From : The New Zealand College of Midwives (Inc)
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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

NATIONAL NEWSLETTER

FEBRUARY/MARCH 1993

Tribunal Submissions

Midwives in Action

Vancouver Conference

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

National Midwifery Resource Centre
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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

MEMBERSHIP APPLICATION FORM

NATIONAL INFORMATION **REGION** _____

Name _____

Address _____

Telephone _____ Home _____ Work

Workplace _____

Date of Birth _____ ARE YOU CLAIMING FROM MATERNITY BENEFIT SCHEDULE? YES/NO

ARE YOU A MEMBER OF NZNA? YES/NO

TYPE OF MEMBERSHIP ARE YOU A MEMBER OF NZNU? YES/NO

Full Membership (Waged)	$155.00 } Includes	NEW ☐
Full Membership (Unwaged/Students)	$ 50.00 } Indemnity	RENEWAL ☐
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REGIONAL

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

New spa bath for local waterbirths

Delivery suite charge midwife, Lenna Young, [redacted] with the new spa bath in the base hospital delivery suite.

BY STEPHEN NECKLEN

Waterbirth is now an even more attractive option for women in the Wanganui district, with the installation of a new spa bath at the base hospital's women's unit.

The new bath, commissioned late last year, is a joint effort between hospital staff and the community.

Zip Bathroomers supplied the spa bath at a reduced price while other companies chipped in with donated goods. Paul Owen Ltd supplied curtains for the room, Wanganui Furniture a new bedside cabinet, Choice Furniture donated a bed, Noel Leeming a radio-cassette player and Kmart a table lamp, cushions, bedlinen and sheets.

The hospital's patient amenities fund contributed the money needed to pay for the cost of the bath and its installation.

Charge midwife in the delivery suite, Lenna Young, says the hospital has been doing waterbirths for the last two years.

"We do three to 10 waterbirths a month and that equates to 15 percent of normal births," she says.

As well, 90 percent of women use water in labour for comfort and relaxation.

Lenna says parents are attracted to waterbirths because they feel the process is gentler for the baby and allows the new born a gradual introduction to new sensations.

The buoyancy and warmth of the water reduces stress on the mother and alleviates pressure and backache.

It also gives parents prolonged contact with the baby without fear of it becoming cold.

"The bath gives women a free range of movement, a sense of weightlessness and relief from pain and it is very comfortable for most women," Lenna says.

A study she carried out confirmed that women who chose waterbirths used less pain relief.

Hospital consultants and GPs now support the use of waterbirths, but Lenna says they will intervene if the pregnancy is not normal or if complications arise during delivery.

The hospital supplies a pamphlet to women who are considering the option and it also suggests they discuss it with their doctor.

Much of the publicity about waterbirths comes from word of mouth, as mothers share with their friends about the benefits of it.

Lenna says not many hospitals offer waterbirths within a hospital setting and Wanganui is getting inquiries from midwives around the country.

She says staff insist on strict cleaning procedures and they sterilise the bath after every use.

River City Press 21 January 1993

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REGULARS

Next Newsletter due out early May.
Deadline for informtaion for consideration for inclusion is
19th April

EDITORIAL

Dear Members,

Welcome to 1993 and the first Newsletter for the year. Despite holidays, much has been happening for midwives and mothers in our country and this Newsletter will endeavour to bring some of those events to your attention.

At time of writing, we still await news of the outcome of "The Tribunal" but we still wish to acknowledge the huge amount of work that many midwives and consumers contributed before and during the proceedings. We have included just two of the many submissions which will give you a taste of the calibre and dedication of the majority of the submissions received.

There's much information on upcoming events and snippets on some midwives' achievements around the country.

Please note the new subscriptions on the back page. These will apply from 1st May 1993

Happy reading! *Karen Barnes*

MIDWIFE REQUIRED

An experienced Midwife is required to join an Independent Midwife working in association with a busy South Auckland General Practice

Interested Midwives should apply, in writing enclosing CV to:

Drury Midwifery Service
P O Box 19, DRURY

Applications close 20 March 1993

NEXT NATIONAL COMMITTEE MEETING

Friday 26th and Saturday 27th March 1993

Midwifery Resource Centre

First Floor 183 Manchester Street

Christchurch

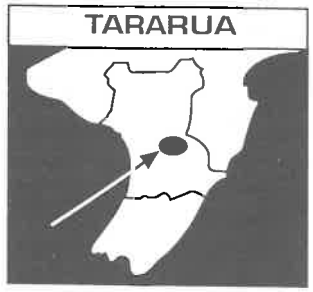
Commences 6.00pm Friday

and

9.00am Saturday

MANAWATU WANGANUI AREA HEALTH BOARD "COAST TO COAST" Magazine.

BIRTH OF A NOTION



Over in the Tararua, the midwives have given birth to a complete women's health service, and the community is reaping the benefits.

Beth Strong, Nurse Co-ordinator for the Midwifry Service, says she and her staff of one full-time and two part-time midwives, plus four obstetric nurses and an enrolled nurse, have been gradually expanding the range of services they are offering the community. The move began three and a half years ago in an effort to provide a flexible, safe maternity service.

"To enable us to do this, we asked the community what they needed," says Beth. "What they wanted was for their birthing to be the kind of birth that suited them, with family and friends able to offer support.

"To help prepare people for the birth of their children, we developed a comprehensive antenatal programme incorporating a series of ten early pregnancy classes and a "three-month" day for adolescent mothers-to-be and young mothers who, perhaps, can't get to regular classes."

And from this beginning, more and more services were developed in response to the demand from the Tararua community. At the moment (and we say this because Beth and her team are constantly adding new services) the Dannevirke maternity service offers:

* individual tuition in antenatal and postnatal.
* early pregnancy classes
* preparing for motherhood (in conjunction with public health nurses)
* personal choices ... where clients talk about then document their own preferences for the kind of birth they want - at home or at the hospital etc
* a hot line (telephone) direct to the maternity unit
* post natal counselling
* pre-discharge training for new mothers in CPR and preventing SIDS (sudden infant death syndrome - cot death)
* feeding and parentcraft classes
* women's health education, covering topics such as BSE, cervical screening and family planning
* contraception advice
* preparation for going home with a new baby
* home visits for women discharged earlier than 5 days.

Beth Strong (right) and fellow midwife Islay Thompson (left)

* refresher classes for mothers who have had children before
* preconceptual classes.

The preconceptual classes are an example of the team's innovation. On two or three occasions each year, the team organises an evening at which all the health professionals handling a birth (physician, GP, midwife etc) attend to give advice and support to couples thinking of having a family.

The team's activities involve all members, although each staff member has responsibility for one or two programmes. programmes are documented to enable anyone to take over if necessary.

And what of the future?

Beth and her team are hoping to get resources to turn an old room at Dannevirke Hospital into a whanau room for families of women undergoing childbirth. Also on the drawing board is an organisation similar to an "Acorn Club" to provide parenting advice to the community.

Carey Virtue midwife

Carey Virtue is one of 400 independent midwives in New Zealand who assist at many of this country's 57,000 births each year. Working with expectant mothers and their families, both within hospitals and in their own homes, she sees it as a privileged role, an initimate job in which she shares in one of life's great occasions.

The phone rings in the night. It's 1.00am and one of Carey's expectant mothers is in labour. It sounds fairly early in the labour, and after giving some reassurance, Carey goes back to sleep. It's 3.30am when the second call comes. The amnotic fluid has had a small leak, but it's still fine. The woman feels happy, but she just wanted to check ... that's ok, she did the right thing. Carey snatches a little more sleep.

