Waikato Home Birth Association Inc. Newsmagazine 2003

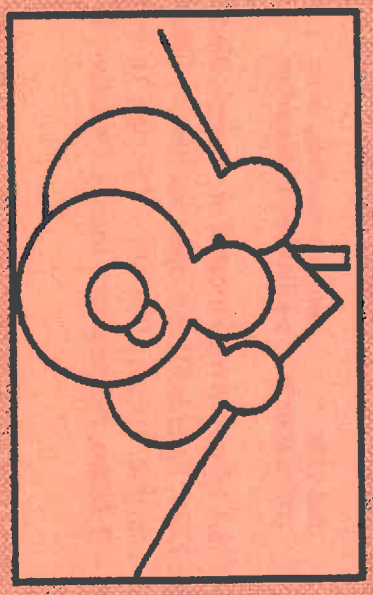
Disclaimer: Opinions expressed in this magazine are not necessarily those of the Waikato Home Birth Association Inc. Articles are intended for educational and informational purposes ONLY and are not intended to be a substitute for your health care providers consultation.

SENDER:
Waikato Home Birth Association Inc.
P O Box 15043
Hamilton

WHBA CORE GROUP MEETING
Monday 18th August 2003 at 6:30pm.
Unit 2- 8 Te Aroha Street, Hamilton
Contact Dianne De Estena on 07 854 9686
for details or agenda items.
• ALL WELCOME •

Newsmagazine

Waikato Home Birth Association Inc.



AUGUST 2003

Home Birth = A Safe Option

WAIKATO HOME BIRTH ASSOCIATION
P O Box 15043, Hamilton
http://www.homebirth.org.nz

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LIBRARY: The WHBA Library is now located at "Parents Place" 4 Little London Lane, Hamilton Ph: 838 2229. Parents Place is open for the toy library and therefore access to our library is also available. Tuesday 9:30am - 11:30am, Thursday 6:30pm - 8:30pm & Saturday 9:30am - 11:30am, Please phone Dianne De Estena Ph: 854 9686 if you have any problems.

NEWSMAGAZINE: We welcome your contributions but reserve the right to edit or decline at our discretion. Every effort will be made to ensure that all details are accurate but we accept no responsibility for errors or omissions.

Please send your birth stories, photo's and articles to:
Dianne De Estena
Unit 2 - 8 Te Aroha Street, Hamilton
Ph: 854 9686
E-mail: unusual1@slingshot.co.nz

Advertising rates: Advertising space is available in our newsmagazine. Our rates are: $15 (full A5 page), $10 (1/2 A5 page), $8 (Business Card Size). We also offer a %10 discount for pre-paid runs of 6 months or more. For further information please contact Dianne ph 854 9686.

DEADLINE: Material for the next magazine is accepted up to midday on the 20th of the month. This also includes birth notices.

"Have you considered a Home Birth?" Booklets

Free copies of these booklets are available for distribution by Midwives who are financial members. For non financial members of the WHBA there is a 50¢ charge per copy.

Please contact Telisa Ph: 854 7585

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If there is a GREEN spot on this form then it is time to renew your subscription.

NO Green spot? Pass the form on to a friend.

The $20 minimum fee will list me a s member of the association and entitles me to 11 issues of the newsmagazine and use of the library, located at "Parents Place", 4 Little london Lane, Hamilton, Ph: 838 2229.

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P O Box 15043, Hamilton

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Phone: ..... E-mail: .....
ARE YOU A NEW MEMBER? Yes ☐ No ☐

Starter
This is the most flexible course and indeed because of the reduced risks of consuming a small portion of food (prawn cocktails excepted) you may decide to eat your appetiser at home.
Main course
A maximum of one hour will be allowed for first time customers. More experienced diners will normally require no more than 30 minutes.
Dessert
Any expert will tell you that no meal is over until the pudding plates are cleared away and in order to keep up to speed with expert thinking, your plate will be removed after three minutes, whether you have eaten it or not. The three minutes will begin as soon as you have finished your main course. You will almost certainly require a small injection of appetite stimulant to complete your dessert within the allocated time.

Some diners may fail to progress at the required rate but help will be at hand in the form of naso-gastric feeding. Some critics have unfairly described this necessary assistance as force feeding, when in fact it is correctly termed, augmentation of nutrition. Anyone who is struggling to cope with the final few mouthfuls will be advised to take advantage of instrumental delivery of food. i.e. Your remaining food will be fed to you in one large mouthful. If necessary and only then, we may increase the size of your mouth by making a small incision, called "Easi-peasi-otomy". You will not feel any pain, only relief on finally seeing in front of you, a clean plate.

All tables are for two people but by special arrangement two tables may be pushed together to cater for larger groups. My aim is to provide one waitress for each table but at times of peak demand, it is sometimes necessary for each waitress to attend up to six tables. No matter how busy we are, your meal will never be delayed.

In fact, thanks to my commitment to customer service, your meal may even be slightly undercooked. Should this occur, your waitress will immediately (before you even see it) take your plate back to the kitchen for special incu-baking.
Training at all levels is continuous and essential for consistent quality treatment, therefore I feel confident you will agree to catering students (any number of) closely scrutinising your eating habits. Please do not worry if a student has to check progress by sticking his/her fingers down your throat. It is important you do not swallow during these examinations, no matter how irresistible the urge.

Every evening, a prize is awarded to our "Diner of the Day". A year's supply of After Ates from the Prozac Selection.

You may prefer a table in a quiet, candlelit corner especially if you are a little in awe of our high tech safety equipment. You can be reassured that all tables are equally safe and attractive but in the "Cosy Corners" I have hidden the clinical equipment underneath the colour co-ordinated table linen. I do not offer Take-Away or Home Delivery services. Some eccentric people will continue to take the risk of dining at home or in small local establishments but ask yourself this - Which is more important- Perfect nutritional provision in a state of the art safety area or enjoying your food?
Bon Appetit.

Editorial...

Hola

HI there hope all is well out there, included is the reports from the AGM PLEASE if anyone is interested in the Secretary's position please give me a ring.

Look out for the In The News page, it tells what we have been doing lately and what we plan to do in the very near future.

I would personally like to thank "Chiropractic for Life" for Donating $5 from each child check they did in a week in July. It is great to see alternative care options supporting home birth. We appreciate your very generous donation to out group, so homebirthers out there if you need a chiropractor please ring them.

Also included is a questionnaire from the evaluation team who are evaluating our home birth classes. This has not gone to all members – just to those of you who attended a class in the past four years. I know it's hard to find time to fill in surveys when you're busy parents. But I would urge you to take 5 or 10 minutes to fill in the survey and send it back to us. This is your chance to have a say to help improve our classes for other mothers and fathers-to-be. We are committed to improving all we can so really need to know what you think!

