AUCKLAND HOME BIRTH ASSOCIATION
PO Box 7093
Wellesley St.
Auckland

NEWSLETTER No.27 March 1985

EDITORIAL

HOMEBIRTH
NELSON ~85
National
Homebirth Conference
Nelson, May 11th and 12th 1985

Already it's March, nearly on quarter of the way through 1985! Those of us actively involved in the work of the Auckland Homebirth Association have found that the New Year's activities have already demanded considerable time and energy. All the Support Groups have at least started their first set of antenatal meetings for the year and it is good to learn that in many areas new people have come forward to help with these. Postnatal meetings have also been organised in most areas. The committee has been meeting regularly since January and already has projects afoot. We would like to remind you that Committee meetings are open to all members. We would be delighted to seem some new people come to these meetings and become involved in the work we do. (Meeting dates and times are listed later in this edition.)

Nationally, plans are already underway for the National Conference which is to be held in Nelson in May this year. The issue of 'Incorporation' for the National Association is to be discussed again. Last year Auckland formally withdrew from the existing Incorporated Society structure of the National Association. This move has prompted discussion amongst other Branches during the year and, as a result, a special meeting of representatives from all the Branches is to be held just prior to the start of the Conference to share ideas and hopefully to come up with an alternative structure for the NZHBA which will serve the individual needs of the Branches and which will assist us nationally in fulfilling the 'Aims' of the NZHBA.

The following is an outline of the ideas which were formulated at our 1985 AGM at the beginning of March and which we will be presenting to the National Meeting on your behalf.

At our 1984 AGM the Auckland Branch unanimously passed a proposal to put the following remit to the National AGM:- That the NZHBA Inc. be wound up as from

N.Z. HOME BIRTH ASSOC.
AUCKLAND BRANCH BOX 7093
WELLESLEY ST. AUCKLAND.

STOP PRESS
Rally planned for
29th April postponed

Dr. B. Conyngham
4 Grange Rd
Mt Eden AKL.

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GLEN EDEN N.Z.
PERMIT NO. 20

the 6th day of May and that any funds be distributed among the branches equally and that notice of this resolution be given to the Registrar. This remit (with date changes) was again passed unanimously at this year's Auckland AGM.

Although this remit looks rather negative when read by itself, we firmly believe that the existing 'Incorporated' structure of the NZHBA is hampering rather than helping us to work towards our aims.

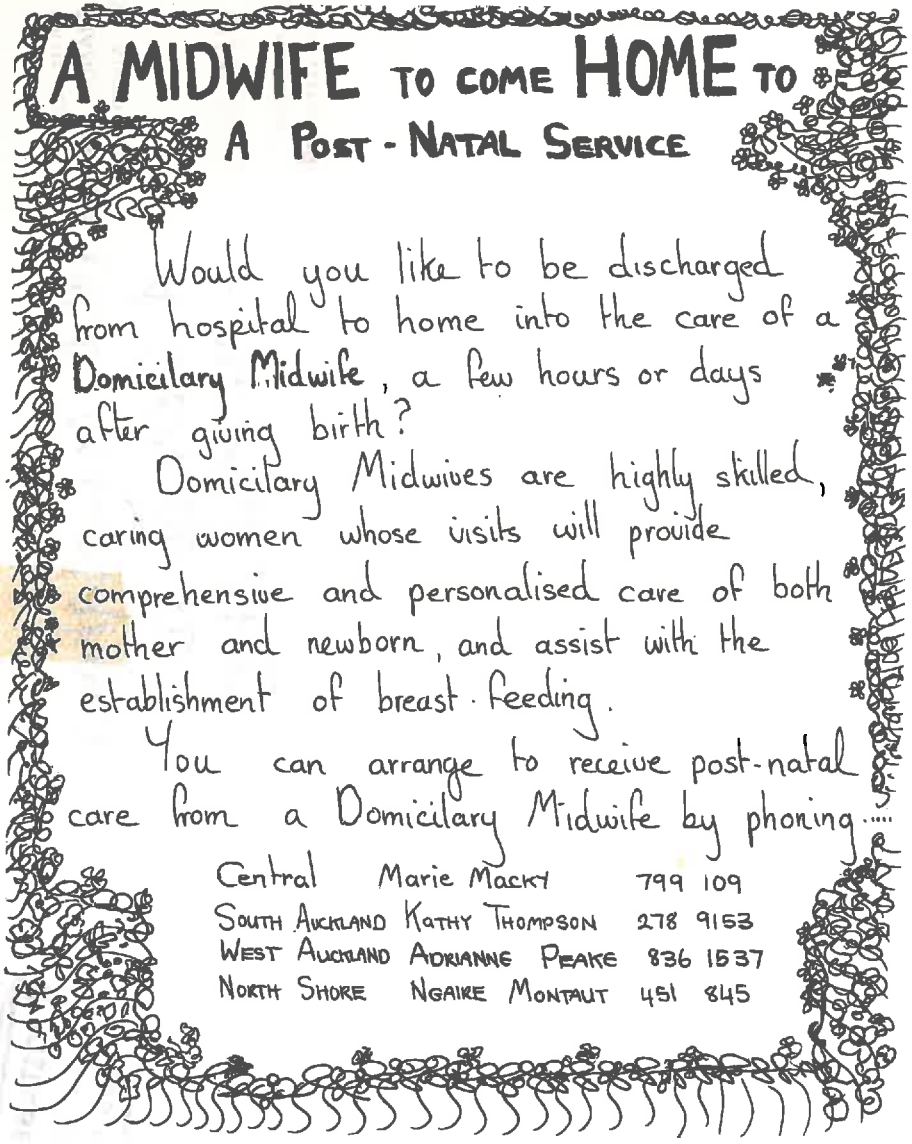
The existing constitution, 'Rules of the NZHBA' is a traditional and formal document which binds us to a hierarchical structure and bureaucratic system which we feel is unnecessarily cumbersome and unsuited to a voluntary organisation which functions cooperatively and whose aims and beliefs are, in general, the opposite of those held by 'establishment' organisations.

Since we became incorporated more time has been spent at National Conferences etc., servicing the organisational structure and discussing possible amendments/ additions to the constitution than any other single issue, and in spite of these lengthy discussions aggreement has never been reached and we have continued to function outside the 'Rules' in our Incorporated document. If we were constitution-less this time could be spent working directly towards our aims.