"I usually go back to sleep and dream about the birth in between times."

In this instances, it's a home birth and Carey is out the door and driving at 6.45am. It's still dark when she arrives. The house has that night-before-Chrismas feel. The special room has been set up, there's a birthing mat, lots of comfortable things around the room and the husband is massaging his wife's back.

Suddenly caught up in one of life's real dramas, what does the midwife do? Boil water of course ... to make a cup of tea.

"It's really important that you don't make it into a big drama. It's her event and it's very tempting to come in and make a big deal and rush around. They've been in labour for some time, they're progressing along nicely, there's no need to interrupt their pattern.

Making a cup of tea is quite a good way of giving them confidence that everything's okay", Carey says.

They sit and chat, sometimes about the labour, sometimes about something completely different, like sailing, and the boats that are just discernible in the harbour through the pre-dawn light.

Carey: "I used to ski every weekend and go sailing and windsurfing but that's almost non-existent now. I fought it for a while but then realised that it's too stressful to try and do both."

In between contractions, Carey lays out her equipment. It's all there but, apart from some swabs and scissors, little is generally needed. The key piece of technology is usually a Pinard, a little wooden earphone, a primitive feotal stethoscope that the midwives have been using for centuries to listen to the baby's heartbeat.

Most births Carey attends need little or no medical intervention. Carey sees herself in a supporting role helping women, their partners and their families to be strong and confident, to see birth as a normal event. Derived from a very old Anglo-Saxon word, midwifery literally means "with woman". The French for midwife is Sage Femme which is "wise woman"., In Aborigine communities the word for midwife means "women's affairs".

Many times over the pregnancy Carey has visited this house and these people, to check the progress of mother and child and, importantly, to build the woman's confidence that she can do this, that she can take control of it.

She's seen the couple respond, almost unconsciously, to the nesting instinct. Decorating the baby's room, buying the pram, completing the alterations, streamlining the kitchen, changing the house around, making it a better place to live, to raise a family.

She's also seen a motivated, corporate woman be forced by Nature to slow down, and for a time, tune into life's most basic instincts, to replace reports, projects and deadlines with a deeper perspective.

"You can't control a baby and that slowing down in the last weeks is a really important part of that - adjusting to the baby all the time," Carey says.

The house is peaceful. Nobody is making much noise, apart from the woman who is groaning a little, using powerful, rhythmic breathing to help her contractions. Nothing else is happening, seemingly anywhere.

The pain is growing. He has his hand on her back most of the time now. She's hanging on tight, gripping his other hand. Carey's hands - large and strong for a woman - are there supporting. They're both telling the woman how well she's doing. They are moving in closer, giving that extra support, so important near the end of the labour. You're are doing really well. Let it go, just take some slow breaths again. It's not far to go now, the baby is going to be here soon, you're nearly there, you've done most of it, you're doing really well, any moment, you'll see the baby's head.

And there it is.

"Most things in life, we see or can understand how it's going to be . This is something that you can't, even though you know it's going to be a baby and you know what babies look like.

"It's new life that you've never met before, it's a human being that's been growing all this time and has already got part of its personality formed and it's been there but you've never been able to see it and you don't know whether it's a boy or a girl and it's starting to appear .... it's that change from pregnancy to a baby ... it's one of the miracles of life."

The relief in the house is huge. Sometimes that relief turns into hilarity, sometimes into an awed, all pervading quiet. And those amazing duties/rituals are performed - the cord is cut, the first feed is given, phone calls are made, tea is brewed and the light is up over the harbour's edge with the promise of a bright new day.

National Co-ordinator's Forum

After a wonderfully relaxing Xmas and New Year holiday, I am refreshed and ready for the challenges of 1993. No doubt there will be many so I am hopeful all of us are prepared and feeling strong for whatever this year brings.

We have not yet had the results of the Maternity Benefits Tribunal announced by the Minister of Health. I know this has caused many midwives some anxiety as it is difficult to plan your life not knowing the level of income to expect.

We can only have faith that our case was heard fairly and without prejudice. The College of Midwives witnesses, both consumer and midwife, were impressive. They were articulate, knowledgeable and creditable. They provided ample evidence that the Midwifery philosophy of women centred care will ensure safe and satisfying outcomes for women and their babies. The supportive submissions from over 186 women (individuals and groups) and midwives confirmed the quality of the New Zealand Midwifery service. There was no doubt that Midwives provided a service equal to the medical model and deserved equal renumeration for that service.

When repealing the Employment Equity Act in 1990, Bill Birch said the Government was not denying the principles of equity in fact it supported "...the concept of equal pay for work of equal value among other employment equity principles."

The Minister of Women's Affairs, Jenny Shipley, is quoted as saying "there are a number of positive initiatives which will do more for achieving and maintaining equity than the artifice of imposing provisions on employers and employees through legislation.

The Maternity Benefits Schedule is not imposed. It is a negotiated document. The Medical Association negotiated the schedule with the Department of Health and it is evidence that the DOH, as the people dependent on the service being provided were prepared to pay the fees as outlined in the schedule. In other words that is what they believed the service to be worth. We have no reason to believe that the same service with worth less if provided by Midwives.

When Midwives were once again able to provide an independent maternity service the barriers that confront most women dominant services were removed also and pay equity achieved. Maintaining that equity now rests with the Minister of Health. We await with confidence the Minister's confirmation of the right of Midwives to equal pay for work of equal value.

Meanwhile the NZCOM is pressing on investigating its relationships and role within the new health funding system. Regions are holding workshops to look at contracting for normal birth services. Make sure you take part in this planning that is underway countrywide as we will be the role models for future midwifery services. Sally Pairman and I will be meeting with the RHA executives in the next few months to promote midwives and their services.

MATERNITY BENEFITS TRIBUNAL SUBMISSIONS

4 November 1992

Maternity Benefits Tribunal
P O Box 1131
Wellington

Dear members of the tribunal,

When you meet on November 23rd to discuss the scale of fees for maternity services, we wish you to take note of the recommendations which follow.

Birth Wise (Inc) is a consumer lobby group established in 1991 committed to ensuring that parents can make informed choices about birth options.
In making this submission we are representing the views of consumers - mothers and fathers - who stand to make no pecuniary gain from the outcome of this tribunal, but in whose best interests this issue should, after all, be resolved.

It is now commonly acknowledged that in the Western World at least 80% of births can proceed normally, naturally and with a healthy outcome **without** medical intervention in the process. However, the medical model which undermines parents' confidence in birth as being essentially normal and natural and encourages submission to and acceptance of the so often unnnecessary medical interference in birth, is still being promoted as the norm.
Birth Wise does not accept the medical model for the majority of births. Our belief is encapsulated in this quote from the Health Committee's report on Maternity Services which was ordered by the House of Commons in London and presented in February 1992:

"Becoming a mother is not an illness. It is not an abnormality. It is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestion of health. It is physically very demanding and is a time when women are vulnerable in many ways. They require help and support during the process of being pregnant, giving birth, and postnatally and some of this, though not all, needs professional help. In some circumstances the quality of professional help is literally vital. But it is the mother who gives birth and it is she who will have the lifelong commitment which motherhood brings. She is the most active participant in the birth process. Her interests are intimately bound up with those of her baby."

Birth Wise believes that all legislative decision making concerning maternity services should recognise as its fundamental starting point that birth is a normal, healthy life event - indeed a manifestation of health - and that pregnancy is not an illness terminated by birth.
It is therefore necessary to establish an environment which supports this positive life view of the vast majority of births, as well as providing the facilities and expertise to care for the small number of abnormal births which do require assistance.