We had a special meeting in July 28th to organise Home Birth Week which is in October, if anyone out there would like to help in organising peoples, places, etc please ring me - many hands makes the job a whole lot easier.

Take care, see you next month!

Dianne

CONTENTS:

Your Newly Hatched!

On	These Parents	From	Had a	Named	Attended by
16/05/2003	Sharni & Jamie Budd	Kihikihi	Boy	Jayden	Maggie
24/05/2003	Vicki Ludlum & Dan Valentine	Hamilton	Girl	Kelsey	Maggie/Carla
30/05/2003	Vanessa, Lachlan & Estelle McColl	Te Awa-mutu	Girl	Awhi	Maggie/Susan
07/06/2003	Caroline& Tommie Andrews	Raglan	Girl	Grace	Jo/Carla
08/06/2003	Muriwai Harper & Wayne Callesen	Ngongotaha	Boy	Tane Wiremu	Heather/Reitu
Sadly, our beautiful boy left this world on 13/07/2003.					
11/06/2003	Brigid & John Devicich	Hamilton	Girl	Eliza	Jo/Susan
12/06/2003	Shannon & Matt Double	Putaruru	Girl	Shayla	Heather/Hannah
15/06/2003	Lynley Peke-Paenga & Katene Paenga	Hamilton	Girl	Hinemoa Te Iwa	Heather/Jo/ Maggie
21/06/2003	Catherine Wright & Wayne Brown	Thames	Boy		Sue/Jenny
29/06/2003	Rawi Nuku & Joost Dekker	Tauwhare	Boy	Joost Puke-moremore	Heather/Hannah
02/07/2003	Aroha & Mosses Koiatu	Te Aroha	Girl	Marion	Sue
13/07/2003	Merea Wharawhara & Issac Kaukau	Whaharoa	Boy	Ihaka	Heather/Hannah
14/07/2003	Jaynie Keir & Ken Hansen	Raglan	Girl	Sienna	Maggie/Carla
18/07/2003	Nolene Mutch & Guy Fearon	Hamilton	Girl	Peta	Maggie/Jo
24/07/2003	Senae & Ojay Turner	Hamilton	Boy	Kainoa	De/Jo
26/07/2003	Justina & Aiden Knox	Hamilton	Girl	Charlotte	De/Hannah
27/07/2003	Casey Shalders & Mani Witika	Whaharoa	Boy		Heather/Sue

THE LAST LAUGH CORNER ....

Tongue and Monitor in Cheek! By Fiona Campbell-Smith

Looking for a business opportunity which would guarantee success, I decided to follow the example set by maternity services and increase safety in the normal physiological activity of eating. I call my restaurant "Pasta, Dates and Lettuce in Juice" and hopefully I will soon see it expand into a chain of similar establishments throughout the country. Eating is an essential part of life and our bodies are superbly designed for the process but disasters do occur, the most obvious being choking on a piece of food. Is your epiglottis 100% reliable? Although such incidents are rare, I consider it essential that full emergency resources be available to all dining individuals. I suggest you make use of my facilities for those special meals in your life; birthdays, anniversaries, etc. The times when you are just not prepared to take the slightest chance of anything going wrong. So come along, sit well back in my gastronomically designed, almost horizontal chairs and enjoy total safety.

The figures speak for themselves. Last year almost one fifth of customers realised with gratitude that they were saved from certain death, by my investment in highly trained staff and high tech cutlery. On making a reservation for dinner, a range of simple tests will be carried out, to establish the best time for you to dine. You will be required to give a detailed history of your eating habits in the previous 24 hours. Of course you may be so greedy and irresponsible that you are prepared to lie or you may be unable to remember. Appetite alone is a very blunt instrument in meal planning, therefore an ultrasound scan of your stomach and some routine blood tests, will be carried out to allow precision timing of your meal and to help guide you in choosing from the menu.

During your meal, continuous monitoring of several body processes will be carried out. This is entirely routine and includes observation of vital signs, eg, pulse, temperature and blood pressure. You will also benefit from my external throat monitor which can detect (even a tendency to) choking at the earliest indication. A small number of clients have reported feelings of nausea and even a choking sensation which they have associated with this type of monitor. I must reassure any potential clients that there is no evidence to support these concerns and there will always be some individuals who are more sensitive than others. However, customer satisfaction is very important, so in response to client feedback, I am currently working on an internal cheek monitor which clients have indicated would be less restrictive. In the meantime, anti-emetic and anxiety relieving drugs are always on the menu.

Emergencies can arise without warning, for example, anaphylactic shock: a severe, life threatening, allergic reaction, often seen as a result of eating shellfish or nuts. We do not, therefore feature these dishes on our menu. I regret to say that very occasionally, irresponsible diners have brought in packets of peanuts, a significant cause of both choking and allergic reactions. For this reason all diners will have an intravenous infusion set up. This represents a super safe, luxury extra for which no added charge will be made. The time taken to consume a meal varies widely amongst individuals and having considered all factors such as maximum profit from efficient use of tables and the advantage to customers in knowing how long their meal will take, I have devised the following timetable.

W.H.B.A. FUNDRAISING MERCHANDISE

T-SHIRTS: **ADULTS: $15.00**
CHILDREN'S: $12.00

Quality adults 190 gram t-shirts in 100% cotton. Good sizing and of longer length. These are embroidered with the WHBA logo and "Home Birth Naturally".

Sizes L, XL, XXL & XXXL. **White, Grey and Black**
(no black available in L or XXXL)

Children's t-shirts are good quality cotton fabric and these are screen printed with the WHBA logo and "I was born at home" in large print.

Sizes 1 **Orange, Red, Lilac, Lime, Aqua and Royal Blue**
2 **Aqua, Lemon, Sky Blue, Natural and Red**

CALICO CARRY BAGS: **$10.00**
These are strong handmade calico bags which are screen printed on one side with the WHBA logo and "Home Birth Naturally".

PROPITS: **$4.00 (or 3 for $10.00)**
A really nifty gadget! Ideal for use near the computer, phone, desk, where-ever you have paper/bills/photos that need "propping" up. The are white with the WHBA logo and "A Safe Choice – Homebirth" printed the front.

BUMPER STICKERS: **$2.00**
As seen on great cars! White background with "Home Birth Naturally" in large purple printing.

Ordering Information - Please allow up to 21 days for delivery. Postage is 40 cents for bumper stickers and $1.00 for T-shirts, bags or propits. Please enclose a cheque for payment with your order.

WHBA MERCHANDISE ORDER FORM

Please post orders to: Waikato Home Birth Association,
P O Box 15-043, Dinsdale, Hamilton.

Name: .....

Address: .....

Phone:..... .....