The constitution requires us to have a National Executive. We have been unable to satisfactorily agree on the geographical placing of the officers. If they all come from one Branch (on a rotating basis) that Branch loses a good deal of the people energy available to them at a local level. If the officers come from different Branches throughout the country communication becomes very cumbersome. We feel that direct communication among the Branches is more efficient and effective than filtering communications through a National Executive no matter what their geographical positon.

The system of voting at AGMs etc has also never been resolved. The options have been one Branch one vote, or having the number of votes proportional to the number of members. We believe that an organisation whose aims and beliefs are as clearly able to be defined, and agreed on, as ours, can easily reach consensus on any issue of practical relevance to the Association so has no need of a voting system.

If we have a National Executive, we have to support it through levies from the Branches. We believe that this money is much better used at the local level and if smaller Branches need financial assistance this can be requested directly of the larger Branches rather than filtering it through a National Treasurer.



Although we feel that the Incorporated structure as it stands is unsuited to our needs nationally, we recognise that there are certain advantages in being Incorporated at Branch level - if only to enable us to apply for funding and other types of assistance from other organisations and agencies. We propose that all groups Incorporate at a local level and that Nationally we become a Federation of New Zealand Home Birth Associations.

A number of Branches feel that it is at least necessary to have a National Spokesperson to coordinate submissions etc to Government etc. and provide a focus for replies and Press statements etc. We suggest either, one Association can take responsibility for coordinating or, if it would be more effective, each of the Associations can present its own submission which supports those being presented by the others.

Similarly individual Associations could take responsibility for specific other areas of our collective function eg communication - through the National Newsletter, manufacture and distribution of promotional material eg buttons, bumper stickers, T Shirts etc., education eg pamphlets, booklets, photographic displays etc, statistics - collecting, collating and setting up comparative surveys.

We look forward to the forthcoming meeting to discuss possible changes in the structure of the National Association. We hope that the other Branches will agree that a Nationally Incorporated Society is unnecessary, that National AGMs can be done away with and that time at National Conferences can instead be used to share ideas and information which will really assist us in achieving our aims.

- Brenda Hinton

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FORTHCOMING COMMITEE MEETINGS

16 April at Joan Donleys- 3 Hendon Ave Mt. Albert. Ph. 887759

21 May at Mayette and Bruce Gulley's - 131 Haverstock Rd. Mt. Albert. Ph. 869458

18 June at Brenda Hintons's - 2 Sherwood Ave Grey Lynn.

16 July at Jenni Churton's at 39 Wood St. Ponsonby. Ph. 768245

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ACTIVE BIRTH CLASSES

Angela Cuddihy will be running a small pre-natal group.
- stretching and relaxation exercises
- discussion on pregnancy and labour
Emphasis on active birth and use of upright positions in labour.

Enquiries to Angela ph 894 713

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POSTNATAL CARE FOR EARLY DISCHARGE FROM HOSPITAL

Auckland Domiciliary Midwives are now able to provide postnatal care (daily visits for ten days postnatally) for women wanting an immediate or early discharge from hospital following giving birth.

Immediate discharge from hospital enables the bonding between baby and family to develop unhindered and allows mother and baby to settle into feeding and sleeping patterns independent of hospital routines.

Domiciliary Midwives provide skilled and comprehensive care of both mother and newborn and assistance with the establishment of breatfeeding. All homebirth mothers will endorse the value of the personalised care and support our midwives give during their daily visits.

If you have any friends etc unable or not confident enough to give birth at home but desire an immediate discharge from hospital, please put them in contact with the Auckland HBA or with a DMW directly. We have enclosed a handbill suitable for display on noticeboards etc, if you are active in Playcentre, Parents Centre etc or have contact with Plunket, Doctors etc please ask if this can be displayed on their noticeboard. Otherwise try your local library, community noticeboard, C.A.B. etc or simply give it to a pregnant friend.

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BIRTHCHAIR

Mr Hubert Sweetman of Castor Bay has designed and built a birth chair. He brought it along to our annual seminar in November last year to demonstrate it. Several expectant mothers tried it and found it comfortable and made suggestions

is radically different to the majority of Obstetricians' and Pediatricians' point of "normal", which is in my opinion, bordering on criminal insanity.

Will the New Zealand Obstetricians and Pediatricians follow the "blood letting" example of their Americans Colleagues?

What might be the next cure for jaundice? Routine liver transplants, daily blood transfusions?

This type of interfering obstetrician belongs to a group of people described by one Obstetrician as:

"Many doctors, especially in the technologiaally developed Western part of the world do not agree with this premise (that in the majority of all pregnancies and deliveries interference is unnecessary.) They have another philosophy also an idealogy, and that is that we aan improve everything, even natural chilbirth in a healthy woman. This philosophy is the philosophy of people who think it deplorable that they had not been consulted at the creation of Eve, because they would have done a better job."

Thanks to Wendy and Davaki for the typing and Bruce for the printing.

in overloading of the systems, respiratory distress, and perhaps other unrecognised complications as well, such as oxygen insufficiency in the brain. (anoxia - hypoxia?)

In a situation where hyperbilirubinemia is caused by Rh isoimmunization, prematurity, or iatrogenic ("doctor" induced) factors, neonatal help maybe required, but in normal infants, physiological jaundice is the means of storing iron which is essential to the baby.

In the United States, where most of the babies are "drugged" through medication during labour, the neonatologists have decided that all jaundice is caused by high haematocrit levels. As has happened in all cases of obstetric "problems", instead of eliminating the iatrogenic factors (that would cut their incomes!) they are "curing" jaundice by a new cure, which has as usual not been proven to be safe, and could possibly be very dangerous. When the baby is born, the cord is cut immediately (baby is now minus 50% of his blood ...), a sample of placental blood is taken, and if the heamatocrit level is high (according to whose judgement?) the baby is bled before even waiting to see if it is going to develop jaundice or not. The baby is now minus 50% and MORE of its blood and while they might have got rid of the yellow skin before it didn't happen, what might they have caused as a result? How many more problems are they adding to the already tough life of a hospitalised baby? If this baby wasn't SICK before it was born, it sure is now. Of course, that will memely serve as justification that the procedure was needed in the first place, and that all babies are born sick.

All this has come about because obstetricians have lost sight of what is natural, and what is not. They view "normal" as what happens when theyare in charge, and base further interventions on that definition. From a babies point of view, "normal" is what should have happened if obstetricians had not interfered, and that

for modifications. Mr Sweetman has now completed these modifications and is anxious to have it tested at a birth.