BAY NEWS, WEDNESDAY, OCTOBER 28, 1992

Maori women's birth group a first

MAORI Women in the Tauranga region may now tap into a new home birth support group.

Te Ahuru Mowai (The Sheltered Place) has been set up with the blessing of the Tauranga Home Birth Association and offers support and information to Maori women before, during and after birth.

Group spokeswoman, Laureen Heenan says a group of women recognised a need for the group — a group that promotes health and informed decision making — and the group has grown from there.

"Maori women are often shy and will not ask doctors questions about pregnancy and birth. Sometimes they're uninformed about what's going on and what options they can take,"says Laureen.

The group meets regularly in private homes and will introduce women to Maori midwives who will deliver babies at home and provide continuing care after the baby is born.

Mrs Heenan, who has had two of her four children at home, says the group will support women through both home and hospital births.

"It's all about Maori women supporting Maori women. If a woman doesn't feel confident having her baby at home, members of the group will go with her to hospital and support her there.

"But in my experience, most Maori women really feel inadequately provided for in hospital. Spirituality is missing in hospital. For Maori women their home is their marae — it is safe and private. At home you just feel so comfortable."

Mrs Heenan says home birthing suits the extended Maori family.

"Your family doesn't have to come and visit because you are already at home. What happens in hospital is that the whole mob will just show up anyway — sometimes not at visiting hours and sometimes they're not all allowed in at once.

"At home there may be someone cooking and someone else looking after your children. You don't have anyone saying you have to do this and you have to do it this way."

The Tauranga Home Birth Association has just granted Te Ahuru Mowai $3100 from its Bay of Plenty Area Health Board contract.

Mrs Heenan says the money will be used to print pamphlets and cards that will be placed in doctors surgeries.

"We'll be using it to promote the group and to help fund a newsletter."

The group hopes to establish a library with books on women's and children's health written from a Maori perspective.

LAUREN HEENAN B4655

And Te Ahuru Mowai mothers will visit local Kohanga Reo to talk about birthing choices with mothers there.

Mrs Heenan believes Te Ahuru Mowai is the first Maori home birthing group in the Bay of Plenty and she says when it is well established, group members would be more than happy to help get similar support groups off the ground in other centres.

- ❑ Offer information and discuss options (eg for pregnancy, childbirth, another child) instead of giving negative or judgemental advice.
- ❑ Develop and distribute printed materials to local libraries on special devices and techniques (eg how to cope in pregnancy with increased weight, how to lift baby in the morning when fingers are stiff, what type of crib to use, how to bathe infants safely).
- ❑ Discuss sexuality-related issues without waiting to be asked.
- ❑ Include partner in the medical and psychosocial counselling (eg in explaining the real, though non- visible, disabling condition as related to fatigue or pain).
- ❑ Prepare local health professionals to be able to assist with special questions and needs (eg safety of intercourse during pregnancy, plans for another child).

The women repeatedly stated that coordination of services was lacking but was necessary to ensure quality care for their preparation in safe and confident childbearing and parenting. The feedback we have received from our clients in private practice and the results from formal controlled interviews of 36 other women with a variety of orthopaedic, neurological, and sensory disabilities have been consistent with these findings. It was also apparent that specialized agencies (maternity hospitals, rehabilitation or nonprofit voluntary facilities, and public health units) in our local area referred women with physical or sensory impairments elsewhere without attempting to determine the referee's ability or preparation to assist these women toward confident, healthy and safe childbearing and childcaring.

Our experiences and formal studies have been limited to British Columbia, Canada, but there does not seem to be any contrary data from elsewhere. Readings and findings of our colleagues have led us to believe that these findings could be representative of the gaps related to maternal and child health promotion efforts in North America concerning special-needs women. Nurse-midwives, who are well known for both their commitment to disadvantaged populations and their in-depth knowledge of the total childbearing cycle, might well want to become resource persons for physically challenged parents and health professionals in their community. Obtaining the cooperation of physical therapists, social workers, occupational therapists, and physicians is vital to successful provision of service.

For over 80% of births, the 'safe and successful outcome' cited in your terms of reference is the outcome which could and should occur naturally when birth is viewed as a normal life event and women are given the sort of care throughout their pregnancy, labour and post natally, which fosters and reinforces this view.

When this vast majority of normal, healthy births are **allowed** to proceed naturally and without interference the outcome in terms of increased satisfaction to parents and baby is immeasurable. The outcome in terms of $ savings to RHAs are figures with which we presume you are familiar.

Birth intervention is traumatic for mothers and babies, and it's very costly to taxpayers.

To eliminate unnecessary intervention in birth should be a prime consideration in this tribunal's recommendations to the Minister of Health because this issue is inextricably linked with the issue of who should be paid what and on which scale of fees under the maternity benefits.

The Tribunal is no doubt aware of the huge amount of research showing that intervention in birth is very much increased in countries and in hospitals where the person intervening stands to gain (usually financially) from the intervention. For example caesarian rates are much higher in institutions where surgeons are paid on a fee per operation basis.
This type of practice is abhorrent.

In devising a fee structure for paying practitioners it is imperative that there is no facility for pecuniary or other gain to be made through the unnecessary intervention in the natural birth process.

By educating birth practitioners and parents of the natural, positive model of healthy and normal birth, a far greater satisfaction in the process and a huge cost saving is inevitable. In this environment, maternity care is likely to move towards being more community based and thus easing pressure on our overburdened hospitals. As far as safety goes this would not be a bad move - to again quote the House of Commons Report,

"There is no evidence to support the claim that the safest policy is for all women to give birth in hospital, or the policy of closing small obstetric units on grounds of safety"

And according to the editorial in the Lancet in 1986 *"In light of the accumulated British evidence, neither the lack of safety of birth in hospital has been proved, a judgement contrary to established medical claims."*

Public attitudes still lag sadly behind this evidence, with the result that most people still **perceive** there to be little or no choice in childbirth. We are now, thankfully, looking back at the old days when birth involved such ludicrous, humiliating and even dangerous measures as shaving of the mother's perineum, routine episiotomy, the physiological counterproductive practice of supine birthing position, and many other backward attitudes and practices. We trust that in the near future we will also be looking back at some of the current attitudes and practics and relegating them to the dark ages of childbirth where they belong. We refer to the shameful degree of unnecessary intervention, the misconception in many people's minds that natural birth without intervention is rare, that home birth is dangerous - if not illegal, and that a woman is best to deliver herself over as a passive patient to the medical profession which will ensure the "safe" removal of the baby from her body.

How different this is from an attitudinal framework (as quoted at the beginning of this submission) which perceives birth as healthy and normal, and perceives the birthing mother as being active, vital and central to the whole process?

A healthy attitude to birth, and the fact that the parents will take an active role in the process and the decision-making goes hand in hand with providing consumers with free choice. It is essential that maternity care remain free and universal in New Zealand. However this does not mean that maternity care must remain as costly to the taxpayer and use as many professional resources as it does at present. It is, after all, a normal healthy event.

This tribunal would do well to demonstrate to the Minister of Health that there is much to be gained by educating this country's parents to develop a positive, healthy attitude to birth and make informed and educated choices about maternity care.

Since the Nurses Amendment Act of 1990, parents have had wider choices for maternity care. However, two whole years have since gone by and most expectant parents are completely oblivious to the options open to them. Despite this fact thousands of women have chosen "midwife only" maternity care, the DOMINO option of home birth. These options are hardly widely advertised and it seems that only the most resourceful and informed of parents are aware of the choices. Yet there are parents who will go to considerable lengths to research their options despite the best efforts of many professionals to steer them into the standard medical model.
Parents will not accept inferior options in what is one of the most significant events of their lives. The birth debate has exploded in recent years and parents are demanding their rightful involvement in the whole process.

