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In 'Mother and Baby at Home: The Early Days', the Maternity Services Committee (MSC) "affirms its position that it cannot recommend the practice of domiciliary confinement." (p 21) This "position" was reached on the assumption that "the drop in the percentage of home births (in U.K.) has gone along with a marked drop in infant and maternal mortality." (p 21); and "...that the increased rate of hospital confinement has been a major contributing factor to the reduction in mortality." (p21)

This is the crux of the Report.

Re: Maternal Mortality:
Maternal deaths include deaths from a number of causes - motor vehicle accidents, malignant disease, medical causes, homicide, suicide and abortion as well as obstetric accidents. The period of coverage varies. The international definition of maternal mortality includes all deaths during pregnancy and within 42 days of delivery or abortion. The British definition extends the period to one year, while the U.S. one is to three months.

Since the Report submits a U.K. graph (Appendix VI, p 41) from some undocumented source, it is obviously drawing its conclusions on the basis of the U.K. experience. This being the case, it is well to be aware of some of the U.K. statistics. A 1970 - 1972 computerised study of women in Social Class I - the best fed, best housed and least under stress and also the most likely to patronise an obstetrician - showed that these women had a higher incidence of maternal mortality than women in Social Class II.[1]

As it is obvious it is obstetric deaths only that are of relevance to maternal mortality/home confinement. Today, a major contributing cause of obstetric deaths is anaesthesia. A U.S. 1969 - 1972 survey shows that 19.4% of maternal deaths from obstetric causes were the result of anaesthetics and associated causes. (12 out of 62 deaths); 18 were due to thromboembolic

disease, but whether triggered by surgical procedures and/or the Pill, the survey does not state.[2] However, what does come across is that the risk of obstetric death occurs in hospitals where interventions, surgical procedures and anaesthetics are increasing, which is why women elect to have their babies at home.

Since maternal mortality figures clearly implicate hospital not home births, it is specious for the NSC to try and use this as a reason why it cannot recommend the practice of domiciliry confinement.

Re: Perinatal Mortality Rates (PNMR)

Again, the conclusions appear to be based on the U.K. graph. U.K. figures show that 70% of perinatal deaths come from 7% of babes weighing less that 2500 grams, i.e. premature babes.[3] N.Z. statistics, 1970, show that these low birth weight babes account for every 6/1000 early neonatal deaths out of the total of 7.4/1000. Prematurity is basically a socio-economic problem. Smoking also contributes to prematurity and dysmaturity. It should be noted that in the N.Z. home birth situation most domiciliary midwives will not book a woman who smokes, and should a booked woman come into labour prior to 37 weeks she is immediately transferred to hospital.

In assessing the U.K. home birth statistics it is well to remember that these include all births outside a hospital, i.e. births in taxis, council homes, homes for unmarried mothers and reception centres. Even so, a U.K. 1970 obstetric survey showed that the PNMR was 27.8/1000 in hospitals compared with only 9.5 in GPMUs attached to large hospitals, 5.4 for other GPMUs and 4.3 for home deliveries.[4]

Between 1970 - 1978 there was a decrease in hospital PNMR. Marjorie Tew, Research Statician, Department of Surgery (Orthopaedic), University of Nottingham Medical School has done some

analyses on these PNMRs in relation to obstetric/technology claims. (Copy encl). She shows that one-third of this decrease was due simply to dilution with low risk births which would previously have taken place in GPMUs or at home. Tew also says that the 1970 incopplete data published "affords convincing evidence against the validity of thwie chain" (that hospital births had lowered the PNMR.

A U.K. computerised study, 1970 - 1972 of women in Social Class V showed that the PNMR had not gone down at all in this critical area. [5] A similar Auckland St Helens study shows the same trend. Between 1966 - 1978 the stillbirth rate was considerably higher among Pacific Island women than among European - 11.1/1000: 6.6/1000. [6]

Therefore, to adopt a "position" and make far-reaching recommendations on evidence that cannot be sustained is not only unreasonable, it is blatantly dishonest.

1. Robinson, Jean, 'What Happened to Normal Labour' in Birth Centre London Newsletter 16, 1981.
2. ~~Maternal Mortality Newsletter no 7, April 1981, Government Printer,~~ Botham Prof D.G. Confidential Lecture Notes. Nov 1975.
3. Martin Richards, Journal of maternal & Child Health, sept 1979 quoted by Aims Beverley Beech & Nancy Stewart.
4. Obstetrics versus Midwifery - The Verdict of the Statistics.
5. Robinson, op cit
6. Gunn, Tania, Neonatal Paediatrician, 'A Comparison of Pacific Islander and European Stillbirths,' NZMJ 28 Oct 1981