Regional Boundaries of the New Zealand College of Midwives

Contents

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Contributions
Contributions such as letters, reviews, forthcoming events and other items of interest are needed, and are welcome from anyone who feels they have something to offer. Art work will also be gratefully accepted. We can return originals.

Articles herein express the opinions of the author. Articles may be reprinted with the written permission of the Board of Management.

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Advertising of Breast Milk Substitutes

The Board of Management and the Co-Editors decided unanimously that it is unethical to advertise breast milk substitutes.

In 1981 WHO and UNICEF published an International Code of Marketing of Breast Milk Substitutes. Manufacturers try to comply by altering the wording of their advertisements to imply that breast milk is better than powdered milk for babies. Many advertisers pay only 'lip service' to this code.

COMING EVENTS

Anne Oakley Tour
17th - 26th September Auckland
30th September Dunedin
3rd-5th October Auckland
Anne Oakley, the world renowned Eng-
lish sociologist and supporter of midwives,
will be visiting New Zealand this year as the ASB Visiting Professor.

International Confederation of
Midwives 22nd International Congress
October 8-12, 1990
Congress Secretariat
C/- Japanese Nurses Association
8-2, Shomue Jingumae
Shibuya-ku, Tokyo Japan
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2nd National Homebirth Conf.
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P.O. Box 107
Lawson, N.S.W. 2785
AUSTRALIA
Telephone: Sydney 94 371/569 2590

CONGRATULATIONS!!

Congratulations! You are one of the first enrolments for our new midwives training programme.

We are delighted to hear that you have chosen to train as a midwife. This is an exciting and challenging time in your life, and we are here to support you every step of the way.

Congratulations on your decision to pursue a career in midwifery. It is a rewarding profession that allows you to make a difference in the lives of others.

The New Zealand College of Midwives welcomes new members like you into our community. We look forward to supporting you as you embark on this journey.

Sincerely,
The New Zealand College of Midwives

Welcome to the NZCOM Journal

WELCOME TO THE FIRST ISSUE OF THE NEW ZEALAND COLLEGE OF MIDWIVES OFFICIAL JOURNAL.

The aim of this journal is to enable midwives to share their reflections in the whole field of midwifery including practice education and research, imparting knowledge and personal experiences.

To communicate information and insights by engaging in fruitful dialogue and debate with the providers and consumers of midwifery services.

The first issue highlights the political aspects and the formation of the New Zealand College of Midwives.

Congratulations go to Joan Dobley for her inspiration, to the Board of Management and the regional chairpersons for all their hard work and effort to get the College of Midwives established.

Judy Hedwig, Helen Manoharan
Co-Editors, NZCOM Journal

We acknowledge the $1,500 grant given by the Ministry of Women's Affairs.

Guest Editorial

THERE HAVE BEEN A REMARKABLE YEAR FOR MIDWIVES AND MIDWIFERY IN NEW ZEALAND. THE FUTURE MIDWIVES WILL VIEW THIS YEAR AS A SIGNIFICANT STEP FORWARD IN OUR HISTORY.

The decisions made and directions taken have had a far-reaching effect on the New Zealand family. The reformation of midwifery as a profession in its own right will, I believe, lead to a stronger and more effective midwifery service which in turn will strengthen women's perception of birth as a normal life event.

This year we have seen the re-introduction of separate midwifery education. These changes have started in Auckland, Wellington and Dunedin and reports so far, from midwives and students, have been very positive.

The New Zealand College of Midwives was launched officially on April 2nd, 1999, after many years of soul-searching discussion. The New Zealand Nurses Association wished us well and we continue to have a close liaison. Our early fears of the "umbilical cord" not being realised - we have come of age!

We continue to receive overwhelming support from the women of New Zealand - i.e. many groups are actively campaigning for a return of the midwife as defined by the WHO.

Thanks to the marathon efforts of Judy and Helen (editorial marvellous), midwife colleagues and New Zealand women, we can now celebrate our achievements with the publication of our own journal.

It gives us great pleasure to welcome you all to these pages and I am confident that this "public voice" will enable us to continue to move forward.

Karen Guilhein
President

THE ROYAL COLLEGE OF MIDWIVES TRUST

I was delighted to hear the decision that a new journal for midwives is to be produced in New Zealand for the New Zea-
land College of Midwives. It is the College's experience in the UK that midwives are hungry for information and up-to-date material and I am therefore sure that you will find success when you begin publishing your new journal.

