From: NEW ZEALAND COLLEGE OF MIDWIVES (INC)
P O Box 21-106
Christchurch New Zealand

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NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

April / May 1995

AGM : Call for Nominations
: Remits

Folic Acid

Triple Test

NEW ZEALAND COLEGE OF MIDWIVES (INC)

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Many choices for childbirth

CH CH PRESS

PARENTING

by Sally Blundell

From the day the pregnancy test comes back positive the birth of your child becomes the main focal point for the following months.

The when, where, how, and who with are gone over again and again but, as more birth options become available, decisions are harder to make.

Karen Guilliland, national co-ordinator of the New Zealand College of Midwives, believes the very range of birth options can make it complicated for women trying to make choices.

"In Christchurch every possible choice is available to suit your philosophy of life and your health needs," she says.

Because birth has a huge social and psychological component, as well as physical, the importance of being in an environment and with people you are happy with and informed about cannot be underestimated.

The ideal, says Karen Guilliland, is to take away the fear of the mystery of birth, to de-mystify birth and get information free from fear and bias.

"You need to know what is incorporated in each option. Choice is only good if it's informed choice."

Few of you reading this would have been born in an environment chosen by your mothers — the options now are a far cry from the simple see your doctor, book into the local hospital instructions they would have received.

To begin with, you have a choice of persons who will care for you during pregnancy, deliver your baby and provide care for you and your baby after the birth.

You can choose:

- An independent midwife (also known as a domino or domiciliary midwife) — specialises in normal pregnancy and birth and can provide care before, during and after birth at your home, birthing centre or hospital.

- Family doctor (GP) — will provide care before, during and after birth at a hospital, birthing centre and, by some doctors, at home. Some GPs will not attend the birth or will attend for only part of the labour and birth.

- Hospital midwife — will provide care before, during and after birth at a hospital. Some hospitals can provide midwifery care where the midwife will visit you at home before and after the birth and attend the birth in the hospital without being replaced when shifts change.

- Private obstetrician — specialises in complications during pregnancy and birth. Provides care before and during birth and may provide some care after the birth. Like GPs, they may attend only part of the labour and birth and are usually supported by the hospital midwife on duty. Care from an obstetrician is available through the clinic at Christchurch Women's Hospital or privately through their own rooms (at a fee).

- Shared care — you can choose a combination of caregivers such as: an independent midwife and your own GP, a hospital midwife and your own GP; a midwife and an obstetrician; a GP and an obstetrician.

Choosing a caregiver or lead professional to care for you takes time. Ideally, the person you choose is one who will listen to what you want, who understands and is in touch with what you want, who shares your ideals and provides all the information you need to make safe and satisfying choices.

Shop around. It is your right to be treated with dignity and respect, to choose your caregiver and change your caregiver/s at any time if you are not completely happy with your choice.

Once you have decided the who, you should be given all the information to best decide the where. Again, the advice is to investigate each option:

- Home — where you can be attended by an independent midwife of your choice or your midwife and a homebirth doctor.

- Small maternity hospital — Burwood, Lincoln, Rangiora, St George's where you can be under the care of an independent midwife of your choice; an independent midwife and your GP; a GP and a hospital midwife; one or two hospital midwives (except at St George's Hospital); an obstetrician and hospital midwife; obstetrician and independent midwife (no obstetricians attend births at Rangiora Hospital).

- Large maternity hospital — Christchurch Women's Hospital under the care of the same options as above, or by the hospital team of midwives and doctors who happen to be on duty.

- Birthing centre — Avonlea Birthing Centre attended by two Avonlea midwives.

Birth at any of these places is free as long as you are a New Zealand citizen. You will have to pay only if you choose the care of a private obstetrician. It is advisable to ask smaller hospitals if there is any fee for staying longer than is deemed necessary by the health professionals or for transferring from another hospital more than 24 hours after delivery.

The advice from Karen Guilliland is to shop around, talk to people, visit maternity hospitals or wards.

"There's plenty of research that shows the caregiver of your choice plays a very important part in the whole birth. You need to find someone who will lead you through every option and encourage and promote the decision-making.

"You have nine months for planning, learning and making changes, that's what pregnancy is all about."

Every woman has the right to give birth where she wants attended by who she wants, including for her first baby.

- To find out more about birthing options in Canterbury, the Midwifery Resource Centre at 906-908 Colombo Street offers information by way of books, leaflets and videos every week day between 9am and 5pm. A midwife is available to discuss options every week day between noon and 2pm.

An information night for women and their partners is held on the first Tuesday of every month from 7.30pm to 9.30pm at the Midwifery Resource Centre. For more details phone 365-2789.

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NATIONAL COMMITTEE MEETING CALENDAR 1995

19th and 20th May

25th and 26th August (and AGM)

17th and 18th November

ADVERTISING

Advertising in the National Newsletter is FREE to affiliated non-profit making organisations with maternity related issues, i.e. NZCOMI Regions, Home Birth Association, etc. For advertising rates and more information, please contact:

Julie Richards
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DEADLINE

for the next Newsletter is 1st June 1995
Posted 26th June 1995

Any contributions to the National Newsletter should be addressed to:

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DISCLAIMER

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EDITORIAL

Welcome to another newsletter, hot off the press. I am excited to print my first Letter to the Editor - thanks Viv. It was great to get such a constructive response.

Remember, this is your newsletter therefore I want to provide the information and material that you want to read about. If you have an article that you want to share - send it in. If it's long - you could write an abstract from the article. An abstract also avoids the need to obtain permission to reprint.

Thank you to the members who have sent in material, you may not see it printed immediately but it will generally come through. Some of the newspaper articles have been too large to print - again, a summary of the article would be ideal in this situation.

Also if anyone would like to write a book review or a report from a workshop/seminar - I'd be delighted. Just send it in. How about the recent Vaccination Sympossium and Chloe Fisher Workshop - I'll be expecting reports in the mail shortly. Enjoy!

Julie Richards

"Quote of the Month"

I was recently in the not too unusual situation of needing to request test results from a GP as the woman had moved towns and also changed to total midwife care. My first request received a patronising response asking me to advise of a GP to whom the results could be sent.

I was somewhat shocked and stunned as it had been some years since I'd received a response of that nature in Christchurch, but I reminded myself this wasn't Christchurch.

I therefore politely responded making reference to the Nurses Amendment Act 1990 and the Privacy Act.

The second response was prompt, the results were included and at the end of the letter was a little gem that I thought should be shared:

"Helpful hint : Don't lecture to your betters"
Dr P R Sparks, MB, ChB, DCH, DRCOG

So do you think the women of Ashburton are given their full range of choices?

POLITICS - NEWS — The Dominion 17/2/95

Fewer unmarried women giving birth - statistics

FEWER babies were born in New Zealand last year and the number of unmarried women who gave birth fell for the first time in nearly 15 years, government statistician Len Cook said yesterday.

The latest births and deaths statistics were presenting subtle changes in the dynamics and structure of the New Zealand family, he said.