One criterion for the success and satisfaction (or otherwise) of any particular option is whether it is provides the mother with **true continuity of care.** While this phrase "continuity of care" has been so overused to be in danger of being meaningless, what women want is care from the **same person** during pregnancy, birth and the post natal period. This is far more likely to nurture an environment of support and confidence which maximises the probability of a normal, natural birth and minimises the likelihood of varying prognoses, contradictory advice, unnecessary intervention and demoralising switches in personnel.

When birth is normal and natural, the "job" of the health professional is to let nature take its course. We would consider it inequitable if the tribunal recommended that one type of health professional be paid more than the other for this work - **or that the schedule allow for one to benefit through causing a normal birth to proceed other than naturally.**

When birth is abnormal, other professional expertise may be required, but there must ideally still be one professional giving true continuity of care to the mother.

True continuity of care is most likely to lead to a successful birth outcome. The consumer is well able to choose which professional gives them the type of care that they want.

We make these recommendations within the framework of an environment which educates and encourages parents to recognise birth as a normal, healthy, positive life event and that parents can take an informed and active role in this process.

Thank you for considering the above in your recommendations to the Minister.

Yours faithfully,

C Dalty & J Huygens
for Birth Wise (Inc)

Ref: House of Commons Health Committee second report
"Maternity Services" Volum 1 13 February 1992

Guidelines for Midwives

Disability, Pregnancy & Parenthood International
January 1993

Elaine McEwan Carty, Tali A.Conine and Lorraine Hall

Disabled adults have the right to bear children; their condition need not be a handicap to responsible and effective parenting. Nonetheless physically or sensory challenged individuals often need more than specialised medical care or traditional midwifery care during the perinatal period. They need information or training that has been modified to their unique situation to help them cope with the physical and emotional changes of pregnancy, the challenging period of labor and birth, and the skills involved with parenting. They also need to make changes in their physical environment and have specially designed and adapted aids and furniture for infant care. The nurse-midwife may be sought for the role of case manager,

coordinating and integrating services that may be needed to assist the disabled pregnant woman to cope with the divergent medical, social, emotional and family forces that press upon her.

We have developed guidelines based on the results of five years of research, development and service focusing on the problems and needs of disabled first time mothers. In our first study, 24 women who had been diagnosed to have classic rheumatoid arthritis (RA) before or during their first pregnancy were matched with 24 similar able-bodied women on the basis of age, education, and area of residence (metropolitan/ non-metropolitan) in British Columbia, Canada. Both groups were interviewed for the purpose of determining what types of health and safety information women had received during pregnancy, from whom, and suggestions for improvements in the services provided. A rather surprising finding was that during pregnancy significantly more women with RA depended for guidance on lay resources rather than health professionals for information on nutrition; use of alcohol, tobacco and non prescription drugs; sexuality; consequences of pregnancy on the disability or disease; and baby care techniques, baby care equipment, and devices.

The suggestions for improvement in childbirth education services, made by the women in that study included:

- provide care and adapted courses in accessible surroundings (eg hospital beds with electric controls and accessible to wheelchair, exercise mats on a raised platform, classes without stairs)

Cot deaths "not ethnic"

NZPA

London

SOCIAL and economic status and habits such as smoking, rather than ethnic differences, have been blamed for the higher rate of cot death among Maori babies.

New Zealand pediatricians believe the greater prevalence of risk factors among Maori infants is the reason more than twice their number suffer from cot death as other New Zealand babies. The conclusions, based on a study that compared 485 victims with 1800 control infants nationally, have been published in an issue of the "British Medical Journal".

The comparison showed that many of the known risk factors were higher in Maori families, researchers said.

Maori mothers tended to be socio-economically disadvantaged, younger, and more likely to smoke, and their infants were of lower birth weight. They were also more likely to lie sleeping babies on their stomachs instead of the recommended position of chest up, and not to breast-feed.

Cot death, or sudden infant death syndrome, is the unexpected and unexplained death of an apparently healthy baby.

The study, led by Auckland University senior lecturer in pediatrics Dr E. A. Mitchell, said New Zealand had probably the highest cot death rate in the developed world.

In 1986 there were four such fatalities for every 1000 live births. But while the figure for non-Maori was 3.6 deaths per 1000, the Maori rate was 7.4.

Dr Mitchell and his colleagues said the specific risk factors, although more prevalent among the Maori population, were much the same as for non-Maori.

An exception was having a baby share a bed with another person, which was identified as a risk factor with Maori babies.

The study noted that failure to identify bed-sharing as a risk factor in non-Maori children was probably because of the tiny proportion of infants in this group who both shared a bed and were exposed to maternal smoking.

"Further analyses suggest that exposure to both factors is required for bed-sharing to be associated with a raised risk of sudden infant death syndrome."

In a separate report in the same issue of the journal, British researchers suggest that letting babies sleep close to other people might reduce the cot-death risk.

Contrary to popular belief, babies do not need peace and quiet and do better in noisy, bustling homes, according to the study of British infants from Welsh and Bangladeshi backgrounds.

There are about 1500 cot deaths in Britain every year, but death rates are known to be far lower for Bangladeshi babies than for white infants.

The study of 60 families in Cardiff found Bangladeshi babies lived in large extended families.

They slept close to other people, day or night, and at night slept either in their mother's bed or in a cot next to it.

In contrast, babies born to Welsh mothers were encouraged to sleep alone, where possible in their own rooms.

They were pushed to become independent by mothers wanting to get back to work or have time to themselves.

Other previous research has suggested that the recent Western approach of making infants sleep by themselves deprived them of the external stimulation that might stabilise breathing.

The Welsh findings were greeted with caution by the Foundation for the Study of Infant Deaths, the major funder of cot death research in the Britain.

The foundation's secretary-general, Ms Joyce Epstein, quoting the research by Dr Mitchell and his colleagues, said other studies showed babies sleeping in the same beds as adults could be at an increased risk.

She said the Welsh study was not sufficient for a national campaign.

However, she added: "It suggests that babies might be kept in their parents' room in a cot by the side of the bed, until at least six months of age."

6 November 1992

Submission to the Maternity Benefits Tribunal

I am writing as a mother of two children. The first was delivered at home and the second required an emergency Caesarian Section. Both births happened in their appropriate settings and for both I had the appropriate personnel. I did not want a specialist obtstetrician at my normal home birth. However I did need a specialist obstetrician for my complicated labour and Caesarian.. For both I benefited from midwifery care. I would like to think all women and their families had access to these services and settings and the appropriate practitioners.

Our culture, which in turn affects our social structures, focuses on birth as a dramatic event. There is a belief that our safety relies on technology and technocrats. Sometimes that is true. However if our focus becomes more realistic and normal birth our expectation then the appropriate personnel become obvious.

How can one know beforehand what will be needed? You can't and you need practitioners who do know - midwives. Midwives have always supported women in labour: they know a normal labour when they see one and are trained and experienced to act if it no longer is normal. They are the experts in determining when a labour is abnormal and will contact a general practitioner or specialist obstetrician if necessary.

Midwives are the experts in normal labour. Although this skill is not valued in our culture it is an area of special and particular knowledge. Could doctors do as well? Well, they might, but it takes a long time in terms of each individual labour and many labours to gain experience of the normal.