We at the Royal College of Midwives in the UK wish you every success in this venture and congratulate you for having made the decision to go ahead.

With our very best wishes.

Ruth Ashton
General Secretary

The Federation of New Zealand Parents Centres Inc.

Congratulations to the New Zealand College of Midwives and to all those involved in the setting up of a professional body for midwives and consumers.

The Federation of New Zealand Parents Centres sees this as a step forward for those who work with birthing women and their families.

We are pleased that our representative, Sharon Cole, Rotunui, will be joining your College.

Well done from the Executive and myself.

Karen Eagles
National President

Ministry of Women's Affairs

I am pleased to have the opportunity to congratulate the New Zealand College of Midwives and to acknowledge their commitment to the well-being of women.

We believe that midwives should be supported in their commitment to responding to women's needs during childbirth and providing a consumer-bred programme for the education of their profession.

At this time of change in the health serv-
ices in New Zealand, it is encouraging to see midwives asserting themselves as a profession through the establishment of the New Zealand College of Midwives.

The publication of this journal will be welcomed not only for the communication and debate it will encourage within the profession but as a forum which will provide for the expression of consumer needs.

Margaret Shields
Minister of Women's Affairs

Australian College of Midwives Inc.

Congratulations and good luck with the new professional organisation and journal.

Martin Goring
Editor
Australian College of Midwives Journal

SEPTEMBER 1999
The importance of consumer control over childbirth

Joan Donley

The 'threats' we see are not the reaction of the knowledgeable middle class women against the medicalisation/con- trolilation of childbirth that led the rebellion. These women were able to opt out of the system because they had the support of a handful of domiciliary midwives (DMs). Although the DMs were seen by their colleagues as mavericks and the women seen by the medical establishment as the 'fringe', the trickle soon became a flood. From being a 'reformist minority' this group grew to considerable lobbying power.

In the matter of only a few years, the Domiciliary Midwives Society Inc. - formed by eight DMs - was recognised by the Department of Health as the bargaining body for DMs, completely independent of the medical hierarchy. The achievement of this power base could never have been attained by the DMs alone. It only happened because of the consumer support. Now the DMs have set up their own Standards Review (regional) committee comprised of equal numbers of consumers to health professionals.

Similarly, there are less than 3000 midwives practising in New Zealand. A number of gaining midwifery autonomy against the well-organised medical lobby backed by M.P. 's and others - not only because of their voting power, but because they control the clinical material which is the real power of the marketplace.

Women will only support midwives if midwives are accountable to them and share power with them - which is why they have been included as members of our College.

No doubt, some midwives will see consumer choice and participation in our 'professional' organisation as a threat to their status and allied power (which is really only reflected from the medical profession). Surely, we no longer have to fear an outburst of discord and professional code that is seen to be violated if a professional yields to consumer demands. In one way, it will do them good in establishing their power base, such practitioners were called 'quacks'. Quacks were defined as those who pleaded their patients in preference to their colleagues, e.g. they let their patients define their reality. In the state of anxiety, the doctor in New Plymouth who refused to support a woman wanting a home birth (out of respect to his structures), which is another way of saying he lacked the courage to stand up to peer pressure. Hope-
Babycare Lambskins

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A 1983 project on very low birth weight babies named on lambswool flannels carried out by the Child care Development Group at Cambridge University discovered that:

- Very low birth-weight babies made significant weight gains
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*The results consistently show a significant improvement of weight gain for babies named on lambswool. We have previously speculated that the contact provided by lambswool may have a calming effect on infants similar to that seen with swaddling. The present results would be compatible with the idea that when named on cotton, these babies are under some stress which is reduced by lambswool.*

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To My Dear Sisters in New Zealand

Caroline Flint
S.R.N., S.C.M., A.D.M.

Midwifery Consultant to Riverside Health Authority and Independent Midwife, Caroline is wife and mother to three adult children. Author of 'Sensitive Midwifery' and co-author of 'Community Midwifery'.

Until the day I die one of the great highlights of my life will always be the wonderful week I spent with the midwives of New Zealand in August 1988—a time when I was acutely conscious of history being made and brave decisions being taken. The time when the midwives of New Zealand decided to form their own College of Midwives and break from the Nurses Association. A frightening decision, one surrounded by doubts and a wish to be able to see into the future to check out that it was the right decision and not one taken in a moment of madness and impulse. The sirens call "stay with us we are so much bigger and therefore so much more influential!" sounds so reasonable but did size ever win anything? I doubt it.