They showed that 57,439 babies were born last year, 1427 (2.7 per cent) fewer than 1993, the fourth successive year births have declined since the peak of 60,153 in 1990.

The decrease occurred despite continuous growth in the pool of potential childbearers, and the total fertility rate of 2.05 births per woman fell below the level required for the population to replace itself in the long run without migration, but was still well above the record low of 1.92 in 1983.

Unmarried women, many living with partners, had 22,140 babies, 214 (1 per cent) fewer than 1993, the first break in an uninterrupted rise since the early 1980s.

Statistics New Zealand said it was too early to tell whether the decline in ex-nuptial births was short-term interruption to the trend or evidence of a definite change, perhaps because of changing social attitudes to childbearing outside formal marriage.

Births to married couples fell by 1213 (3.3 per cent) to 35,299, but first-time mothers, whose average age was 29, were about three years older than those of 1984.

Longevity continued to improve and provisional figures for 1992-1994 showed the life expectancy of men (73.4 years) and women (79.1) was up about six months on 1990-1992 values.

Deaths totalled 27,092, down 151 on 1993, but the excess of births over deaths shrank from 31,623 to 30,347, a decline of 5.3 per cent.

Birth weight linked to cholesterol levels

CH CH PRESS 20/4/95

Two research papers from the University of Southampton, Britain, published in the "British Medical Journal", report that high cholesterol, and the risk of heart disease, are associated with impaired growth during the last months of pregnancy and the first year of life.

The researchers believe this link, found in both men and women, may be caused by the effects of undernourishment on liver growth in the foetus during the late stages of pregnancy. It seems this impaired liver growth may permanently alter a person's ability to adequately control their cholesterol levels.

These findings, from the university's Environmental Epidemiology Unit, are part of growing evidence which shows that the metabolic abnormalities which lead to heart disease are programmed by nutrition during gestation and infancy.

Data on 236 infants born in Jessop Maternity Hospital in Sheffield, England, was obtained from hospital records and the National Health Service register. The study found that middle-aged men and women who had a small abdominal circumference at birth — a factor reflecting the size of the liver — tended to have raised cholesterol levels as adults.

These findings correspond with previous research showing that adult men and women who had low growth rates in the womb, or in the first year after birth, tend to have raised blood pressure, impaired glucose tolerance, abnormal blood coagulation, and raised death rates from coronary heart disease.

The implications of this research could have a major impact on public health. Lowering the average cholesterol level from 6.5 to 6.0mmol/l has reduced the risk of heart disease by around 30 per cent.

The researchers conclude by referring to current public health measures that emphasise the importance of reducing weight to lower cholesterol levels in adult life.

A second study from the same research group confirmed that the correlations between heart disease and birth weight are similar in men and women. They also showed that heart disease in men is related to weight gain in infancy, although there was no connection found between weight in infancy and death from heart disease in women.

This study screened the medical records of more than 5500 women born between 1923 and 1930 and provides the first evidence that early growth may be linked to death from heart disease among women.

Death rates from heart disease in men and women fell progressively as the birth weights ranged from low to high. It also replicates the researchers' original observations among men.

Given that the death rates from heart disease among women and men fell progressively as birth weights increased, the researchers conclude that reduced early growth is a cause of heart disease.

BUCKLAND — Sharon, Ross and Jamie are thrilled to announce the arrival of Troy Alexander, on Sunday, March 5, 1995. Troy was born naturally at home (following a previous Caesarean). Baby weighed 8lb 10oz and both mother and baby are doing well. Special thanks to our wonderful midwife Rose Gray and Kate Salmons, the Christchurch Home Birth Association, and our tremendous helpers and supporters Janelle, Annette, Raylene and Brett. (Thanks also to the R.H.A. whose policies convinced us that home birth was the best alternative.) Visitors are welcome but please phone first.

Another example of the strength of consumers and the need for a maternity service that meets consumer demand

Rural Southanders to trial pilot maternity scheme

PREGNANT women in rural Southland will be among the first in the country to trial controversial new maternity care arrangements.

The area is one of only two chosen by the Southern Regional Health Authority to pilot the "lead professional" scheme. The other area is metropolitan Dunedin.

Midwives and doctors say their working relationships could deteriorate under the scheme and the administrative workload could be excessive.

The authority is distributing model contracts to potential providers next week and inviting comments before drawing up final contracts.

In the pilot, women will choose their preferred health professional to provide all the services they need before, during and after the birth of their baby.

The lead professional can be a midwife, a doctor or a specialist. The person chosen will sub-contract any services they are unwilling or unable to provide.

The New Zealand College of Midwives said it had some reservations about the lead professional concept, but was willing to try and make it work.

National co-ordinator Karen Guilliland, of Christchurch, said the college did support one of the main philosophies behind the scheme — to give women continuity of care.

But there were some concerns that professional relationships between doctors and midwives could deteriorate.

Doctors might resent having to take instruction from a midwife lead professional and vice-versa...

"At the moment they generally work well together but with the new arrangements the relationships might not be so harmonious," she said.

The college was also unhappy at the implications of shifting the administrative workload from the regional health authority to independent providers.

Winton GP Phil Jacobs said there were concerns on how the subcontracting aspects of using a lead professional would work in practice.

Before entering into any contract with the authority, Winton doctors would want to be sure it was advantageous for women and did not burden the GPs with an administrative workload they would struggle to cope with.

Tuatapere GP Clem LeLievre said any contract would have to compensate for the extra paperwork involved.

"There'll be a lot more accounting to do. The subcontracting will mean keeping track of a lot of ingoings and outgoings.

"But from a clinical viewpoint, I don't believe that patient care will be (adversely) affected under the system," Dr LeLievre said.

Health authority women's health needs manager Veronica Casey, of Dunedin, said lead professionals would have to meet safety and quality criteria.

In the pilots there would be no compulsion for women to choose a lead professional.

Those that did would be involved in an evaluation study to ensure the scheme was resulting in safe outcomes for both mother and baby, she said.

SOUTHLANDER (INVERCARGILL)

Cultural safety 'misunderstood'

Chch Press, 21/2/95

PALMERSTON NORTH — Cultural safety courses for nurses do not mean knowing how to swing a poi, according to their architect, Irihapeti Ramsden.

Ms Ramsden, a nursing educator, was responsible for introducing the controversial "cultural safety" component into New Zealand nursing training.

Speaking at Massey University's health care ethics conference at the weekend, she said cultural safety had been misunderstood by the public, and suffered a raw deal in the media.

It did not mean learning traditional Maori customs, nor did it relate solely to Maoris, though the concept had come from the Maori people.

Cultural safety was about access to services and communication. It was about nurses listening to their patients, respecting their cultural and social backgrounds, and not making stereotypical assumptions, so patients from all cultures felt safe. "Cultural safety in health services occurs when people feel fully able to use a service provided by people from another culture, without risk to their own (culture)."

Nurses had to understand their own culture and attitudes so they could be flexible towards patients coming from different cultures to themselves.