As long as our culture supports the dramatic and the odd-ball occurrence as if it were the norm, women will have enormous fear surrounding birth. There is a transition in process at present. From this fearful mode, developed to its height in the '70s with high medical intervention rates, to a more balanced "my GP or midwife, or both can provide my maternity service - I'm happy and healthy and normal". You, members of the Maternity Benefits Tribunal, are in charge of that transition completing itself.

I believe it is the women themselves who should choose the appropriate practitioner and the setting. I would like to see all players in the maternity squabble appreciating the roles and expertise each brings but realising the women themselves are the only one who can really be trusted to choose wisely. And their wisdom will be based on their beliefs about birth. Their choice may change over the next decade. There is no one way to sort out the appropriate personnel in advance since no one knows what choices women will make.

Midwives are experts in normalcy which must be acknowledged and encouraged. GPs offer another dimension which some women also seek; continuity over many years. But labour care, like the remainder of general practitice care, is episodic. The midwives are the only practitioners to be there throughout the whole labour, are well known from pregnancy and will follow-up at home afterwards. This is more in-depth care but obviously a shorter continuity than the GPs birth to the grave philosophy. Specialist obstetricians have been, I believe inappropriately, engaged for healthy normal women giving normal birth. They will probably continue to be. They are enormously skilled and are very valued members of any maternity service but their skills are best used for the abnormal. I believe we need all these practitioners to remain involved in maternity care but with the understanding that we are all experts of varying appropriateness.

Finally I wish to confess I am a midwife who has been trained for twenty years this year and have been attending home births for six. In this setting I have enjoyed working with GPs if this is what the woman chooses. However in hospital I believe only one practitioner is appropriate as I can always call on another pair of hands if I should need them.

Whether you share my understanding or not I would like you for a moment to appreciate my point of view and share my vision.

Yours sincerely,

Susan M Lennox

REPORT ON BIRTH IN THE 21ST CENTURY CONFERENCE

Taken from ICEA (NZ) Newsletter January 1993

One of my first tasks as New Zealand Co-ordinator was to display for ICEA at the Birth Conference in Auckland. This was a great experience both from the point of view of attending some of the sessions, and also from meeting and talking with all those who stopped by the display. I would like to congratulate the organisers for a tremendously successful event.

Among the approximately 500 registrants were midwives, physiotherapists, GPs, obstetricians, childbirth educators, and mothers. For me personally, one of the most rewarding aspects was the fact that it was strongly bi-cultural. I think in the past many of us have paid lip service only to being bi-cultural in our approach to childbirth education, so it was very relevant and timely to hear the Maori women give their point of view - and the message delivered was a powerful one. It is interesting, although not entirely surprising, to discover that many of the things that keynote speaker, Janet Balaskas, was espousing were common practice in Maori culture in pre-Pakeha times, i.e use of warm water, steam, squatting, being supported between the knees of a family member, swaying, touch and massage.

There was much emphasis throughout the conference on empowerment of women, cultural issues, women's sexuality, working together in partnership, active birth, as well as legal issues and standards in childbirth education. One of the session titles was *So Much in So Little Time* - and that probably summed up the experience of the conference for many of us! I believe that Birth Conferences are to become a regular event from now on - the next one will be in October 1993, again in Auckland. Following that they will be held every second year in different cities throughout New Zealand, alternating with the NZ College of Midwives Conference.

Copies of proceedings and tapes from Birth in the 21st Century are available.

Enquiries to: Glenda Stimpson
P O Box 52-065
Kingsland
Auckland

Jenny Drew

COT DEATH UPDATE

Bed sharing plus smoking escalates cot death risk

The Paediatric Society of New Zealand held its Annual Scientific Meeting in Auckland in November. LYNNE LARACY reports on important findings presented to the meeting.

Contrary to original statements made by cot death researchers, bed-sharing itself, does not significantly increase the risk of cot death, but if a mother smokes and bed shares, the risk of her child dying of cot death is very high.

If those mothers stop one or both of those activities, researchers expect to see a further one third reduction in the cot death rate.

Already public health campaigns based on the findings of the National Cot Death Study have resulted in a 50 per cent reduction in the death rate (from four per 1000 babies to two per 1000 in two years).

The major identified risk factors were:

- putting the babies to sleep lying face down
- mothers who smoke
- babies who are not breast fed.

The rate of cot death associated with bed sharing is higher in Maori than in Europeans but, according to researchers, that is because both risk factors are more commonly present.

Pacific Islanders commonly bed share, but have smaller incidence of smoking, while for Europeans it is the other way round.

The two behaviours together are most common in Maori.

Researchers are still debating what the public health message should be.

"They cannot exclude a small risk of bed sharing even when mothers do not smoke, so they are reluctant to fully retract their previous statement that bed sharing is a risk factor.

First message not premature

Researcher and senior lecturer in paediatrics at Auckland School of Medicine Ed Mitchell said the research team is convinced their initial message was the right one and not premature.

"bed sharing appeared to account for a large number of deaths and we passed on that information in good faith.

"Further analysis has allowed us to qualify that and say bed sharing is a risk in those who smoke," he said.

Dr Mitchell believes simply targeting smoking will have less impact on the cot death rate than encouraging mothers not to bed share because smoking is one of the hardest behavioural changes for people to make.

He said public health messages must take cultural factors into consideration as well as other benefits of bed sharing.

"These are fairly nebulous and while many people say it increases breast feeding, studies show that is not the case and that would have been my main concern," he said.

The risk of bed sharing increases the longer a baby stays in bed.

"It doesn't mean mothers can't take the baby to bed for breast feeding and cuddles, but when she goes to sleep, the baby should go back in its own space.

"It may happen that she goes to sleep, but the important thing is to cut down the time and the number of episodes to reduce the risk," said Dr Mitchell.

Dr Ed Mitchell

Vaccination and dummies protect

Researchers have found that contrary to some statements by anti-immunisation lobby, immunisation has a protective effect against cot death.

Some anecdotal reports have linked cot death with vaccinations but the study showed that not being immunised doubles the chance of cot death.

Although some babies died the day of their vaccinations or several days afterward, it was less than the numbers that were expected on those days.

The use of dummies also appears to offer some protection but researchers say more work needs to be done in this area.

Researchers have discounted any connection with nappy sterilisers or disposable nappies and work is continuing on thermal regulation.

Preliminary results show that being too cold can be as much a risk factor as overheating.

Researchers have also been trying to identify any risk factors that may indicate when a baby is at risk of cot death, but so far no common symptoms have emerged.

Studies show that only a small percentage of those babies who died of cot death showed symptoms which suggested severe illness and parents of these babies had sought medical help.

"High risk infants belong to a group which on the whole don't get immunised, don't have six week checks and avoid preventive programmes, but they do come if the baby is ill.

"GPs should try to use these contacts for immunisation, health checks and health promotion.

"In fact they should pass on the main messages we have outlined to all mothers at every opportunity," said Dr Mitchell.

NZ Doctor
Conference Report
December 1992

Central

Mr Murray Burns - Central

Quality improvement, health and efficiency gains and risk sharing are priorities for Central RHA.

Chief executive Murray Burns said, "We will be looking for better specification of services in all our contracts in 1993, but we recognise the difficulties in regard to general practice."

There are six practices in the region which already have contracts, and patient enrolment and budget holding are two options offered to Central GPs next year.

"We would be keen to talk with GPs about any other schemes they have in mind or if they want to take part in pilot schemes because we wish to foster innovation and more integrated service," said Mr Burns.

Although GPs in this region have been among the more vocal of those opposed to contracts Mr Burns believes the problems can be sorted out.

