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MIDWIVES
DELIVER
BETTER
BIRTHS

MATERNITY ACTION FOCUS:

1. To oppose the unnecessary medicalisation of childbirth
2. To emphasize & facilitate the partnership between consumers and health professionals
3. To highlight the need for and availability of birth options and choices (ie.homebirth,small hospitals,birthing centres)
4. To encourage families to participate fully in their pregnancy, birth and parenting
5. To share information & ideas; and to explore alternative patterns of care

MATERNITY ACTION

Save The Midwives

JULY/AUGUST 1992

NUMBER 27

COPING WITH THE TRANSITION

The legislative changes enabling midwives to resume practice as practitioners in their own right has led to a time of transition and adjustment which has been both heartening and frustrating. The choices for women have increased significantly and women are now more able to have continuity of care and a midwife of their choice. Midwives are able to practice more creatively and provide services better suited to the women they care for. Women are becoming better informed about the advantages of midwifery care and are participating more in decisions about their pregnancy and birth.

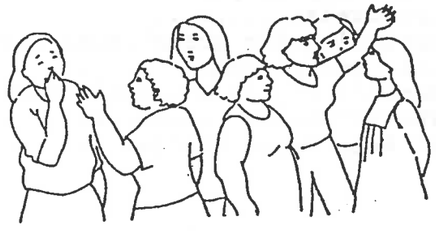
However the professional and territorial issues have managed to intrude into the brighter aspects of these changes with the medical profession trying to undermine midwives by raising unfounded doubts about their safety and by suggesting they are abusing the maternity benefit. At a time when every aspect of the health system is under review it is interesting to note that only midwives as a profession have produced standards for practice. However, it is particularly important that the commitment to work collaboratively together continues and is not lost.

Another success story is the achievement of direct entry midwifery programmes in this country. Although Katherine O'Regan decided to only approve two experimental programmes which require evaluation before further intakes are possible, courses are up and running at Auckland Institute of Technology and Otago Polytechnic. In a letter to Maternity Action/STM Katherine O'Regan stated the reasons for her decision. She wanted one experimental course in the North Island and one in the South Island. The Auckland Institute of Technology was chosen because they already had an established school of midwifery.

Women and midwives can help improve the chances of direct entry being accepted as a "normal" course by writing to urge the Minister to allow intakes to continue during the evaluation process and for the evaluation to be undertaken as soon as possible. It is also a good idea to keep on reminding them that there is considerable support for direct entry midwifery.

Thank you to those of you who have provided information for the newsletter - in particular Joan Donley and John Stevenson who willingly provide an ongoing source of material.

Judi Strid



This pregnancy:

Estimated gestation (%):

36-37 weeks	38-40 weeks	41-43 weeks	44 weeks
3	63	34	0.1

Smoking (%):

Never in pregnancy	0-5 cigarettes per day	6-20 per day	More than 20 per day
89	6	5	0.3

Procedures in pregnancy (%):

none	ultrasound scan	amniocentesis	cervical suture	other	unknown
42	55	3	0	1.5	0.2

Labour & delivery:

Place of birth (%):

home	hospital (antenatal transfer)	hospital (intrapartum transfer)	other
84	0.4	14	1

Labour onset (%):

spontaneous	medically induced	surgically induced (ARM)	no labour
98%	1%	0.7%	0.4%

Procedures in labour (%):

46% of births (51% of those born at home) had none.
Of those that did, some had more than one.

	homoeo-pathics	acupuncture	ARM	sutured laceration	pain relief drugs	episiotomy
all births	34	7	16	18	7	4
birth at home	31	0	13	18	0.4	0
transfer	50	47	34	14	42	25

Presentation (%):

vertex	pop	breech	shoulder	other
97	2	0.8	0.1	0.2

Type of delivery (%):

spontaneous cephalic	spontaneous breech	forceps	ventouse	caesarian	other
93	0.4	3	0.5	3	0.2

Complications of labour (%):

none	foetal distress	prolonged labour	retained placenta	antepartum haemorrhage	cord prolapse	other
83	3	8	1	0.8	0.3	3

Third stage (%):

	normal physiological	active management	unknown
All planned home births:	84.5	15	0.5
Birth at home:	91.6	8.3	0.1

Apgar score of 9 or 10 (%):

	At 1 minute:	At 5 minutes:
All planned home births:	71	97
Birth at home:	73	98

Resuscitation (%):

	none	oxygen	other resusc.
All planned home births:	93.5	5.5	1

Vitamin K (%):

	not given	oral	intramuscular
All planned home births:	56	24	19
Birth at home:	62	24	14

Meconium staining (%):

none	old	slight 1st stage	thick 1st stage	slight 2nd stage	thick 2nd stage
86%	3%	4%	1%	3%	2%

Blood loss (%):

	less than 250ml	250-500ml	over 500ml
All planned home births:	63	30	7
Birth at home:	67	28	5

Oxytocics (%):

	not given	intramuscular	intravenous
All planned home births:	78	15	7
Birth at home:	86	13	1

Complications of puerperium (%):

	infection:						
none	urinary	genital	breast	venous thrombosis	secondary pph	postnatal depression	other
1%	9%	35%	39%	14%	2%	0.3%	

Postnatal care of mother (%):

If birth at home:			If birth in hospital:	
remained at home	transfer for treatment	transfer to accompany baby	normal discharge	intensive treatment
86	3	4	1	3

The baby:

Sex:

male	female
52%	48%

Condition:

live born	still born
99.7%	0.3%

Birthweight (grams):

	average	minimum	maximum
All planned home births:	3637	1750	5275
Birth at home:	3647	2200	5275

Postnatal care of baby (%):

If birth at home:			If birth in hospital:		other:
remained at home	transfer for treatment	transfer to accompany mother	normal discharge	intensive treatment	
86	3	4	1	3	3

Congenital anomalies:

3.3% of babies had some kind of congenital anomaly. Of babies born at home, 2.6% had a congenital anomaly.

Neonatal morbidity (%):

none	extreme prematurity	jaundice with phototherapy	infection	birth injuries	other
93.6	0.2	2	2.6	0.2	1.3

Feeding at two weeks (%):

breastmilk only	breast plus supplement	bottle feeding
98.2	0.8	1

1148 births were analysed. 974 of these births were at home.

As most of these cases occurred in the spring and summer, it seems obvious that the mother contracted a viral infection during the winter which crossed the placenta. Because viruses have a predilection for the liver and mucous membranes, they can affectintestinal absorption and liver function. It is unusual for a virus to persist for months but it can happen and this is a rare disease. A persistant virus infection weakens resistance and stamina. I feel confident that babies affected in this way would be listless, irritable and slow to thrive. Such babies should be watched carefully for warning bleeds or spontaneous bruising.

NATURAL SOURCES OF VITAMIN K

As a baby has an immediate need for Vitamin K following birth Queensland researchers have advised women to ensure they include Vitamin K in their diet, particularly in the latter stages of pregnancy. The major food sources of Vitamin K are green leafy vegetables and soya beans.

...AND THE VITAMIN K INJECTION

The British Department of Health is setting up a working party which will examine whether the Vitamin K injection routinely given to newborn babies might increase their risk of developing cancer. A study by Professor Jean Golding of the Institute of Child Health in Bristol suggests that Vitamin K injections may double the chances of leukemia. As well as a statistical link between cancer and the vitamin K treatment, a link between childhood cancer and mothers treated with pethidine has also been noted.

Roche, the company that manufactures vitamin K, gave Professor Golding funding for a follow-up investigation. In this latest study no link with pethidine was seen but there was a two-fold risk of leukemia in children who had received injections of vitamin K, but not those who received it orally.

NZ Home Birth Statistics 1991

Mother:

Marital status (%):

married/ defacto	single/ unmarried	separated	divorced	widowed	unknown
93	5	1	0.3	0.1	0.6

Ethnic group (%):

Caucasian	Maori	Pacific Islander	Asian	other	unknown
89	7	1.3	0.5	1.4	0.2

Age (%):

15-19	20-24	25-29	30-34	35-39	40-44	45-49
1	9	35	39	14	2	0.3

Highest education completed (%):

secondary 1-2 years	secondary 3 years	secondary 4+ years	tertiary	graduate	unknown
2	18	26	28	23	2

Previous pregnancies:

19.4% had never been pregnant before this home birth. (80.6% had at least one previous pregnancy, with the outcome of some of these being a miscarriage or termination.)

