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The New Zealand Home Birth Association

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The Minister of Health
The Right Honourable Aussie Malcolm
Parliament Buildings,
Wellington.

THE NEW ZEALAND HOME BIRTH ASSOCIATION (Inc) SUBMIT THE FOLLOWING IDEAS ON THE REPORT OF THE MATERNITY SERVICES COMMITTEE: "MOTHER AND BABY AT HOME: THE EARLY DAYS."

1. INTRODUCTION.

The committee's attitude to home confinements is summed up by the statements "We accept that some families may wish to have home confinements ..." (p.5), and "Another group of risk factors however occur at the time of birth and many of these are not predictable. With some, removal to hospital at this time can retrieve the situation, but with others the outcome may not be so fortunate. For this reason the committee affirms its position that it cannot recommend the practice of domiciliary confinement. Accepting, however, that such confinements will continue, the committee sees as its responsibilty the formulation of recommendations to reduce the risks of such confinements to a minimum and the following comments and recommendations are put forward on this basis." (p. 21. para 9)

The committee's attitude is apparently one of passive tolerance of a situation which they see as medically inadvisable. This is an assumtion which is not based on any evidence other than statistics relating to another country, in the past, and concerning a different kind of home birth than are occurring in New Zealand today.

The U.K statistics on which the committee bases its decision are for these reasons, and others described in Appendix 1, specious and unreliable.

We think that the committee's decision that it has a responsibility "to reduce the riskd to a minimum" is unfounded. The current standard of pratice of domiciliary midwives is very high and there is no evidence to suggest that the risks are not already minimised . We feel there is no basis for the imposition of further supervision, regulation and control in the name of 'reducing risks'. We suggest that the Minister take into account the NZHBA's recent statistical survey of 1,000 home birth which have taken place in New Zealand over the past ten years.

The committee evidently has concentrated its efforts on this 'reducing of risks' and in doing so has omitted to give due consideration to a: the valid arguments of parents choosing this alternative. For too long the voice of the parents, especially the mother, and the silent voice of the unborn child, for whom the parents must surely speak best, have not been listened to. b: the considerable amount of overseas literature and research on the safety and advantages of planned home births.

The committee in our opinion has not examined all sides of the question they are addressing, and this is a major shortcoming when its function is to advise the Minister on matters affecting the lives of the people he represents.

If the committee had tried, they could have found statistical evidence to prove that home births are as safe as, if not safer than hospital births, and that they have advantages for both the mother andthe child, as long as they are planned, properly prepared, the mother carefully screened. and the birth attended by properly qualified birth attendants.

New Zealand would be leading the world indeed if it was the first country where the Government can acknowledge these factors as validating home births. We are already in a superior position to many countries in that women here have a legal right to choose where to give birth to their babies. But this legal right is meaningless, and the Government is not supporting its own policy, if it does not at the same time provide an adequate , proficient domiciliary midwifery service.

Domiciliary midwifery deserves more than passive tolerance, it needs the active support and positive sanctioning ofthe Government and Health Department as an alternative which is viable for a small proportion of New Zealand women.

2. COMPOSITION OF THE COMMITTEE.

The composition of the committee is such as leads to a bias against home birth,for the following reason:

-11 of the fifteen memberswere men

-eght of the members were obstetricians

-only one member was not a health professional.

Parents and domiciliary midwives are probably the ones most qualified to know what conditions are best for a natural birth, and their views should be taken as seriously as those of obstetricians, who are experts only in abnormal and pathological childbirth.

In our experience, most obstetricians are opposed to home births . We feel that this is probably because of their training, but also because they have a vested interest in doing deliveries , need the

mothers for training, and because they are personally unconfident about delivering in a home setting.

We ask the Minister to compensate for the imbalance by giving extra attention to the submissions of the Home Birth Association and parents who are writing to him.

THE RECOMMENDATIONS

Recommendation 3(3) and 3 (5).

"That the plan for aftercare following early discharge should include home aid services, and other forms of relieving aid, for mothers with young children, and a napkin service."

It would be discriminating against home birth mothers to provide these services for early discharge mothers and not for home birth mothers.
We recommend that these services also be provided for home birth mothers who choose them.

We also recommend that, as part of 'other forms of relieving aid" a "Paternity Benefit" be made available to those fathers of early discharge and home birth babies who would choose to take the time off work in order to provide aftercare for the mother.

In our experience, many fathers are interested in being at home, as a vital part of the family unit, in a support and bonding role, as well as giving practical care, during the postnatal period. The Home Birth Association believes that this is an important factor in the bonding, adjustment, and emotional wellbeing of the family during this important time and for the future.

Recommendation 10.

"That the domiciliary midwife be based at the obstetric unit in the area, and the contract of the domiciliary midwife for domiciliary confinements be with the hospital board."

Recommendation 11

"Now that the review committees for obstetric standards have been set up by hospital boards they should also review the midwives' contracts for domiciliary confinements in the community served by the hospital board."