"The changes made to the Health and Disability Services Bill address the issue of GPs who do not want to enter into full purchase contracts. These amendments were prepared with the advice of the NZGPA. I trust that we will be able to work with GPs towards appropriate arrangements.

"We would prefer to

continued on page 32

RHAs

continued from page 31

continue the dialogue we have commenced as a means of resolving any differences," he said.

Formal discussions with providers are expected to start in February and Mr Burns said simple contracts appropriate to the provider will be prepared.

The authority asks providers to look at their own service capability and costs and to consider who can provide cooperative and complementary services.

Providers are also expected to detail quality assurance and customer satisfaction measures and what changes their practices need to be able to respond to the new contracting environment.

An information sheet has been sent to Central providers to help them prepare for contracting.

Stuart Macdonald and Barry Taylor, who deal with provider contracts, will specify what services will be purchased and what quality standards must be met.

Southern

The speed of change is likely to be slower in general practice than other areas of health reform, according to contracting manager Victor Klap.

He has no fixed idea of how contracts with GPs should be formed and says this will be developed after consultation with them.

Mr Victor Klap - Southern

Informal discussions have already begun with individuals and GP groups.

"We want to get a really good idea of where GPs want to go and would like to hear how they feel they can respond positively to the changes to deliver better service.

"There is general agreement, among GPs I have spoken to, that there are things which can be done much better," he said.

Mr Klap said changes to current arrangements for general practice will be gradual and any contracts will be phased in over time.

In the meanwhile the RHA has assured patients they will have the same access to services.

"1 July this year is not a magic date when everything will change.

"Existing arrangements will be in place for those GPs who have not agreed on a new one, but we want an understanding that during 1993 and 1994 we will enter into specific and explicit contractual arrangements with them," he said.

NOTICE

NURSING COUNCIL NOMINATIONS

The New Zealand College of Midwives is required to nominate one Midwife member to the Nursing Council of New Zealand.

Nurses Amendment Act 1990

(h) **One** Registered Midwife to be appointed on the nomination of the New Zealand College of Midwives (Inc)

Karen Guilliland is the current nominee but is wanting to stand down and consequently is unavailable for a further term.

The term is completed in March 1993. It is unlikely that the Nurses Act will be reviewed by then so we need to proceed under the current legislation which is to present a name to the Minister of Health to enable an appointment to be made.

Please consider who your region would like to nominate and forward a name to your regional chairperson by 3rd March 1993.

Voting will be at national level to decide whose name goes forward to the Minister.

CONGRATULATIONS

The Medical Misadventure Advisory Committee's recent appointments of two well known and respected women's health campaigners will be heard with delight throughout the women's health sector of New Zealand.

Judi Strid - Co-ordinator of Auckland Federation of Women's Health Council and long time supporter of Direct Entry Midwifery education.

Sharon Cole - Co-President of Parents Centres NZ. Sharon was one of the original Consumer representatives on the NZCOMI National Committee.

Each committee (Auckland based and Wellington based) has two standing members, one lawyer and one lay person. This committee then co-opts advisors (e.g. midwives, doctors) as the case necessitates.

The College extends its congratulations to Sharon and Judi and wishes them well in their deliberations.

ACC Voluntary Cover

Ministry of Women's Affairs "NEWS" Jan 1993

Did you know that you can now insure yourself with ACC for loss of potential earnings?
The Accident, Rehabilitation and Compensation Insurance Act 1992 includes a provision for individuals to purchase voluntary cover for loss of potential earnings when leaving the workforce, that is when "between" jobs or on leave for longer periods.
Voluntary cover can be purchased for a period between three months and two years. Costs vary according to age, occupation and gender. Policies are cheaper for women because statistically they have fewer accidents. This cover provides the claimant with earnings related compensation for up to five years from the date of the accident.
The Ministry recommends women investigate purchasing cover, under this provision, if they are taking unpaid maternity leave, are making a change of career, or having a period out of the workforce, or being made redundant and they have had at least 12 months continuous employment before leaving work.

Cover must be taken out while still employed, or within one month of ceasing employment.

RHAs say contracts are essential in primary care

In his Policy Guidelines to RHAs, the Minister of Health laid down general principles on how providers' contracts must be handled. However, each region has considerable autonomy in its arrangements for primary care. In our continuing series on the business aspects of health reform LYNNE LARACY looks at the four RHA plans for general practice.

North Health

Dr Ray Naden - North Health

Individuals or groups who can provide a comprehensive range of services and more seamless care will be favoured in contracts with North Health.

Health services manager Ray Naden said GPs are well placed to have more control of total care of patients but other individuals such as specialists, nurses or business managers or groups such as Maori trusts may choose to hold contracts and employ doctors.

Such schemes will require patient enrolment and may be budget holding arrangements but there is no plan for compulsory enrolment.

"People must retain the right to move from one provider to another easily and freely," said Dr Naden.

GPs will have to specify what health needs their service meets, what quality measures are in place, what service is being provided and the price.

There will be provision for doctors who do not want to contract.

"We are working on a range of contractual options which will be voluntary but I'm sure when GPs see what is available, they will want to contract," he said.

Fee for service payments will continue after 1 July for those who want it but budget holding appears to be more favoured by the authority.

"Fee for service is so limiting because GPs are paid for volume rather than quality. They are forced to do things which are not good use of their time and there's no incentive for preventive care," said Dr Naden.

North Health will work with the RNZCGP on quality assurance measures, and direct customer surveys are planned.

There are approximately eight IPAs in different stages of development in the region and the RHA has begun discussions with some of them.

Many pilot schemes on different ways of delivering primary care are under way or planned and special emphasis is placed on Maori health, community care and community nursing.

Special projects manager Colin Tukuitonga said in preparation for working with the RHA, GPs should look at the services they offer now, what they want to provide in the future, who their clientele are, and the way their business is structured.

They should also look at how they are achieving the various health goals and their relationships with their colleagues.

"This is particularly important in areas where there are other players such as maternity care," he said.

He said the RHA will be assessing the cost effectiveness of various treatment options and how services are provided.

A replacement had not been appointed at the time of writing. Dr Warwick Tong of Whangarei who was originally appointed the North Health primary health services manager has refused the position.

The appointee will be working with Dr Naden and contracting manager Chris Gedye.

Midland

Dr Lester Levy - Midland

All Midland providers must have an explicit formal contract with their RHA from 1 July in order to receive funding.

Manager of health contracting Lester Levy said initial contracts for GPs will be simple and may simply define the relationship between the two parties.

However, a circular to providers put out by Midland said contracts will be subject to regular review and, where necessary, to annual renegotiation.

If providers' services are not satisfactory, resources will be reallocated to other providers, it said.

GP contracts will eventually have to specify the type of service they provide, how, where and when it will be made available, and what quality standards will be met.

Priority will be given to providers willing to accept all or some of the financial risk inherent in service delivery.

"We aim to replace most existing, open-ended, demand driven payment arrangements with either population based block contracts or, in the case of referred services, payments tied to specific levels of activity," said the circular.

An advisory group on primary health care will be set up and according to Dr Levy will include "GPs working at the coalface" who will assist the development of strategies for the area.

A liaison person will soon be in each region covered by Midland.

Various pilot schemes are planned and several GP groups have already offered to host them.

"It's critical that we don't bring in changes without trialling them first.

"We have to work within a capped budget and we want to try a range of things to achieve that.

"I'm not sure that capitation as it is commonly understood is the answer and I will not lurch wildly into it.

"Neither will fee for service be completely out of the question. In some areas it may be quite legitimate.