Item Description:	Price	Colour	Size	Quantity	Total
Postage & Handling:					
Total Enclosed:					

Calendar of coming events

WHBA Core Group Meeting: Monday 18th August 2003 at 6:30pm at Unit 2-8 Te Aroha Street, Hamilton. Contact Dianne 854 9686 for agenda.

ALL MEMBERS INVITED TO ATTEND.

Immunisation Awareness Support Group: Anyone with Immunisation Inquiries are welcome to the coffee mornings, or ring Traceyann May Ph: 858 3494. "For an Informed Choice" tapes - two copies are available to borrow from the WHBA Library.

Home Birther's Coffee Mornings: Thursday August 14th, 10am, bring a plate and share morning tea at 74 Wellington Street Contact Traceyann ph 858 3494. Welcome to all members, pregnant women who are having a home birth or thinking about having one. Children are most welcome.

Cambridge Home Birth Support Group: Contact Tania Bullick ph 827 5165
Te Awamutu Home Birth Support Group: Small library available. Contact Karene Clark ph 07 871 9114.

Preparation for Birth Classes: The next series dates are in July to book in please contact Jo Simpson ph 846 9226 or leave a message with Dianne on 854 9686.

Pregnancy Yoga and Relaxation Classes - Monday 1:30pm or Thursday 5:30pm, at the St Andrews church centre, 6 Te Aroha Street. **Friday 5:30pm** at Parents Place, 4 Little London Lane, Hamilton.
Contact Hannah Mae ph 856 0221

Te Ahuru Mowai o Waikato - Whakawhanau ki te Kainga. The sheltered Haven Homebirth for Maori Women.
Contact Rangimarie Hohaia 07 871 5858.

La Leche League monthly meetings - Chartwell Group: 3rd Friday,10am, Richmond St Plunket rooms, Annemarie ph: 856 6471. **Westside Group:** 2nd Thursday, 9:45am, Parents Place, Little London Lane, Hamilton, Lynn ph: 846 1013. **Hillcrest Group:** 3rd Thursday, 7:30pm, 51a Wellington St, Hamilton, Anne ph: 849 7675. **Cambridge Group:** 3rd Monday, 10am, Parents Centre, Taylor St Cambridge, Tracey ph: 823 2259.
Te Awamutu Group: 2nd Wednesday, 10am, Kindergarten Room, St Andrews Hall, Mutu St TA, Mandy ph: 823 6522 (Ohaupo). **Morrinsville Group:** 1st Wednesday, 10am, Plunket Rooms, Anderson St, Morrinsville, Anne ph: 849 7675 (Hamilton). **Raglan Group:** 2nd Tuesday 10am contact Dianne for venue 854 9686.

Homebirth Under Fire: What the Headlines Don't Say

By Jill MacCorkle

Media reports of the latest study on homebirth were short and to the point: Infants born at home had twice the risk of death, and both mothers and infants had higher risks of other complications. The study, "Outcomes of Planned Home Births in Washington State: 1989-1996," appeared in the August 2002 issue of Obstetrics and Gynecology, the official journal of the American College of Obstetricians and Gynecologists (ACOG).1 On the day of publication, ACOG, which represents the interests of 40,000 obstetricians and gynecologists in the US, issued a press release titled "Homebirths Double Risk of Newborn Death."2 The lead author of the study, Jenny W. Y. Pang, said in media reports, "It's still a small risk, but women should know there is an added risk with homebirth."3

In contrast to the headlines, the study itself states, "The results... suggest that planned homebirths are associated with an increased risk of adverse neonatal and maternal outcomes, particularly among nulliparous women. Nonetheless, more light needs to be shed on this controversial topic before practitioners and expectant parents can be fairly counselled about the safety of planned homebirths."4 This presents a tale quite different from the one spun for the media.
Knowing that most consumers and reporters will not read the actual study, ACOG can be reasonably confident that, if its statements simplify or overstate the conclusions, few will realise it. But midwives and homebirth experts were immediately skeptical, because the study appears to contradict a large body of research on homebirth that demonstrates that planned, attended homebirth for low-risk women is as safe as, or safer than, hospital birth. The list of studies that confirm that idea is impressive in its length, depth, and breadth. What, then, to make of the Washington State data?

Findings of the Study The stated objective of the Washington study was to evaluate the risk of neonatal (i.e., less than 28 days of age) death for planned home deliveries with professional providers compared with that of intended hospital deliveries. In addition, the authors analysed a short list of other complications. They used linked data from Washington State birth and death certificates as their data source. Unfortunately for the accuracy of their research, "Washington State birth certificates do not identify which homebirths are planned."5 The researchers acknowledged the importance of determining that the homebirth group contains only planned births; unplanned births and unattended births are associated with much higher risks for mothers and babies.6

The homebirth group, after correcting for gestational age of 34 weeks or more and for certain pregnancy complications, included 6,133 singleton births, 279 of which were classified as planned homebirths that were transferred to the hospital during labour. The hospital birth cohort included 10,593 singleton births. These formed the main groups of the study. In further analysis, the authors compared only those births of at least 37 weeks and babies with birthweights of more than 2,500 grams (5 lbs. 8 oz.).

Demographic data for the two groups showed that the homebirth mothers were more likely to be white, married, older, nonsmokers, and parous (having had a previous birth). Curiously, the researchers failed to match the two groups for risk factors, instead matching for birth year only. Since the stated objective was to isolate the effect of birth environment on birth outcomes, the researchers should have made the two groups as alike as possible. They did not do so. Although they later adjust for factors such as age and parity, they report the results of these adjustments inconsistently in their data.

There were 20 neonatal deaths noted in the homebirth group, for a rate of 3.3 per thousand, compared to 18 deaths (1.7 per thousand) in the hospital group. The homebirth group also had higher risks of very low (0-3) five-minute APGAR scores and slightly higher rates of assisted ventilation of more than 30 minutes. The risk of assisted ventilation was statistically significant only for babies born to first-time mothers. The researchers also report that mothers in the homebirth group had slightly higher rates of prolonged labour and postpartum bleeding; again, this was statistically significant only for women having a first birth.

The five authors of this study are all physicians. One works in paediatric haematology and oncology, one is an obstetrician-gynaecologist, and three are epidemiologists (one of these is also a professor of orthodontics). None of the five has direct experience with homebirth, and no midwives were included in the research group. The assumptions they made, as well as the outcomes and analysis they omitted from the study, illustrate their lack of experience in homebirth and their firm roots in the medical model of childbirth. This was confirmed for me when I spoke at length with Jenny Pang.