Women at this time probably more than at any other in the whole history of womankind need midwives more than ever before. Why am I suggesting this? I am suggesting this because women in 1989 are at lower obstetric risk than they have ever been and yet they are being subjected to greater and greater levels of intervention.

Professor J. MacVicar, Professor of Obstetrics at Leicester (UK) pointed out in an article in 'Maternal and Child Health' that "there is an increasing number of mothers who come into an obstetric low risk category for themselves and their babies." He went on to say that "this may account for some of the decrease which has taken place in perinatal mortality".

The reason that women are in such a favourable state for giving birth is that women today are better educated, better nourished and better off than any generation of women have ever been and most importantly of all, the babies they have are babies which they intend to have. Women in 1989 do not have 13 or 18 pregnancies just because that is the lot of women most women have no more than 2 or 3 pregnancies during their fertile years and they have those children because they want them. The babies who have always been at most risk are the babies who come to the woman who has more than enough children already or the babies who come to women who are still children themselves at 13, 14 or 15.

Nowadays 80% of deliveries occur to women aged between 20 and 35 years—the safest years for women to have babies and yet the caesarean section rate is going up and up, in the UK from 4.3% in 1970 to 11.3% in 1987, and the whole concept of birth as a normal or even possible event seems to be fading. Every woman you meet has either 'needed' an episiotomy because the baby was "in distress" or "needed" forceps because the mother was exhausted or 'needed' a fetal scalp electrode because the baby was "in distress", or has had a doctor who "saved my life" or who "saved the baby's life". The com-
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MYLES TEXTBOOK FOR MIDWIVES 11/e
Edited by Bennett & Brown, 1989 $30.00
A radical revision of this well-known textbook. Aimed at students and also qualified midwives.

MIDWIVES, RESEARCH & CHILDRETH
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SENSITIVE MIDWIFERY
Caroline Flint 1986 $38.00
An enormously successful book; warm, humane and often very unorthodox. Recommended for all midwives and students.

COMMUNITY MIDWIFERY: A Practical Guide
Mary Crock & Caroline Flint 1988 $41.00
Recognises the particular needs of midwives helping equip them for the experience of pregnancy care in the community, home birth and domiciliary deliveries.

THE MIDWIFE CHALLENGE
Edited by Shelah Kitzinger 1987 $33.00
With contributions from midwives all over the world, this is a book not only for midwives themselves and their health care workers, but for any woman who has ever had a baby or intends to have one.

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Janet Balsaks is the founder of the International Active Birth Movement. She has campaigned for women to have the right to choose an active birth and has helped to effect change in maternity practices and midwifery education internationally.

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THE PROFESSIONAL BOOKSHOP

September 1989

Attempting to Involve Consumers in Midwifery Policy Development

Joy Bickley


The paper is aimed at describing an exercise that the NZ Nurses’ Association Ad Hoc Committee on Maternal and Infant Policy went through to try and collate consumer views about midwifery and the services provided by them. Those views were expected to help shape the resulting policy document.

As a starting point, I want to reflect for a moment on the term ‘consumer’. To me, the word presupposes a passivity, an object to which something is done: the end result of the process of production. It fits easily into the capitalist model of production and reproduction, and in so doing accounts for the commodification of those people who use the health services during the process of childbirth i.e. those who pay for a service. At this point, it is not necessary or useful to develop that model to illustrate how the commodification of birth is designed to increase the profits of the health care providers (i.e. obstetricians). Others have done that. What is relevant is the consideration of the term consumer and its development, paradoxically, into ‘health activism’. That’s what the development of the consumer movement suggests, historically. Regardless of context, ‘consumer’ connotes some form of relationship with the health care system. The economic consequences need to be acknowledged. The word consumer can refer to individuals groups or institutions. Certainly, the consumer movement has gained momentum in the last thirty years undoubtedly it has its origins in dissatisfaction with health care practices. Health activism and self-help groups use a critique of professionalism, and especially in relation to childbirth the women’s movement has made a profound impact.

An example of a consumer movement in the New Zealand context is the Direct Entry Midwives, co-ordinated by Judith Strid. To me, this represents the core of the consumer movement: the part that will be accused of being radical, overzealous or unrealistic. But it is the core that gives the consumer movement its focus, drive, intensity and constancy of purpose.