An important aspect was teaching students not to blame the victims of historical and social processes for their current plight. For example the problems of Maori youth were often blamed on poor parenting skills, young Maori women were blamed for their high smoking rate.

"(These problems) are about colonisation, and every nursing or medical student should know that."

Ms Ramsden

Ms Ramsden said cultural safety training was still relatively new and she admitted not all polytechnics had handled it well. One polytechnic had been teaching students the Lord's Prayer in Maori, and how to use Maori poi, but this was inappropriate. Nursing students wanted something they could apply to their work.

The Nursing Council was working towards standardising the cultural safety component of all polytechnics.

Ms Ramsden said New Zealand led the world in cultural safety training and other countries were now looking to introduce similar components into their nursing courses. She hoped other New Zealand health professionals, such as doctors, would eventually include cultural safety in their training too.

She realised the term "safety" had put people off, but said it had been chosen in consultation and would not be changed.

The idea of cultural safety evolved after Maori groups said some Maoris were not using health services because they did not feel emotionally and spiritually safe.

Cultural safety also applied to nurses dealing with patients of a different age, sexual orientation, or socio-economic level to themselves.

"The issue is to recognise that people can differ in profound ways from their service providers." —NZPA

LETTER TO THE EDITOR

Dear Ed,

I note your clipping included in the National Newsletter Feb/March 1995 p34 on Postnatal Depression. It is great to see this included but I felt no recognition in reading this note (titled psychiatry) of what postnatal depression means to me as mother, midwife and woman.

Specifically (1) I am not sure what a 'vulnerable personality' consists of, and wonder of psychiatry's understanding of the psychology of pregnant women and new mothers.

(2) The medicalised description of the three categories of postnatal mood disorders disturbs me. The labelling of three distinct entities as clinical disorders does little to address the huge socio-cultural issues surrounding this distress and implies that hormones, pregnancy and difficult births, difficult babies and tiredness are causes. Nothing is discussed re changing family dynamics, partner depression, or lack of social awareness re the reality of childbirth and mothering. I refer you to a 1992 paper by Cooper, Murray and Stein from Journal of Psychosomatic Research vol 37 No 2 pp171-176, and note that these authors found no correlation between difficult births and postnatal depression. In fact the correlation is between the amount of information and control the woman was given in her labour/difficult birth.

(3) Consequences of maternal depression are identified as cognitive impairment of the child and increased risk of child abuse. In fact, perhaps the cognitive impairment for the child, and the child abuse could be seen to stem from the same dynamics that are causing the depression. Of note, is that it seems to be that in our society, feeling distressed after having a baby is not seen as within a normal response spectrum, and this normalisation and legitimisation (often in my experience very effective in decreasing symptoms) does not occur.

Labelling is distressing itself in that it leads to perhaps implying that families and society have no part in triggering a woman's distress and do not need examining. Often anti-depressants are prescribed needlessly (not always) and without a change in social dynamics are not effective in dealing with the distress. Perhaps we all need to look at our labelling processes and reflect on who this label is befitting.

Kind regards
Vivienne Axon, Midwife
Auckland

INTERNATIONAL MIDWIVES DAY

Friday 05th May

What do you and your region have planned to celebrate this day?
Reports and photographs welcome for the next issue .....

NATIONAL CO-ORDIANTOR'S FORUM

- Karen Guilliland

As independent midwifery practice grows so too does the understanding that independence is centred on how you practice not where. More and more CHEs are accepting and working towards empowering their employed midwives to practice independently. Continuity of care is being recognised as the vehicle for midwifery practice which provides the maternity service women want and to which they are entitled. Caseload management is increasingly understood and being considered as the most effective and easier way to employ midwives. Women of course have been telling us this for some time.

Midwifery knowledge is increasingly respected as valid and the College is now being asked for input into clinical consensus statements which guide practice.

We have worked hard as a profession to have our profession acknowledged as existing in its own right. We are finally moving some organisations and some institutions towards understanding the difference between proscriptive protocol setting for mindless judgements and consensus positions arrived at through discussion and decision making which centres on the needs of women and their families.

I feel cautiously excited by the now possible reality of providing a truly woman-centred midwifery and maternity service in a collegial and user friendly environment. For those more cynical I know that we have a way to go before this environment is universal. Many midwives still face hostility and obstruction in their day to day working lives. However, the signs of change are around us and we should be heartened. Social change is never rapid yet we have achieved some major concessions and acknowledgments in less than five years. These changes have also occurred in trying circumstances where medical hostility and media campaigners have all contributed to less than an ideal start.

The changes for midwifery I have noticed include:

College and individual midwives being requested for input on health policy by a variety of professional organisations, Government, RHAs and CHEs.
The Governments acceptance of and neutral stance towards doctor and/or midwife as lead maternity provider. The RHAs policy direction for women-centred maternity services based on choice of provider and continuity of care.

MEDIA WATCH

PHOTO: DOMINION

Midwife Sandra Sinclair with Tania James-Hall and baby Kuini Rose, whose birth had unexpected complications in the form of police

Sinister screams disguise a joyous event

THE PRESS 14/2/95

WELLINGTON — Police got a surprise when they entered a Lower Hutt house after reports of prolonged yelling and loud moaning.

Inside the Richmond Grove home, two officers found a man with blood on his hands, some very surprised women — and a new-born baby.

No-one was more surprised at the arrival of the police on Sunday than Tania James-Hall who, only seconds before the intrusion, had given birth to 4.2kg Kuini Rose.

Neighbours had misinterpreted Mrs James-Hall's yelling as some very active love-making but, when the yells persisted, thought something more sinister might be happening.

The blood-covered man was father Jonathon James-Hall.

"My mother answered the door and when the police saw me coming down the stairs covered in blood their face just dropped," Mr James-Hall said.

Mrs James-Hall said the neighbour were probably not aware of her con dition because the family had move into the house on Saturday.

"I guess it's a bit embarrassing t think that they thought we were mak ing love, but it's nice to know neigh bours are ready to act when they thin something is wrong." —NZP

"I regard it as an unbearable defect that doctors, social workers, nurses and psychologists have constantly to ensure that the various groups work together, but they do not give a thought to the frictions resulting in their teamwork". Dr Peter Mehne, chief psychiatrist for Merheim District ("The German Tribune" 21 February 1992). Exaggerated competition and protection of careers are negative forces.

Reactions to Motherhood

Jean Ball

£9.95

144 pages

1-898507-08-2

Following the success of the first edition, this revised and enlarged book describes the reactions to motherhood of a group of 279 women from the last month of pregnancy until six weeks after the birth of the baby. The mothers' reactions are considered within the context of other research into postnatal depression and the role of support systems.

Chapters include:

- Birth and change
- Factors involved in the coping process
- Emotional reactions to motherhood, maternal-child relationships and postnatal care
- Undertaking the research
- Some personal details about the mothers, their labour and delivery, and observations of postnatal care
- Factors surrounding the mothers' emotional well-being six weeks after the birth
- 'Loading the dice': interaction of personal needs and support systems
- Developing a flexible support system

Published September 1994

Holding On?