The chair is designed to be placed on a bed or 3 chairs. The base is detachable and, with the chair, can be stowed in a car for transport. The reason for the base is so that the chair can be set at a comfortable angle. A hand lever, easily operated by the labouring woman raises and lowers the seat.

Anybody interested in trying the chair can contact Mr Sweetman by phoning 467 358.

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AUCKLAND HOME BIRTH ASSOC. ANNUAL PICNIC

The annual picnic was held on Sunday afternoon 10 February at Cornwall Park. Although there seemed to be some confusion between magnolias and kauris, the 25 or so families who came found each other and mingled happily for the afternoon. It was good to see a few new faces and renew acquaintances with others. We look forward to meeting more of our members at the 1986 picnic, if not before.

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ANTENATAL YOGA AND BIRTH PREPARATION

Liese Groot teaches an eight week antenatal yoga course for pregnant women and their partners/support persons. This course includes yoga relaxation and breathing techniques and general preparation for labour and delivery and is held in Ponsonby on Monday nights. If you would like to join one of these courses please phone Liese on 4139 577 evenings. Please phone relatively early in your pregnancy as these courses are quite heavily booked in advance.

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CLASSES IN PREPARATION FOR NATURAL CHILDBIRTH

Sue Hadlow teaches the psychoprophylaxis method of preparation for natural childbirth. This method is based on a series of breathing and relaxation techniques. Sue organises her classes into an eight week course for small groups of parents either at her own home in Maraetai or if there are a group

of parents in another area who have a suitable space she will come to you. The course is designed to suit people at about the 28th week of pregnancy so it is advisable to contact Sue by your 20th week if you would like to join a group. Please phone 536 5163 after 4pm.

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MUMS AND BABES CLASS

This special class includes Postnatal exercises and dance for mothers and exercise and massage for babies to increase physical confidence and coordination. This class is taken by Alison East at the Limbs Dance Studio in Ponsonby on Tuesdays - 1.30 - 2.30 pm and Thursdays - 10.30 - 11.30 am. The cost is $3 per class.

Alison also takes Preschoolers dance classes on Fridays - 9.30 - 10.15 am and 10.30 - 11.15 am.

If you are interested in coming along to any of these classes please phone Kit Suuring (Studio Manager) 762 429 or just turn up at the class.

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NEW MOTHER SUPPORT GROUPS AUCKLAND INC

This organisation was formed in response to the awareness of the isolation and changes many women experience after the birth of a child. It organised a series of weekly discussion groups in a specific neighbourhood. These groups are co-led by 2 mothers who help guide the discussion and organise such things as creche and venue. Possible topics covered in these sharing sessions include - the good things about being a mother - feeding/sleeping problems - your needs as a mother - physical changes due to pregnancy and childbirth - changes in relationships - local support networks etc.

These gorups usually meet weekly for eight weeks then the women involved decide whether they want/need to continue meeting, and on what basis. It is hoped that the groups will provide ongoing friendship, support and child-sharing.

If you would like to know more about New Mother Support Groups please contact: Fay Habib - 418 0953 or Trish Dempsey - 789 551.

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medical intervention in labour must produce a corresponding increase in the incidence of trauma.

Any drug administered to the mother, or baby, must be viewed with suspicion because there is no drug which has been proven safe for a baby during labour, and there have been NO follow-up studies by the manufactures which indicate that any of the drugs on the market do NOT have potential dangerous effects on any ar all of a baby's organs.

With regard to Sytocinon, it has been proven that the seriousness of the non-physiological jaundice is directly related to the quantity of sytocinon used during the mother's labour. The more syntocinon used, the fewer bilirubin sites on the plasma are available. D'Souza also found the same, and said that the incidence of jaundice increased 120% after the introduction of artificial inductions in 1971. He also hypothesized that part of the cause could be linked with the higher frequency of much stronger contractions than those in non-induced labour especilly when combined with routine amniotomy (breaking of the membranes which hold that water surrounding the baby inside the uterus.)

The quote which says

"... the time of cord-clamping may be involved in the pathogenesis of idiopathic respiratory distress syndrome." mentions this in various places, and at one point, mentions the choice of early clamping/respiratory distress, late clamping/hyperbilirubinemia. Presumbly delayed cord clamping decreases the risk of respiratory distress syndrome. It does not state why, but putting abnormal factors together, it could well be that a baby, deprived of 50% of red blood cells and blood volume, and pernaps depressed by a number of drugs as well, could be in a position where the lungs have to work so hard to provide enough oxygen with only half the proper amount of oxygen carrying cells that the heart-rate and blood-pressure rates are such that the strain may be too much, resulting

life. Obviously, the large size of the liver is as it is for a good reason - to cope with this process and the many others which it has to do.

In a normal delivery of a full term infant with the cord clamping left until after the placenta has delivered itself normally, without chemical (syntocino interference) physiological jaundice is a natural essential process which shows up from the third day onwards.

However, there are certain "procedures" which produce non-physiological jaundice, and they are:

1. Premature birth - before the glucoronly transferase activity has matured.

2. Drugs, such as asprin, sulphanomides (sulfadimethoxin 99 ((madribon)), sulfisoxazole, sulfadiazine) penicillin and Vitamin K analogues.

These drugs compete with the bilirubin sites on the albumin thus allowing free bilirubin to diffuse through membranes, that were impermeable to protein, into the central nervous system which can result in kernicterus, which is a condition where unexpected bilirubin is incorporated into vital cells in the nervous system usually resulting in serious impairment of the baby, or death.

The above list is not complete, because no-one knows how many others routine drugs which pass through the placenta into the baby during labour (and before) also displace bilirubin later on. However, there are two more to add to that list. Induction of labour with syntocinon, used in conjunction with epidural anesthesia has been conclusively proven to be linked with non-physiological (iatrogenic) jaundice, and this same study also implicated intrumental deliveries and ventouse extraction as contributing to non-physiological jaundice as a result of traumatic bruising of infants:

"Mothers do not inflict serious injuries on themselves or on their children. The element of trauma is introduced into labour by the doctor and any procedure which increases the need for

FORUM ON ARTIFICIAL INSEMINATION AND IN VITRO FERTILISATION

The Auckland Women's Lawyers Association Inc. is organising a one day forum on Artificial Insemination and In Vitro Fertilisation to be held on Saturday 15 June at the North Shore Teachers Training college Hall.