The only reason the committee gives for these recommendations is that the domiciliary midwife will then be supervised by 'people who themselves are practising midwifery and are familiar with most recent activity and progress in this area.' (p.22, para.2)

We agree that the Principal Public Health Nurse, who has until now been responsible to a great extent for the supervision of domiciliary midwives, is not the appropriate person for this function. However, we feel that the role of supervision and review should not be entirely the responsibility of obstetricians and health professionals involved in institutionalised health care. These professionals are experts in abnormal and pathological childbirth and cannot therefore be the most suitable people to assess the practice of domiciliary midwives, which we see as being concerned with the natural birth process which needs to be protected from any kind of intervention.

We recommend that any committe involved in the review and supervision of domiciliary midwives should consist of:

A hospital midwife
A general practitioner doing home births
Another domiciliary midwife
A representative of the Home Birth Association
An obstetrician
A representative from Parents Centre Federation.

We do not agree with the recommendation that the contract be shifted from Head Office of the Dept. of Health to the hospital boards, for the following reason:

1. There is a danger that hospital boards who have a bias against home birth would use their powers to restrict and even prevent home births in their area.

2 Individual hospital boards may want to change the existing contract to include more requirements and regulations which we fear may interfere with the professional autonomy of the midwife and threaten the very special, essential nature of home birth.

3. There is a danger that individual hospital boards will vary significantly in their contracts, thus creating a situation where it is easier to have a home birth in one area than in another. This would mean that not every woman in New Zealand would have the same opportunity for a home birth- an opportunity which is her legal right.

We recommend that that the contract be continued to be held with the Minister of Health, through the Clinical Services Division of Head Office of the Department of Health.

Recommendation 14.

"The midwife be granted a contract to operate in a defined area, based on the obstetric unit to which she would refer, and that no domiciliary midwife be permitted to operate in more than one hospital board area, except with the approval of the obstetric unit concerned in cases where the amount of travelling required will be less if the boundary is crossed. "

Although we agree that the greater the distances between the place of birth, the obstetric unit, and the midwife's residence, the greater the risk in case of a transfer, we feel that these distances should be assessed by the midwife and General Practitioner concerned.

If individual hospital boards have to define the area in which a midwife can operate, there could be once again unfair variation between different areas.

We recommend that the distances be defined by the Head Office of the Department of Health, if they have to be defined at all.

The midwife should not have to ask permission to deliver a mother in another hospital board area. If the mother is suitable and all other requirements in the contract are honoured, that mother should automatically be allowed to have a home birth. Since, however, in case of a transfer, the midwife would be dealing with the other hospital board's obstetric unit, she should make the necessary communications with this unit to prepare for this.

We also recommend that the parents' right to choose where to give birth be respected in the case where they live outside the limit considered to be 'safe'. Every effort should be made to make them aware of the increased risk, and they should be prepared to take the ultimate responsibility should anything go wrong..

Similarly, the midwife and doctor concerned should be able to make the choice of whether to attend a home birth outside this defined area, based on their own professional judgment.

In some cases, it could be recommended that the parents and doctor and midwife sign a legal agreement indemnifying the latter of any liability should there be a fatality.

We feel it is important to allow this, in order to prevent home births attended by lay midwives or other unqualified birth attendants.

Recommendation 23.

"There should be certification from a senior midwife and the senior obstetrician of the hospital attesting to the satisfactory professional competence of the midwife."

We do not agree with this recommendation. There has been no such requirement for hospital midwives. Certification should apply equally to hospital midwives. This certification cannot be regarded in any way as in dication of the competence of the midwife in the domiciliary field. A midwife may not work very well in a hospital setting yet make an excellent domiciliary midwife.

Recommendation 25

"The review committee of the hospital board should decide what relevant experience is required of the midwife when reviewing the contract."

We do not agree that there should be any requirement for refresher experience in a hospital at the reviews made after the first year and after every five years.

This recommendation should apply only when an application for the contract is made, and then only if there has been a time lapse between the applicant's two years' continuous service in an obstetric unit and her application.

We suggest that the word'reviewing' be replaced by'considering an application for'.

Recommendation 26 (2)

"That the review committee when reviewing a midwife's contract at the end of the first year and at five yearly intervals, take into account that the number of deliveries conducted by the midwife be preferably in excess of 15 normal delive ies a year."

There are at present a number of domiciliary midwives doing home births in areas where the demand is less than 15 a year- mainly in the smaller centres and more rural parts of New Zealand. We feel that the rural population and small centre population should have an equal opprtunity for a home birth as their city counterparts. These domiciliary midwives should be given every chance of being employed by the base hospital in their area.

Midwives working both in an obstetric unit and in the domiciliary field would also obliviate the need for refresher experience, create good liaison between hospital staff, specialists, and

domiciliary midwives, and break down some of the rivalry which exists in some areas today.