RESTRUCTURING OF THE HEALTH SYSTEM

The massive restructuring of the health system will have implications for maternity services. The maternity benefit is expected to go, so funding arrangements for practitioners providing maternity care will change.

Midwives are likely to receive funding via a contractural arrangement that will outline specific criteria including access to facilities and certain outcomes will probably be specified. There is no way of knowing how this will affect women's choices.

The Obstetric Regulations have been recently reviewed so there could be changes in this area as well. Changes to ACC mean it will be more difficult for people to receive compensation for medical misadventure and more likely that there could be cases brought against a practitioner through the courts.

An increasing number of practitioners are looking at the need for indemnity insurance and both the NZNA and College of Midwives offer an indemnity package for midwives.

Also under review is the whole area of professional disciplinary procedures. The very important Health Commissioner Bill if passed in its present form will provide a nationwide network of patient advocates, a Code of Patient's Rights and a place for health consumers to take complaints.

There is concern that the opposition from the medical profession to the proposed Health Commissioner Bill may undermine its present form resulting in a less effective compromise.

Next year the 14 area health boards will be replaced by 4 Regional Health Authorities (RHAs) and a Public Health Commission (PHC) which will all have purchasing powers. David Skegg an epidemiologist from Otago has recently been appointed as the chairman of the PHC and various business men have been appointed as the chief executives of the RHAs. The exact role of the PHC is still not clear, but it is expected that it will determine public health policy and purchase public health services while the Department of Health will have a monitoring role.

Crown Health Enterprises (CHEs) will be created around existing hospitals and community health services. The Minister of Crown Health Enterprises is Paul East.

CORE HEALTH SERVICES

The concept of defining core services is also a part of the proposed health changes. The intention of the present government is for a core health services list to be defined at a national level to describe health services that RHAs must ensure exist for the people in their region. The defining of core health services is expected to be quite broad and maternity services are likely to be included although it is

impossible to tell what the definition of maternity services will be and if it will include the postnatal period for example.

A National Advisory Committee on Core Health Services (NACCHS) has been established with Sharon Crosbie as the chairperson. This committee will advise the government on what health services should be in the core. It will conduct a stocktake of existing services, looking at their cost, effectiveness, the range available and their distribution around the country.

NACCHS is expected to consult widely with the public and health professionals. It will recommend annually to the Minister of Health which core services should be purchased and how they should be distributed.

PUBLIC HEALTH COALITION

- is alarmed at the moves to privatise the New Zealand Health System and is encouraging people to write to the Health Ministers and their local MP to voice concerns about the changes. Of particular concern are the appointments of business men to the top RHA positions who have no background or previous involvement in health, and the emphasis on the market model. Decisions are being made without widespread consultation with the community and health workers and it is unacceptable that health care is run as a profit making enterprise.

There are fears that we are heading the American way which costs a huge 22% in administration compared to our 8% at present. Since user charges were introduced there has been a 30% drop in attendances to GPs and there are increasing reports of people not filling prescriptions or attending outpatient appointments because of the cost. The number of patients not paying hospital bills remains very high as people object to the charging of health care in this way.

The Coalition For Public Health is dedicated to maintaining a publicly-funded, quality health system available to all on the basis of need.

An information kit about the health changes which includes overheads is available for $15 from the Coalition, PO Box 6645, Wellington (ph 04-384 2222)

paediatrics, midwifery and an encyclopaedic medical disctionary, the only figures I found were in Townsend (one case in 400-500) and in Beischer who studied under Townsend (about two per thousand). These figures do not agree with my series in which I had no cases in approximately 500 hospital births followed by 1300 home births. So the incidence has to be substantially less than those figures, at least amongst homebirthers with their fresh vegetable diets.

The data collected also shows that late haemorrhagic disease of the newborn is relatively common, and frequently associated with intra-cranial haemorrhage. The incidence increased in the summer months (also recoded in Japan). The research had some problems with frequent mistakes, misunderstandings and mis-diagnosis. Of the 27 cases, 19 had not been given Vitamin K and six had recived an oral dose. 17 cases were of the late type and ten of these developed intra-cranial haemorrhage. Two of these died and there was concern about the future mental health of the others. The two doctors concluded that all babies should receive Vitamin K preferably by inkection, or if orally, by repeated doses as a preventative measure. Extra vigilance and investigation are essential after warning bleeds from the nose, mouth, rectum, umbilicus, Guthrie test or spontaneous bruising.

The third article is a discussion and summary by two paediatricians. They discuss the variability of policy around Britain, where some units give Vitamin K by injection to all babies, others give it orally to most and injection to a selected few, whilst others only give Vitamin K to a select few. They also refer to modifications over the years, and the tendency to increase coverage and the injection method. They mention the danger of giving the wrong injection, which could be a fatal mistake and the considerable variation of dosages used in different units. They also mention the worries of some groups that Vitamin K might have adverse, delayed or long-term effects.

I must add some further comments. These three articles are by doctors and for doctors with no consideration of parents' views. I believe it was my skill in evaluating and trusting the intuition of the parents that was the key to my success in homebirth practice, and I remain confident in supporting their refusal to let their new born baby be injected. More progress could be achieved by open discussion and listening to interested and thoughtful parents, than by statistical surveys and decision-making behind closed doors. I feel sure that intensive dietary education of pregnant women would make a beneficial difference, and that prompt response with intra-muscular Vitamin K to warning bleeds or spontaneous bruising would generally prevent disasters.

The late onset cases pose an interesting problem. Most cases presented in the second or third month or later. Oral propylaxis was ineffective because Vitamin K was not absorbed from the intestine, and the serum deficiency was prolonged and increased. Tests revealed that liver function was poor and inefficient, and this was the group that experienced the most disasters, especially intra-cranial haemorrhage.

THE VITAMIN K CONDRUM

BY DR JOHN STEVENSON
AUSTRALIA

An old English proverb states "When Drs disagree, disciples may go free". This probably pre-dates Alexander Pope's celebrated assertion. "Doctor" in this context means not a medical practitioner but a teacher, a university graduate, and a specialist in the subject he taught. The proverb could be modernised to "When experts disagree, commoners are not bound", or "When professors cannot reach agreement, their pupils may compute their own deductions". These concepts might appear frivolous, but women will recognise their relevance; especially in relation to choosing a midwife instead of "doctors of obstetrics" who so often shift their ground.

Perhaps its most appropriate application is to the question of Vitamin K injections for the newborn. The very latest concepts amongst medical authorities are clearly set forth in three articles in the British Medical Journal, vol 303, number 6810, 2 Nov 1991. These articles indicate considerable disagreement amongst doctors, giving parents the room and the right to make an informed decision on this contentious subject. They need the most thorough information available and in comprehensible terms rather than medical jargon. They would naturally look to their midwife to supply such information.

The first article is a one-page editorial giving an historical review. Almost 100 years ago, a bleeding syndrome in newborns, not due to trauma or inherited disorder was recognised and called "haemorrhagic disease of the newborn". 50 years later, deficiency of Vitamin K was identified in the syndrome, and Vitamin K was given to mother or baby as a prophylaxis. However, doubts about its effectiveness or necessity persisted, and resulted in different policies of treatment in different nurseries throughout the British Isles.

In 1983, two types of haemorrhagic disease were identified. The so-called "classical" type affects babies in the first few days of life, whereas the "late in onset" type struck in the second or third month. It was noticed that the majority of affected babies in both groups were exclusively breast-fed. It was also noticed that, although most new-borns are very deficient in Vitamin K, the early or "classical" haemorrhagic disease was surprisingly rare. Oral Vitamin K was effective as a prophylaxis in the early group, but not in the late onset group, which needed injection.

The second article is the report of a two year prospective study of haemorrhagic disease of the newborn in the Bristish Isles. During the two years there were 27 cases of haemorrhagic disease reported amongst 1,671,000 live births, the majority of whom would have had some form of Vitamin K. This is an incidence of 1.62 per hundred thousand, or a percentage of 0.00162. I tried to find the incidence before prophylaxis was established around 40 years ago, but after searching many text-books of obstetrics,

MATERNITY INITIATIVES

Ten primary health care initiatives have been funded by the Health Reforms Directorate which is looking at innovative approaches to delivering health care services. Three of them include the provision of maternity care. Two of these are in Wellington and one is based in Auckland at the Papakura Marae.