Hazel McHaffie

£9.95

224 pages

1-898507-21-X

Holding On? combines the gripping drama of a novel with the serious exploration of the ethics of prolonging the life of preterm or severly abnormal infants born on the edge of viability. Set in a busy, regional Neonatal Unit, this novel traces the agony of staff and parents in trying to decide Peter Flanaghan's fate. Should he, a preterm baby, be kept alive on life support? Each of the individuals involved brings something of their own, personal life experience to their attempt of answering this question - experiences with severely abnormal children, with infertility, with incapacitating illness. Personalities, religious convictions and childhood trauma all influence the way each of them feels and responds to the issue. Can so divergent a group of individuals reach a consensus? Resolving the dilemma is urgent. A decision cannot be put off. The hours tick by inexorably. The reader is held in suspense to the last page.

This book will touch the hearts of parents and all those who have experienced the tragedy that the birth of a 'less than perfect' baby can bring to a family. It will also open the eyes of health professionals to the living experience that can surround the care of premature or severely abnormal infants and pose the ethical dilemmas that this novel illustrates so poignantly.

Published September 1994

BIRTH REGISTERS
now available

These allow midwives to keep comprehensive records of client's details and are tied into information needed for Midwifery Standards Reviews

$18.00 each

Cash with order to
P O Box 88
Tauranga

Acceptance of the equal pay for work of equal value for maternity services. CHEs acceptance of continuity of care and recognising this responsibly with increased remuneration packages equal to self employed midwives. Medical organisations approaching the College for discussion on issues of mutual interest and concern.

Direct entry midwiferys acceptance as the ideal way to educate independent practitioners. The employment of new graduates by CHEs and the mentoring by self employed midwives.

Individual midwives uptake of independent practice and their determination to be respected as professionals.

Individual midwives working out relationships with medical practitioners which recognise their right to equal status and provide women with real choice. Individual midwives who take annual standards review as an integral part of their professional life.

Midwives ongoing commitment to a partnership relationship with consumers in both organisational and clinical roles.

The continued success of independent practice will rest on the clinical judgements and practices of individual midwives as they face the challenge of autonomy.

It is imperative that all midwives practice from a research base and where that is grey, from an informed choice basis.

There are many available resources for midwives. The College regions are all steadily working towards a building to focus local midwifery resources but chairpersons in your region are always available to refer you to the resources you need. The National Midwifery Resource Centre is available to either provide the information or point you in the appropriate direction. MIDIRS is a publication subscribed to by midwives who find it invaluable. Midwifery schools located in Auckland, Hamilton, Wellington, Christchurch and Dunedin have excellent libraries and references if you are enrolled in any of their continuing education courses. The local College region offers seminars, workshops and updates sometimes jointly with the polytechnics and sometimes as separate courses. Write and ask your local polytechnic or College region for the dates and places of any courses available. If there are none

scheduled create a demand! The Open Polytechnic offers long distance modules on midwifery practice which many are finding valuable. The Universities of Victoria and Massey offer post-graduate education opportunities for the more academically inclined. More and more midwives are entering into research projects jointly with medical and CHE organisations.

The College is currently developing a collection of consensus statements on a variety of clinical situations, together with references to be available from your local region.

The Handbook for Practice which describes the professions standards and ethics provides the foundation for practice which protects both midwives and women and promotes competence and confidence. The Midwifery Standards Review Committees throughout NZ provide all midwives with the opportunity to discuss, share and learn from their experiences. A competent practitioner reflects, analyses, consults, questions, documents and acts on her assessments. The Midwifery Standards Review is the measure against which a midwife can confidently believe her own practice to have reached a standard acceptable by both colleagues and clients.

The responsibility for the success of the profession and a safe reliable and wanted midwifery service rests on each individual midwifes shoulders. It is not a responsibility to be taken lightly.

Real Women don't have hot flushes!

They have POWER SURGES!

The reason for so many of the recommendations in the earlier pages really comes together in the author's personal account (p93). I believe that readers should very much keep this in mind when considering the advice throughout the book. On page 124 the author's own advice "don't expect a mother to choose the same path as others in her situation", makes very good sense.

Finally, despite the author stating that books and guides on babycare mostly "consist of advice and opinion rather than fact" (p37) I consider this one also substantially lacks fact. In the context of this book I found myself agreeing with one passage (p33) said by a male specialist in one of the personal stories that it is "unrealistic for women to use contraceptives, delay pregnancy, have children when it suited, go to work, and then wonder why their bodies didn't oblige". This is not a book that I would recommend to my clients but the fact that it has been written will I'm sure mean it will be of value to some people.

Marcia Annandale IBCLC
Christchurch, February 1995

HOT OFF THE PRESS

A Guide to Effective Care in Pregnancy and Childbirth

Enkin, M., Keirse, M., Renfrew, M., Neilson, J.
Oxford University Press, New York, 1995

The second edition of this essential book is now available. COST:$50.00

Principles of Neonatal Resuscitation 4th edition

Northern, Neonatal Network, Northern RHA, England, 1994

This practical booklet will appeal to midwives and students. The physiology of asphyxia is made easy to understand and the steps in resuscitation are clearly explained and illustrated with colour photographs. A full equipment list and referencing add to its value. Can be used in conjunction with the video *The delivery room care of the newborn child.* Available through MIDIRS.

Review: *A Working Mother's Handbook*

A New Zealand Guide for Expectant and New Mothers

Francesca Holloway, Longacre Press Limited (1994), $24.95

As Francesca Holloway says there is little encouraging reading material for women who participate in the workforce. Her 136 page book "for and about *working mothers*" sets about addressing issues such as sleeping, feeding, childcare and balancing work and home commitments. The focus is on the first 12 months with baby. The book also contains a little about fathers as primary care-givers, solo and lesbian mothers, mothers of twins, adoptive parents, volunteer workers and babies with special needs.

I have many concerns about the content of this book not least of which is its lack of advocacy for the baby and its somewhat super-mum theme. There may be a limited readership for those who do not view the needs of a baby under 12 months old as secondary to the mother's needs.

Chapter 1, "Pregnancy and Birth", seems incorrectly named and contains jumbled ideas with the author obviously keen to impart all her knowledge at once and as it comes to mind. For example, there is a giant leap (p22) from the heading "The Absolute Necessities for Babies are:.." (in the antenatal context) to "teaching baby to sleep at night will be a major challenge in the first 18 months." Many working mothers find it quite common for their breastfed babies to seem to make up for lost time by nursing well and frequently through the night; a far cry from heavy handed "teaching" them to sleep right through the night.

The suggestion that the birth facility be checked out for access to a phone and fax (p28) because "with some jobs things don't stop just because you've had a baby!" is alarming and at odds with the information provided p14-16 regarding legislative protection. Suggestions are made to go out without baby "at least once every second day" yet the following page the reader is told to "make the most" of this very special time with your baby.