It is because of the tenacity of people in the core of the consumer movement that the movement survives against attempts by providers (or professionals) to foist them off with tokenism and dismissive attitudes towards their degree of knowledge or commitment. Such attempts exist. These examples are:

1. The refusal of the Health Department and other decision-makers to allow consumer representation in the group preparing for the new midwifery curriculum.
2. The comment by a member of the Medical Research Council at a meeting I attended recently. He dismissed the idea of consumer representation on the Council (which has a major responsibility for funding research projects) because consumers
One of those respondents was Merenaa Pitman, a Maori women's health activist and nurse from Waitakere. Merenaa Pitman is the chair of the Ministry of Women's Affairs Committee and an advocate for women's health in New Zealand. She believes that there is a lack of understanding among the public about the importance of breast care.

The next topic of discussion was the need for more research on breast cancer. The workshop participants emphasized the importance of conducting more research to improve our understanding of the disease and to develop better treatments.

One of the key points raised in the discussion was the need for more support for women with breast cancer. The participants agreed that more support and resources are needed to help women cope with the physical and emotional challenges of breast cancer.

Another important issue discussed was the need for better communication and collaboration between different stakeholders involved in breast cancer care. The participants highlighted the importance of involving all stakeholders, including patients, caregivers, healthcare professionals, and policymakers, in the decision-making process.

The workshop also focused on the need for better education and awareness campaigns. The participants agreed that more effort is needed to educate the public about breast cancer prevention, screening, and treatment options.

In conclusion, the workshop was a valuable opportunity for stakeholders to discuss and identify key issues related to breast cancer care. The participants agreed that there is a need for continued collaboration and partnership to improve breast cancer care and support for women and their families.
Maintaining the Links
Karen Guilliland

A history of the formation of the NZCOM.

Midwives in New Zealand have come to acknowledge the pivotal role the consumer plays in the protection of their profession. In the following discussion, I hope to outline for you how New Zealand midwives have come to this realisation and how women as consumers of the service have made it possible.

Medical domination over maternity health services has been part of New Zealand's history. As in other western societies, hospitalisation, sedation and infection redefined birth outcomes and shaped today's "management" of the pregnant woman. This lead to maternity services, provided "clinical material", and kept medical monopoly on childbirth. The move from small cottage hospitals into large city hos- pitals was therefore a response to the health professionals' needs - not to women's needs.

Women became segregated into antena- tal, intranatal and postnatal components; therefore outside the midwives ability to provide total continuity of care.

The significance of these events for the profession of midwifery was often lost on midwives whose main allegiance was to nursing. Midwifery was totally in the hands of the nursing profession - decisions were made by nurses and nurse midwives on that which was considered best for nurs- ing. There was no recognition of mid- wifery being a profession, separate, but complementary to nursing.

Midwifery's only representation came from the Midwives and Obstetric Nurses Special Interest Section of the New Zea- land Nurses Association (NZNA) set up in 1969. Initially the role of the section was to provide a forum for updating midwives knowledge; meetings were held every two months or so and generally busi- ness was of an apocryphal nature.

Several events changed this low key approach.

1. Women started questioning the medical approach to birth as the only way to have a baby.

Joan Donley, a highly respected midwife and researcher who has inspired many midwives and is a founder member of the College of Midwives, says "I would give first place to the women who rebelled against the medicalisation of childbirth, thumbed their noses at the monopoly of regionalisation, and opted for home births, supported by the few midwives working outside this system. In 1975, the Home Birth Association was formed. This was a strong political lobby. It was aided by an extensive overseas network which pro- vided information on development and struggle elsewhere."

2. More and more small maternity hospi- tals closed as a result of regionalisation and the downturn in the New Zealand econo- my. The high risk protocol forced the GPs to refer women to their obstetrician col- leagues. Consequently, birthing decreased at small maternity hospitals, rendering them non-viable.

Women's choices over where they could have their babies were reduced. Local communities rallied to protect their mater- nity hospitals.

3. Legislation changes in 1971 to the Nurses Act, took away midwives independent practice and made it illegal to attend births without a supervising doctor.

4. Midwifery education was moved out of the maternity hospital schools in 1979 into the Polytechnics and became an option within the Advanced Diploma of Nursing. Midwives were beginning to recognise that the NZNA, Departments of Health and Education's objectives for nursing could well be at the expense of midwifery.

5. Further legislation in 1990 allowed nurses without midwifery qualifications to carry out midwifery care under the supervision of a doctor. Restrictions were also made to the Direct Entry midwife's scope of prac- tice and the Domiciliary or Home Birth Midwife's legal requirements were inten- sified.