Faulty Assumptions in the Study Design Because Washington State birth certificates do not indicate whether a homebirth was planned, the authors attempted to isolate planned births by limiting the group to births of more than 34 weeks' gestation. According to Pang, this cut-off point was chosen because a baby born at 34 weeks or older would not necessarily need medical backup or transfer to a tertiary care centre. However, midwives, as a rule, do not attend births of less than 37 weeks gestation; using 34 weeks as an initial cut-off gives the unfortunate impression that midwives are attending preterm births at

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home. The researchers' later analysis, which used cut-offs of 37 weeks and a birthweight of greater than 2,500 grams, may have eliminated some additional unplanned homebirths, but may also have skewed the results in favour of the hospital group, as I explain below.

In contrast to the Pang study, another study of homebirth in Washington State, by Janssen, Holt, and Myers, included a licensed midwife among the authors; the expertise brought to the study design by previous knowledge of homebirth is obvious to even a casual reader.7 The Janssen study concluded that licensed non-nurse midwives' outcomes in out-of-hospital settings were as safe as outcomes for physicians in hospitals or CNMs in or out of hospitals. [See sidebar for additional studies that show the safety of homebirth.] The study used a list of licensed midwives provided by the Department of Health to cross-check data from attendant codes on birth certificates, allowing them to state with confidence that no attendant in their study was misclassified. Pang and her colleagues took no such step, merely selecting records where the birth certificate listed a physician, nurse, or midwife as the attendant. They did not account for the possibility that anyone, regardless of training, experience, or licensing, could self-identify as a midwife.

The authors further restricted their study group by eliminating women who had one or more pregnancy complications listed on the birth certificate, assuming that women with those complications would be considered high-risk and therefore would not plan a homebirth. This is another questionable assumption, given that some of the complications listed (such as a previous large baby, previous preterm or low-birthweight baby, or herpes) do not always automatically exclude women from homebirth care. Midwives usually consider risk case by case, taking into account the history and entire health of a woman rather than simply relying on risk labels. Thus, some well-planned births may have been thrown out of the study group. Pang told me that they were aware of this possibility, but because diagnosis and estimation of the risk of these complications are subjective, they chose to be conservative and exclude all complications. This seems fair, but may not be. More than 24 percent of pregnancies in the hospital birth group were excluded for one or more of these complications, while only 18 percent of homebirths were. Several of these complications might be overdiagnosed in the hospital group, or even caused by medical management; excluding them may obscure the negative effects of hospital birth.
Another telltale sign that the authors did not have a complete picture of homebirths lies in the rate they found of transfer from home to hospital. According to their data, the transfer rate was 4.8 percent. However, studies of midwifery practice indicate that a typical transfer rate for planned homebirth ranges from 8 to 16 percent.8 In a state where homebirth is well established and more prevalent than the national average, it is unlikely that the transfer rate for experienced, knowledgeable midwives such as one finds in Washington State would be so far below normal. In fact, another homebirth study found a high probability in Washington State of appropriate, selective transfer from home to hospital.9 Pang and her colleagues either may have missed a substantial number of homebirth transfers or may have assigned an inflated number of births to the planned homebirth group. If they had been familiar with homebirth, they would have recognised that the transfer rate they found was abnormally low, indicating a problem with their population.

Taking into account all of the potential ways in which the data may have been incomplete or misclassified, it is clear that the authors cannot state with confidence that they adequately controlled the makeup of their study groups. They are well aware of this fact, stating that "misclassification of any unplanned births as planned homebirths in this study would result in inflated risk estimates of neonatal mortality and other outcomes for planned homebirths."10 If the data going into the analysis are not accurate, the results will not be either.

Questionable Choice of Outcomes The choice of outcomes measured in this study is noticeably incomplete, ignoring the negative effects of hospital birth and medical management of low-risk labours. Pang et al. chose to include in their list of outcomes only neonatal death, postneonatal death (the period up to one year of age), very low Apgar score, assisted ventilation of more than 30 minutes, postpartum bleeding, and prolonged labour. They failed to report on any measures of other serious maternal and infant morbidity, such as caesarean section, induction of labour, forceps or vacuum delivery, maternal infection, perineal lacerations, total maternal blood loss, hysterectomy, use of pain medications, postpartum rehospitalization, meconium aspiration, neonatal infection, cord prolapse, placental abruption, uterine rupture, foetal distress, jaundice, or failure to breastfeed. Many of these outcomes are readily available on birth certificates, and other studies of homebirth have documented increased risk of maternal ad infant mortality for hospital births in these categories.

Of all of the complications that the study's authors could and should have considered, caesareans have the greatest impact on immediate and long-term maternal and infant health. Existing homebirth studies already inform us that caesarean rates for women planning to birth at home are drastically lower than for women planning to birth at the hospital.11 The failure to account for the difference in women being unnecessarily subjected to major surgery suggests the authors' bias toward the belief that hospital birth is the standard of safety. The medical model of birth views caesarean section as an inherent risk of birth itself, rather than as an increased risk of hospital birth. But unnecessary caesareans are a serious problem in the hospital setting. In addition to the immediate higher risks of having a surgical birth, such as blood loss, infection, and death, caesareans confer lifelong higher risks to reproductive and general health. Caesareans also leave the next baby at increased

isk of complications, including death.12

n our interview, Pang stated that the researchers considered reporting the differences in caesarean section rates but felt they vould be unable to fairly compare the two because ascertainment of caesarean rates would be less reliable in the homebirth roup. However, they did choose to consider the differences in rates of postpartum bleeding and prolonged labour. Complica- ions such as caesarean delivery, postpartum bleeding, and prolonged labour are indicated by means of check boxes on the irth certificate form. The odds that the person filling out the certificate would accurately report subjective findings of minor norbidity but inaccurately report objective occurrences of major abdominal surgery is difficult to believe. At the very least, ve know that the rate of transfer to the hospital was 4.8 percent; since caesareans are not done at home, we know that the verage caesarean rate for the homebirth group could not have been higher than that, and was probably lower. In contrast, the verall national caesarean rat for the years of this study ranged from 20.7 to 22.8 percent.13

Jut of the wealth of data available, the authors chose two outcomes that are not in and of themselves serious complications, ut that seem to cast homebirth in a negative light. Women giving birth at home may have had longer labours (although the tudy provided no definition of "prolonged" labour), but women in the hospital were likely not allowed to have labours that xceed "normal" length. A longer labour in the hospital is usually "treated" with Pitocin augmentation, instrumental deliv- ry, fundal pressure, episiotomy, or caesarean section. Women in the homebirth group whose labours were longer than those n the hospital group probably had less morbidity as a result, certainly less iatrogenic (doctor-caused) morbidity. When asked vhat the significance of the finding was, Pang maintained that prolonged labour could have serious consequences in the resence of a positive culture for Group Beta Streptococcus (GBS). However, the researchers did not provide data on the inci- ence of GBS, nor did they report any death due to GBS. Two babies from the homebirth group and three from the hospital roup died of unspecified infection/sepsis, but the difference in rates of death from infection was effectively the same. We can herefore assume that the prolonged labours in the homebirth group did not result in a higher rate of neonatal death from GBS r other infection.