"We also want to compare new ideas with the current system so we can keep parts that work well and improve those which don't," he said.

All contracts will have to show some sign of progress, or detail goals in line with Government health priorities, that a practice is moving towards.

Dr Levy said primary care providers should look for opportunities to develop a more integrated approach to health care.

Sub contracting and joint ventures among providers is being encouraged by the RHA.

Midland wants to introduce competition among providers particularly in the fields of elective surgery, rest homes, and continuing care of the elderly, home based support, diagnostic services, pregnancy and childbirth services, well child services and specialist outpatient services.

But GPs should not feel pressurised by accountants, lawyers and computer vendors into investing a lot of resources into setting up some sort of "super-business", said Dr Levy.

The system we are working on will be simple and non bureaucratic so that GPs can focus on what they do best - which is treating patients.

"We will continue to meet with GPs and develop the system with the people doing the work," he said.

COMMUNITY BASED PROGRAMS

The following health care coalitions have initiated quality improvement programs targeted at reducing unnecessary cesaereans.

Vermont Employers Health Alliance
The Greater Detroit Area Health Council
Bay Area Business Group on Health (San Francisco)

LEGISLATIVE INITIATIVES

Access to information regarding area hospitals' annual rate of primary cesaereans, repeat cesaereans, VBAC rate, and medical interventions has helped women make informed choices. The following states have passed "maternity disclosure" legislation mandating hospitals to make such data public.

Prepared by
Nicette Jukelevics, MA ICCE
ICEA Cesaerean Options Chair

For ASPO/Lamaze Annual Conference (Roundtable Discussion) Anaheim, CA 1992

Note: Each of the strategies listed above is medically researched and documented. Anyone wanting more detailed information on any aspect of this paper is welcome to write to:

Nicette Jukelevics
c/- Centre for Family
24050 Madison Street, Suite 200
Torrence CA 90505
USA

CAPERS BOOKSTORE

A huge selection of books, videos and teaching aids are available from this organisation. Here are a few suggestions.

1. **Preterm Babies Can Breastfeed Too**
- a great video supporting breast-feeding of premature babies - 1991

2. **Birth Without Doctors**
- Jacqueline Vincent-Priya

This book is the result of journeys and conversations between the author; traditiional midwives and mothers which took place over several years, describing traditional birthing practices and communities in Malaysia and Indonesia. 1991

3. **Vaginal Birth After Caeserean** - Lynn Richards

Intimate experiences of VBAC as told by mothers, fathers, midwives, obstetricians and others. 1987

For further infomation, catalogue, costs and ordering contact:

Capers Bookstore
P O Box 567
Nundah
Queensland 4012
Australia
Phone 07-266-9573
Fax 07-260-5009

Resolve Through Sharing

Resolve Through Sharing was started at Lutheran Hospital in La Crosse, Wisconsin as a comprehensive perinatal bereavement program to assist staff in identifying and addressing the needs of families who have lost a baby through miscarriage, ectopic pregnancy, stillbirth, and newborn death. Our approach to the families has always included one or more of the following professionals: nurses, physicians, social workers, midwives, as well as clergy and funeral directors. The Resolve Through Sharing program provides participants the information and skills they need to address the issues surrounding pregnancy and newborn loss and assess the needs of families as they go through a normal grief process. This program has become a "standard of care" for our patients here as well as at 1400 other hospitals throughout the United States.

If you would like to know more, please write to:

Brenda Jorgenson
Administrator
Resolve Through Sharing
Lutheran Hospital - La Crosse
1910 South Avenue
La Crosse, WI 54601 USA

NATIONAL COMMITTEE MEETING TIMETABLE
- 1993 -

Friday and Saturday
Midwifery Resource Centre
183 Manchester Street Christchurch

26th and 27th March
25th and 26th June
27th and 28th August
26th and 27th November

UPCOMING EVENTS

ICM CONFERENCE - Vancouver Canada

Headquarters:
10 Barley Mow Passage
Chiswick, London W4 4PH
Tel: (081) 994 6477
Fax: (081) 994 1533
Telex: 8811418

To : All Associates
cc : Board of Management
Regional Representatives

January 22 1993

Dear All,

I enclose a form which I would ask you to return naming your country's nominees (NB not association nominees) for participation in the workshops and forums that are planned to take place in the context of the Triennial Congress in Vancouver. There are two forums, on Research and Education, and six workshops, all of them English language only. Space is limited, and it may be necessary for Headquarters to select from among your nominees; a list of nominees who have been accepted will then be displayed within the Congress Registration area.

The workshops are as follows:

On Research: A beginners' workshop, led by Jennifer Sleep, a midwife researcher based in the UK.

On the Media: led by Malcolm Macmillan, Press Officer at the Royal College of Midwives, this would aim to enable member associations to work more usefully with the media in their own countries.

On Classification: to pursue lines of information established at the Collaborating Centres meeting, developing ideas on classification for midwifery. Led by Ruth Ashton and Joyce Thompson. Nominees to this workshop should be familiar with classification systems and classification work now going on in their own countries, particularly in the nursing or medical fields. They should be prepared to contribute actively to the working out of an ongoing classification system for midwifery.

On Ethics: an introductory workshop, to be led by Joyce Thompson, reviewing the newly approved and/or amended ICM Code of Ethics.

On Informatics: intended as a managers' meeting, looking at informatics in midwifery resource management.

On Legislation: the aim is to develop guidelines for legislation and the regulation of midwifery, also to enable Headquarters to gain appropriate advice as to how satisfactory legislation is that is either new or in course of development.

The forum on **Research** is envisaged as a formal opportunity for researchers to meet together to share and discuss their current work and future plans. The forum on **Education** is set up in response to senior midwives who have pinpointed weak areas in international midwifery information and teaching, and would offer the opportunity to explore this concern in more depth.

Yours sincerely, Miss Joan Walker
Secretary General

ARTICLES OF INTEREST

STRATEGIES FOR LOWERING PRIMARY CESAEREAN SECTION RATES AND INCREASING VBAC (Vaginal Birth After Cesaerean)

Reprinted from ICEA Newsletter

1990 United States overall cesaerean section rate	22.7%
Primary cesaerean rate	16.8%
VBAC rate	20.4%

In 1988 4 major categories accounted for 86.7% of all cesaereans:

Repeat cesaereans accounted for	35.6%
Dystocia accounted for	28.9%
Breech presentation accounted for	12.3%
Fetal distress accounted for	9.9%

DOCUMENTED HOSPITAL BASED INITIATIVES

VBAC as the standard care for all eligible women
Active parent education program which includes safety of VBAC
Increasing the number of midwives for low-risk deliveries
Establishing clear guidelines for manag ing dystocia
Include trained female labor assistants (proven in certain situations to reduce the rate of complications)
Confirm fetal distress with fetal scalp sampling or acoustical stimulation
External cephalic version (ECV) for term breech
Mandatory second opinion for non-emergency situations
Physicians opinion leader program to increase compliance with specific criteria for management of labour
Comprehensive peer review and auditing of all cesaereans
Publication of physician cesaerean rate on quarterly basis
Investigate reasons why women chose to have elective cesaereans

HEALTH EDUCATION STRATEGIES

Childbirth preparation programs are encouraged to include the following:

Information on patient's rights and informed consent
Four major indications for cesarean
Safety of VBAC
Cesaerean prevention strategies
Community resources and referrals.
Worksite Prenatal Education
Corporate employee programs can offer:

Preventative maternity education
Contact, idientification, and follow-up of pregnanct women with prior cesaerean by registered nurse
Make VBAC information available at health fairs, health education liberated, health newsletters, and phone-in services on health options.