The purpose of the forum is to inform interested parties of the moral and legal issues involved in the aforementioned techniques and it is hoped that the forum, will promote discussion of the Justice Department's paper which is due to be released in March 1985.

This forum will commence at 9am on the 15th June and a registration fee of $7 will be charged at the door.

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AMNESTY INTERNATIONAL

Amnesty International is a non-political, non-religious organisation which works for the release of prisoners of conscience all over the world.

It works through writing polite letters to the appropriate authorities which express concern at reports of imprisonment, torture and disappearance.

For new members there is an introductory evening to outline the aims of Amnesty International and, a comprehensive handbook which describes its work and ways to help, is available.

For further information, and to join - contact the Auckland Office, PO Box 3861, Auckland or phone 34 520.

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BIRTH NOTICES

Joan Donley

12.11.84	Angeline & Allan Greensill	son, Thomas Lima (2nd home birth)	2950g
23.11.84	Anna & Ken McKee	son, Euan Robert	3540g
5.12.84	Kathryn & Brian Reay	daughter, Josie	3860g
16.12.84	Helen Adeane & Godfrey Hall	son, Michael at Waitakere, early disch.	4080g
17.12.84	Juliet & Greg Dunning	son, James (2nd homebirth)	3830g
29.12.84	Shelley & Tom Tamatoa	daughter, Sheena Boio (2nd homebirth)	3940g
29.12.84	Linda McKay & Craig Smith	daughter, Josie (2nd homebirth) Video	3630g
8. 1.85	Cynthia Young & Rhys Gardner	daughter, Cara Louise	4310g
15. 1.85	Meryl & Roger Simmons	daughter, Michaiah	2890g
17. 1.85	Trisha & Grant Dunlop	daughter, Molly (2nd homebirth)	3135g
18. 1.85	Michelle & Colin Thomson	daughter, Lise caught by Colin!	3540g
21. 2.85	Cathrine Wishart & Tom McWilliams	son, Allan NWH, early disch.	3480g
23. 2.85	Des & Clare Paget-Hay	daughter	3680g
24. 2.85	Christine & David Haskell (for Carolyn)	son (2nd homebirth)	4000g

Heather Waugh

8. 1.85	Hineware Harawira & Fa'afete Taito	son, Hone Pani	4200g

Gillian McNicoll

26. 1.85	Sue & Bruce Farley	son, Rory (2nd homebirth)	8lb 8oz

Kay Burnside

13.11.84	Jan & Graeme Tweedie	son	4150g
10.12.84	Colleen & Angus McCullock	daughter	3650g
17.12.84	Rosemary Innes-Jones & Nick Barrow	son	4750g
23.12.84	Emma & Simon Francis	son	4000g

sion

- 50% of its red blood cells.

This is what your baby is deprived of when the cord is clamped immedialely. As another study states:

"The placental blood normally belongs to the infant, and his failure to get this blood is equivalent to submitting him to a severe hemorrhage at birth."

- "deprivation of placental blood esults in a relatively large loss of iron to the infant,"

"If delayed cord clamping is adopted as a means to reduce the incidence of respiratory distress syndrom in premature births, there will be an accompanying augmentation of hyperbilirubinemia to deal with."

"Placental blood acts as a source of nourishment which protects infants against the breakdown of body protein."

This raises a serious question mark over the treatment of another condition which is directly related to the cutting of the cord, and is introduced in one of the quotes - that of jaundice (hyperbilirubinemia), and since the results of immediate clamping may affect the baby's ability to deal with this condition it is worth looking at in the context of this study.

At birth, the liver constitutes approximately 4% of body weight and occupies a considerably larger portion of the abdominal cavity at birth than in later life. After birth, the liver is the primary organ involved in bilirubin metabolism, of which at least 75% is derived from red blood cells, with the remainder from cytochromes and other hepatic heme. This is achieved by "glucoronyl transferase activity" in the liver which only becomes operational around 36-38 weeks gestation. Red blood cells, cytochromes and heme are converted to biliverdin then to bilirubin, which is then released into the plasma and immediately bound to albumin, and the iron is then concentrated in the liver cells for release during the first year of

Three independent groups each reported that early clamped infants had a much higher incidence of cardiac murmers during the first 14 days of life. While many of the effects of early clamping on the circulatory system are documented, no-one has studied the possibility of damage to the baby of oxygen transportation with only half of its red blood-cell count. Since red blood cells only start to break down on the second to third day in a non-drugged baby, all the evidence points toward the necessity to the baby of the high haematocrit levels, the higher blood pressure levels and, especially the high oxygen consumption by the newborn baby, associated with their relatively high cardiac output.

What extra strains, which are not measurable, or have not been measured, are put on normal un-drugged babies by the present routine practise of early cord clamping?

Obviously, Obstetricians regard the quantity of blood in the cord and placenta as insignificant, and therefore not worth investigating. They have <u>absolutely no statistics</u> to support this practise.

Here are some of the pubished statistics, which are well-documented in numerous studies, relating to the quantity of blood and percentage of red blood cells in the cord and placents.

From an Obstetrics textbook:

A baby's optimum blood volume is calculated at 85mls per kg of body weight.

"delayed clamping of the cord results in transfer of about 55% of the infants blood volume"

"In full term infants placental transfusion increases the blood volume of the newborn baby by 40 - 60%... such infants retain a 50% larger red cell volume dispersed through a slightly enlarged blood volume, with higher heamatocrit values that are found in infants whose umbilical cords are clamped immediately at birth."