'ang et al. also offer no information about the consequences of cases of postpartum bleeding; the information that women at ome had higher rates of bleeding does not mean anything by itself. Although, Pang said, the authors would have liked to xamine rates of postpartum transfusion instead, those data were not reported on birth certificates. But if postpartum bleeding oes not result in complications like severe anaemia, hysterectomy, or transfusion, it is just one more variation of normal. nd, as in the case of prolonged labour, women in the hospital are routinely given injections of Pitocin in the third stage, naking their rate of postpartum bleeding artificially low. Since the authors acknowledge that maternal complications of abour and delivery are reported with questionable accuracy on birth certificates, and since there was no reported clinical sig- ificance of the two complications they reported, their inclusion of these outcomes is questionable.

Deficient Analysis When the authors restricted their analysis to pregnancies of 37 weeks or more gestation and birthweights f 2,500 grams or more, they did not report on the resulting differences between the groups. By comparing the number of ba- ies excluded from each group for low birthweight and/or preterm birth, we find that 81 (1.3%) of babies in the homebirth roup were born between 34 and 37 weeks, or mildly premature. In the hospital group, 392 babies were born between 34 and 7 weeks. This preterm birth rate of 3.7 percent is almost three times the rate for planned homebirth babies. These births vere excluded after restricting the group for complications of pregnancy; they occurred in an otherwise low-risk population. his apparent increased risk of prematurity for the hospital group was not noted or explained in the study. It may be due to hance, or could reflect babies forced out of their mothers' wombs early by induction or elective caesarean. In any case, Pang t al. may have unknowingly found a unstated risk for hospital birth of having a mildly premature baby. Mild prematurity has onsequences: A recent study by Kramer et al. demonstrated that rates of infant death (from birth to one year) are increased hreefold in the US for babies born between 34 and 36 weeks gestation.14 Excluding these babies from analysis means it is mpossible to say whether the increased risk of mild prematurity and potentially higher death rates would have changed the esults of the study.

'ang and her colleagues include information on the causes of death for each group. One cause that accounts for five of the leaths in the homebirth group is congenital heart disease, with approximately 1.7 times as many babies in the homebirth roup dying from this complication. However, the authors fail to provide data on the overall rate of congenital heart disease n either group, including babies who did not die. Without the denominator "that is, without knowing how many total babies n the homebirth group had congenital heart problems to begin with"the comparison to hospital birth is meaningless. Another serious deficiency in the data is the distribution of deaths in the homebirth group. The Pang study does not state vhich deaths from the homebirth group actually occurred at home rather than after transfer to the hospital. In fact, according o Pang, the researchers did not check this, and thus could not report it. This is important because one of their contentions is hat death from congenital heart disease and respiratory distress might be "expected to be amenable to prevention in the hos- ital setting."15 From that statement it appears that they assumed all deaths in the homebirth group happened at home. How- ver, in another study from Washington State, which used some data from the same years as the Pang study, L. Cawthon

Co-ordinator's report for June 2002– June 2003

Well I only took on the role in November/December last year since Clare left us to live in Samoa. So I was only 'acting' the role. Last year we have spent money on advertising. Last year Clare kept to her promise and kept us in the news, Ruth wrote letters and we had adverts regulary. Also our Home Birth week was very successful with a lot of great speakers and throughout the whole week it was widely attended. The gas caliphonts were put together and work great. We sent two representatives to the NZCOM conference in Dunedin in July. We had a great Xmas party with Santa Claus making a special guest appearance for the kids. We had a garage sale this year, which was a huge success. I plan to keep at maintaining a high profile out in the community this year. Our subscription numbers are down, so hopefully we will raise awareness of the importance of being a member and supporting Home Birth. We are hoping to raise money through grants, so we as a core group can focus more on lobbying and getting out there more, instead of fund-raising. Thanks to all the Core Group and members who have helped us in the past year, I hope you will continue to support us.

Dianne De Estena

Treasurer's Report June 2002 – June 2003

It has been an interesting year as Treasurer – lots of banking money, paying bills and keeping accounts up to date. Despite knowing that 'no one ever wants the Treasurer's job' I have actually enjoyed the role.

In the last year we managed to spend a significant amount of money! We spent $16673.88 and our income was $8614.98 so we made a loss of -$8058.90.

We purchased two califonts to help with heating birth pools as a service to members and home birthing women and whanau. We also spent $2149.07 on publicity and advertising which was more than the $1200.00 we had budgeted for but well worth it as home birth is getting more press than it has done in previous years. We also spent $1035 on sending two representatives to the Midwifery Conference which was in Dunedin so costly for us to get to but important that we continue be a presence there. We also spent $2314.93 on birth pool liners which was $1514.93 more than we had budgeted for but we will see that money returned as we on sell them and hire the pools out in the next year.

We continued to receive funding from the Health Funding Authority for our antenatal classes. Hireage of birth pools and selling birth pool liners brought in slightly less than budgeted for. Subscriptions were not as high as we expected so we need to look at ways that we can increase subscriptions in the next year. We also did not put a lot of effort into fundraising – only earning $123.80 (rather than the $1000 we had aimed for!) so the next year may see us putting some effort into fundraising and perhaps getting some grants for other expenses like conference attendance. It is important though that all our energy is not taken up with trying to fundraise as that leaves us with less time and energy to put into promoting and supporting home birth which is really our core business.

All in all, a good year – lots of enthusiasm for getting the word out about home birth and a chance to focus our energies this year on improving our income, maybe trying to secure some grants and of course using our funds to promote home birth and support home birthing women and whanau.

Ruth Hungerford

found that, depending on the cause of death, 85 to 100 percent of the deaths in the Pang study homebirth group happened after transfer to the hospital.16 If this is true also for the Pang population, it would negate their implication that the deaths from congenital heart disease ad respiratory distress in the homebirth group might have been prevented had the babies been in a hospital. Cawthon's data demonstrate that there is a good chance these babies probably were in the hospital when they died.