INTERNATIONAL BOARD LACTATION CONSULTANT EXAMINERS PROGRAMME

With the publicity being given to the results of the New Zealand Cot Death Study showing that breastfeeding is an important fact in reducing Cot Death, and more recently the Baby-Friendly Hospital Initiative promoted by UNICEF and WHO worldwide, all insititutions involved with mothers and babies will be expected to re-evaluate their promotion and management of breastfeeding. UNICEF sets sights for 1993 on the International Code of Marketing of Breastmilk Subsititutes enforcement in industrialised countries by the end of the year. The goal is empowerment of all women to breastfeed exclusively.

I draw your attention and to that of your colleagues and students, the International Board of Lactation Consultant Examiners' certification programme which should be part of this strategy. Staff members can have their professional knowledge upgraded by study for the certifying examination and be confident that their competence will be recognised to an international standard.

As Lactation Consultants they will have better access to a network of information on up-to-date research on breastfeeding physiology and management.

The exam has been available annually since 1985 at different sites worldwide. 1990 was the first year a New Zealand site was included.

IBLCE

The International Board of Lactation Consultant Examiners, Inc
Announces the
Certification Programme for
LACTATION CONSULTANTS
Examination Date - 30 July 1993
Examination Sites - to be confirmed

Health Care Providers who are

- INVOLVED IN INFANT FEEDING
- ENCOURAGING & PROMOTING BREASTFEEDING
- SEEKING A CHALLENGE
- INTERESTED IN AN ADDED CREDENTIAL

For information or application form write to:

RACHEL WALKER
41 Hanlon Street,
Christchurch 5

Closing date for fees : 30 April 1993

ATTENTION ALL MIDWIVES ATTENDING THE VANCOUVER CONFERENCE IN MAY 1993

Could any Midwife interested in representing New Zealand at these workshops please notify their Regional Chairperson (see front page of newsletter) of your interest by 3rd March 1993.

Decisions on representation will be made by vote at national level. As we have no funds available please note nominations are restricted to people who are prepared to take part in these workshops at their own expense.

ICEA 1993 International Convention

MINNEAPOLIS MINNESOTA USA
19TH 20TH 21ST MARCH

For further information contact :
ICEA
P O Box 20048
Minnesota 55420, USA Fax 1-612-854-8772

BREASTFEEDING HANDBOOK

If you purchased your copy of the Breastfeeding Handbook at Conference please return this misprinted copy with a SAE to the Midwifery Resource Centre. You will receive a brand new correctly printed copy, FREE!

The Baby-Friendly Hospital Initiative: A worldwide movement takes hold

Imagine the unveiling of a new feeding system that could claim to provide a baby with a nutritious, satisfying meal while it fulfilled all daily requirements for vitamins; at the same time, it would protect the newborn from disease and infection, and strengthen the bond between baby and mother. The product would require no packaging, storage, refrigeration or preparation. Imagine that this product is readily available, in exactly the quantities needed, and it is free.

.... That product is breastmilk.

Breastmilk is a single source of food, health and care that satisfies all of an infant's nutritional needs.
UNICEF and the World Health Organisation (WHO) launched the Baby-Friendly Hospital Initiative worldwide in early 1992 to foster national action to empower women to breastfeed and to end the supply of free low-cost infant formula.

Because the myths continue to dominate popular knowledge about breastfeeding, BHFI is focused on hospitals, to remove misinformation before it spreads. To become baby-friendly a hospital must practice the "Ten Steps to Successful Breastfeeding" which include informing pregnant women of the benefits of breastfeeding, helping mothers initiate breastfeeding within half an hour of birth, training health workers to implement a written breastfeeding policy, and supporting mothers who breastfeed.

Studies show that breast is best

✔ A study in Chile found that none of the exclusively breastfeeding women had become pregnant within six months of giving birth, compared to 72 per cent of non-breastfeeding women. *(Zacharias et al, "Return of fertility in lactating and non-lactating women,"* Journal of Biosocial Science, *1987.)*

✔ Incidences of diarrhoea can be cut by 40 per cent among infants up to two months of age and by 30 per cent among those aged 3 to 5 months by promoting breastfeeding through changes in hospital practices and providing mothers information and support. *(Feachem and Koblinsky, "Interventions for the control of diarrhoeal diseases among young children,"* Bulletin of the World Health Organization, *1984.)*

✔ Infants in Brazil who received no breastmilk were found to have a risk of death from respiratory infections 3.6 times that of exclusively breastfed infants. *(Victoria et al, "Evidence for protection of breastfeeding against infant deaths from infectious diseases in Brazil,"* The Lancet, *1987.)*

✔ A recent study showed that children who were born prematurely and were fed breastmilk as infants later scored higher on intelligence quotient (IQ) tests in childhood. *(A. Lucas, et al, "Breast milk and subsequent intelligence quotient in children born preterm,"* The Lancet, *1992.)*

✔ Children who are breastfed for at least four months can have overall reduced rates of childhood cancers, including leukemia and lymphoma. *(Davis et al, "Infant feeding and childhood cancers,"* The Lancet, *1988.)*

It's about time: a half-century movement to end supplies sees results in 1990s

1939 — Cicely Williams' book *Milk and Murder* recommends that deaths resulting from "misguided propaganda on infant feeding" should be "regarded as murder."

1968 — Dr. Derrick Jelliffe coins the term "commerciogenic malnutrition" to describe the impact of marketing practices on infant health.

1974 — The World Health Assembly recommends regulating inappropriate sales promotion of infant foods used to replace breastmilk.

1977 — Nestle boycott is launched in the United States to protest marketing practices.

1979 — WHO and UNICEF host international meeting on infant and young child feeding, calling for development of international code of marketing.

1981 — International Code of Marketing of Breastmilk Substitutes adopted at World Health Assembly.

1986 — World Health Assembly passes resolution banning free and subsidized supplies.

1990 — The Innocenti Declaration calls upon all governments to enact the 'Ten Steps to Successful Breastfeeding' and the International Code.

1991 — UNICEF and WHO launch the Baby-Friendly Hospital Initiative in 12 starter countries. UNICEF calls for end of all free supplies by 1992. Infant formula manufacturers promise to end supplies in developing countries by 1992.

1992 — UNICEF and WHO expand BFHI to a worldwide movement. Hundreds of thousands of women participate in first annual 'World Breastfeeding Week'.

1993 ... — UNICEF sets sights on Code enforcement in industrialized countries by year's end. Goal is empowerment of all women to breastfeed exclusively.

Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

2. Train all health care staff in skills necessary to implement this policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Help mothers initiate breastfeeding within a half-hour of birth.

5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.

6. Give newborn infants no food or drink other than breastmilk unless medically indicated.

7. Practice rooming-in - allow mothers and infants to remain together - 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The high cost of bottle-feeding

* In Sierra Leone, the cost of formula to feed one baby is 90 per cent of the minimum wage.
* If 25 per cent of mothers in Indonesia stopped breastfeeding, the resulting cases of diarrhoea would cost more than $40 million to treat, about 20 per cent of the country's annual health budget.
* In New York, the total cost for hospital treatment of bottle-fed infants in their first four months is 15 times that of breastfed infants.

What resources would be needed annually to replace breastmilk?
* Indonesia would need $62 million
* Tanzania would need $22 million
* Papua New Guinea would need $12.5 million
* India would need an additional 114 lactating cattle
* Worldwide, $15 billion would be required to feed 120 million infants.