The Obstetric Regulations were altered in 1986 to allow Hospital Boards to run maternity institutions without having mid- wives on duty at all times and re-enforcing the view that the medical practitioner was the only person best suited to dealing with childbirth.

It was these legislation changes, how- ever, which finally mobilised New Zeland midwives into action. It united and politicised midwives as nothing else had. Midwives started to seriously consider the need to establish their own voice as distinct from the Nurses Association. While midwives throughout the country were re-educating and defining the role of the midwife, New Zealand women were doing the background work of lobbying their Members of Parliament and writing letters to government departments demanding the return of the traditional midwife role. Another group was formed to support midwifery called "Save the Midwife". Its members were made up of consumers and midwives. Out of this initial group arose the Direct Entry Midwifery Task Force - their specific objective is to get a direct entry midwifery course established.

In August 1989 at the second New Zealand Midwives Conference, Joan Donley pre- sented her paper "Midwives or Moas?" and called for the formation of a "NZ Col- lege of Midwives. Midwives had spent five years, at least, talking about this possi- bility and her call was greeted with enthusiasm. A working party was nomi- nated from the ACM to start the process.

Consumer representatives from the New Birth Association, Maternity Action Alli- ance and Save the Midwives were immedi- ately nominated to the working party. This background was to set the scene for the structure and function of the New Zealand College of Midwives.

Significantly, the opening of this confer- ence fell on the day that the Cartwright Report on the Cervical Cancer Enquiry was published.

Judge Cartwright's recommendations included the importance of consumer contribution and participation in policy and decision making in the health services. The New Zealand College of Midwives has taken these recommendations to heart with their commitment to consumer par- ticipation at the decision making level of their professional body.

Radical, legal and social changes are needed in New Zealand if we are to return the midwife under the ICM definition. We will not achieve these changes without women's support as the WHO report on Strategies for Health for All points out, "together we are a power house of change". On April 2nd, 1989, the Constitution of the NZCM was formally adopted at the inaugural AGM. Our constitution allows for consumer participation both region- ally and nationally.

The majority of regions have consumers on their committees of management and there are three consumer representatives on the national committee.

Obviously the structure of the College has evolved as a response to a uniquely New Zealand situation. With the support of New Zealand's strong women's con- sumer movement, midwives both region- ally and through the Conference membership, can play a leadership role in changing the system to give women back the control over their birth experiences.

The College consciously recognises that the only real power base we have rests with the women we attend.

Structure of the NZ College of Midwives

- Full Member: Midwife, Student Midwife
- Associate: Consumer, Non-Midwife
- Affiliate: Interested Organisations

Region of The New Zealand College of Midwives
- 10 Regions throughout New Zealand
- Decision makers for Region
- Representatives of related organisations
- Elect regional committee/collective and office bearers
- Formulate regional constitution or rules

National Committee of NZCOM
- Select and finance representatives
- National Committee
- Collect subscriptions and manage regional finances
- Facilitate ongoing education in region with seminar workshops
- Provide region
- Communicate regularly with Board of Management
- Disseminate information to members

Board of Management of NZCM
- 6 Regionally elected members from the region holding office, at least 4 of whom shall be midwives
- Disseminate information to the regions
- Responsible for day-to-day Housekeeping and Secretarial needs to aid management of College
- Manage National Committee finances
Photos from the AGM
Christchurch, April 1st-2nd, 1989

NZ College of Midwives - National Committee

Regional Representatives

Northland
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Southland
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Consumer Representatives

Parents Centre
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Rotokura

Leche League
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National Constitution of the NZ College of Midwives

1. NAME
The name of the society shall be New Zealand College of Midwives (hereinafter referred to as "the College").

2. INTERPRETATION
Unless the context otherwise requires:

"College" shall mean The New Zealand College of Midwives.
"Conference" shall mean the Biennial Conference of the College.
"Midwifery" is any person whose name is entered on the New Zealand Register of Midwives.
"National Office" shall mean the registered office of the College situated at such a place as the National Committee may from time to time determine.
"National Committee" shall be the regional representatives, the Board of Management and three consumer representatives.
"The Board of Management" shall comprise six regionally elected members in the region holding office, at least four of whom shall be midwives.
"AGM" shall mean the National Annual General Meeting of the College.
"SCM" shall mean a Special General Meeting called by the National Committee of the College.

In this constitution any term implying the feminine gender shall be deemed to include the masculine.