The quips throughout the text may be very unappealing for some readers. Examples include, "the pregnant woman is not an invalid nor does her mind shrink as her waistline expands"..."who's looking after baby? After you've been asked this for the hundredth time, you may be tempted to tell them that you have a very clever cat!"..."don't run the risk of some bright spark using it (expressed milk) for their coffee!"

Information on pages 70-77 in relation to breastfeeding and milk expression and storage contains numerous inaccuracies and clearly has not made use of research on the subject. Reference to breastfeeding on other pages is usually surrounded by negativism such as "...difficulty especially if you are breastfeeding" and breastfeeding being very tiring is mentioned several times. The reader is told that all three types of pumps (manual, battery and electric) operate in a similar way and that most are portable and easily fit into a handbag; simply not true! The suggestion to express at work only to maintain milk supply (not for collection and use) if a refrigerator is not available is certainly not in the best interests of the baby either. Breast pumps are not necessarily fast and efficient (p71), as stated, by any means. They are, in fact, entirely dependent on the mother's ability to eject milk since neither pumps nor babies simply suck milk out. It would be difficult, in my opinion, to choose breastfeeding and working based on the feeding information in this book. The barriers and possible problems including a big focus on sleep and lack thereof would seem insurmountable.

It is interesting to read how a lactation consultant is considered such a valuable source of information. I agree that some are however, the kind to which the author refers to as working privately number a mere handful in New Zealand. This could be a frustration for women trying to access one. Relying on the doctor, midwife, La Leche League or maternity centre for information to access a lactation consultant, as suggested, may not be fruitful either if experience is anything to go by.

NZCOMI - ANNUAL GENERAL MEETING

Friday 25th August 1995
Christchurch

CALL FOR NOMINATIONS

The NZCOMI National Committee wishes to call for nominations for the following positions :

(1) NATIONAL PRESIDENT

The National President shall be a Full Member and is elected for a term of two years with right of renewal.

Regions shall submit nominations to the Board of Management three months prior to the AGM.

The Board of Management shall forward nominations to each region.

Voting shall be at regional levels and results sent to the National Committee 14 days prior to the AGM.

SALLY PAIRMAN IS AVAILABLE FOR RE-ELECTION

Nominations close end of May 1995.

(2) CONSUMER REPRESENTATIVES

The National Committee shall have three Consumer Representatives. At least one consumer representative shall be from the same region as the current Board of Management.

Nominations for consumer membership shall be called from affiliated consumer organisations, three months prior to the AGM.

Nominations shall be sent to the Board of Management who will then forward them to affiliated consumer groups for voting.

National Committee Members are elected for a period of two years, with right of renewal.

Two of the current three consumer representative positions are due for re-election. Glynette Gainfort representing the Home Birth Association has just started her term. Sharron Cole's (Parents Centre) and Rea Daellenbach's (Maternity Action Alliance) terms have expired. Sharron is standing down after many valuable years contribution. Rea is keen to stand again and continue her involvement.

Nomination close end of May 1995.

REMIT FOR AGM

Change to Constitution 15.5.1

Delete "This amount to be sent from the regions at a date set by the National Committee"

BY LAWS

2. A years membership shall be from the date of joining.
3. Delete
4. Delete
5. Change to read "That the regional treasurer/membership rep check all details on a computer printout of membership list on a regular basis as determined from time to time by the National Treasurer.

NEW CLAUSE

That individual members or prospective members will be invoiced by the National Treasurer or delegated representative as subscriptions are due.

Rationale: These changes are in line with the recent moves towards centralising the subscription process.

BOOK REVIEW

The following book was read and reviewed by two working mothers. Another example of our individuality.

A Working Mothers Handbook
A NZ Guide for Expectant and New Mothers

Francesca Holloway / Ngaire Gardner

ISBN:09583405 IX Published by Longacre Press, 1994

In the introduction of this valuable book, Francesca Holloway states "Working mothers, whether they are such through choice or necessity, want and deserve the best for their babies..."

And so begins a book which goes a long way towards assisting women with achieving the vital balance between work and home committments, thus being a timely supplement for New Zealand women amongst other available literature.

Clear, concise and helpful information is provided including current legislation regarding workplace discrimination/addresses to the Human Rights Commission and also the Employment Protection Act, issues of Income and Family Support are discussed as well.

This is also an excellent referral guide for women who wish to seek out other helping agencies - Midwives are frequently mentioned, good to see the New Zealand College of Midwives as a starter point for readers.

The darker highlighted boxes throughout the text are also excellent as reference guides - Practical boxed, helping tips, are great and each chapter ends with personal stories by means of case studies which is another pleasing touch.

Quick menus are included (haven't tried yet but look delicious). There is also a Recommended Reading Guide which will hopefully include NZCOM Breastfeeding Handbook in a later reprint.

All in all this is a very worthwhile and readable book - it should be highly recommended to clients, especially those with relevant employment return to work issues. This is also a great tool for Antenatal teaching.

Read and Reviewed by Brigid Mieras

good health
Wanganui

VACANCIES - MIDWIVES

STAFF MIDWIVES
Wanganui Maternity Services

The Wanganui Maternity Services are seeking qualified midwives to work within their area. We have a 17 bed antenatal/postnatal ward, Delivery Suite and 4 cot Level 2 Neonatal Unit.

Opportunities for further education would be encouraged and if you are returning to midwifery a re-orientation to this area could be arranged. For further information please contact Julie Foley, phone 06 348 1234, extension 8305.

Application and job description are available from
Recruitment Co-ordinator, phone 06 348 1234 extension 8337
Good Health Wanagnui, Private Bag, Wanganui

BIRTH, BABIES & BRIDGES
in the 21st Century

21, 22, 23 October 1995
(Labour Weekend)
Centra Hotel Auckland
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CONFERENCE ISSUES INCLUDE
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For further information:
Birth in the 21st Century
Box 52065 Kingsland Auckland 3 NZ
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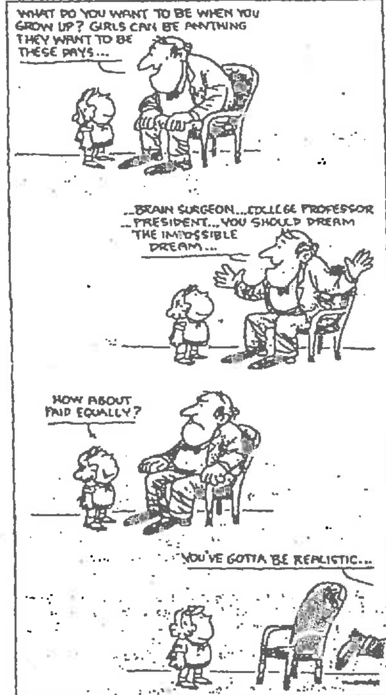

EVENTS CALENDAR

Breastfeeding - Refresh, Renew, Revitalize
Brisbane - 20th and 21st May 1995

PLUS

Breastfeeding Update & IBLC Exam Preparation Seminar
Brisbane - 22nd May 1995

Seminars conducted by : Mary Lantry, Angela Smith and Ruth Worgan

Cost : $175 if paid before 15th March 1995 or 1st May 1995

Contact : CAPERS
P O Box 567 Nundah
Queensland 4012
Phone 07 266 9573 Fax 07 260 5009

Teaching Skills Courses for Childbirth Educators and Other Health Professionals

Adelaide 6th - 9th May 1995
Sydney 2nd - 6th June 1995

Workshops conducted by Ronnie Pratt

Cost : A$350 if paid 21 days prior to starting date

Enquiries : CAPERS
P O Box 567 Nundah Queensland 4012
Phone 07 266 9573 Fax 07 260 5009

MIDWIVES HOMEBIRTH WORKSHOP

A workshop for all midwives about the philosophy of Homebirth Midwifery. Hear Midwives Joan Donley, Maggie Banks, Jenny Johnston and others.

