwives Bill was held on December 14 1994. Karen Guilliland and Sally Pairman represented NZCOM at that meeting. Following that meeting Sally Pairman and Elaine Papps (from Nursing Council) prepared a draft of the proposed Nurses and Midwives Bill based on the agreements from the meeting, which was circulated to all Network members for comment. It was hoped that general agreement could be reached so that the Minister of Health could be encouraged to put the Bill on the legislative timetable for 1995. However there was disagreement from NZNO regarding the fazing out of enrolled nursing and so the Bill will not now be on the agenda for 1995. We hope agreement can be reached in time for a law change in 1996.

The meeting of 8 May was facilitated by the Nursing Council. Colleen Singleton has been appointed CEO of Nursing Council.

Agreed at the meeting were the following principles for a new Nurses and Midwives Act:

The Nursing and Midwifery Council Members would be:
Director General of health or nominee
2 Tangata Whenua - 1 nurse and 1 midwife elected by Tangata Whenua
2 Registered Midwives elected by RMs holding practising certificates
3 Registered Nurses elected by RNs holding practising certificates
1 nurse/midwife educator appointed
5 lay persons appointed

Underlying principle of balance between professional and lay but recognition that primary function of Council is to develop policy and heavier weighting of professional to lay may be appropriate. This in contrast to the Tribunal where primary responsibility is discipline and heavier weighting of lay to professional may be more appropriate.

Education

Council seen as the appropriate body to have responsibility for setting standards of entry into nursing and midwifery professions (in consultation with the professions).

Council to approve programmes and also to accredit institutions.
Accreditation would need to be in line with current trends in tertiary education.

Registration/Enrolment

There will be two registers only - one for nurses and one for midwives. Possible to have two practising certificates but may need to nominate current professional orientation when being assessed for competency to maintain practising certificate.

Most debate centered around whether to continue with Roll and second level of nurse - the enrolled nurse. Strong opposition from Enrolled Nurses Section of NZNO. A process was established to advance this debate and reach some decision by July 1995.

Overseas nurses and midwives seeking NZ registration to meet same standards of registration as currently in place for NZ nurses and midwives.

Post Registration

Nursing keen to develop general competencies for post registration then specialist competencies for any vocational registrations which may be developed. Midwifery keen to have only post registration competencies as midwifery seen as an end in itself and no need for development of specialties.

Disciplinary/Disability

* A separate Tribunal for this area. Chair and vice chair to be consistent people. Could be lay or professional. Our recommendation is 1 midwife and 1 nurse but if Select Committee prefer 2 lay people in these positions we will not object.
* Hearings will be open to public except in exceptional circumstances and reasons must be transparent.
* A pool of 4 midwives, 4 nurses and 6-8? lay people to be available for selection by Chair for a particular hearing.
* Underlying principle that midwives hear midwives, nurses hear nurses and equal numbers of lay and professional in this part of Tribunal.
* Misconduct needs to be more clearly defined.
* Disability to be changed to mean impairment of ability to practice.

Infant feeding patterns in Canterbury

RPK Ford, MD, FRACP, Community Paediatrician; CJ Wild, Research Assistant; EA Mitchell, BSc, FRACP, Associate Professor; P Tuohy, FRACP, Director Child Health Policy; from Community Paediatrician Unit Healthlink South, Christchurch, Department of Paediatrics, University of Auckland, Auckland and Royal New Zealand Plunket Society, Dunedin.

Abstract

Aim. To examine infant feeding patterns during the first 6 months of life in Canterbury.

Methods. A random sample of 10% of all births over a 12 month period in Canterbury was taken from birth notifications (n=520). Information on the type of feeding was recorded prospectively at three time periods and extracted from available Plunket nursing notes. The participation rate was 81%. Data from nonparticipants on the method of feeding at discharge was obtained from obstetric records.

Results. Overall, 90.7% were breastfed at discharge. There was no difference between breastfeeding rates of the participants (91%) compared to the nonparticipants. For participants, 88% were exclusively breastfed at discharge which steadily declined to 36% at 24 weeks. However, some breastmilk was still being given to 70% at 24 weeks.

Conclusion. Breastfeeding rates are good in comparison to other nations. However, there is room for improvement, particularly maintaining exclusive breastfeeding to at least four months. This could be stimulated by the Baby Friendly Hospital Initiative and the fostering of a baby friendly environment to further support and promote breastfeeding in the community.