PAPAKURA MARAE PROJECT

A maternal and infant health service is to be established at Papakura Marae for Maori women and their pre-school children. It will primarily be an integrated service to address the childbirth related needs of Maori woman and their infants.

This pilot scheme plans to demonstrate how a radical change of emphasis from a pakeha directed health service can be changed in accordance with the principles of partnership inherent in the Treaty of Waitangi, to one which both identifies and meets the real needs of Maori women as they exist today.

The service will provide:-

1. Full maternity care for Maori women from first contact in pregnancy through birthing to the end of the immediate post partum period at six weeks.

2. A wide range of associated health services related to reproductive and gynaecological functioning.

3. Support services for the care of the infant from birth to one year.

The service will be controlled by Te Tangata Whenua of Papakura Marae in consultation with the primary health care providers. Once established, the service will demonstrate its potential for being transferable to any Maori community in New Zealand.

The contact people for the project are Jilleen Cole or Lil Joyce ph Papakura Marae (09) 299-8492.

WELLINGTON DOMINO MIDWIVES PROJECT

The Domino Midwives group in Wellington will trial bulk funding to provide comprehensive maternity services to approximately 180 women over the next year. During the trial the present fee-for-service payment will change so all subsidies likely to be paid to the midwives over this period will be given to the group as a bulk amount.

The domino midwives will be working from the philosophy that birth is a normal process, not a medical event. They will provide continuity of care from antenatal classes through labour and birth to postnatal care. Independent midwives will be looking to data from this trial project to demonstrate the cost-efficiency and quality of their services.

Planning for the bulk funding trial has also taken account

of births needing medical intervention. Although most women should be able to receive all their care from a midwife, there is a percentage of cases for which the midwife will need to arrange medical assistance. The group has stated their intention to look at intervention rates and client satisfaction in order to provide a service that is better for both mothers and babies.

WELLINGTON WOMEN'S HOSPITAL DELIVERY SUITE

have a special morning tea on the first Friday of every month at the delivery suite for pregnant women, their partners and children to come and meet the team of midwives who work in the delivery suite.

Projects selected for funding

1. Developing a primary care network in Tauranga

The aim is to enrol primary care providers into a network that can provide comprehensive primary care services to its customers. The network aims to provide an efficient service with an emphasis on quality and meeting patient needs. Consumer input will be included in developing the network.

Initially the project will link GPs and clinics throughout the area. A steering committee will also look at other services to be included.

2. Polynesian health service centre for Auckland

A feasibility study on establishing a health service for Pacific Island people in Auckland. Such a service would be unique in modelling a service specifically for Pacific Island people.

The study will aim to find a way of overcoming the lack of information and education on health issues and the poor access to basic health care faced by many Polynesian people living in Auckland.

3. Integrating funding and management of primary and related services in a remote rural area

Project to integrate funding and management of GP services in the Whanau-a-Apanui Special Medical Area with services provided by the Eastern District of the Bay of Plenty Area Health Board.

A GP will be responsible for coordinating and managing board services such as mental health, child and family health, and services for elderly people in a way which is appropriate for people living in the area, as well as continuing to provide GP services.

4. Christchurch south health centre

This project will set up a database, conduct a feasibility study and develop budgets for budget-holding for primary care, district nursing and some specialist hospital services. This capitation practice provides an integrated service and has a comprehensive database from which to develop a budget-holding contract.

5. An integrated marae-based maternity/ neonatal health service in Papakura

This project seeks to provide a maternity service that is comprehensive (antenatal through to postnatal) and culturally appropriate for Maori women in Papakura. A wide range of associated services will be provided including health promotion, referrals to secondary service, counselling for abuse, cervical screening and traditional Maori healing arts.

Support services, including immunisation for infants from birth to one year will also be provided. The project will be managed by the Papakura Marae Committee. It provides an exciting model of a community trust targeting maternity services to a priority group through the services of a midwife.

6. Managed primary health care

A proposal from the Union Health Services to trial budget-holding. This means that a union health centre itself will buy some of the services to which patients are referred.

Two Wellington union health service practices are included in the proposal and management plans to administer maternity care, child health care, and immunisation as well as the GP and practice nursing in the centres.

7. Professional nurse case management: women, child and family service in the Hutt District

This initiative from the Wellington Area Health Board aims to establish the feasibility of having a nurse case manager act as liaison for all the treatment given to children with complex health needs.

8. General practice budget-holding: Royal New Zealand College of General Practitioners

Four general practices in Dunedin will participate in a comparative study on GP budget-holding. Two will administer funds for the services they refer their patients to - the "budget-holding" practices - and two will be "controls" that carry on under the current funding system.

9. Waiheke community health project

The aim of this project is to improve the health of a specific community through budget-holding for an integrated primary care service. It proposes to develop a contract to manage the budget for general practitioner services, pharmaceuticals, public and continuing nursing care services. The project aims to reduce the population's hospitalisation rates and to develop and implement a preferred medicines list. The value of this initiative is that it is serving a specific area and will serve as a model for practices providing a wide range of services.

10. Domino: comprehensive maternity service provision using bulk-funding

This project proposes bulk-funding for a service for the antenatal, childbirth and postnatal care of a defined population of women in the Wellington area. It aims to be cost effective, accessible and with a high level of user satisfaction. The midwives are are also looking at managing pharmaceutical and laboratory costs related to their service.

WOMEN HAVE THE RIGHT TO

* INFORMATION ABOUT THEIR HEALTH AND OPTIONS

* CHOOSE THEIR CAREGIVER AND PLACE OF BIRTH

* INFORMATION ABOUT THE INTERVENTION RATES OF LOCAL MATERNITY SERVICES

* MAKE THEIR OWN DECISIONS

THE WORLD HEALTH ORGANISATION ALSO RECOMMENDS

* Women should be able to move around during labour and choose a position for birth

* Electronic monitoring of the baby's heart in labour should not be routine

* Drugs should not be routinely used for pain relief

* Babies should not be separated from their mothers and breastfeeding should be promoted

* Labour should not be induced for anyone's convenience and the rate should not be higher than 10%

* Artificial rupture of the membranes should not be routine

* Episiotomies should be avoided

* The caesarean section rate in any region should be no higher than 10-15%

VIDEO FOR PACIFIC ISLANDS PARENTS

A video available from the Pacific Foundation, PO Box 28-346, Remuera (fax (09) 773-553) has been produced to help Pacific Islands families in the transition from a traditional way of life to the fast-moving modern New Zealand culture.

The video is available in english, samoan and tongan versions at a cost of $29.95. It takes 18 minutes, focuses on the roles of men, women and children, and encourages listening, talking and co-operation.

WOMEN'S SUFFRAGE

Last year the government established a 1993 Suffrage Centennial Year Trust, chaired by Dame Miriam Dell; and a Suffrage Centennial Services Unit which is situated at the Ministry of Women's Affairs in Wellington.

The Trust has about $5 million to distribute to Suffrage projects over the next 3 years. For further information and to go on to the newsletter mailing list write to:

Ruth Biggs
Suffrage Centennial Services Unit
Ministry of Women's Affairs
PO Box 10-049
Wellington

CENTENNIAL 1993 Women's Suffrage

Occupational Health in Helsinki. They measured the amount of radiation women using VDUs were exposed to. They discovered that pregnant women computer users exposed to extremely low-frequency fields of greater than 9 milligauus (mG) had a miscarriage risk close to three and a half times greater than those only exposed to 4mG of radiation.

Women exposed to 4-9mG had nearly twice as many miscarriages as those exposed to less than 4mG and there appeared to be a dose-response relationship between magnetic fields and miscarriages. The study did not reveal a miscarriage risk when women were classified according to the number of hours they worked at the screen. The research work also revealed that only the older model screens had the higher levels of radiation.

Boring repetitive VDU work has also been identified as an important source of stress at work which may adversely affect reproductive health.

The idea of psychosocial factors in pregnancy is a recent development, but studies have already indicated their significance in repeat miscarriages and cleft palate. Stress is also known to depress nutrition, cause insomnia, raise smoking levels and alcohol consumption which all impact on reproductive health.