Pang et al. also failed to examine the hospital charts of the 38 babies who died in both groups. Had they done so, they could have excluded any babies who could not have lived no matter where they were born or what kind of care they received. Deaths unrelated to birth environment should not be included in an analysis of home vs. hospital birth. They might also have been able to find more information about the course of labour and delivery among the babies who died, shedding more light on what effect the birth environment had, if any. With such a small number of records to check, the task would not have been overly difficult. When asked, Pang stated that they lacked the resources to do so and that it would have introduced a new level of complexity to their study. Nevertheless, this information would have added a great deal of credibility. Clearly, the potential for error in this research is great. In addition to making assumptions out of ignorance of homebirth practices, the authors made no attempts to cross-check their data. They freely admit that the study "has several limitations that are related to the reliance on birth certificate data. These include the potential for misclassifying unplanned home births as planned home births and for misclassifying various outcomes and covariates."17 In a study where the differences between two groups are measured in single digits and tiny percentages, the proper classification and interpretation of data are crucial. A few misclassified records could lead to very different conclusions. Moreover, when researchers omit clearly important data, even if by oversight or lack of resources, the results cannot be considered reliable.

Asking the Wrong Question Despite this flawed study, the existing research demonstrates as well as we can ever expect that homebirth is a safe and valid choice for mothers and babies. What needs to happen now, in both the world of research and in practice, is to accept what is known about the safety of homebirth and move on to determine what changes could make home - and hospital - births even safer. Currently, the controversy over the safety of homebirth actually makes it more dangerous. In states where physician groups have managed to make homebirth midwifery illegal, or where obstetricians refuse to provide reliable backup care to midwives, homebirth is not as safe as it could be. A lack of midwives in some areas makes it more difficult for mothers to find a well-trained, experienced homebirth attendant. Increasing the number of practising midwives and ensuring a co-ordinated system of transfer for hospital care when necessary will add to the proven safety of homebirth.

We know, too, that hospital birth can be made safer by adopting the midwifery model of care, which has been shown to result in lower rates of intervention and better outcomes, regardless of setting. We already have a comprehensive blueprint for how to achieve better hospital birth: the Mother-Friendly Childbirth Initiative from the Coalition for Improving Maternity Services (www.motherfriendly.org).

NOTES 1. J. W. Y. Pang et al., "Outcomes of Planned Home Births in Washington State: 1989-1996," Obstetrics and Gynecology 100, no. 2 (2002): 253-259.
2. American College of Obstetricians and Gynecologists, "Home Births Double Risk of Newborn Death," news release, July 31, 2002. Available online at www.acog.org/from_home/publications/press_releases/nr07-31-02-3.cfm
3. Reuters Health, "Home Births Linked to More Infant Deaths," Health eLine, August 5, 2002; available to subscribers at www.reutershealth.com/en/index.html 4. See Note 1.
5. See Note 1.
6. C. A. Burnett et al., "Home Delivery and Neonatal Mortality in North Carolina," Journal of the American Medical Association 244, no. 24 (1980): 2741-2745.
7. P. A. Janssen et al., "Licensed Midwife-Attended, Out-of-Hospital Births in Washington State: Are They Safe?," Birth 21, no. 3 (1994): 141-148.
8. P. A. Murphy and J. Fullerton, "Outcomes of Intended Home-births in Nurse-Midwifery Practice," Obstetrics and Gynecology 92, no. 3 (1998): 461-470.
9. L. Cawthon, Planned Home Births: Outcomes Among Medicaid Women in Washington State, Report 7.93 (Olympia: Office of Research and Data Analysis, Washington State Department of Social and Health Services, 1996).
10. See Note 1.
11. O. Olson, "Meta-analysis of the Safety of Home Birth," Birth 24, no. 1 (1997): 4-13
12. J. MacCorkle, "Fighting VBAC-lash: Critiquing Current Research," Mothering 110 (2002): 58-66.
13. S. Ventura et al., "Births: Final Data for 1998," National Vital Statistics report 48, no. 3 (2000); available online at www.cdc.gov/nchs/births.htm
14. M. S. Kramer et al., "The Contribution of Mild and Moderate Preterm Birth to Infant Mortality," Journal of the American Medical Association 284, no. 7 (2000): 843-849.
15. See Note 1.
16. See Note 9.
17. See Note 1.

Unless otherwise cited, all statements by Dr. Jenny Pang are from a telephone interview with the author.

Jill MacCorkle, BA, ME-PD, is a freelance writer and editor of The Clarion, the newsletter of the International Cesarean Awareness Network. She lives in Paris, France, with her husband, Sean, and their children: Griffen (5), born in a hospital, and Carlin (2), born at home.

Home Birth Story

What a surprise to find out I was pregnant. After conference in Dunedin in July I had my suspicions and then in Invercargill waiting for my period to come, I knew it was not going to. My van broke down and instead of a week's rest without my boys it was stress. I was missing them and they both had chicken pox while I was at conference. The thought of leaving my partner and our so very new relationship was hard enough; we didn't know what we were going to do. Then to be pregnant WOW what a shock. My friend in Invercargill brought me a pregnancy test and when it was positive both of us said I was having a girl. Well we would have to wait to find that out.
I travelled back to Hamilton, stopped in at Dunedin overnight and stayed with Belinda, a midwife and ex co-ordinator for the WHBA. We talked and worked out when I was due, it got me excited to be on this wondrous journey that being pregnant brings.
I left there at 9am, stopped at Christchurch for a break to see my sister. The further I got away from Mark the more scared I was for our future. I got to Wellington at 12 (midnight), fuelled up and went to Bulls and went for a coffee at a mates. I meant to crash there the night, but was too wired and wanting to see my boys. So I left and got to my parents place in Taumarunui just after 6am – 21 hours drive, with only a few hours sleep on the Lynx crossing the strait. After trying to sneak in and go to sleep I heard my boys just waking – I couldn't wait to cuddle them and share my news.
After a few hours sleep, my thoughts turned to midwives. I rang Maggie from Taumarunui, as I wanted to be sure she was available. The pregnancy went well with no problems. Mark and I kept in contact by phone and e-mail; he planned to visit for 2 weeks in October. This was stressful as I wanted him here to support me and to experience the pregnancy. Add to stress levels my van breaking down and not being fixed properly – but finally got sorted. Tarantino (my 7 year old) was throwing up from December for a whole month up to 6 times a day. Many tries at homeopathic treatment then three visits to the doctor and one to the hospital and no help, he stopped. This was hard with him throwing up in the night and not fully waking up. He would sit up – so I would rush in, sometimes it meant a shower and bed change. YAY three months till my due date of March 21st. Mark moved up at Christmas and we adjusted to living as a family.
During this time we talked about the birth – how different are our views, if it was up to Mark we would go to hospital, for me though having had two awesome homebirths there was no way I'd birth anywhere else. This was hard on us both our very different philosophies.
Sunday March 16th I got up late and vacuumed, cleaned the kitchen walls and oven and washed floors (my last thing I wanted done before baby came and strangely enough the same thing I had done before Tarantino was born!!). Then I rushed off to our Core Group WHBA meeting. I relaxed after that.
Mark and I watched the movie, and then I headed to bed tired from the day. A few niggles though lead me to suspect I was not to sleep this night. 10 minutes apart I go back out to the lounge to Mark and ask him "Are you ready to have baby tonight?" he said "no" then asked was I serious... YIP I was.
We moved the couch and started setting up the birth pool. I rang my Mum and Dad and said I'd ring back in an hour, but I think you need to get ready to come. I rang back in ½ hour and it went to the answer phone – I kept trying and got frustrated. Got them 1ish and they are on their way.
I had been going to the toilet frequently I went again and saw a small amount of blood. I also found I couldn't stand or sit through the contractions as it was uncomfortable in my tummy. Which I knew was different to my previous labour pains.