NZ Med J 1995; 108: 59-61

COMPLEAT MOTHER - Spring 1995

Lactation suppression drug withdrawn from US market

On August 18, the pharmaceutical company Sandoz, announced the withdrawal of the indication of lactation suppression (stopping production of breastmilk after childbirth) for Parlodel (bromocriptine) in the US. Sandoz' move came a day after the US Food and Drug Administration (FDA) announced its intention to withdraw approval of this indication and two days after the US consumer advocacy group Public Citizen sued the FDA because of their five-year delay in banning this indication.

According to FDA, the risk of hypertension, seizures and stroke with bromocriptine far outweigh its marginal benefit in preventing postpartum lactation. Since 1980, when bromocriptine was first approved in the US, 531 severe adverse reactions have been reported, including 32 deaths. Although Sandoz has notified its subsidiaries around the world of the US withdrawal, it has not taken steps to withdraw the indication in other countries, except Canada.

The FDA further stated that "lactation suppression can be managed effectively -and more safely - by the use of cold packs, compression bandages and pain medication, as needed."

Source: Health Action International press release, August 24, 1994

Consequences of varicella and herpes zoster in pregnancy: prospective study of 1739 cases

In a joint prospective study in Germany and the United Kingdom between 1980 and 1993, 1373 women who had varicella and 366 who had herpes zoster during the first 36 weeks of gestation were followed up.

9 cases of congenital varicella syndrome were identified, all occurring after maternal varicella during the first 20 weeks of gestation. The highest risk (2.0%) was observed between 13-20 weeks gestation, with 7 affected infants identified among 351 pregnancies (95% CI of risk 0.8-4.1%). Only 2 cases of congenital varicella syndrome were identified among 472 pregnancies in which maternal varicella occurred before 13 weeks (observed risk 0.4%, 95% CI 0.05-1.5%). Herpes zoster in infancy was reported in 10 children whose mothers had had varicella in pregnancy. No infants with clinical evidence of intrauterine infection were born to the 366 women with herpes zoster in pregnancy (upper 95% confidence limit of estimated risk 1.0%). Varicella-zoster-specific IgM antibody was found at birth in 4 of 16 (25%) infants with clinical manifestations of intrauterine infection and persistent specific IgG antibody in 5 of 7 infants tested. The corresponding rates in asymptomatic infants whose mothers had varicella were 12% (76/615) and 7% (22/335) respectively. No serological evidence of intrauterine infection was found in infants who mothers had herpes zoster in pregnancy. In 97 pregnant women, varicella occurred after post-exposure prophylaxis with anti-varicella-zoster immunoglobulin. No cases of congenital varicella syndrome or zoster in infancy occurred in this group.

Our estimates provide a sound basis for counselling women with varicella in pregnancy. Although the risk of congenital varicella syndrome is small, the outcome for the affected infant is so serious that a reliable method of prenatal diagnosis would be valuable. In the long term, prevention of maternal varicella would be an option if a safe and effective vaccine were to become routinely available.

Enders G, Miller E, Cradock-Watson J, and others. Lancet, vol 343, no 8912, 18 June 1994, pp 1548-1551.

Author abstract. © Lancet, 1994.

Risk factors at delivery and the need for skilled resuscitation

This study describes one hospital's approach to the problem of paediatric attendance at delivery. A typical policy in an English hospital would have a paediatric SHO attend all operative and instrumental deliveries, all preterm and multiple deliveries, all vaginal breech deliveries and all deliveries where labour is complicated by meconium staining or fetal distress. As shown in this paper this involves paediatricians attending 37% of deliveries with crash calls to a further 1.5%.

It is inconceivable that all of these babies require assistance. In order to refine the attendance policy the reasons for calling a paediatrician as well as the actions taken at delivery were analysed over a 3 month period.

Following this assessment the revised policy no longer recommends that a paediatrician attend singleton elective sections or uncomplicated instrumental deliveries. This resulted in a fall in attendance rate to 25% with no increase in crash calls.

Interestingly they also recorded a fall in intubation rate from 7.3% to 1.6%.

This paper makes interesting reading as an example of planned policy change. However, the authors continually suggest both in the text and the tables that because a baby *received* intubation or some other intervention that this intervention was *required*. Their own figures on the change in intubation rate with no change in mortality would suggest that this is not so. If one also reads the Swedish data on the subject[1] one can see that an attendance rate of 25% is still way too high.