More well-conducted prospective studies are needed to clearly identify what affect VDUs have. This needs to include the different types of VDUs, length and regularity of exposure.

EPISIOTOMY VERSUS TEARS

A team of doctors in Brazil who have studied women giving birth in a squatting position over the past 10 years have discovered that 30% suffer no tears to the pelvic tissue at all. They have noted that when women squat only 5 women in 1,000 have third degree tears to the anus whereas up to 130 episiotomies in every 1,000 extend to the anus. They also noted that the worst tears are irregular, less extensive and easier to repair than episiotomies.

Squatting has long been noted as widening the pelvis by 20-30%. Imposing artificial breathing and pushing may actually cause tearing and stress to the fetus causing an irregular heart rate.

IN THE NEWS

TRADITIONAL BIRTHS SUPPORTED

Maori health workers have recommended that Auckland hospitals provide facilities to allow Maori women to give birth in a more traditional manner. This recommendation follows a year-long study by Auckland Area Board Maori staff members on the board's Whakatapu management training programme.

The study team, who interviewed 376 Maori woman users of board maternity services, has also recommended such services be expanded in South Auckland. The team said that hospital delivery suites should make mattresses and bean bags available and allow sitting and kneeling positions to enhance a more traditional style of delivery. They also said it was important Maori women be involved in developing maternity services and looking after Maori women.

The study found that the younger the mother, the more whanau support for her with 69% of partners present at the birth, 32% of mothers and 20% of fathers present.

The survey was prompted by concern that maternity services were not being fully used by Maori women and recommended a review and redirection of services to better cater for them. The study team recommended setting up marae-based health programmes for pregnant and new Maori mothers and more consumer research by and for Maori people.

FUNNY IDEAS IN WELLINGTON

Strange ideas amongst the medical profession in the Porirua Basin have resulted in hundreds of women bypassing Kenepuru Hospital because they have been led to believe it is not safe to have their babies there. At present 40% of local women have their babies at Wellington Women's Hospital leaving Kenepuru with empty beds. Other mothers have had to fight to have their children locally. One woman changed her doctor because she believed in supporting the local hospital.

GPs are advising women to go to Wellington Women's Hospital where there are full specialist facilities "just in case".

INDEPENDENT MIDWIVES IN KENEPURU

Two Kenepuru midwives Sara Pearson and Jane Arthur have started an independent midwifery service in the Porirua Basin to provide total care to women before, during and after the birth. They want to offer women the benefits of continuity and the chance to get to know their midwife. Women will also be able to get advice from the same person, so they aren't confused with conflicting views. They have the support of staff and management at Kenepuru Hospital.

NEW AUCKLAND MATERNITY HOSPITAL

A new maternity hospital in Botany Road on the outskirts of Howick opened late last year replacing the Howick Obstetric Hospital which has

been bought by an investment company to convert into a 35 bed rest home. The new maternity hospital is run by the Auckland Area Health Board (AAHB) and serves the Pakuranga, Howick, Otara and East Tamaki regions.

The new $2.2 million facility has 20 beds for low risk childbirth, postnatal maternity care and neonatal care. A sel-contained outpatients area will provide paediatrics and mental health services.

The Howick Obstetric Hospital was one of several small obstetric units which in 1989 were marked for closure as part of the AAHBs change to its pregnancy and childbirth services.

Planned changes to the Waitakere Maternity Unit and the Pukekohe Maternity Hospital created an uproar in their respective communities as local people protested at large public meetings about the lack of community consultation before making decisions.

THE AUCKLAND BIRTH CENTRE

is a private maternity hospital in Epsom, Auckland. It provides antenatal and postnatal education, exercise classes and on-going mother support groups.

There are 8 birthing suites, 2 spa rooms, a lounge room, a teaching room and birth support equipment including birthing stools and bean bags. Each suite has its own ensuite, TV and amenities with back-up emergency equipment if needed. One-to-one midwifery support is provided during the birth with a midwife they know.

CONTINUITY CHOICE CHALLENGE

MIDWIVES NEED WOMEN NEED MIDWIVES NEED WOMEN NEED MIDWIVES

NEW ZEALAND COLLEGE OF MIDWIVES CONFERENCE

AUGUST 28,29 & 30 1992

VICTORIA UNIVERSITY
WELLINGTON

Contact: Conference Committee
P O Box 9600
Wellington
New Zealand

Ph 04-388-6592

NEXT NATIONAL MEETING

Saturday 29th August
1992
at
3.30pm
Student Union Building
Victoria University
Kelburn Place
Wellington

ELECTRONIC FETAL HEART MONITORING

Eight prospective studies of data from over 50,000 births comparing women monitored by electronic fetal heart monitoring (EFHM) reported little difference in neonatal and perinatal mortality and morbidity between the two groups. However, all eight studies reported a significant increase in caesarean sections when the baby was monitored by EFHM.

SMOKING

Smoking by fathers as well as mothers is a causal factor in cot death. The risk of cot death for babies, of mothers who smoke, is four and a half times greater than for babies of non-smokers. If the mother smokes a packet a day and the father also smokes, this risk increases to seven and a half times.

NUTRITION

After two years of research the NZ Nutrition Taskforce produced a report released last year which describes a comprehensive food and nutrition policy for NZ. It is called *Food For Health* and recommends over 400 strategies to improve health and reduce disease through diet. (Copies are available from the Department of Health, PO Box 5013, Wellington)

There is a lack of trained people to teach about nutrition and a need for food and nutrition legislation to be improved particularly in relation to labelling. The food industry needs to expand its activities in nutrition research, education and new product development.

The food and nutrition guidelines developed by the Nutrition Taskforce are:

1. Eat a variety of foods from each of the four major food groups each day - vegetables and fruit; breads and cereals; milk and dairy products; meat and alternatives.

2. Prepare meals with minimal added fat (especially saturated fat) and salt.

3. Choose pre-prepared foods and snacks that are low in fat (especially saturated fat) salt and sugar.

4. Maintain a healthy body weight by regular physical activity and by healthy eating.

5. Drink plenty of liquids each day.

6. If drinking alcohol, do so in moderation.

VISUAL DISPLAY UNITS (VDUs)

The use of VDUs has increased dramatically over the past two decades along with anxiety about health problems that are suspected to be associated with them. The suspicion that they are harmful to reproductive health has arisen following reports of women working with VDUs experiencing an increase in menstrual difficulties, miscarriage and birth defects.

Compelling evidence has been found by Finnish researchers working for the Institute of

oo early in labour it tends o slow down or stop labour ltogether. Pethidine rosses the placenta to the aby and may be a cause of eo-natal depression, including respiratory depression. It will appear in the breastmilk of those mothers who are given the drug.

Adverse Reactions

Pethidine may cause dizziness, disorientation, nausea and vomiting, mild euphoria, hallucinations, mental confusion, hypotension (low blood pressure) and tachycardia (racing pulse rate of over 100 per minute). Many of the discomforts attributed to labour are the result of Pethidine.

ASPIRIN HAZARDS

The Food and Drug Administration (FDA) in the United States is now requiring all over-the-counter aspirin products to carry a warning which says they should not be taken by pregnant women in the last trimester unless directed to do so by their physician. Aspirin can affect fetal circulation and uterine contraction, which can harm the baby and complicate labour.

The warning must read: *It is especially important not to use aspirin during the last 3 months of pregnancy unless specifically directed to do so by a doctor, because it may cause problems in the unborn child or complications during delivery.* (From National Women's Health Report)

FOLIC ACID AND SPINA BIFIDA

For a long time it has been suspected that diet is in some way linked to neural tube defects such as spina bifida, anencephaly and encephalocele. A 1983 trial firmly established that women at high risk of having a baby with a neural tube defect can significantly reduce the risk by taking 4mg of folic acid each day.

Results of an english study published in the Lancet last year confirmed earlier studies which showed the risk of spina bifida and related brain and spinal cord defects could be reduced by adequate storage of the vitamin folic acid. A lack of folic acid could be responsible for up to 72% of spina bifida cases.

Spina bifida is a developmental defect in which the newborn baby has part of the spinal cord and its coverings exposed through a gap in the backbone. Symptoms can include paralysis of the legs, incontinence and mental retardation.