May 27th and 28th - Thames

Organised by the Kauraki Homebirth Midwives.
Contact Jenny Johnston (Phone 07-868-2116)
or write c/- PDC Waiomu 2850.

4th Annual Midwifery Today West Coast Conference

15 - 18 June 1995

Keeping Midwifery Alive and Growing

Eugene, OR.

Speakers include Ina May Gaskin, Joan Donley, Elizabeth Davis, Anne Frye.

Fax 503 344 1422

WORLD BREASTFEEDING WEEK

1 - 7 August 1995

3rd Annual Birth Gazette Conference

The Farm

Summertown TN

Speakers include Robbie Davis-Floyd and Anne Frye.

42 The Farm, Summertown TN 38483 USA

Tel 615 964 3798 (no fax available)

NATIONAL HOME BIRTH ASSOCIATION CONFERENCE

Home Birth - Your Choice

September 1st, 2nd and 3rd 1995

Palmerston North College of Education

Palmerston North

Paediatric Conferfence

27th to 29th September 1995 Sheraton Hotel, Auckland

Contact : Organising Committee
1995 Paediatric Conference
P O Box 12736
Penrose, Auckland

ing methods. "Anxiety may be the price women pay for the benefits of new knowledge," says Nicholas Wald, professor of environmental and preventive medicine at St Bartholmew's Hospital, London. He was instrumental in developing the triple test. "With adequate information and counselling, "inappropriate" anxiety can be avoided, he argues."(4. The Independent, op cit.)

You decide.

B.H.

Footnotes and References:

Screening for Down's Syndrome, Sanjay Vaas, BMJ, Vol.309. 24 September 1994
The New Pregnancy & Childbirth, Kitzinger, Doubleday Australia 1990
Background notes on the maternal serum screening programme, Webster, Auckland 1994.
[1] *Diane Webster background notes on the MSS programme supplied by North Health.*
[2] *The Independent II, 25 January 1994.*
[3] *Childbirth Choices, Bennett, Etherington & Hewson, Viking Pacific 1993 page 110.*

Eastbay Health
Te Whatumauri Hauora

EASTBAY HEALTH LTD
STEWART STREET
PO BOX 241
WHAKATANE
TELEPHONE 0-7-307 8999
FACSIMILE 0-7-307 0451

VACANCIES - MIDWIVES

I write to you seeking your assistance. I have been having some difficulty recruiting Staff Midwives to work at Whakatane Hospital. Should your office receive any enquiries from suitable applicants I would be most grateful if you would refer them to me.

The Obstetric Unit at Whakatane Hospital offers level II care, with approximately 1,000 deliveries annually of which 70% are performed by Midwives. We have full specialist O&G and Paediatric cover. Midwives have the opportunity to practice continuity of care as ante natal, intra partum, and post natal services are all one the one level. Clients may then receive domiciliary care in their home by the same Midwife if this is required. The Obstetric is very client focused and friendly.

Please direct all enquiries to: Lareen Cooper, Manager, Women Child and Family Health Services at the above address.

December 3: Get home from work: message from hospital on the answerphone. Exact words escape me. Test results normal. Feel hysterical with relief,dance around the kitchen when Bernard gets home.
Now that this difficult time is over, maybe I can start enjoying this baby. Oh, and by the way: it's a boy.
Reprinted from The Independent II, 25 January 1995

*Nuchal Translucency Scan is an ultrasound scan which can be carried out as early as 11 weeks gestation and is thought to be able to detect about 85% of foetuses with Down's syndrome and other chromosomal abnormalities. During the scan, doctors measure the "black space" behind the neck of the foetus. A large space - 3mm or more - may indicate the presence of a nuchal membrane associated with abnormality. This scan may also indicate heart conditions and other foetal problems. The result of the scan is computed with the woman's age to give her an individual risk factor. The nuchal scan is still part of a research project so levels of accuracy have not yet been determined.

**Triple Plus: This test can be carried out at 13 weeks, although the ideal time for spina bifida detection is 16-18 weeks. The Triple plus measures levels of AFP and uE3, as well a free beta HCG, a breakdown product which makes it possible for the test to be carried out earlier than the triple test. It also measures a fourth biochemical marker for Down's sydrome - neutrophil alkaline phosphate (NAP). Reading levels of NAP is labour intensive, which is why this test is not yet available in New Zealand.

After reading the information about MSS and discussing it with other parents I am left with many concerns. Do we need a routine screening test that has the potential to cause this level of anxiety? What effect does this much maternal anxiety have on the developing foetus? Already many parents report that they are unable to "bond" with their baby until they've seen it during an ultrasound scan. Will parents for whom termination of pregnancy is an option, intentionally put off "bonding" with their unborn baby until after the results of every available prenatal screening and diagnostic test have revealed that they have a "normal" baby? What effect does this intentional delay in bonding have on a developing baby? How will the small percentage of parents who have a imperfect baby, even though the tests said "normal", cope? Currently available tests cannot diagnose all types of genetic and congenital imperfection and accidents can occur later in pregnancy and during the birthing process which can cause fetal damage.

"Supporters of the new screening methods point out that some anxiety is inevitable and even appropriate with the new screen-

KNOWLEDGE AND WISDOM

The KEYS TO SAFE MOTHERHOOD

CALL FOR ABSTRACTS
for
Australian College of Midwives Inc
9TH BIENNIAL CONFERENCE
Sydney Convention Centre, Darling Harbour
September 12-15, 1995
Abstracts due 28th February 1995
Completed papers will be required by 30th June 1995
Abstracts must be submitted on official abstracts forms.
Forms available from:
Conference Secreatria
ACMI Biennial Conference
P O Box 787, Potts Point NSW 2011 Australia
Telephone (02) 357-2600
Facsimile (02) 357-2950

1995 World Women's Conference Beijing September 1995

Poverty, violence and women's access to education, health services and decision-making will be among the concerns of thousands of women meeting at Beijing next September for the Fourth United Nations World Conference of Women.