Reference

1. Palme-Kilander C. Methods of resuscitation in low Apgar score newborn infants - a national survey. Acta Paediatrica, vol 81, 1992, pp 739-744.

Kroll L, Twohey L, Daubeney PEF, and others. European Journal of Obstetrics and Gynecology and Reproductive Biology, vol 55, no 3, 30 June 1994, pp 175-177.

Abstract written for MIDIRS by Sam Richmond, Senior Paediatric Registrar. © MIDIRS, 1994.

Fees

Council to set own fees.

One for practising certificate to cover costs of Council and One for discipline to cover costs of Tribunal.

Other issues raised but no discussion or decision as yet

Need for clarification of obstetric nurses role in comprehensive programmes to reflect reality of maternity service in NZ. Add that midwife must attend a women in labour if she is called and if she is unable to find anyone else, even if she does not feel the woman is in a safe situation.

Future Action

Nursing Council to write to Jenny Shipley on behalf of Network Group saying we have agreement in principle except for outstanding issue of enrolled nurses.

Next meeting towards end of July

Women's Health Research: An HRC Priority

THE Health Research Council of New Zealand at its June meeting added women's health to its five existing priority areas - Maori, mental, child, Pacific Islands and environmental health.

The HRC Women's Health Committee reasons for the recommendation included -

- The health of women reflects the health of society; if women's health is ensured, the health of children, the extended family and all of society is ensured.
- Without an overall focus on women's health, the health of women can become neglected and invisible.
- Women can experience particular health problems as a result of their position in society, as well as from their biological differences.
- Research about women's health needs to be increased because there is a danger of over-medicalisation and inappropriate intervention.
- Specific research into why women are disproportionately vulnerable to gender-based violence like sexual abuse, rape and domestic violence would be lost if women's health research were not a priority in its own right.
- Research into gender inequality and bias in parts of the health care system should be a high priority because of the potential for adverse health outcomes.
- Women need information and accurate research as part of their roles as caregivers, voluntary community workers and as a major part of the health care workforce.
- Specific areas like the predominance of women in our ageing population, poor infant mortality and high teenage pregnancy rates need urgent attention.

The Women's Health Committee aims to promote the training and improve career structure for women health researchers; stimulate consultation on women's health issues between researchers and consumers; and foster women's health research projects.

Emeritus Professor Nan Kinross of Massey University chairs the committee and members are Dr Susan Bagshaw, New Zealand Family Planning Association, Christchurch; Dr Ruth Bonita, University Geriatric Unit, North Shore Hospital, Auckland; Marilyn Brewin, Unitec, Auckland; Sandra Coney, Women's Health Action, Auckland; Dr Marilyn Duxson, Department of Anatomy, Otago Medical School; and Anna Pasikale, Education Training and Support Agency, Wellington.

The HRC Priority Planning Advisory Committee is in the process of determining the process and strategies for implementing HRC priority areas.

Information - Women's Health Committee secretary, Sara Bennett, HRC, PO Box 5541, Wellesley St, Auckland 1, phone 09-379-8227 ext 840, fax 09-377-9988.

Reprinted from the HRC Newsletter, June 1995

EMAIL

What is Email?

Electronic mail (email) is a simple and quick way to send messages between people using computers.

In this specific case (Mass-e-Mail) you call a number that connects you to the Massey University email system. The number you dial is the same all over New Zealand.

The software on your MacIntosh or IBM compatible PC "talks" to the Massey mail computer and arranges to send and receive messages as you require.

What are the Benefits?

The great benefits of email are that you can:

- Send messages anywhere in the world at low cost.
- Stay in touch with people who are hard to get hold of.
- Send the actual text of messages rather than just fax images or letters that may need to be retyped before they can be used further.
- Easily share ideas with groups of people in far away places.
- Keep track of decisions and conversations with minimal effort on your part.

Sounds useful? it is, and once you start to communicate by email, you'll wonder how you ever did without it.

How Does it Work?

To send an email to another person, you must use an address. Rather than street and city, with email you use another convention which looks like this:

"nzcom.nat.coord@uni.massey.ac.nz"

The address part in front of the "@" is the name of the person or organisation, the second part is the location of the mail computer for this person. Another address could be: "ruth.martis.1@uni.massey.ac.nz".