So, to take an average figure, when the cord is clamped immediately as is now performed routinely, the baby only receives:

- 50% of its total blood volume through no placental transfu-

BIRTH NOTICES

<u>Kay Burnside cont.</u>

20.12.84	Fay & Ivan Kitson	daughter	3650g
3. 1.85	Debbie & Floyd Speedy	daughter - power	3000g
5. 1.85	Jane & Terry Logan	daughter	3700g
30. 1.85	Sandra & Jack Simpson	daughter	3650g

<u>Carolyn Young</u>

4.11.84	Bishop/Connor: Racheal & John	son	8lb 6oz
		trans. NWH after valiant effort	
7.11.84	Mullen: Anne & Peter	son	9lb 12oz
10.11.84	Beverley/Cull: Beverley & David	daughter	7lb 13oz
14.11.84	Yates: Christine & Tony	son	6lb 9oz
23.11.84	Sadler: Cathy & Ray	No 4 son	8lb 13oz
8.12.84	Stevens: Elizabeth & Paul	daughter	8lb 6oz

<u>Veronika Muller</u>

25.11.84	Odette & Paul Gillis	daughter, Jane	8lb 11oz
		(2nd homebirth)	
25.11.84	Pierette & Colin Curtis	daughter, Bronwyn	7lb 12oz
26.11.84	Ann Gill & Michael Rippon	son, Harley	9lb
27.11.84	Mary & Robert Lorden	daughter, Sarah Emily	7lb 9oz
18.12.84	Linda & Norman McGregor	daughter, Kathleen	6lb 12oz
		(planned hb, antenatal trans.)	
21.12.84	Merrylyn Hope	son, Alexis	9lb 5oz
14. 1.85	Ann Piper & Donald Shepherd	son, Billy	8lb 3oz
17. 1.85	Carol Walkley	daughter, Greer Alice	6lb 9oz
17. 1.85	Liz Mardon	daughter, Elspeth	5lb 13oz
	(Carolyn delivered this one)		
19. 1.85	Jane & Carl McDowell	son, Chase Lawson	8lb 2oz
7. 2.85	Carol & Steve Corbet	daughter, Carla Marie	7lb 2oz
		(planned hb, breech, trans., early disch.)	
24.12.84	Debbie Taylor & Ian Alexander	son, Samuel	9lb 3oz
8. 1.85	Debbie & David Johnston	daughter, Monica	7lb 9oz

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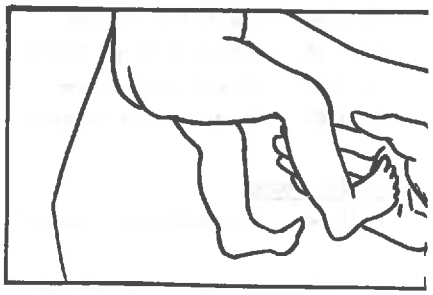
A DIFFERENT BIRTH STORY



The monopoly control of childbirth in New Zealand in the hands of obstetricians is clearly demonstrated in the following birth story. It is about a 34 year old primigravida who arrived in NZ in mid July from Tonga because her baby, which was due on 29 August, was breech. She wanted a home birth. A number of attempts were made to turn the baby with acupuncture and by the pelvic tilt - to no avail. So began the rounds of the obstetricians. Because the babe was a flexed breech - and small for dates - the conventional wisdom said she must have an elective caesarian. She was booked into hospital for 22 August.

However, Jackie is a very determined and independent young woman. She was quite prepared to have a caesarian if absolutely necessary but not without a trial of labour. So she phoned Dr Michel Odent in France and discussed the matter with him. Although he was prepared to give her a trial of labour he advised against such a long trip at this late date. Nonetheless, Jackie went ahead with her arrangements. The difficulties were numerous and time was short. There were problems of finance, air travel at 38 weeks, and she was a stranger in a strange country with no supporting facilities. Jackie left NZ on August 25, 12 hours to L.A. with a three hour wait, then 10 hours to London, a two hour wait and one hour flight to Paris. From there she took a taxi for the 50 mile trip to Pithiviers, which cost her $60. Odent was surprised to see her. He examined her and estimated her due date to be September 6. He arranged accommodation for her at a nearby farm where she could rest and recover from her grueling trip. Odent left on a prearranged speaking tour to be back on September 6. No one else on the staff spoke English.

At midnight on September 6 Jackie's waters broke with labour starting about half an hour later. She went to the hospital. She spent most of her four-hour labour on her hands and knees, being delivered in the supported standing position of a male footling breech! The cord was around his neck three times (which was probably why he wouldn't turn with acupuncture). To hasten delivery of the head Jackie had an episiotomy and the babe required oxygen. Outside of the initial few minutes for resuscitation Jackie had no separation from her baby. He weighted 2700 grams. Had this dysmature babe been born on 22 August he would no doubt have been in intensive care with respiratory distress.

ties freely, (do they get pins and needles?) provides ample space for the baby's blood from the placenta. Any mother who has watched her baby turn from a blueish colour to pink possibly wonders why this is so. I'm not sure, but it could have something to do with the circulation speeding up with the freedom of the limbs, but several American reports suggest that the tendency for hospital born babies whose cords are clamped immediately to have 'poor circulation', and blueish limbs and one can't help wondering if this could be due to the fact that they didn't have sufficient blood to do the job with 100% efficiency.

Circulatory changes are also taking place at this time, but I won't detail them as they are not relevant to this case apart from one detail: that of the Umbilical arteries.

If any clamping is felt necessary, the ONLY vessels to be clamped should be the two <u>umbilical arteries</u> which wind around the outside of the cord, but thes is not usually necessary since the arteries should close off quickly at birth. If a blood pressure gauge is placed on the umbilical cord, it can pick up pressure rises as high as 60mm Hg with each contraction which indicates that uterine contractions are intimately involved in the mechanism of the transfer of placental blood. There is also a striking rise in pressure in the vena cava, and the right atrium of the heart which persists through the first couple of hours oflife. All studies on this indicate a significantly higher systemic pressure in infants who have been clamped late (90% in the first nine hours) and conversely a very significant drop in early clamped infants (70% of systemic by second hour down to almost 50% of systemic by the fourth hour), so while the "experts" might consider an early clamped infant to be in optimum condition, this may not be the case. Until an unbiased study is conducted on this situation in a large New Zealand hospital, no Obstetrician has the right to continue this practice.

Some babies that are born must have their cord clamped immediately, if, for example, they have the cord tightly around their neck. These babies seem to do well enough, though that is hard to assess because we cannot know just how much better a baby might have done had the cord been left. It is well documented that early cord clamping can be injurious to premature babies, but it is not known what damage could be done to a healthy full-term baby, partly because it is impossible to have a 'control' for every baby born. No long term studies have been done on early versus late clamping following up babies into later life, presumably because the subject is not considered important. We would like to think that no damage is done through early clamping, but we do not know, since what a full-term 'healthy' baby appears to be at birth is presumed to be its optimum condition.