The conference will be attended by government delegations and non-governmental organisations which have official status with the United Nations, such as the International Federation of University Women. Parallel to the main conference, a special forum for non-governmental organisations (NGOs), Forum 95, will be held.

The Committee's address is:
New Zealand Non-Governmental
Organisations Co-ordinating Committee: Beijing 1995
P O Box 12-117
Wellington

11th Birth Conference

7 - 8 October 1995

Innovations in Perinatal Care : Assessing Benefits and Risks

Baltimore MD

Sponsored by the journal Birth & John Hopkins University

Speakers include Marc Keirse, Judith Lumley, Beverley Chalmers, John Kennell, Ruth Lawrence, Mary Renfrew, Charles Mahan, Bruce Flamm, Ellen Hodnett and Frank Oski.

Birth

43 Oak St, Genesoa

NY 14454 USA

Tel/Fax 716 243 0087

NEW ZEALAND O&G SOCIETY BIENNIAL CONFERENCE

October 27th, 28th, 29th 1995

Palmerston North Convention Centre

Contact:

Sue Peek

P O Box 474 Palmerston North

Phone (06) 351-4469 Fax (06) 356-9841

24th Triennial Congress of the International Confederation of Midwives

26th to 31st May 1996 Oslo, Norway

Theme : *The Art & Science of Midwifery gives Birth to a Better Future*

CALL FOR ABSTRACTS

Deadline 31st March 1995. Completed papers due 4th June 1995

For more information, contact: MIDWIFERY RESOURCE CENTRE
P O Box 21-106
Christchurch Ph 03-377-2732

antenatal helpline, get sympathetic female voice. Explain worries. She says I can have a "Triple Test" (MSS) at 16 weeks, available through GP and local hospital. If the risk is high I'll have an amnio.

November 14: Fourteen weeks pregnant. Woman at a party tells me about the "Triple Plus"**. It's done privately by a hospital in Leeds and better than the Triple.

November 15: Phone Leeds: yet another helpline, another reassuring voice. The Triple Plus has a detection rate of 80%. They can post a test kit to me immediately, which I must take to my GP. Forget to ask about the cost. Hard to believe that I can order by credit card a kit testing for foetal abnormality through the post.

November 16: The kit arrives: a white cardboard box with glass slides, test tubes, pre-paid bag for posting back and five forms to fill in. There is a power cut. By candlelight I write a cheque for 88 pounds to "University of Leeds Innovations Ltd".

November 17: GP seems bemused by all the instructions but takes the blood samples. I feel apologetic: another pushy, neurotic, middle-class woman who knows too much for her own good. Pack up the glass slides and tubes and send them back, special delivery, cost 2 pounds.

November 24: A phone call from Leeds: the friendly voice again. My risk factor is 1 in 240: positive but borderline. My biochemistry looks fairly normal. It's my age that has pulled the risk factor up. Report is faxed over to my partner's office. There it is, in black and white: screen positive for Down's. One in 240. Had it been one in 251, I would have been negative. "Further investigation" advised, even though the risk is now five times less than my age risk alone. Could we cope, living with the risk? What if it came to the worst?

November 25: Call specialist unit where I had the first scan. They can do an amnio after the weekend, on Monday morning.

November 28: Sunday night and I lie in bed paralysed with indecision. Shall I go for the amnio tomorrow?

November 29: On our way to the hospital. Feel wobbly, undecided, want to turn back; partner suggests we go for lunch instead. Keep driving in the same direction.
At the unit gel is spread on my stomach for preliminary scan before amniocentesis; I look at the screen and see my baby. The placenta is at the front, so a chorionic villus sampling would be technically easier than amniocentesis, the doctor says. I would have the results in a week. He sees our indecision, our distress and leaves us alone for five minutes. Bernard says: Let's leave it, let's get out." I say, finally: "let's get it over with."
The test is painful, more traumatic than I imagined. I can see and feel the needle digging into the placenta, the baby below it. It's over in a few seconds; it feels like a lifetime. The doctor says it went well: the heart didn't stop and there was no blood. I lie down in a side room and we cuddle. I cry and apologise to my baby. That evening I feel anxious, aching and tearful.

November 30: Still feeling violated, still wondering if I have done the right thing.

December 1: Back at work; feeling delicate.

"older" women. "Older" women who screen negative are spared the risks associated with routine amnio. It is considered a added bonus that the screening test is can also assess risk levels for other chromosome abnormalities and neural tube defects.

In countries where MSS has been available for some time, caregivers have noticed increased levels of maternal/parental anxiety amongst women of all ages about the risk of an "imperfect" baby. This anxiety is further exacerbated by the high rate of false positives and false negatives associated with this screening test and by the fact that in most places screening programmes are being offered without an adequate counselling component. In some places women are having blood samples screened without being given any information about the screening test at all.

amniocentesis. The advantage of CVS over amniocentesis is that it can be performed before 12 weeks gestation and that the procedure is usually performed through the vagina rather than through the abdominal wall. CVS carries a 2-4% risk of miscarriage. Other risks include maternal infection and bleeding. Most women experience some discomfort during and for a while after the procedure is performed.

Diary of a late pregnancy- by Cherrill Hicks

Reprinted from The Independent II, 25 January 1994

September 8: Do a pregnancy test and it's positive. Yippee! But a *frisson* of anxiety; at 43 the risk of Down's syndrome and other chromosomal abnormalities is 1 in 45. Have heard there are tests that mean I might be able to avoid amniocentesis and the accompanying risk of miscarriage.

October 18: Attend a "counselling" session at a hospital unit offering an ultrasound scan at 11 weeks. It's called nuchal translucency scanning* and is said to detect 85% of abnormalities. A long drive to get there, with my sick four year old. Wait an hour in a stuffy corridor. Read leaflet. The midwife seems abrupt: do I have any further questions? Perched on a very uncomfortable stool, my four year old whining to go home. Feel lonely and exhausted and burst into tears. Midwife apologises. I make appointment to have scan.

October 27: Return for scan, accompanied by partner, Bernard, and son Harry. Another hour's wait, but the doctor is friendly, the scan reassuring. It's lovely to see the foetus bouncing around on the screen: to tell Harry that this is a baby. More tears, this time of relief. Computer print-out is impressive, encouraging: I have the risk of woman aged 34 rather than one of 43. At birth, this means a risk of 1:400. Feel able to make first connection with the baby growing inside me.

November 1: Doubt sets in. Supposing I'm one of the cases they miss? Telephone

NEW ZEALAND COLLEGE OF MIDWIVE (INC)
National Conference

August 1996

Lincoln Conference Centre, Canterbury, New Zealand

Theme : *Midwifery : The Balance of Intuition & Research*

Contact: Judy Henderson Phone (03) 377-2732

☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆

■ Women hoping to meet a man who understands them may be searching for the impossible.

For the first time, scientists have linked the emotional differences between the sexes to differences in the brain.

Using a scanner, they discovered that men have a more active metabolism than women in the primitive brain centres that control sex and violence.