3. OBJECTIVES
3.1 To promote and enhance the profession of midwifery in New Zealand.
3.2 To uphold the International Confederation of Midwives definition of the midwife's role and scope of practice.
3.3 To foster and promote the New Zealand "Standards of Midwifery Practice, Service and Education.
3.4 To adopt and promote the New Zealand Nurses Association "Midwifery Policy Statement".
3.5 To speak nationally and regionally in the interests of midwives.
3.6 To promote the health status of women and their families.
3.7 To nominate midwife advisers to the Minister of Health and Education and Women's Affairs.
3.8 To provide and promote midwifery education and research.
3.9 To produce newsletters, publish books and material concerning midwifery.
3.10 To promote and encourage the College’s book account.
3.11 To liaise with other organisations within New Zealand and internationally.
3.12 To affiliate to the International Confederation of Midwives.

4. PHILOSOPHY
In the implementation of these objectives, the College relies on the following philosophy:

Midwifery is a profession concerned with the promotion of women's health. It is centred upon sexuality and reproduction and an understanding of women as healthy individuals progressing through the life cycle.

Midwifery is a dynamic process based upon an integration of knowledge that is derived from the arts and sciences, tempered by experience and research, combined with the wisdom of the culture. Midwifery values places in the context of mutual support. Clients play a role in shaping midwifery.

5. POWERS
The College shall be empowered to:

5.1 Make any decisions at its meetings which could further the objectives of the College.
5.2 Employ such persons as may be deemed necessary by the National Committee.

6. MEMBERSHIP
6.1 Those who support the objectives and philosophy of the College shall become members upon paying any membership fee fixed under these rules.
6.2 There is individual membership to regions.
6.3 Honorary Members
6.3.1 Those members who by virtue of their contribution to midwifery can be granted honorary membership by the National Committee.
6.3.2 Honorary membership shall be proposed by a region of the College and shall be subject to such criteria as the National Committee shall determine.
6.3.3 An honorary member shall pay no subscription, but have all the rights and responsibilities of a full member.
6.4 Full Members
6.4.1 Any person who is a registered midwife may apply for associate membership of the College.
6.5 Associate Members
6.5.1 Any person not being a registered midwife may apply for associate membership of the College.
6.5.2 Associate members shall have no voting rights over matters concerning the midwifery profession.
6.6 Affiliate Members
6.6.1 Any organisation may apply for affiliate membership but will not have voting rights.
6.7 Affiliates elected on to the National Committee shall have voting rights only on issues concerning the midwifery profession.
6.8 Rights and duties of Members
6.8.1 Subject to other provisions in this constitution, all members shall:
6.8.1.1 Have the right to nominate and elect to positions of responsibility, to participate in any meeting of the College.
6.8.1.2 Be eligible to accept nominations for positions of responsibility.
6.8.1.3 Shall receive on joining a copy of the constitution of the College.
6.8.1.4 Termination of Membership
6.8.1.5 The member gives notice in writing to the region.
6.8.1.6 The member has paid no subscription for one year.
6.8.1.7 The National Committee decides their actions are prejudicial to the objects and philosophy of the College.
6.9 Membership Fees
6.9.1 May be determined from time to time at the College's AGM or at any meeting of the College.
6.10.1 The National Committee shall be made up of one full member from each region, three consumer representatives and the Board of Management.
6.10.2 Meetings of the National Committee shall be by consent of one vote per region, one vote per consumer (not on issues concerning the midwifery profession) and one vote per Board of Management member.

7. BOARD OF MANAGEMENT
The Board of Management is made up of six members from the region elected in a secret ballot to the Register of the Incorporated Societies.
7.1.1 Keep records and handle the College’s finances.
7.1.2 Give an annual statement of income, expenditure and a balance sheet to the Register of the Incorporated Societies.
7.1.3 Inform members of meetings.
7.1.4 Notify the Register of any changes of the address of the Society.
7.1.5 Register to the Register of any changes in the name of the Society.
7.1.6 Control the common seal as stated in the rules.
7.1.7 Carry out the policies and directions of the National Committee.
7.1.8 Provide a newsletter to all members.
7.1.9 Keep records of members as necessary.
7.1.10 Maintain a good relationship with all regions.
7.1.11 May employ a person to carry out secretarial duties.
7.1.12 Nominate from amongst its own membership a spokesperson and co-ordinator of finance.
7.2.1 The region elected to hold national office and its Board of Management shall be elected for two years with a two year right of renewal.