In the case where you wish to exchange news among a group of colleagues, a "list" can be created. This way instead of you sending mail to each of the people in a group, you simply send a single piece of mail to the list "manager". This electronic manager reads the list named, and sends a copy to each of the people named. A typical list name would be: "nzcom@uni.massey.ac.nz"

There are two types of list; "moderated" and "unmoderated".

Moderated lists have a list owner who will exercise discretion over which people may be members of the list.

In unmoderated lists, anyone may subscribe to (join) the list.

In order to find out if you have m ail waiting to be read, you need to contact the Massey mail computer and empty your "mailbox".

Mite-infested sheepskin - a risk factor common for cot death and atopic asthma

- NZ Medical Journal 10/5/95

An association between early exposure to house-dust mite (HDM) allergen eminating from sheepskin and lifetime wheeze has been reported[1] consistent with one study significantly coupling early exposure to HDM-allergen to later development of atopic asthma[2] and another demonstrating HDM-allergen-specific immunoglobulin E (IgE) in sera of cot death victims predominantly in atopic families.[3]

HDMs, prevalent throughout New Zealand,[4,5] thrive in sheepskin underbedding,[6,8] the sleeper providing required nutrients (desquamated skin), warmth and humidity. The underbedding can become laden with allergens, the most potent, a proteolytic digestive enzyme, concentrated in faecal pellets. These tiny pellets can apparently be inhaled when stirred up by body-movements, fasten in the respiratory mucosa and stimulate production of IgE by an immature immune system, ultimately leading to cot death alternatively asthma. Since HDMs are practically impossible to eradicate, sheepskin is patently inappropriate as infant bedding in NZ and wherever else HDMs are prevalent.[4-8]

Studies indicate that breast feeding, sleeping alone, not sleeping prone and parental abstinence from smoking reduce risk for cot death. These same factors are presumably also protective against development of asthma.

Breast milk could protect by augmenting infantile IgA.[9] Body-movements of a single sleeper would stir up less allergens from underbedding than aggregate movements of sundry sleepers, and an infant lying supine or laterally on allergen-laden underbedding would reasonably inhale less allergens than if lying face-down (with nares thus in close proximity to the allergen reservoir). An infant whose parents abstain from smoking would avoid adverse effects on respiratory and pulmonary function and it has been reported that "maternal smoking ... appears to exert a pronounced effect on the IgE system already in fetal life, predisposing ... infants to subsequent sensitisation".[10]

It is unfortunate that sheepskin was ever recommended as infant bedding. This recommendation was apparently based only on illusory benefits,[11,12] and may have cost the lives of some infants and abetted development of asthma in others. This has a parallel in the earlier recommendation that infants be laid in the prone or lateral position based on the then prevailing misconception that infants lying supine would be at significant risk to lethally inspire regurgitant. When it became known that prone sleeping was linked to cot death, it was difficult to accept that this well-meant advice may have led to the demise of some infants. It now appears that in areas where HDMs are prevalent it may also have led to development of asthma. Well-meant recommendations for infant-care sheepskin may have the same dire consequences!

This is unequivocally a bitter pill – also for sheepskin merchandisers but surely no one with moral integrity can, for the sake of prestige or corporate gain, wilfully jeopardise the health and very lives of infants and children.

Royal Elfast
Västra Frölunda, Sweden.

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12. Elfast RA. Rebreathing from sheepskin (letter) NZ Med J 1994; 107: 362.

Midwifery Today International Midwives' Exchange Network

Join now and you will receive the premier issue of International Midwife!

❑ I would like to join the Network, which includes a quarterly magazine and Directory. The information I list will be entered in a database and will be shared with other birth practitioners. I will keep Midwifery Today informed of any address/phone changes so that the database remains current.
Residents of the U.S.: ❑ 2 years, $55 ❑ 1 year, $30 **Residents of Canada/Mexico:** ❑ 2 years, $75 ❑ 1 year, $40
International Residents: ❑ 2 years, $95 ❑ 1 year, $50 **(U.S. funds only)**
* Please enter my membership for the calendar year(s) of _____.
❑ I've enclosed a check or money order. ❑ Please charge my Visa or MasterCard (circle one). Exp. Date: _____
Signature: _____ Credit Card No. _____
❑ I don't wish to join the Network at this time. However, please include my information on the database. I understand that I must keep Midwifery Today informed of any address/phone changes so that the database remains current.