We recommend that the total number of deliveries required to be done by a domiciliary midwife include deliveries the midwife may have conducted in the obstetric unit of a hospital.

Recommendation 26 (3)

"That the review committee, when looking into the practice of a domiciliary midwife, take into account that the midwife has attended an approved institution for refresher experience, for a total of at least two weeks a year."

We think that refresher experience in an obstetric unit should not be necessary for a domiciliary midwife who does a full case load of around 50 per year.

For domiciliary midwives who do not have a full caseload, complementary employment in a hospital would seem desirable, and would obliviate the need for refresher experience.

We would recommend that there be some form of refresher course which would refer specifically to the practice of natural childbirth. This would not include doing deliveries in a hospital, but would focus on techniques and theory applicable to the home birth situation. Such a course would best be planned and directed by midwives (both hospital and domiciliary).

Recommendation 28

" The equipment for domiciliary obstetrics listed by the committee should be available at the time of delivery. "

The HBA feels that some of the equipment listed may be quite inappropriate for domciciliary midwifery and that many domiciliary midwives would not want to carry them.

We recommend that the Minister not finalise this list until there has been further consultation with the domiciliary midwives. The list should as far as possible reflect agreement between the Health Department and the domiciliary midwives who have to adhere to it.

Recommendation 30

"Whether or not each sterile pack is paid for by the midwife is a matter which should be negotiated at the time the fees are negotiated."

We believe it would be better to have a uniform policy on this matter. It seems logical that it would be simpler for the hospital boards to supply the packs free, as a service to the mother concerned. Some hospital boards already supply this service.

Recommendation 31.

"The risk factors in the antenatal period which indicate the need for a hospital delivery are observed".

As with the list of equipment which the committee says the midwives must be supplied , the 'indications for referral to an obstetric specialist at a public or private hospital' as given in appendix VII (p. 42), also contain some indications which the Home Birth Association considers to be dubious. We recommend that, before such a list be finalised, it be discussed with the Domiciliary Midwives' Society, and that the final list be one agreed upon between this society and the Department of Health.

APPENDIX I

MATERNAL AND PERINATAL MORTALITY RATES

Maternal Mortality.
Maternal deaths include deaths from a number of causes: motor vehicle accidents, malignant disease, medical causes,homocide, suicide and abortion as well as obstetric accidents. The period of coverage used varies from country to country. 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 New Zealand 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 U.K. experience. This being the case, it is well to be aware of the U.K. statistics- a 1970-1972 computerised study of women in Social Class I (the best-fed, best-housed, least under stress and also the most likely to patronise

showed that these women had a higher incidence of maternal mortality than women in Social Class II.[1]

It is obstetric deaths only which are of relevance to maternal mortality when assessing the safety of home confinement. Today, a major contributing cause of obstetric deaths is anaesthesia. A New Zealand survey(1969-1972) 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. This is one of the reasons why more and more women elect to have their babies at home. Potentially normal deliveries have more chance of staying normal when confined at home than when deliveried in a hospital.

Since maternal mortality figures clearly are concerned with hospital not home births, it is specious for the committee to use these as a reason for not recommending the practice of domiciliary midwifery.

Perinatal Mortality Rates.

Again the conclusions reached by the committee are based on a U.K. graph. U.K. figures show that 70% of perinatal deaths occur in 7% of neonates weighing less than 2500 grams, i.e. premature babies. New Zealand statistics (1978) show that these low birth weight babies account for 6 out of every1000 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 New Zealand home birth situation, most domiciliary midwives will not book a woman who smokes, and should a woman come into labour prior to 37 weeks she is immediately transferred to hospital.

In assessing the U.K. birth statistics it must be remembered that these include all births outside the hospital, i.e., births in taxis, remand homes, homes for unmarried mothers and reception centres. Even so, a U.K. 1970 obstetrics survey showed that the perinatal mortality rate was 27.8/1000 in hospitals compared with only 9.5 in General Practioners' Maternity Units (GPMUs) attached to large hospitals; 5.4 for other GPMUs and 4.3 for home deliveries.[4]

Between 1970 and 1978 there was a decrease in hospital PNMR. Marjory Tew, Research Statistician, Department of Surgery (Orthopaedic), University of Nottingham Medical School, has done some analyses on these PNMRs in relation to obstetric/technology claims. She shows that one third of this decrease was due simply to the dilution with low risk births which would previously have taken place in GPMUs or at home. Tew also says that the 1970 incomplete data published "affords

convincing evidence against the validity of this claim"(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 critiacal area [5]. A similar Auckland StHelen's study shows the same trend. Between 1966-1978 the stillbirth rate was considerably higher among Pacific Island women than among Europeans-11.1/1000:6.6/1000.[6]

1. Robinson, Jean. 'What Happened to Normal Labour', in Birth Centre London Newlsetter 16, 1981.

2. Bonham, Prof. D.G. Confidential Lecture Notes, Nov. 1975.

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.

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