Medical researchers believe that spina bifida is caused by genetic and environmental factors, but this english study shows that folic acid is the major environmental factor.

Folic acid is crucial to the development of the embryo in the first two months. That is when the cells of the neural tract are dividing and forming. Folic acid is found in green leafy vegetables and strawberries.

COMING EVENTS

ICEA 1992 INTERNATIONAL CONVENTION: 13-16 August
Orlando, Florida - organised by the International Childbirth Education Association

NATIONAL CONFERENCE OF THE AUSTRALIAN ASSOCIATION OF CHILDBIRTH EDUCATORS IN BRISBANE: 1-3 October 1992
Enquiries: AACE National Conference Committee, PO Box 567, Nundah, Queensland 4012, Australia (ph 07-266 9573)

THE POLITICS OF CARING II
Health & Health Care Policy: Women's Strategies For Change
November 6-9 1992 Atlanta, Georgia, USA
Enquiries: Jennie Perryman, Planning Committee, Emory University, 1364 Clifton Rd, NE, Box 7, Atlanta, Georgia 30322, USA. Ph (404)727-3181 Fax (404) 371-8200

13th Australian Home Birth Conference

Ursula College, Australian National University, Canberra.
9th-13th April 1993.

BIRTH - A CELEBRATION

The Canberra Homebirth Association invites the submission of papers and workshop proposals for this conference. Send abstracts to:

Shane Marsh
13th Australian Home Birth Conference
PO Box 88 O'Connor ACT 2601

by 31st August 1992.

Certificate in Health Promotion

Commencing: October 1992, (two year part-time course)

Offered by: Central Institute of Technology (School of Health Professionals) in conjunction with the Health Promotion Forum.

Who for:

- Comunity workers and those working in the community who have a focus on health promotion
- People seeking health promotion models frameworks and skills to facilitate their work.
- It is ***not*** for people who already have a extensive knowledge of health promotion

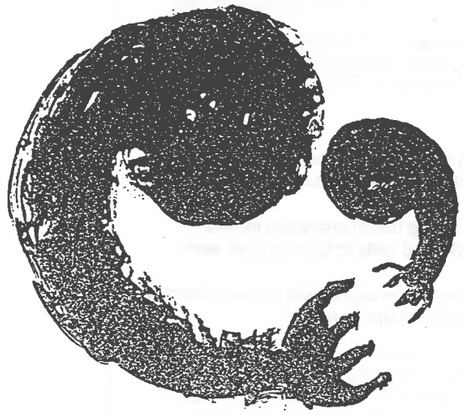
The course will involve participants in an interactive learning situation. For further information and an application form contact: The Secretary, Central Institute of Technology, PO Box 8391 Symonds St, Auckland. Phone: 309 1722, Fax: 309 1721

SECOND INTERNATIONAL HOMEBIRTH CONFERENCE

"RECLAIMING OUR HERITAGE - CREATING OUR FUTURE"

4 - 7 OCTOBER 1992
UNIVERSITY OF SYDNEY

Any enquiries you may have should be directed to:
Conference Secretariat
Second International Homebirth Conference
GPO Box 2609
Sydney NSW 2001 AUSTRALIA
Tel: (61 2) 241 1478; Facsimile: (61 2) 251 3552



BIRTH
in the
21ST CENTURY

Te Whanautanga i te ao hou

The possibility of normal birth as a choice

CONFERENCE

16 – 18 October 1992
Centra Hotel, 128 Albert St, Auckland
Aotearoa/New Zealand

CONFERENCE OFFICE

All enquiries and registration forms should be directed to:
Birth in the 21st Century Conference office
Box 52 065, Kingsland, Auckland 3, Aotearoa/New Zealand.
Phone 09. 525 3437, fax 09. 827 7024

The Third National Biennial Conference
of the
National Association of Childbirth Educators

Refresh – Renew – Revitalize

Photograph by Harriette Harrison/Artemis

1 – 3 October 1992
Professional Development Centre, Bardon
BRISBANE

Join us in Brisbane for the Biennial Conference
A wide range of topics and an impressive list of speakers from Australia and New Zealand

FIVE DAY
WORKSHOP FOR WOMEN

Celebrate Universal
Girl Woman
Mother Woman
Wise Woman
Get to know Family Birth/Life Patterns
Power, Transformation, Healing, Self-Delight

SPIRITUAL MIDWIFERY

WITH
RACHANA
INTERNATIONAL THERAPIST AND BIRTH EDUCATOR

1992 WORKSHOPS

Nelson Workshop
September 4-9

Christchurch Workshop
September 16-20

DISCUSSION GROUP
SEPT 4 & 14

FREE INTRODUCTORY TALK
SEPT 4 & 15

For Information: Caroline Nye
101 Harris Crescent
Christchurch
Phone:(03) 352-7683

section. The percentage was 8.5% in 1986 and 18.5% in 1989. According to the centre, these figures indicate a significant shift in obstetric practice. (? the demands of better informed women!!!) A third of all c-sections are performed on women who have had a previous c-section and the rate also appears to rise with the age of the mother. Women over 30 are more likely to have a caesarean than women in their teens or early 20s.

They are also some interesting system trends. C-section rates are higher for non-profit and proprietary hospitals than for government-owned hospitals. Women with private health insurance are more likely to have a caesarean delivery than women with Medicaid coverage or no insurance.

Even though maternal mortality is very low in countries like NZ the rate of maternal death after a caesarean is 2-4 times higher than a vaginal birth. Most forms of maternal morbidity are significantly higher with a caesarean than with a vaginal birth. These include:
- infection
- haemorrhage (average blood loss for a c-section is about twice that for a vaginal birth)
- injury to the bowel and bladder
- delayed recovery
- possible prematurity
- decreased maternal-infant bonding
- effects on fertility
- trauma and grief

Statistics also show that caesareans have effects on babies that cannot be ignored. Labour has been demonstrated to trigger the release of stress hormones which are important to survival outside of the womb. A 1988 study conducted by Burt, Baughan and Daling showed that babies born by repeat caesarean were approximately 30% more likely to have a low Apgar score than those born vaginally.

In 1991 an American study conducted by Kennell et al demonstrated that women who received continuous support during labour had an 8% caesarean rate compared to 18% for the control group. As well as reducing the trauma and risks from a c-section, there are obvious cost savings that can be achieved from the continuous support provided by midwives during labour.

PETHIDINE

Pethidine is a narcotic analgesic (pain-killer) and sedative. It is given by injection, usually in the buttock or thigh. It takes about ten minutes to start working with peak action at about 30-50 minutes. It may last from 2-4 hours and is broken down by the liver to be passed out in the urine. Pethidine is used for the relief of moderate to severe pain (medical and surgical); as a pre-anaesthetic prior to surgery; and to provide obstetrical analgaesia. It was first introduced as a non-addictive alternative to morphine although pethidine is now know to be addictive as well.

Pethidine should not be used in pregnant women prior to labour unless in the judgement of the physician the benefits outweigh the possible hazards. If given

BITS & PIECES

BABY WALKERS

In the United States almost 15% of children under 2 years old seen for head injuries had been hurt while in a baby walker. Almost half had a fractured skull. Baby walkers have no known benefits for infants or toddlers.

NEW TREATMENT FOR TUBAL PREGNANCY

A Californian pilot study is injecting F2 protaglandin directly into a fallopian tube (with the use of ultrasound to guide the injection) to end a tubal pregnancy without having to resort to surgery. Methotrexate injections have been available as an alternative to surgery but the side effects are severe even in low doses. They include bone marrow toxicity requiring blood transfusion and shock and the effect on the tubes is not yet known. Prostaglandins are viewed as a safer alternative and appear to be successful when administered to women who have not had previous tubal surgery.

AN AUDIT OF COMPLAINTS

Errors in management - in diagnosis, decision making, and treatment - accounted for over half the 1371 claims for negligence against obstetricians and gynaecologists, general surgeons, anaesthetists and radiologists in the American state of New Jersey in 1991. A further third were due to poor technical performance, and the remainder involved failures in staff communication and coordination. The authors suggest that study of such claims could prompt guidelines for safe practice, monitoring of procedures, and systems for sharing patient information among staff. (Journal of the American Medical Association 1991)

TAKING CARE OF BREAST MILK

Freezing breast milk and then thawing it in a microwave can cancel out virtually all the benefits of breast milk. Microwaving breast milk reduces - and in some cases virtually eliminates the milk's bacteria-fighting properties. Breast milk contains antibodies and a protein called lysozyme which inhibit the growth of bacteria and provide protection during infancy from a number of illnesses including diarrhoea.