Please fill in as much of the following information as you wish. The more you list, the more it will help new friends network with you. *Please print clearly.*

NAME: _____

ADDRESS: _____

_____

PHONE: _____ **FAX:** _____ E-MAIL: _____

TYPE OF MIDWIFE/PROFESSION: _____

TYPE OF PRACTICE: _____ YEARS OF PRACTICE: _____

NUMBER OF BIRTHS PER MONTH: _____ TOTAL BIRTHS ATTENDED: _____

AGE: _____ MARITAL STATUS: _____ RELIGION: _____

NAMES AND AGES OF CHILDREN: _____

WOULD YOU BE INTERESTED IN: ❑ A PEN PAL ❑ VISITING ANOTHER COUNTRY/PRACTICE
❑ HOSTING A MIDWIFE AT YOUR HOME/PRACTICE ❑ FINDING BACKUP FOR YOUR PRACTICE
❑ EXCHANGING RESIDENCES WHILE ON VACATION (❑ house ❑ apartment ❑ _____)
(circle the appropriate responses please: I live in the city/country; Bus/car/bike transportation is available; smoking is/is not allowed in residence; children are/are not allowed; I have cats/dogs/_____)
❑ MEETING OTHER MIDWIVES IN YOUR AREA ❑ HAVING A MIDWIFE TO LUNCH/DINNER
❑ OTHER IDEAS: _____
TELL ABOUT YOURSELF (HOBBIES, INTERESTS, GOALS, LANGUAGES SPOKEN, PRACTICE, ETC.)

_____

_____

_____

_____

_____

_____

_____

IF YOU WOULD LIKE TO INCLUDE MORE INFORMATION ABOUT YOURSELF, PLEASE FEEL FREE TO ATTACH ADDITIONAL SHEETS OF PAPER.

Return to: Midwifery Today ❖ P.O. Box 2672-398 ❖ Eugene, OR 97402 ❖ or FAX it: (503) 344-1422

How Much Does it Cost?

The (free) software supplied to connect to this service assists you to create, address and send your letters. The connection to the outside world over your modem is largely automatic, once it has been set up initially.

To check your mail it costs about 12 cents. To send or receive a couple of letters (say 5 pages each) may cost around 20-25 cents.

How Do I Start?

To become a user of email on the Massey service is very simple. As long as you have a computer and a modem, you only need to register by contacting Ruth Martis, 467 Church Street, Palmerston North - Phone (06) 356-2354. You pay a set charge of $20 for registration and user guide, and a further $20 to put against a credit account which pays for your use of the email system.

Please Note: National Office has recently had email software installed and it is envisaged that it will become a quick and effective way of communicating between regions/midwives/groups in the future.

As previously mentioned our email number is

nzcom.nat.coord@uni.massey.ac.nz.

"The three main types of ultrasound diagnostic devices at present separate theoretical risks. If it were shown that TOTAL ultrasound exposure is a critical factor, then the external EFM monitor might prove to be the most dangerous, as the total time of exposure is often ten hours or more.

IF the gestational age of the baby is critical (as it was in Thalidomide) then the doptone might prove to be the most dangerous, as it is used at intervals throughout gestation. If there is a sensitive period, the doptone will probably hit it. If there is a sensitive organ or target area in the baby, then the scan may be the most dangerous, as all parts of the baby are sure to be exposed."

Jay Hathaway, AAHCC

Close to Home

After months of study, management reveals the new organization plan.

World Breastfeeding Week
1-7 August 1995

"Breastfeeding: Empowering Women"

Empower women to breastfeed!

Most women *choose* to breastfeed and can do so if they have adequate support, correct information and are free from various obstacles. Unfortunately, the reality for many is not conducive to breastfeeding. Women are disempowered because of the lack of support from their families, health workers, and workplaces; because manufacturers of breastmilk substitutes often provide misleading information; and, because the media portrays negative images of breastfeeding; in short, because everything diminishes her self-esteem, her right to choose.

To be empowered, women have to have the *ability to act* and the *right* to do so. A conducive breastfeeding environment is one which ensures that women have the *right* to correct information so as to make informed choices, the *right* to legal protection and social support for breastfeeding in public and at work, and the *right* to skilled counselling and sympathetic support.

World Breastfeeding Week 1995 focuses on ways a community can help women secure these rights. Family members, hospitals, schools, public places, government and private workplaces, the media, the courts, women's organisations, development organisations, everyone can actively support breastfeeding.