La Leche League MEDIA RELEASE
BREASTFEEDING OFFERS PARENTS PEACE OF MIND

World Breastfeeding Week is held from 1st – 7th August every year, and this year's theme is 'Breastfeeding in a Globalised World'. La Leche League will be promoting the World of Difference that breastfeeding can make.

"Breastfeeding makes a world of difference", says Rosemary Gordon, Director of La Leche League in New Zealand. "In fact, it is something that unites us globally. It doesn't matter what language you speak, it still means the same thing. Breastfeeding means healthy mothers and healthy babies".
The World Health Organisation (WHO) and UNICEF advocate that infants are breastfed on demand and that babies be exclusively breastfed for the first six months of life, with the introduction of complementary foods and continued breastfeeding thereafter – preferably until the child is two years of age, and beyond.
Babies who are breastfed in accordance with the WHO guidelines are less likely to suffer from diarrhoea, respiratory infections, meningitis, ear infections, chronic digestive disorders, dental problems, urinary tract infection and learning difficulties than those who are fed entirely – or even partially – on formula.
"Many women tell us they enjoy great peace of mind, knowing that their babies have a head start on health that artificial milk does not provide", says Rosemary Gordon. "Breast milk is the superior infant food"
Recent Plunket figures show that at four to six months of age, only 9% of New Zealand babies are exclusively breastfed (that is only breast milk and/or medicine given), and just 12% are fully breastfed (only breast milk, medicine and water given). This falls far short of the World Health Organisation recommendation that all babies should be exclusively breastfed until they are six months old.
"It is unsurprising that many of the diseases that breastfeeding helps to prevent, such as obesity, are prevalent, while our breastfeeding rates – especially those of exclusive feeding – continue to languish below the targets set by the Ministry of Health." says Rosemary Gordon.
La Leche League offers information and support to women who want the peace of mind that comes from knowing their child enjoys the best nutrition possible – breast milk.
"We encourage mother-to-mother support, and have trained Group Leaders present who can provide information regarding specific breastfeeding situations" says Group Leader ...Dianne De Estena.
La Leche League New Zealand can be contacted at llinz@clear.net.nz

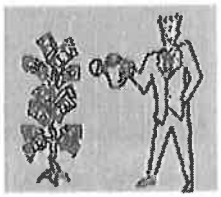
Please note: "La Leche League" is pronounced "La Lay-chay League"
'La Leche' is Spanish and translates directly to *'the milk'*

For more information please contact:
For local details of groups see page 5.
Rosemary Gordon ph: 07 378 8044 or email jrgordon@xtra.co.nz
(Director – La Leche League New Zealand)
Amanda Clifton ph: 07 823 6522 or email amanda@themarketeers.co.nz
(World Breastfeeding Week Co-ordinator – La Leche League New Zealand)

We were helped on the day by Annie Halse-Smith, Joanne Ridder, Telisa Pearson-Collett (and me) who got stuck in and sold furiously to the teeming millions that descended on my house at 7am! Also thank you to two marvellous husbands Stu and Simon who made shelters from the storm and got out and sold stuff when the hordes started breaking down the gate to get in! And thanks to Traceyann Mae for helping to set stuff up and sort through clothes the day before.

We also got some (free – the best kind) press coverage in the local Hamilton papers. Not sure if we got anything in the community papers from other areas but they were sent our press release so we'd love to hear if anyone saw an article about us in their local paper.

We are keen to make this an annual and maybe even bi-annual event so start putting aside those things you don't need now. *If you want to donate some stuff but can't store it please phone Ruth (855 2683) or Telisa (854 7585).*



Other fundraising news

As money doesn't grow on tree as my dear Mama always said, we've been tossing around ideas for fundraising and have set ourselves a goal to raise $1500 this year (we've already raised $500 with the garage sale and merchandise so only $1000 to go!). We don't want to spend all our energy fundraising as then we have none left for spending the money on promoting and supporting home birth. So things like the garage sale are fairly low stress for pretty good return.

We are planning a sausage sizzle outside a supermarket or Warehouse or something *(we need some volunteers to give an hour to stand outside and sell some sizzlers – please call Dianne, Telisa or Ruth if you can help).*

We'll probably have a raffle this year – *if you have something that you would like to donate for us to raffle that would be great.* It could be anything – a load of firewood, a voucher for a free 'something', or …(feel free to offer something here).