C-SECTION TRENDS

A recent US report from the National Centre for Health Statistics has noted that the rate of caesarean sections has levelled off after rising steadily over the past 20 years. The rates per 100 births have been recorded as:
1965 - 4.5
1986 - 24.1
1987 - 24.4
1988 - 24.7
1989 - 23.8

They also noted a large increase in the number of women giving birth vaginally following a previous

UPDATE ON ORGANISATIONS

ICEA NEW ZEALAND

The following NZ women have retained their positions for another term:

Barbara Hanrahan as ICEA International Director

Jill Wassenaar as NZ Co-ordinator

MATERNITY ACTION CHRISTCHURCH

Have a strong commitment to continuity of care as an integral part of all maternity services provided. They have recommended that 8-10 antenatal clinics be provided in the community to provide low tech. facilities, be run by midwives and act as a focus for preventative care for healthy women.

The group also want women to hold their own records and for a patient/women's advocate to be appointed for O&G services.

A further recommendation is for a specialist lactation consultant to be employed in the public system to work:

- as a resource person for staff at all levels
- with women wishing to establishbreastfeeding who request this support
- in antenatal care and education
- to monitor and evaluate the service provided
- to help establish an infant feeding protocol

WOMEN'S HEALTH INFORMATION SERVICE

Run by Fertility Action the information service provides information on a wide range of health topics including:

* Access to medical records
* Breast cancer
* Breast implants
* Cervical smears
* Colposcopy
* Depo provera
* Endometriosis
* Fibroids
* Heart disease and hormones
* Hysterectomy
* Hormone replacement therapy
* IUDs
* Liposuction
* Mammography
* Osteoporosis
* Pelvic inflammatory disease
* Premenstrual syndrome
* Roaccutane
* STDs
* Ultrasound scans

Information can be obtained for a small charge to cover costs from PO Box 4569, Auckland (ph 09-520 5295)

THE IMMUNISATION AWARENESS SOCIETY

This group publishes a bi-monthly newsletter which contains articles by independent researchers, letters from parents of vaccine-damaged children and news about research findings and political developments.

Information about immunisation and how to go on the mailing list can be obtained by writing to the Society at PO Box 56048, Dominion Road, Auckland.

AUCKLAND CAESAREAN SUPPORT GROUP

Have been actively monitoring the statistics of childbirth practices in Auckland hospitals. These are the statistics collected to date by the group.

North Shore Hospital

	April'90-March'91		April'91-March'92	
Births	2304		2506	
Epidurals	712	(30.9%)	852	(34%)
Ventouse	6	(0.2%) (12.8%)	12	(0.5%) (14.1%)
Forceps	292	(12.6%)	341	(13.6%)
Total c-sections	278	(12%)	338	(13.5%)
C-section acute	179	(7.7%) (12%)	207	(8.3%) (13.5%)
C-section elective	99	(4.3%)	131	(5.2%)
C-section epidural	247	(10.7%) (12%)	296	(11.8%) (13.5%)
C-section GA	31	(1.3%)	42	(1.7%)

Middlemore Hospital

	April'90-March'91	
Births	4529	
Epidurals	850	(18.7%)
Ventouse	62	(1.3%) (5.4%)
Forceps	186	(4.1%)
Total C-sections	431	(9.5%)
C-section epidural	279 (discrepancy - incomplete log entry)	
C-section GA	125	

(Separation of acute and elective caesarean statistics unavailable)

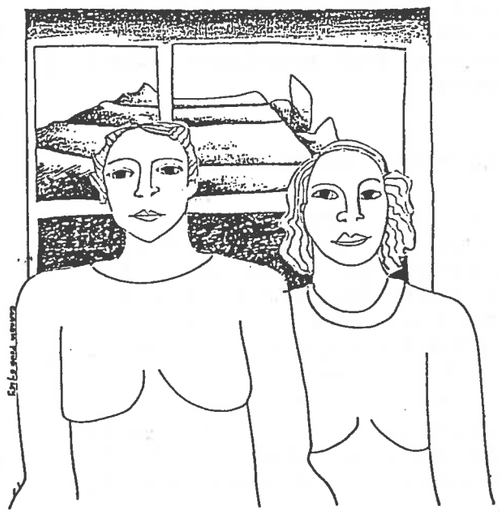
There are women with consistently high blood sugar levels which will increase the risks to themselves and their baby who need insulin or diet intervention. Consistently high levels can result in the baby getting too much sugar and growing too large which can cause problems at the birth. These babies may end up with shoulder dystocia, forceps, c-section and other trauma. The baby produces extra insulin to handle the excess sugar and can be hypoglycemic with tremors at birth. The incidence of jaundice is also higher.

50% of women with one or more risk factors develop GD but 50% don't. The risk factors are:
- over 30
- obesity
- diabetes in the family
- previous baby or their own birth weight over 9 pounds
- previous pregnancy with gestational diabetes
- problems such as stillbirth

Urine tests done at antenatal visits aren't very good indicators as about 1/6 of all pregnant women spill glucose in their urine. The renal threshold for sugar changes during pregnancy as does the excretion rate. It is estimated that 75% of people shown by the GTT to have impaired glucose tolerance never actually develop diabetes. The test can't be good for mothers since a pregnant woman should not fast for 8-12 hours and the glucose often makes her vomit. The better a woman's nutrition, the less likely her body is to be accustomed to large doses of straight sugar. The effects on the baby of glucose flooding after several hours of fasting is unknown.

In *A Guide to Effective Care in Pregnancy and Childbirth* by Enkin, Keirse and Chalmers they reviewed all the literature in english to determine the efficiacy of the glucose tolerance test for gestational diabetes. They conclude that except for research purposes, <u>all forms of glucose testing for gestational diabetes should be stopped.</u> They suggest that women in whom overt diabetes is suspected should be followed with repeated fasting or blood glucose estimation 2 hours after meals throughout pregnancy.

They go on so state that the diagnosis of gestational diabetes, as currently defined, is based on an abnormal glucose tolerance test and the risk of this "condition" has been overemphasised. No clear improvement has been demonstrated with insulin treatment for gestational diabetes, and screening of pregnant women with GTT is unlikely to make a significant impact on perinatal mortality.



SCREENING FOR GESTATIONAL DIABETES

There appears to be an increasing trend in some parts of New Zealand to routinely screen for gestational diabetes (GD) particularly amongst polynesian women. Well known american author of *Special Delivery*, Rahima Baldwin also notes this trend in the United States. The American Diabetes Association now recommends that all pregnant women be screened for GD between 24 and 28 weeks of pregnancy.

It is interesting that there is disagreement in the studies about the "normal" levels for pregnant women and whether they should be higher or lower than non-pregnant women.

Rahima records that 30% of pregnant women routinely fail the glucose challenge test and experience the anxiety of returning for the more rigorous glucose tolerance test (GTT). Yet, according to the American Diabetes Association, only 2-3% of all pregnant women have actual blood sugar levels above those deemed normal for pregnancy.

Of these 2-3% diagnosed because they failed the test (rather than exhibiting clinical symptoms), only 15% will be prescribed insulin for the remainder of the pregnancy.

This means that the result of universal screening finds that less than one percent (.45%) of all pregnant women have blood sugar levels requiring insulin therapy.

Rahima raises the question of whether the women who failed the test did so because of the nature of the test.

85% of women who fail the GTT and are diagnosed with GD can keep their blood sugar levels within normal range through diet and exercise. She questions how many otherwise healthy pregnant women are incapable of handling 8-12 hours of fasting followed by 100 gms of glucose (the equivalent of about 4 candy bars), but are quite capable of maintaining normal blood sugar levels on their normal healthy diets.

We have no way of knowing how many women diagnosed with GD by the GT test never had high blood sugar when eating their normal diets. Rahima suggests that women suspected of having a problem be sent home with a glucose meter that she has been taught to use. If she returns with normal readings then the condition does not exist for her.