"Workers' right to motherhood. Mothers' right to work."

The *Innocenti Declaration* urges all countries to enable women to breastfeed optimally. It promotes four main actions:

* Ensure that health care practices in every facility providing maternity services are 'baby-friendly' in order to counsel and support mothers to *initiate* breastfeeding;
* Enact imaginative legislation protecting the breastfeeding rights of working women in order to help mothers *continue* breastfeeding;
* Adopt and implement a national Code of Marketing of Breastmilk Substitutes in order to *protect* breastfeeding mothers from harmful commercial practices;
* Set up a multi-sectorial National Breastfeeding Committee in order to *coordinate* activities to protect, promote and support breastfeeding at every level.

Breastfeeding empowers women!

* Breastfeeding promotes optimum maternal and child *health*.
* Breastfeeding encourages *self-reliance* by increasing a woman's confidence in her own ability to meet the needs of her infant.
* Breastfeeding focuses attention on the need to ensure gender *equality* in the distribution of food and resources in the family and in the community.
* Breastfeeding confirms a woman's power to *control* her body and challenges male-dominated medical models and business interests that promote bottle-feeding.
* Breastfeeding reduces women's *dependence* on medical professionals and validates tried and trusted knowledge of mothers and midwives.

Midwifery Today
and Childbirth Education

INTERNATIONAL MIDWIVES' EXCHANGE NETWORK

Midwifery Today is pleased to announce our new network. It is designed to help birth practitioners network, share information, travel, teach, learn and grow. It is for midwives, childbirth educators and other birth practitioners who are interested in promoting the midwifery model of childbirth around the globe.

A major benefit of this exchange network is a magazine for articles, news and views with an international scope. In addition, we are compiling information in a worldwide directory. This directory will help you find a pen pal, meet other midwives in your area, establish backup for your practice, help you find contacts in other countries you might be traveling to, help you find connections if you are interested in working in other countries and much more.

Some of the exciting possibilities for networking might include: spending the night with a midwife in Oregon; visiting the offices of Midwifery Today; working with a Mexican *partera* for two months; arranging to work in Indonesia or the Philippines; volunteering in Africa and working with traditional midwives....

Only your imagination and enthusiasm will limit this directory and its possibilities!

If you want to be part of the International Midwives' Exchange Network, be sure to fill out the form on the back of this letter and return it to us. Everyone will be listed, whether or not you are able to join at this time. The directory will be published annually and will be sent to paid members. Paid members will also receive the quarterly magazine, *International Midwife*, full of valuable, helpful information, media reviews, natural remedies and articles from around the world. The first issue is available now! Directories and magazines may also be purchased separately if you do not wish to join at this time. **Membership is by the full calendar year, from January to December, so when you subscribe, you will receive all the issues that have been published so far that year.**

If you decide to become a part of the directory, but cannot pay for membership, please be committed to letting us know if your address or phone number changes or if you want to be deleted from the next directory. That way we can provide current information to everyone.

We hope this will facilitate a lot of wonderful relationships. Thank you for being a part of it.

Love,

Jan Tritten

Jan Tritten
Editor

P.O. Box 2672-398 ❦ Eugene, Oregon 97402 ❦ USA
(800) 743-0974 ❦ (503) 344-7438 ❦ (503) 344-1422 ❦ E-mail: Midwifery@aol.com
Weave a Global Future with us!

Health Benefits Christchurch

28 April 1995

Julie Richards
Midwifery Resource Centre
C/- P O Box 21106
CHRISTCHURCH

Dear Julie

I would be grateful if you would include our concerns regarding urgent attendances claimed by midwives in the next publication of your newsletter.

Our Compliance Unit staff have established from their investigations that some midwives find it an acceptable practice to be claiming urgent attendance fees for weekend and evening consultations with their clients.

The Maternity Benefits Interpretation Notes make clear that the fee for an urgent attendance is payable for nights, weekends and public holidays. **The criteria for such claims are that the service is afforded "in response to an urgent request" received by the practitioner on Saturdays, Sundays and public holidays or received between the hours of 6pm and 8am on other days.** The essential phrase is "in response to an urgent request". It must appear to the practitioner receiving the request that "it is of such a nature as to demand immediate attention". It is the nature of the request, not the service ultimately provided, which must be urgent.