Before the baby is born his blood is distributed through the placenta and his own body. Both the blood in the baby and the placenta rightfully belong to the baby and should go to the baby at birth. Many people, including doctors, think that the baby's body is already full of blood and that the placental blood is excess, but this is not so. Before the baby is born, his lung alveoli are fluid filled which mechanically impedes the flow of blood to the lungs by keeping the blood vessels of the lungs very constricted. When a baby is passing through the birth canal, the pressure exerted all around his body forces the fluid up and out of his lungs so that when the baby comes out of the vagina the major portion of the lung surface is clear, Sometimes the baby may breathe straight away, but more often than not the baby starts breathing sometime shortly after the chest is delivered, because the chest expands instantly that it is free of the constricting pressure of the vagina. Once the baby starts breathing the blood starts to flow freely through the baby's lungs. This combined with the fact that the baby is no longer restricted by the mother's uterus and can move all extremi-

Because Odent wanted to monitor the labour Jackie was not in the pool. She found labour very painful and says she did a lot of yelling. She spent three days in hospital. The cost of this was $500 and included routine lab tests and consultation and delivery by Odent. Pithiviers is a state hospital.

On her way back to Tonga on 27 December Jackie feels great. Her content fully breast fed baby weighs 19 pounds.

Besides the rigid and arbitrary NZ obstetric 'standards' this story also shows the effect of the mind on childbirth. Although armed with contact addresses and phone numbers of people involved in alternative childbirth in L.A. and London Jackie said she was quite determined not to come into labour before she arrived. She "held the baby in" she says. And even though more relaxed because she had made it to Pithiviers it's interesting that her labour did not commence until Odent returned.

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NEWS FROM THE SUPPORT GROUPS

South Auckland

The first antenatal class for 1985 was held at Liz Ritchies on the 14 February. Midwife Kay Burnside was at the meeting and several couples talked about their recent homebirths. A very successful meeting. Now that South Auckland has a midwife again there is a lot of enthusiasm in the area.

The remainder of the February antenatal classes will also be held at:
Liz Ritchie's
Unit 5/34 Wellington St
Papakura
ph 298 3174
starting at 7pm.

28 February: Val Cooksley on Shiatsu massage for pregnancy
14 March: Nutrition & immunization
28 March: Family Planning

There is a charge of 50c/family or bring a plate. The library is also held at Liz's place.

On 17 April at 10am at Liz Ritchie's place there will be an informal get together to cover Homebirth library books. Again everyone bring a plate. All welcome.

Next committee meeting is on April 2nd at Mary Mark's, 3 Clark Rd, Papakura, ph 298 3975. Everyone welcome. The main business will be to discuss the next series of antenatal classes planned for June-July this year.

North Shore

Antenatal classes were held in February in the rooms of Dr Phil Railton at Takapuna and attended by 12 couples plus support persons.

5 February: Joan Donley spoke on nutrition and Ray Sadler described his supportive role before, during and after his wifes birth.

12 February: Relaxation & exercise was discussed, with liese Groot speaking on antenatal yoga and breathing techniques.

19 February: Carolyn Young covered the process of coping with normal labour and delivery. Dr Phil Railton spoke on the Drs role, safety aspects and reasons for transfer. Cathi Sadler talked as a mother about her recent homebirth experience and reasons for making this choice.

We would like to thank all the speakers for their time and offer our congratulations to Cathi & Ray on the birth of their most handsome son!

26 February: Was a general discussion on all subjects covered in the previous classes plus guidance in preparation for breastfeeding.

5 March: Homebirth video evening to familiarise parents with the birth process.

Would any persons still holding library books from the Nth Shore Group library please return them by delivering or posting to: Felicity Wilson, 102 Calliope Rd, Devonport.

For further information about Nth Shore antenatal classes, please contact Ngaire Montaut, ph 451 845.

Tina Hoyle of 10 Hebe Place, Birkenhead, is hoping to organise a garage sale for the end of March to raise money to buy an oxygen cylinder for the Nth Shore "midwives kit". If anyone can help with a venue, please contact Tina at the above address or phone her on 439 228. Also please contact her if you have any saleable items or know where a dental oxygen cylinder can be bought cheap!

The next coffee mornings will be held at Highbury Community House, Hinemoa St, Birkenhead at 10am on 22 April (when Mary Lorden will speak on Massage) and 24 June. Everyone welcome. Any enquiries re this ring Carol Dye 4180 610.

between the muscles' stucture. These gaps are closed when the placenta retracts, and the uterine walls contract squeezing the remaining blood out, and shutting off the blood vessels, When the cord is left unclamped the blood flows freely to the baby, the shrinking placenta comes away easily and quickly, and the uterus rapidly closes off the blood vessels. However, if the cord is clamped, the counter-resistance from the placenta can be so great that retraction may come to an end, the placenta then separating, (if it does,) by retroplacental blood, which is not normal. Because the placenta is bulky and blood-logged expulsion can be difficult, and if expulsion does not occur, the inevitable result is that in a certain percentage of cases, the placenta will be retained with associated postpartum haemorrhage caused by "free-floating" blood, and imcompletely closed uterine blood vessels. It has been proved that this practice prolongs the average duration of the third stage, and greatly increases blood loss.

It is therefore obvious that anything which promoted retraction will quicken separation and expulsion and reduce blood loss. This can only be acheived naturally by allowing the placenta to remain intact, or in cases where the cord must be cut to allow the other end to bleed freely. In both these methods the placental volume is reduced and therefore uterine contents are reduced by approximately 90mls of blood, retraction takes place, and contraction of the uterus squeezes more blood out of the placenta reducing its size futher, and supplying the baby with the blood in the placenta and cord.

For mothers with a rhesus factor this is very important, since it has been proven that in rhesus-negative mothers who bear rhesus positive babies, few mothers develop antibodies when the separation of the placenta is spontaneous with the cord unclamped. These results emphasise the importance of the third stage of labour and support other findings that the major risks occur at this time.

told them "wash your hands you damn fools!" he was run out of town, and died in a lunatic assylum, even though he had proved his theory in his own hospital.

Up until 1861 delivery of the placenta was completed either by pulling on the cord, or by passing the hand into the uterus in order to remove it manually immediatly after the birth of a child, and childbed fever was rife by then. Semmelweis noted that in his hospital, the women did not fear the Nuns, or the midwives, but they were terrified of the doctors, and he later wrote that these women "believed that the doctor's interference was always the precursor of death." And they were right. And yet, in cultures where men have not got into the maternity field Puerperal fever has never assumed the significance which it has in westernised society, because these so called primitive people allow the cord and the placenta to do the job it was designed for.