Ruth Hungerford

I rang Maggie and said I will ring in an hour, but that it looks like things are heating up so to speak. It is now 2am, by 2:30am there was more blood and the pain in my stomach didn't feel normal. So I had to ask Mark to ring Maggie and told her to come now.
I decided since things were stepping up I'd get into the pool – the temp was too hot so Mark got buckets and filled it up. While he was filling one up outside, I needed him, I was kneeling on the couch leaning over the arm. I yelled at Mark to come – he didn't hear me and I swore and yelled then cried. He came and held me saying he hadn't heard me, I told him not to leave me again. I tried the pool and the temp was fine. So I hopped in, Maggie came not long after 3am and checked baby's heartbeat and all was fine, but we notice small blood clots in the pool. Maggie rings Sheryl (student midwife) and tells her to come and asks shall we ring Sonia (student midwife) and I said to wait until Sheryl arrives.
Also the pool hasn't helped with the pain and I feel I can't relax my stomach in between contractions. Mum and Dad arrive 3:30am and Mum says hi as she comes in, I yell at her to shut up swearing. I'm not coping with the pain as I have no break and I'm feeling scared. Maggie checks baby's heartbeat, it is ok, but there are more clots. Maggie wants me out of the pool to check my stomach, which is very tight. There is a big clot when I hop out of the pool. I kneel by the pool during a contraction and I cry feeling scared, nervous and uncertain of how things will go. I'm feeling scared as I know this isn't normal. Maggie explains we need to check this out with a scan and blood tests, to see whether it is my blood or baby's, it could mean placenta previa. Maggie rings WWH to tell them we are on our way. Dad is here and will stay home since the boys are asleep.
I am lying on the couch and Mark is next to me, holding me, I tell him "It's ok". But I am not sure whether he needs the reassurance or that I do. Am I telling him or myself, I feel scared; this isn't how it is supposed to be. Maggie gets the car ready, I hop in the back lying on Mark, Mum is in the front (she had got baby's clothes from the hot water cylinder – yay). Maggie attempts to back out 6 times I keep thinking get me there this is hideous. A 5-minute drive that I'm sure took an hour; Maggie was explaining what it could be and what tests we needed. We arrive at the hospital at 4:20am and no-one was ready for us Maggie had to get a wheelchair then wheeled us to a room. I wanted out of the chair as it hurt to sit down, Maggie said no and quickly wheeled up to the room – then went and got the registrar, ON to the bed – this isn't happening, I'm not here. On my back (hate this) scan reveals placenta isn't' in front of baby (YAY) and she does a VE (OUCH), I'm fully dilated. They insert a line in my left wrist – telling me to keep still, so I did and tell them to hurry up and just do it. ON my side and someone is messing with my back and I push there hand's away. Sheryl arrives and Maggie tells me so I know. Baby's heartbeat is fine and I get asked if I want gas Maggie says "she's a home birther if she wants something she'll ask for it" I think yeah don't want gas; if I'm here I'd want the hard stuff. I actually said out loud "Don't want gas" was kind of incensed at the offer really. Maggie tells me to turn over onto all fours – telling registrar and other midwife that's how I birth. They keep trying to get baby's heartbeat and can't, so ask to put on a scalp electrode – Maggie whispers no, and then I say NO back to them. Then they look to Mark, wanting him to say yes. I tell Maggie I don't want to be here, she says well push baby out and then we can go back home, push deep into my bum as I hadn't been they last two pushes. I put my head into my nightie – tis like I'm in another place and I tell myself I can do this and I breathe (this feels like I have escaped for ages) then emerge focussed. The other midwife puts the pillows in front of me (making it easier to lean on), and I lean over them. Mark is right next to me, holding me. A good push, then I sit right up so the registrar can listen to baby's heartbeat. Sheryl wipes my forehead ahhh bliss and I cuddle into Mark. Someone

(Maggie) has hot cloths on my perineum and I concentrate my pushing there – they feel sooo good. A few more pushes and Maggie tells me not to stop, baby is right there and then she is born. I pull her threw my legs and up. Maggie helps – baby isn't breathing, so Maggie tells me to blow on baby and talk. She suctions baby and baby coughs a little. I cuddle baby and want to turn around and lie back. I can't wait to check the sex, I have a little girl, Mark is right there and I smile and tell him. I turn around the hospital midwife and registrar are gone, no congrats just gone. We wrapped towels around baby against my body she is breathing fine. 4:20am she was born only 20 minutes after arriving at WWH!! But it seemed a lot longer that that! There is a bit of blood and I feel sticky and yuk, baby's poo's on me as well! Sheryl gets some cloth's and wipes me a bit and we get a clean sheet under me. Maggie tells me baby was born in her caul and she had to break it. Hospital midwife pops in and comments how perfect her head is – Mark liked that.

We have a coffee and baby feeds. I rang Dad to say everything is fine and that we have a girl, and asked him not to tell the boys. The placenta comes 45 minutes later and Maggie catches it this time (with Serrano she missed and it landed on the floor). I laughed at this. Another coffee. I give baby to Mark after he cut the cord. We discuss how I was treated by registrar and Maggie goes to talk with her, she comes back and feels better about why she did VE etc. Mark gives baby to Mum and goes for smoke with Maggie. Sheryl goes over the placenta when he comes back. A lot of blood clots, but otherwise good. We talked with Maggie about why I bled and had stomach pain – "placental abruption" the placenta coming away caused the bleeding and pain. I go with Maggie to showers. Then we get baby and leave – Mum had gotten her dressed while I was in the shower. We arrive at home at 6:30am and Dad and the boys rushed out to meet us, I tell them it's a girl – which they already knew. They were always saying they were getting a sister, dad hadn't told them it was a girl. They had huge smiles on their faces. We sit down and have coffee and biscuits. Dad comments on that it is St Patrick's Day March 17th. I ring Sonia and tell her, she will visit after dropping her son at school. Mark, Ariana Rhiannon Lynda De Estena-Kennedy and I go to bed. Sheryl takes a photo of us all and the boys. Sheryl and Maggie leave. I stay awake until Sonia comes, I'm feeling tired though....then after Sonia left I sleep.

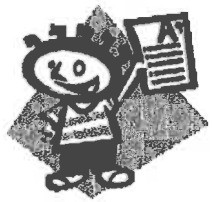
What a journey. Not at all what I wanted and in so many ways I feel sadness at that. I am glad we transferred as there was a risk of placenta previa. The registrar said to Maggie that we could have stayed at home – great to say in hindsight. It was a good reason to transfer and that is what a hospital is for, to use extra equipment if it is required. Funny thing in my notes it says I had a "non-caesarean delivery" I kind of think they need to change the language they use there.

I'd like to thank Maggie for her strength, for her support and her voice. You are an amazing advocate for birthing women, giving them their voice in an environment where they easily lose all strength to ask for what they want. Thank you Sheryl for being a great support to Mark explaining what was happening to him and my Mum. To Mark I know a home birth wasn't your choice, but I than you for supporting me in my choice. You were amazing being there with me and for me. We created a perfect baby through our love, I thank you.

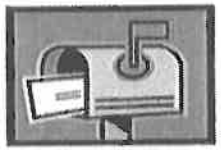
Dianne De Estena - This photo was taken when Ariana was 4 days old.

In the News

Well we have been getting a bit of press lately.



Congratulations to Home Birth Midwife Michelle Keene for doing so well in her state exams. Michelle is an active member of the Core Group and has worked extremely hard to get to this point. Michelle understands the importance of having a home birth philosophy when working with women who choose to birth at home and as a student midwife she actively supported many women to have home births. Well done Michelle. We know you will be an outstanding home birth midwife and we all look forward to continuing to support you and the Waikato women who choose to birth at home.



My letters have also been getting published a lot! And great to see that someone was willing to write a reply to one of them– maybe we'll get some dialogue going! I would encourage any of you out there to write in to your local paper. Also if there are any articles in your local community newspaper that you think need a reply but you don't have the time to write, I am more than happy to write to them to – just post or fax me the article and I'll continue to make myself infamous in the media!

Garage Sale

A big **thank you** to everyone who contributed stuff to our garage sale *(which we had in March but I have only just found the time to write a blurb about it!)*. It was a big success. Despite the rain threatening to postpone the day and the almost drowning us half way through, we made $400.00 which was fantastic! *(I tried to get a photo of Joanne valiantly holding off the rain complete with drizabone hat and rain trickling down the back of neck but my cameral battery was flat! So this clip art picture will have to do)*