Yours sincerely

June Black
MANAGER, OPERATIONS

The goals of World Breastfeeding Week 1995 are:

1. To raise awareness that the right to motherhood, including breastfeeding, is an important women's issue.
2. To sensitise communities and encourage them to be active in supporting breastfeeding.
3. To link breastfeeding with national and international activities for the World Conference on Women (WCW), Beijing, September 1995.

Suggestions for action:

1. Enquire about the status of breastfeeding from your Ministry for Women's Affairs or its equivalent. Propose that breastfeeding be incorporated into women's health and development policies and be supported by legislation, particularly labour laws for breastfeeding working women.
2. Ask women's organisations to jointly organise and participate in WBW 1995 in your country. Use WABA's activity sheet on ***Breastfeeding: A Feminist Issue*** (see **'Issues'** 4:2 December 1994 p 32-3) for discussion and ideas.
3. Find out which agency or organisation is coordinating your country's input into the Action Plan for the WCW, Beijing September 1995. Push for inclusion of breastfeeding under women's health, women's rights, legislation. Use a press release as your lobbying tool.
4. Organise an event to bring together different sectors of the community and describe how each can help protect, promote and support breastfeeding.

(Please note there has been a change of theme for WBW 1995 from that stated in the December 1995 **'Issues'**.)

From WABA

Coming Events

* ***"An Introduction to Lactation and Breastfeeding for Health Care Providers"*** 20 hour course. The aim of the course is to provide on-going lactation and breastfeeding education and to enable care providers to work comfortably in the 'baby-friendly' environment. Tuesdays 6 June to 1 August 1995 9.30am - 12 noon (8 sessions) at Department of Nursing and Health Education, Christchurch Polytechnic, Coventry St, Level 6, Ph 364 9074. The course credits 20 CERPs for IBCLCs, 20 hours continuing education for IBLCE candidates and 2 credits continuing education for Registered Nurses. For more information contact Department of Nursing and Health Education at Christchurch Polytechnic.

* ***The Annual Conference of the New Zealand Association of Natural Family Planning Inc: 'Breastfeeding'***. Keynote speaker: Barbara Gross. Open sessions on 26 & 27 August 1995 at the Airport Hotel, Kemp St, Wellington. For further information contact Bernie Cummings, PO Box 56011, Tawa. Ph (04) 232 6422.

* ***'Breastfeeding: An International Scientific Conference'***, Presented by RACGP and UNICEF (BFHI) in Melbourne, Australia, 19&20 August 1995. Conference enquiries to: Victorian Medical Postgraduate Foundation Inc, PO Box 27, Parkville VIC 3052, Australia. Ph 61 3 347 9633; Fax 61 3 347 4547.

* ***'Breastfeeding: Science & Ethics, Theory & Practice'*** a WABA Global Forum is planned for 14-18 October 1996 in an Asian country. The Forum will review current knowledge on the advantages of breastfeeding, discuss progress in recreating a breastfeeding culture worldwide and focus on the ethical dimension of practices which affect breastfeeding. For further information write to: Global Forum on Breastfeeding, c/o WABA Secretariat, PO Box 1200, 10850 Penang, Malaysia.

MINISTRY OF HEALTH
MANATU HAUORA

C101

27 APR 1995

133 Molesworth St
P.O. Box 5013
Wellington
New Zealand
Phone (04) 496 2000
Fax (04) 496 2340

24 April, 1995

TT50-3552

Linda Collier
Assistant National Co-ordinator
New Zealand College of Midwives (Inc)
P O Box 21 106
Edgeware
CHRISTCHURCH

Dear Ms Collier

Thank you for your letter of 4 April 1995 concerning the availability of oral vitamin K preparations in New Zealand.

The Ministry of Health is currently evaluating an application to market an oral formulation of vitamin K for use in infants. To the best of our knowledge, this is the first oral vitamin K preparation which has been appropriately clinically trialed for use in the prevention of haemorrhagic disease of the newborn and it was first registered in Switzerland, the country of origin, in 1994.

The evaluation process involves review of the quality, safety and efficacy of the product during which the Ministry may request clarification and further information on some aspects of the medication. Following completion of the evaluation, if all outstanding questions are resolved, the Ministry will recommend consent to market. I cannot predict exactly when the process will be completed.

It is important that you realise that, although the medicine can be distributed after consent to market is given, the issue of its subsidy by PHARMAC on behalf of the regional health authorities is a separate process which only begins after the medicine has become available.