8. MEETINGS
8.1.1 The AGM of the College shall be held each year, and not more than 15 months following the previous AGM.
8.1.2 Any regional member may request the National Committee to hold a SCM, specifying the issues to be discussed.
8.1.3 National Committee meetings will be throughout the year as required.
8.1.4 Board of Management meetings will be throughout the year as required.
8.1.5 Notice of Meetings
8.1.5.1 A minimum of 14 days notice of all AGM and SCM shall be given to each member.
8.1.5.2 The place, time, date, time and location of the meeting and specify the reason for calling the meeting.

9. QUORUM
12.1 The quorum for any meeting of the National Committee shall be two members.
12.2 The quorum for any meeting of the Board of Management is four.
12.3 The quorum for an AGM or SCM shall be all National Committee regional representatives or their designated proxy.

10. DECISION MAKING
13.1 Decisions at National Committee meetings shall be made by consensus. Voting shall take place when consensus is not reached by a simple majority.
13.2 Decisions at AGMs and SCMs is by consensus. Voting shall take place when consensus is not possible and shall be by postal ballot to all members.

11. CONTROL OF NATIONAL FUNDS
14.1 The National Committee makes decisions regarding use and investment of national funds.
14.2 The College through its finance co-ordinator shall keep records of its accounts.
14.3 All funds received by or on behalf of the College shall be paid into the bank account of the College.
14.4 The College’s bank account shall be operated by the finance co-ordinator and one other signatory from the Board of Management. These signatories are authorised to sign all cheques and withdrawal slips drawn on the College's account.
14.5.1 Finance will be obtained on a per capita basis as determined by the AGM or SCM. This amount will be sent to the regions at a date set by the National Committee.
14.5.2 Members from the College shall be excluded from personal liability for the safekeeping of financial commitment of the College which shall be guaranteed solely by the College's assets.
14.5.3 The National Committee of the College shall not be responsible for losses incurred by any region.

15. SEAL
15.1 The Common Seal of the College shall be kept in the custody of the Board of Management's finance co-ordinator.
15.2 Seal of the College shall be to be adhered to such documents as the National Committee decide.

16. CONFERENCE
The College will hold a conference every two years.

17. ALTERATION OF RULES
17.1 The rules of the College may be altered, added to or rescinded on a resolution at an AGM or SCM of the College.
17.2 Any proposed change shall be included in the notification calling the meeting.
17.3 The region proposing the change shall submit a copy in writing to the Board of Management not less than 21 days prior to the General Meeting.

18. WINDING UP
18.1 On the winding up or dissolution of the College, the surplus of assets of the College after all liabilities and expenses shall be distributed amongst the National Committee. The National Committee shall decide how the surplus is to be distributed and provided that no portion of such assets or surplus funds shall be distributed to any individual member of the College.

BY LAWS OF THE NEW ZEALAND COLLEGE OF MIDWIVES
APRIL 1989

To be read in conjunction with the National Constitution of the New Zealand College of Midwives April 1989

1. That the College close its financial books on the 30th April annually and that an audited set of accounts be available for presentation at the Annual General Meeting.
2. That subscriptions shall be collected regionally and that a capitulation fee of exactly half the subscription shall be paid to the National Committee.
3. A year's membership to the College shall be from the 1st May to the 31st April.
4. That a capitulation fee be paid annually at the Annual General Meeting by each region based on a number of members for the previous year.
5. That each region forward a list of new members to the Board of Management.
6. That the rates and types of membership are:
   - Full Membership
   - (Registered Midwives - Full or Part Time)
   - (Students, Midwives, Unemployed Midwives)
   - Associate Membership
   - Other interested individuals
   - Associate Membership
   - Unemployed interested individuals

   - Affiliated Membership
   - (Injured Couples e.g. Parent Centre, La Leche League)
Nihil Sine Labor

Dorothy E. C. Taylor
RN.RM.

Congratulations and best wishes to the Midwives of New Zealand for having the courage and initiative to form their own professional body.

I have been asked to share with you a few memories of my Midwifery Training during World War II in England and I deem it an honour and privilege to contribute to this publication.

The Midwifery course was divided into two places - part had been evacuated to a large Stately Home about 40 miles from London whilst the usual Hospital carried on with limited wards and staff. The Hospital was lucky not to be hit by bombs as many surrounding buildings had been demolished in the heavy air raids.

Our country house was about 200 years old - quite large and ornate especially the Ball Room. Most rooms had been adapted for hospital use and even the stables had been altered for our sleeping quarters. The large attractive garden had been neglected owing to labour shortage. Sometimes from the huge fountain we carried buckets of water to wash the nappies when the inside tap was dry - we had to be inventive and improvise in lots of ways but this was all part of everyday life in those days. The babies bottle and teats were boiled in a large pot on a paraffin stove, and couldn’t be temperature at times belching forth flames and dense smoke.