Once women are diagnosed with the GD "disease" they become high risk which reduces their choices and options predisposing them to more interventions. They are also subjected to constant tests and monitoring throughout the pregnancy with monitoring of the baby continuing throughout and after the birth. Rahima is critical of this over-management that persists in spite of the fact that if controlled there is no more risk of problems than with women who do not have gestational diabetes.

Greenlane/National Women's Hospital

	Jan-Dec 1990
Births	7831
Epidurals	2591 (33%)
Ventouse	731 (9.3%)(incl.some purendal block)
Forceps	
Total C-sections	1359 (17.35%)
C-section epidural	1032 (76%)
C-section GA	327 (24%)
C-section acute	1059 (80%)

(discrepancy of 38 so % is on known totals)

C-section elective	262 (20%)

Ten Steps to Successful Breastfeeding

A Joint WHO/UNICEF Statement (1988)

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health-care staff.
2. Train all health-care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
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 are separated from their infants.
6. Give newborn infants no food or drink other than breast milk unless *medically* indicated.
7. Practise rooming-in. Allow mothers and infants to stay together twenty-four hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies and soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.

BREASTFEEDING

World breastfeeding week begins on the 1st of August which is the anniversary of the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding which was signed at a WHO/UNICEF meeting in 1990. This is a time each year to evaluate our progress toward protecting, promoting and supporting breastfeeding. This year a folder has been produced by the World Alliance for Breastfeeding Action that outlines stategies to make sure hospitals and maternity units are "baby-friendly" and supportive of breastfeeding.

The fact that New Zealand has more La Leche League (LLL) leaders per head of population than any other country raises the question of whether this reflects the difficult "climate" for women attempting to breastfeed. LLL leaders continue to report resistance from hospitals when they attempt to provide information for women or offer their services for women experiencing difficulties.

Tui Bevan, 129 Signal Hill Road, Dunedin is a member of the ICEA Breastfeeding Committee and has collated a great deal of reference material on the WHO Code.

THE W.H.O. CODE

In 1981, the World Health Organisation adopted the International Code of Marketing of Breastmilk Substitutes. This code was intended to counteract the powerful influence of the multinational formula companies on the dramatic decline in breastfeeding globally. The advertising wrongly informs women that bottle feeding is as good as breastfeeding.

The WHO Code focuses on the marketing practices of makers of breastmilk substitutes, including the sale of infant foods, feeding bottles and teats. It aims to promote and protect breastfeeding by regulating the marketing of breastmilk substitutes.

To make the Code legal in each country the government must legally adopt the Code, something New Zealand has not yet done. Other countries such as Canada who also rely on the voluntary Code report how ineffective this is. Formula companies have continued to approach hospitals offering special deals in return for accepting donated formula. Internationally, the sale of breastmilk substitutes constitutes a 4 billion US dollar business.

In New Zealand a government appointed Breast Milk Substitutes Monitoring Committee receives complaints alleging breaches of the Code. It also reports to and makes recommendations to the Minister of Health. However, because the Code is still voluntary the committee has no powers to force compliance of the Code.

NZ hospitals continue to accept donated formula which contravenes the code and acts as a move against breastfeeding. There also needs to be a better awareness amongst health professionals about the Code and an extension of this awareness to their practice.

EPIDURALS

Epidurals have been in use for about 50 years so it is time a critical assessment was done on:
1. the side effects of epidurals used during labour
2. the appropriateness of their use
3. their effectiveness for women and their safety.

Significant effects of epidural narcotics include nausea, vomiting and itching. A woman having an epidural during labour is imobilised and confined to bed. She is hooked up to an IV drip and if she is really unlucky - a urinary catheter as well. Once surrounded by all this technical assistance she is then subjected to regular monitoring. In this situation, labour is clearly no longer normal. For some women an epidural is an obvious choice of treatment but an assessment is needed to establish just what percentage is being used inappropriately.

There is also a need for a peer (and/or multidisciplinary) review of cases which have not been normal so a practitioner is accountable for a course of action and must justify any intervention. Hopefully this course of action would reduce the number of women being unnecessarily subjected to the discomfort and side effects of procedures such as epidurals.

Problems that may occur with epidural analgesia in labour include:
- the development of oral herpes complex in 15% of women who have epidural morphine.
- respiratory depression in up to 60% of neonates when alfentanil is used, and 1 case per 1000 women.
- about 30% of women experience nausea and vomiting.
- 80% of women develop symptoms of vaginal itching and irritation when morphine is used and 20-30% when fentanyl is used.
- a failure rate of the actual epidural which ranges between 1.2% and 15%.
- a hypotension rate of less than 2%.
- a high or total spinal block occurring in one out of 12,000 women.
- convulsions or cardio-respiratory complications resulting from the intravenous injection affecting one in 20,000.

Although the safety record of epidural analgesia is very good when given by properly trained and skilled practitioners there can be complications as a result of the technique used.

- dural puncture occurs in 0.9% to 4% of cases.
- spinal headache in 25-80% of those with a dural puncture.
- backache occurs in 5-30% of women depending on the needle size.
- one woman in 3,000 suffers temporary neurological damage and one in 16,000-20,000 suffers permanent damage.

On average there is one death per 200,000 epidurals.

nursery. They were also proud of their milk mixture procedures. However, despite all this most women breastfeed for 10-11 months.

The labour/delivery room had three beds in it. When we visited there was a woman in labour lying quietly and passively flat on her back hooked up to an oxytocin infusion, because they said her contractions were not very strong. There was an attendant (midwife ?) sitting on a chair across the room. When we went in, the woman obstetrician and midwives proudly demonstrated the merits of a very sophisticated sonicaid. On the shelf were two pinnards. I picked one up and asked why they used the sonicaid instead of the pinnard and told them that midwives in NZ use a pinnard in preference to the sonicaid. They invited me to use the pinnard to listen to the fetal heart without asking the woman.

I asked the woman through an interpreter if it was OK. I palped her and listened. Then they pointed to the oxygen bubbling away because they said the fetal heart was irregular at times. (It sounded OK when I listened to it). I asked why the woman was lying on her back so the obstetrician and midwives rolled her on to her side. She was wearing her shirt and her trousers off on one leg and was lying in a puddle. Her membranes had ruptured but the attendant when asked did not know when this had happened. I later found out she had a normal delivery about 2 hours later.

They examine women rectally as they consider there is less danger of infection than doing vaginal examinations. They have a 20% caesarean section rate and do routine episiotimies so 70% of women get one. As there is a national policy of one-child families all the women are primips and most have oxytocin infusions. They were very proud of their laser machine used to treat mutilated perineums! Postnatally there were four women in each narrow room and they ususually go home after six days.

I spoke to the obstetrician and midwives afterwards, telling them about the difference between the medical model and the midwifery model of childbirth. I also demonstrated the positions that women use to give birth in New Zealand, especially at home.

China isn't a member of the International Confederation of Midwives (ICM) so I stressed the importance of joining.

Since leaving China, Joan has made efforts to put chinese midwives in touch with ICM contacts and has provided them with information about ICM, the NZ College of Midwives and also about technology such as oxytocin infusions and episiotomies.

Midwives need to make sure their practice encourages and supports breastfeeding. Using practices based on bottle-feeding, midwives can contribute to the failure of lactation which leads to the introduction of breastmilk substitutes. For example telling mothers to offer both breasts for a stated number of minutes is unhelpful as current research shows that patterns will vary according to the milk production of the mother and feeding style of the baby. When bottle routines like this are applied to breastfeeding they result in breastfeeding failure.

Practitioners often suggest the introduction of formula as a solution to problems instead of seeking breastfeeding solutions. Once a bottle is introduced it quickly becomes part of the feeding routine. It is also important that pictures and displays show breastfeeding rather than babies with bottles.

Ignorance and apathy on the part of health professionals are significant factors in breastfeeding failure and the promotion of breastmilk substitutes. Advice and assistance to women should be based on up-to-date information.

A 1991 article in the Canadian Nurse Journal which highlights the value of the Code and the need for health professionals to support it also addresses the issue of women's choice. To make an informed choice women need to have correct and complete information. This includes the benefits of breastfeeding, plus the hazards and cost of formula feeding. This article includes the environmental cost and hazards which is very significant. For every 3 million bottle-fed babies, 450 million tins of formula are used and 70,000 tonnes of metal produced, of which most is not recycled. That is a lot of pollution.