Yours sincerely

David Smyth
Acting Director-General

CHRISTCHURCH
RADIOLOGY
GROUP

1 June 1995

CHOROID PLEXUS CYSTS

The Choroid Plexus lies within the foetal ventricles and produces cerebrospinal fluid. Occasionally small cystic spaces up to 10mm are seen in the choroid plexus, in the lateral ventricles, with an incidence of between 1% and 3%.

These almost always resolve in the 2nd trimester, eg by 26 weeks, irrespective of chromosomal abnormalities.

Some overseas studies have shown a slightly increased risk of chromosomal anomalies in the presence of choroid plexus cysts, the most common being trisomy 18, which has a poor prognosis.

A Christchurch study in 1993 involving about 170 foetuses showed that if choroid plexus cysts were an isolated finding and the foetus otherwise appeared normal on a scan at 18-20 weeks, then there is no increased risk of abnormality. The 18-20 week scan should be of good quality and repeated of this is not initially achieved.

This is the current policy of the Foetal Anomaly Advice Committee (FAAC) at Christchurch Womens' Hospital, comprising obstetricians, neonatal paediatricians and radiologists. The subject remains under constant review by FAAC.

When choroid plexus cysts are seen in conjunction with other foetal abnormalities, amniocentesis is usually considered.

DR R J CHISHOLM

CHOROID

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

MEMBERSHIP APPLICATION FORM

GST No: 55-323-585

TO : 12 months Subscription to the New Zealand College of Midwives (Inc)

TYPE OF MEMBERSHIP (Please indicate in Box)

❑	Self Employed	$350			
	NB : Your membership is deemed Self Employed if you claim from the Maternity Benefit Schedule				
❑	Employed	$175	❑	Associate with Indemnity	$155
❑	Unwaged	$ 50	❑	Associate	$ 30
❑	Student	$ 50	❑	Affiliate	$ 30

METHOD OF PAYMENT (Please indicate in Box)

❑ Subscription payable to NZCOMI ❑ Cheque Enclosed

❑ Subscription from Salary } Please contact National Office for a Direct Credit Advice

❑ Automatic Payment } to be sent to you (contact details at the foot of this page)

FIRST NAMES : ..... (PLEASE PRINT CLEARLY)

SURNAME :.....

ADDRESS : .....

DATE OF BIRTH : ...../...../.....

PHONE : Work: ..... (Ext .....) Home : .....

PLACE OF WORK (IF APPLICABLE) .....

ARE YOU A MEMBER OF NZNO? YES / NO

I AGREE TO MY NAME & ADDRESS (ONLY) BEING AVAILABLE TO ORGANISATIONS AS APPROVED BY THE NZCOMI YES / NO

REMINDER: *Professional Indemnity Insurance is included with NZCOMI membership for financial members who are self employed, employed, unwaged, student and associate with indemnity.*

Your membership to the NZCOMI will expire 12 months from the date of this payment being received. When your membership is due for renewal we will send you an invoice one month prior to the due date.

ADDRESS MAIL TO : Subscriptions, NZ College of Midwives, P O Box 21-106, Edgeware, Christchurch
Phone : (03) 377-2732 Fax : (03) 365-2789

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

CHANGE OF MEMBERSHIP DETAILS

PLEASE COMPLETE THE FOLLOWING:

CHANGING TYPE OF MEMBERSHIP?

My current Membership type is ..... (i.e. Self Employed, Waged, Unwaged, Student, Associate, Affiliate)

I wish to change my membership to: .....

If necessary we will invoice you on receipt of this amendment

CHANGING YOUR ADDRESS?

My old address was: .....

CHANGING NZCOMI REGION?

My old region was: .....

NOW COMPLETE THE FORM BELOW

These details will update our computer records)

FIRST NAMES : ..... (PLEASE PRINT CLEARLY)

SURNAME :.....

ADDRESS : .....

DATE OF BIRTH : ...../...../.....

PHONE : Work: ..... (Ext .....) Home : .....

PLACE OF WORK (IF APPLICABLE) .....

ARE YOU A MEMBER OF NZNO? YES / NO

I AGREE TO MY NAME & ADDRESS (ONLY) BEING AVAILABLE TO ORGANISATIONS AS APPROVED BY THE NZCOMI YES / NO

NZCOMI REGION: .....

Please return this form to the address listed below:

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Phone : (03) 377-2732 Fax : (03) 365-2789