It was hard work. Not only did we care for mothers and babies but had to do part cleaning of the wards, wash dishes and prepare suppers. About 40 nurses were in Training most of whom were General trained from various hospitals all over England, but some nurses were widows having lost their husbands in the war and were only taking the 2 year Midwifery course and were not interested in General Training.

We had lectures from an eminent London doctor together with two Sister Tutors and no one liked having to get up for lectures when on night duty. Night duty lasted for a month with 2 nights off before resuming day duty when we had half a day a week and a day off every 2 weeks. Twenty deliveries were expected for each nurse on our course, and one case history to be written up. One night I delivered seven babies and this included twins - it was hectic.

In London it was a different scene and I enjoyed the experience of working in the capital City during the war. The patients were so friendly and kind with a sense of humour unsurpassed. I remember one incident when a mother was changing her baby on the table, suddenly it was on the floor (with no apparent harm) and I heard her remark - "That should get up his wind".

Despite food rationing mothers were not generally malnourished the Government provided extra food coupons for expectant mothers. When we heard the air raid sirens we picked up the babies one under each arm and rushed to the safety of the cellars.

After I finished the course I worked for some time in the Abnormal ward of the Maternity wing of a large hospital. I disliked this work seeing grossly deformed babies, the worst cases were not resuscitated.

Instead of taking Part 2 midwifery I joined the Q.A service in India, Burma and Singapore and it was whilst working in the Military Hospital in Singapore that I met my husband.

I have retained an interest in Midwifery over the years - methods, drugs and technology have changed, but in my opinion there will always be a need for midwives in Hospital and in the home.

Mothers will continue to produce babies no matter what. "Nihil Sine Labor" (Nothing without labour.)
THE WINNING COMBINATION: SETTING A NEW STANDARD IN ANTACID THERAPY

- fast relief of hyperacidic pain, simethicone for effective breakdown of gas bubbles
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Each 5ml of the suspension contains aluminium hydroxide, 215 mg; magnesium hydroxide, 80 mg and simethicone, 25 mg. Bottles of 500ml.

DOSEAGE:
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New Zealand College of Midwives Membership Form

Regional Information

Name
Address
Telephone   Home   Work
Place of Work

Type of Membership
Full Member (Registered Midwife Full or Part Time) $52.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged) $26.00
Associate Member (Other interested individual) $52.00
Associate Member (Unwaged interested individual) $26.00
Affiliated Member (Other Groups e.g. Parent Centre, La Leche League, etc) $26.00

Method of Payment
Please tick your choice of payment method.
☐ Subscription payable to College Treasurer (Please enclose cheque or money order)
☐ Deduction from Salary (Please arrange with your pay office)

National Information

Name
Address
Telephone   Home   Work
Date of Birth

Type of Membership

Place of Work

Please return completed form (together with money if applicable) to
Local Regional Treasurer
New Zealand College of Midwives
Address:
WELEDA

Baby Care Preparations

have been working effectively for over 60 years.

The WELEDA Baby Care Range is formulated from biodynamic plant extracts, first quality plant oils, unadulterated natural essential oils and waxes to provide effective and natural protection, while still allowing the skin to breathe.

Unlike the majority of baby products marketed today, WELEDA Baby Preparations are entirely natural. No synthetic preservatives, no colouring materials and no petroleum derivatives, such as paraffin, are used. Such substances are foreign to the human skin (especially the delicate skin of a baby), and hinder the elimination and absorption processes occurring through the skin.

WELEDA recognizes our bodies as living organisms and treats them accordingly with preparations from the living kingdoms of nature. This principle is basic to all WELEDA products, whether for internal or external use.

Calendula, the original Marigold, has been widely acknowledged as a healing plant: herbalists call it a vulnerary. Research shows the Calendula plant to possess marked anti-inflammatory and antiseptic properties. The mild and soothing qualities of Calendula, make it WELEDA’s perfect choice as the basis of the WELEDA Baby Care Range.

For mothers with sensitive nipples WELEDA manufactures Rose-Calendula Creme. This is a safe natural cream used during pregnancy and breastfeeding to prevent and heal sore and cracked nipples.

WELEDA BABY PRODUCTS ARE BABY FRIENDLY

Let your baby discover why!