The function of the uterus in the third stage is to seperate the placenta, expel it, and control haemorrhage. This is effected by contraction and retraction. At delivery there is already micro separation, due to the retraction that takes place in the second stage. The placenta separates because it cannot reduce its surface area, but the area to which it adheres does reduce. This separation can be illustrated by sticking a postage stamp to a piece of stretched elastic. When the elastic is allowed to shrink (contract) the postage stamp will peel off (retract). As the uterus contracts downwards from "chest to vagina" the placenta is forced in the direction of least resistance towards the vagina. If the cord has not been clamped this process is so rapid that retraction has not yet taken place in the cervix, and the placenta, reduced in size is expelled without resistance into the vagina. If the mother is squatting it will fall out by gravity.

The uterine walls contract using the criss-crossing action of the muscles. The blood vessels supplying the placenta run in

Auckland Central

A new series of antenatal classes started on 26 February and will be held fortnightly for a total of four sessions from that date. These classes are held in Dr Nash's rooms, 4 St Stephens Ave, Parnell at 7.45pm. Any enquiries re these classes to phone 799 109.

The next series of antenatal classes will begin after the May holidays.

Coffee mornings: The Auckland Central group are organisisng a series of coffee mornings. All homebirth parents, children and babies welcome. These will be held at 10.30am at:-
12 March: Karen Johnson's, 196 Carrington Rd, Mt Albert, phone 863 080
26 March: Marie Martin's, 38 Milton Rd, Mt Eden, phone 605 558

West Auckland

The February series of antenatal classes in West Auckland have gone really well with an average of 30 couples at each.

The next series will be in September. Any enquiries about West Auckland homebirth support group to Adrienne Peat, 12 Alan Ave, Henderson, phone 83 1537.

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AUCKLAND MIDWIVES UP-DATE

Auckland domiciliary midwives enjoyed a social/sharing session in January.

Report from Veronika: Meeting of Domiciliary Midwives & Health Department

On the 31.1.85 the domiciliary midwives had their 2nd meeting with the Health Department (represented by the principal public health nurse). It was hoped that each PPHN from the 3 areas would be present but only Mrs Peterson (central PPHN) was available, Mrs A Nightingale (Principal Nurse, St Helens) has attended both meetings and there have been about 6 Domiciliary Midwives attending each time.

To be able to discuss matters arising from our work, over the table has been very useful and positive. A lot more is achieved than by written communication. We hope that these meetings will result in changes being made that will improve the home birth service, improve communications between the Health Department

and Domiciliary Midwives and make our working conditions better. These meetings will continue 4 monthly.

Midwives Sharing Skills

Over the last few months the midwives working around Auckland have been having get-togethers to discuss our work, issues involved with it and practical midwifery. This is of particular benefit to those of us just stepping out into domiciliary practice as it is definitely very different from working in a "sheltered" hospital environment.

A lot of knowledge and information is shared, and recently a few of us have started delving into acupuncture, practicing on each other.

We are trying to keep these meetings going every 2 months.

We miss Anne Sharplin who, with her husband Barry, has gone to live in Nelson - but she has promised to return in a year. Her address in Wangapaka Study & Retreat Centre, Wakefield, R.D.2, Nelson.

Before she left Anne took on the long outstanding job of preparing an information bandbook for the Auckland midwives. It outlines Departmental procedures and officers, geographic boundaries, relevant names and addresses and where to get supplies, etc. It is attractive and useful, especially for new midwives starting up in Auckland.

American midwife, Lorie Brillinger visited briefly and was very interested in the New Zealand scene since she once worked here. She along with another midwife and a couple of doctors are opening a shared care, equal status clinic in Berkeley, Calif. Lorie took out subs to our newsletter and to that of Save the Midwives so she could keep in touch.

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mid-wives were hunted out and burned at the stake as witches, the cord was not cut at that stage. The midwives left well alone, knowing that nature had designed our bodies properly, and women delivered their babies standing, squatting, or on a birth stool using gravity to its best advantage, and proceeding much as the Bantu women do today.

In 1737 a man called Mauriceau published a book on women's illnesses called " Traite des Maladies des Femmes Grosses". This timely pulication was widely used since most midwives were killed, dead, or somehow hiding in the woodwork to save their skins, and since, of course, no one took any notice of "witches" none of the up and coming physicians knew the first thing about having a baby, so they were eager for the knowledge of such an esteemed gentleman. This 'knowledgeable' gentleman decided that the active management of the 3rd stage should involve the cord being imediately knotted and cut, and being afraid that the uterus might close, he recommended that the sick patient be relieved of the placenta imediately by turning the cord 2 or 3 times round the left hand, pushing the fingers of the right hand into the vagina to keep the uterus up, and pulling the placenta out. He futher warned against a forcefull pull, because the cord might break off, resulting in a retained placenta, or inversion of the uterus. Presumably he had learned that from experience!

The chances of having a retained placenta were fairly high when young enthusiasts pulled too hard, and the then treatment was to reach in and pull it out. Fine; but where had that hand been previous to that? In the body of a plague victim perhaps? A woman in 'child-bed' soon became synonymous with a woman in 'deathbed'. It is ironic that those women who refused to go to hospitals, refused the ministrations of the 'experts' fared far better than the rest of the population,

When Ignacz Semmelweissa, who twigged onto the doctors'folly

Cutting of the Cord by Hilary Butler.

The literature on the consequences of early clamping of the cord is not extensive; however, the consequences of this routine procedure are potentially disastrous, and seemingly ignored by the vast majority of personnel in the maternity field, presumably they have not had the time to read the research, and probably missed the relevant sentences in their huge text books thereby relying on techniques which were shown to them by persons who were also shown the 'in' technqique, and never bothered to find out the ramifications of what they are doing, why they were doing it and how it came to be done that way. Very few people within the hospital setting seem to have any appreciation of the way nature has equipped a woman's body to deal with the whole aspect of placental delivery, and as a result of what might be termed "power obstetrics" have superimposed their own ideas on nature. Unfortunately for women, nature has a knack of firing right back when her designs are tampered with.

The majority of races, when left to their own devices and not influenced by medical preconceptions, deliver their babies in an upright position using gravity to its best advantage . In South Africa the Bantu people believe that it is completely wrong to touch the cord until the placenta is expelled. The woman delivers her baby by squatting and remains in that position watching her baby until the placenta delivers itself. Then, and only then, the woman turns her attention to the cord. The author of this study worked amongst the Bantu for 10years, and attended 26,000 Bantu cases seeing only abnormal cases. In that time he seldom saw a retained placenta (retained placentas he saw were usually in the vagina, not in the uterus, so could hardly be termed as retained in the obstetric sense) and he stated that he never saw a post-partum haemorrhage needing a blood transfusion.