Although the information given to women may state that breast is best, the information presented often makes breastfeeding sound difficult, inconvenient, embarrassing and even painful. Information is often out of date and incomplete. There may be an implied message that formula and bottles are necessary for proper infant nutrition.

The percentage of women unable to breast-feed their babies is less than 5%. Yet health professionals often reasure women antenatally that they shouldn't feel guilty if they decide not to breast-feed. In no other area of health promotion is this approach used. It is the role of health professionals who have contact with pregnant and birthing women to encourage breastfeeding because it is the superior method of infant feeding.

The WHO/UNICEF Code of Marketing of Breastfeeding Substitutes in summary:

1. No public advertising of breastmilk substitutes, bottles or nipples.

2. No free formula samples to new mothers.

3. No promotion of formula products in health care facilities.

4. No nurses employed by formula manufacturers to advise new mothers.

5. No distribution of formula gift packs or samples to health care workers.

6. No words or infant pictures on product labels idealising formula feeding.

7. Only scientific and factual information on feeding methods should be given to health care workers.

8. All information on formula feeding, including labels, should explain the associated costs and hazards.

9. Unsuitable products, such as sweetened condensed milk, should not be promoted for infant feeding.

10. All formula products should be of high quality and take into account the climatic and storage conditions of the country where used.

BREAST MILK BOOSTS CHILDREN'S IQ

The February 1992 Lancet reports on a study which provides evidence that breast milk may have a beneficial effect on the mental development of children.

In a study of 300 children who were born prematurely, children who were fed breast milk scored significantly higher on IQ tests than children who received formula only.

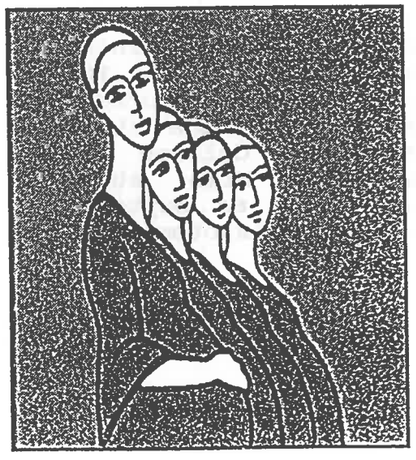
Previous studies linking breast milk to intelligence have caused controversy. Many doctors wondered whether the benefits attributed to the milk were in fact due to mother's motivation and education, or bonding during feeding.

In the new study, investigators said they were able to isolate and assess the effects of the milk itself because both groups of children were fed via tubes since they had been too premature to suckle.

The study is not definitive proof, but "very strong evidence," that an as-yet-unidentified substance in breast milk affects mental development. After taking into account the mother's social and educational status, children who were fed breast milk still showed a significant increase.

Parenthood Federation to dramatise the need to reduce unwanted pregnancies or badly-timed pregnancies which are major causes of maternal mortality, particularly in the third world. The five major causes of death are haemorrhage, infection, unsafe abortion, hypertension and obstructed labour.

According to the Federation, nore than 300 million couples wish to plan their families but have no access to contraception services. It has been estimated that if family planning services were available to all women who wanted them, over 25% of maternal deaths could be prevented. If women could choose to have the number of children they want and no more, the number of births would fall by a third in Latin America and Asia and by 17% in Africa. Maternal mortality would fall by at least an equivalent proportion.



MIDWIFERY IN CHINA

Last year Joan Donley spent some time in China studying traditional chinese medicine that is used in treating children. She was also able to observe the local maternity service. This is the report of some of her experiences whilst on this trip.

Her observations took place at the Hangzhou Red Cross Hospital which was built by the Jesuits in 1928. It is a hospital that combines Traditional Chinese Medicine with Western Medicine. On the one hand there is a large pharmacy with 7,500 traditional medicines, professors and doctors who practice acupuncture, herbal medicine and tuina (infant massage). Then there are those who practise western medicine. The liberal prescribing of antibiotics for viral infections and prednisone for nephritis is very common.

The maternity services have been captured by western medicine. The result is an attempt to use first world technology in third world conditions. Philosophically they are where we were in the 1950s with newborn babies bundled into bassinettes behind glass in a nursery, fed on a 4-hourly schedule and given milk mixtures. When we visited, all the babies were crying - until it was time to wheel them out. They proudly showed us their hygienic procedures - wearing gowns, hats and masks when entering the nursery. Every attendant was required to spray her throat with a disinfectant from a common atomiser before entering the

....AND IS A SUPERIOR "MEDICINE"

Swedish researchers have compared the composition of breastmilk in mothers with premature babies with mothers of full-term babies. They found differences that included higher concentrations of major anti-infective proteins. This varied depending on the degree of prematurity. In brief, the colostrum available to preterm babies is extra-rich in antibodies and other anti-infective agents that help protect them at a time when they are especially vulnerable to infection.

British scientists are now suggesting that the benefits of breast milk extends well beyond infancy. When compared with bottle-fed infants, breast-fed babies have less bouts of pneumonia, middle ear infections, respiratory infections and spinal meningitis. Bottle-feeding is associated with as much as a 16% higher incidence of diseases such as the flu and spinal meningitis.

Researchers have also found a consistent association between bottle-feeding and immune system disorders, diabetes, chronic diseases of the liver, ulcerative colitis, celiac disease and Crohn's disease - many of which develop later in life. Babies who are exclusively breast-fed for the first 6 months have a significantly lower risk of developing these diseases.

The marked decline in the rate of breastfeeding is attributed to the increase in the public advertising of formula.

BREASTFEEDING IS ENERGY EFFICIENT

A recent American study involving a comparison of lactating and non-lactating women showed that women produce milk far more efficiently than a cow and that the basal metabolic rates of lactating women increase after a meal. It was found that the energy cost of milk production was 25% more than the energy content of the milk secreted, so the efficiency was 80% Previous estimations have suggested it could go as high as 90%.

Therefore, during lactation women need additional energy intake not just because of milk production, but also because of the increased metabolic rate following meals. When combined these add up to a 50% greater energy need than nonlactating women. This study is a further reminder that even allowing for the mobilisation of energy stored during pregnancy, lactation is a much greater nutritional stress than pregnancy.

OVERSEAS

UK

WOMANSCHOICE is a charitable trust that developed from the suspension, enquiry and re-instatement of Wendy Savage. The trust has funded a research registrar to explore women's own perceptions of the quality of their antenatal care. Comparisons are made between the experiences of women having hospital based antenatal care, community based care and traditional "shared care".

In 1989 **WOMANSCHOICE** was launched as a national organisation. It aims to fund research and projects which it hopes will make the maternity and gynaecological services more responsive to women's needs.

Enquiries about the trust and donations to support its work can be sent to Womanschoice, 4 Butlers Grove, Basildon, Essex SS16 6 HW, UK

CANADA

The Midwifery Task Force in Vancouver continues its work to legalise midwifery and create an independent profession. Alberta and Ontario are making moves to integrate midwives into their health care systems and Bristish Columbia will be next. The Health Professions Act passed in 1990 allows unregulated health professions to apply for legal status. The Midwives Association of British Columbia has applied.

In November 1991, there was a real victory for midwifery when the Royal Commission on Health Care and Costs recommended that midwifery be legalised under the Health Professions Act. It recognised that midwifery should be an autonomous profession, amd that nursing should not be a prerequisite to victory. However, the commission also recommended that home births should be prohibited and that there be temporary regulation of midwifery through the Nurses Association and the College of Physicians and Surgeons until a proper College of Midwifery is set up.

Canadian women are being encouraged by the Task Force to write to their Minister of Health to urge for the legalisation of autonomous midwifery, midwifery regulated under the Health Professions Act and provision for women to choose the place of birth.

AUSTRALIA

A new bi-monthly newsletter/journal is now available from Caper, PO Box 567, Nundah, Queensland 4012, Australia. (ph 07-266 9573 fax 07-260 5009) The cost is $A60 for overseas subscribers.

UNITED NATIONS

A huge lawn at the UN headquarters was carpeted with 500,000 carnations in May of this year for a ceremony to commemorate the 500,000 women who die each year from complications related to pregnancy and childbirth. The ceremony was organised by the International Planned