If this is "normal", then why is there such medical paranoia surrounding 3rd stage labour? It appears that up until the time when

SOME INTERESTING HIGHLIGHTS FROM ASSOCIATION OF RADICAL MIDWIVES CONCERNING A SKILL SHARING WORKSHOP IN THE THIRD STAGE OF LABOUR, WITHOUT SYNTOMETRINE

A retroplacental clot and/or a show of blood in the third stage does not occur if the placenta separates normally and the membranes remain adherent until pulled off as the placenta descends.

If the cord is clamped and the placenta unable to empty of blood, the bulky placenta will impede the uterus in contracting efficiently. The babe receives its physiological transfusion of blood from the placenta to compensate for the blood now circulating in the newly expanded lungs.

Touching the fundus in the 3rd stage - "fundal fiddling" can lead to partial separation of the placenta and membranes leading to haemorrhage. Reference is made to Ian Donald's textbook of Obstetrics, on what NOT to do as well as what to do in an emergency. Those midwives who left the fundus along notices less blood loss.

The 3rd stage needs to be talked about antenatally so women are mentally aware of their role to deliver the placenta actively - rather than switching off as soon as the babe is born.

W.H.O. has expressed concern about the occurrence of inverted uteri in India since traditional birth attendants have been taught to cut and clamp the cord, then pull on it. In some cultures, says ARM there are strong taboos on touching the cord in the 3rd stage - perhaps we should consider such a taboo. W.H.O. are planning a research project to evaluate the use of oxytocics in the 3rd stage.

One midwife said she gets the husband to stroke or suck his wife's nipples in addition to the babe's suckling. This needed a relaxed and intimate atmosphere.

J.D.

In the National Newsletter, vol 2 no 2, June 1984, Prof Bonham in "Whither Obstetrics" claims, 1982, that about 60 per cent of pregnancies and confinements are supervised by family doctors. A Department of Health Report, 1977 gives the following figures.

	1971	1976
General practitioners	64.6%	53.1%
Specialist obstetricians	14.4%	11.2%
Public hospital staff	21.0%	37.5%

Obviously it is the training of doctors that uses up the 'clinical material'. However crediting the G.P.s with a higher number helps to make the case to squeeze them harder.

UPDATE ON STRATEGIC PLAN

The A.H.B. is now discussing the Strategic Plan at the 3 weekly public meetings of its Planning Committee. Chapter 1 was covered at the last meeting with very little discussion; most of the submissions were presented as a 5 line summary, and the new version of chapter I was presented having been already rewritten !! without any input from Hospital Board members.

It is essential that people go to these meetings to see how their submissions have been dealt with and to make the elected members of the Board aware that they are being observed. If we build up the members at every meeting and have 100 mothers and babies present when the Maternity Services chapter is discussed, in approx 5 months, the Hospital Board will finally realise that this IS and important issue.

A MATERNITY ACTION GROUP has been set up to develop and improve Maternity Services particularly by counteracting the A.H.B. Strategic Plan. The group is a broadly based coalition of representitives of concerned groups including N. Shore Parents Centre, A.H.B.A., West Ak. Womens Centre, Ak. Childbirth Education Assoc., Save the Midwives, Helensville Hospital Community Committee, East Ak. Parent Centre, New Mothers Support Groups Inc., Womens Health Collective. A RALLY outside the A.H.B. building is planned to coincide with the Board's meeting to discussthe Plan. RALLY MON. 29 APRIL A.H.B. Building. KEEP THIS DATE FREE ! More details by phone tree closer to the date.

OG WATCH

"Inexperienced and guillible young women are easy prey to the false message that birth is a simple matter. physicians must teach them that complications are common."-Ranny Brooks M.D. Pres. ACOG (1982)

'Fashionable' Births Risky Says Doctor

NZPA

A British doctor says that the fashion for natural childbirth methods is putting the lives of babies at risk.

Dr Herbert Barrie, consultant paediatrician at London's Charing Cross Hospital, says doctors are being confronted by women with "familiar" and "lethal" shopping lists of demands.

"At the top of the list is their insistence that the birth should be natural whatever the means," Dr Barrie writes in the Royal College of General Practitioners' Faculty News.

"This year it is having the baby in the squatting position . . . last year it was under water.

"Next year it could be hanging from chandeliers."

Dr Barrie's warning follows a Government report earlier this year which said that mothers should normally be allowed to give birth in the position of their choice.

Dr Barrie says that, as adults, mothers were "within their rights to reject professional advice for themselves. But they are not entitled to tell doctors how to do their work."

"In this hospital we have no particular axe to grind with patients who have their own ideas and we try to accommodate all ideas, providing always that we can get a safe delivery. The nine to five service is something that has been, to a large extent, forced upon us due to staff shortages. There is no doubt that manning during the day is at a much higher level than at night and it is, therefore, clearly safer to have your baby during the day. If at all possible, and since the aim of our induction policy is to get healthy women and healthy babies I think the more controlled the delivery the better. There is no merit in rushing into hospital in the middle of the night as an emergency whereas if induction is planned at an appropriate time it can be done calmly with experienced people available to deal with the emergencies.

"From time to time we get patients who have attended special classes asking for delivery in particular positions, the one that caused most controversy recently was, of course, the Frenchman in the bath with his mothers. I don't swim so I don't practice this method. Other methods we can accommodate providing the midwives who are on duty at the time are skilled in the techniques. When patients particularly ask me if they can be delivered in the squatting position I generally point out to them that lying on their backs with their legs pulled up is doing it the easy way — squatting lying down."

Mrs C. Skelding, Staff Midwife, Freedom Fields Hospital, Plymouth, U.K. Reprinted from AIMS Quarterly Journal Summer 1984.

Doctors at National Womens Hospital (Ak) are reported as saying:-"It is very difficult for us to deliver in a squatting position."(!!!)

All it takes to call yourself a midwife is big shoes, greasy hair, an ill-fitting dress, and an abiding hostility towards the medical profession."-Jerald Lucey M.D.Chief of Newborn Services,Burlington,Vermont(1978)

CONTRIBUTIONS WELCOME.