The scientists at the University of Pennsylvania Medical Centre were investigating whether there are sex differences in brain metabolism in the areas of the brain that control emotions and cognition.

Professor Ruben Gur says the scanner revealed that the brain region that is thought to control more "action-oriented" emotional responses was more active in men, while the higher centre of the brain thought to control more "symbolic" emotional responses was more active in women.

The findings support the possibility that men are more biologically inclined to express themselves physically, such as through aggression, and women are biologically disposed to talk things through. Cacn Peel

FOR SALE

Fetoscope Model 225 (KTK). An ultrasonic fetal heartbeat detector, light, small and highly sensitive. Capable of detecting fetal heartbeat at 10-12 weeks gestation.

$250.00 O.N.O

Contact Dawn Heyward

Bridge Valley Road, RD1 Wakefield Nelson

Phone (03) 541-8917

CURRENT ISSUES

MEMBERSHIP DETAILS

Please remember to notify your Regional Treasurer and the National Office of NZCOMI if you :

- change your name
- change your address
- change your place of employment
- move from one region to another
- resign from NZCOMI

This will help us to ensure that our records are kept up to date and that you continue to receive your newsletters, journals, etc.

INDEMNITY INSURANCE

The National Office of NZCOMI are receiving an increasing number of requests for extra indemnity insurance cover.

The NZCOMI have arranged a level of insurance considered suitable for its members. As financial members of NZCOMI, you are covered for up to $200,000 for each claim with a maximum of $400,000 per year. This includes legal costs. The first $500 is deductible on each claim. This does not apply to loss of documents.

The current policy is that if you do require extra indemnity cover, it is to be arranged directly with the insurance company concerned: MINET PROFESSIONAL SERVICES, P O Box 470, Auckland
Phone (09) 379-0929

There is an information pamphlet about your professional indemnity insurance cover and it is available from

New Zealand College of Midwives (Inc)
P O Box 21-106
Christchurch

ated with any screening test, counselling and the provision of clear and accurate information must be an integral part of the process. The Auckland pilot involves an information sheet which women must read before they sign giving their "informed" consent to participate in the pilot and a genetic counsellor is a member of the project team. This is fine for the pilot but will these services be available to the whole population of birthing women if the test is routinely offered and where is the funding for these services going to come from.?

Another potentially expensive spin-off of MSS is the increased uptake of amniocentesis and Chorionic Villus Sampling by women who screen positive. At present these tests are only offered to women over the age of 35, (as these women are statistically at greater risk of carrying a genetically damaged baby) and women with a family history of Down's syndrome etc.

Why introduce MSS ?

Down's syndrome (trisomy) is the commonest cause of mental retardation. At birth the incidence of the syndrome is 1.3 per 1000, with the risk rising with maternal age. At present diagnostic tests like amniocentesis and CVS are only routinely offered to women over 35-37 Hpwever, only 30% of babies with Down's syndrome are born to women over the age of 36. The remaining 70% are born to younger women who are not offered diagnostic testing for Down's and other fetal chromosome disorders. MSS is considered a non-invasive way of assessing every women's risk of carrying a baby with chromosome damage, (in addition it can also assess risk for neural tube defects). Younger women who screen positive can choose amniocentesis etc, tests which were formerly only available to

risk of miscarriage women should be cautioned against amniocentesis unless they carry a well above average risk of having a baby with some defect. If an abnormality is revealed, counselling should be made immediately available to both parents. The error rate in diagnosis is estimated at less than 1%. However, the estimated risk of miscarriage from amniocentesis is greater than the risk of having a baby with Down's Syndrome for women under 35 and about the same for women aged 40.[3]

CHORIONIC VILLUS SAMPLING (CVS)

CVS is a procedure which takes a sample of chorionic villus (part of the outer membrane around the embryo which will later become the placenta) and analyses this tissues for genetic abnormalities. (CVS cannot detect spina bifida) There are two methods of obtaining this sample. (1) A needle is introduced into the uterus through the abdomen under ultrasound guidance and a sample of cells is aspirated. (2) More usually, a catheter is is inserted through the vagina and cervix and up to the placental site using ultrasound for guidance, and a sample of chorionic villi is suctioned from the developing placenta. Cell analysis can be very fast with results being available within a couple of days. Tissue culture results, which are generally more accurate for chromosomal disorders other than Down's Syndrome, take 2-3 weeks The accuracy of CVS results from experienced laboratories is similar to that of

tives are picked up when women who have a positive result go onto have an amniocentesis, but they suffer terrible anxiety and worry until the amniocentesis results come through. On the other hand, the women/parents who receive a false negative result expect a "perfect" baby and are often more shocked and find it more difficult to come to terms with a genetically damaged baby than they might have been had they not had the test.

The Government and the Regional Health Authorities have made it very clear that they are going to cap the maternity budget at the level of expenditure for the current financial year. This means any additional services will be funded by either improving the level of efficiency of delivery of current services, or by removing funding from existing services thus reducing or eliminating the availabliity of these services to pay for this new service, or a combination of these two. Over a year ago the Auckland Maternity Services Consumer Council(MSCC) which is a consumer organisation whose membership comprises over 80 groups or organisations whose focus is maternal and infant health and welfare, (including the Auckland Home Birth Association), met with a group of health professionals who were putting together the proposal for Maternal Serum Screening. The MSCC's view was, and is that there are other types of services which which would benefit many more babies, mothers and families than MSS eg postnatal ervices, and that the MSCC did not support the introduction of another *routine* antenatal test.

Information and Counselling

Because of the high rate of false positives and false negatives which are associ-

AMNIOCENTESIS

Amniocentesis is procedure in which a sample of amniotic fluid, which contains fetal cells and excretions, is taken from the pregnant woman and analysed for chromosomal or biochemical abnormalities or damage. Under local anaesthetic a hollow needle is inserted through the woman's abdominal wall and into the uterus. Ultrasound is used to locate the placenta and fetus and to find a pool of fluid suitable for tapping. About half an ounce(14g) of amniotic fluid is drawn out. The procedure takes about 20 minutes and can be quite uncomfortable. The test cannot be carried out until around 16 weeks of pregnancy. when there is sufficient amniotic fluid for tapping. The fetal cells are separated from the amniotic fluid and these are cultured and examined to check for defects etc. This process takes 2-3 weeks, so women are usually 19-20 weeks pregnant before they receive the results.

Amniocentesis carries a risk of 0.5-2.00% of miscarriage depending on the skill and experience of the technician. Damage to the placenta or fetus has been reported, but can be reduced by using continuous ultrasound at the same time to view the positions of fetus and placenta. Other potential risks are infection, isoimmunisation of blood (where mother and baby have incompatible blood types), bleeding and leakage of amniotic fluid. Many women experience uterine twinges or contractions for a few days after undergoing the procedure.

Because of the small but definite

THE OFFICE OF THE
Minister of Health

17 FEB 1995

Ms Karen Guilliland
National Co-ordinator
New Zealand College of Midwives (Inc)
PO Box 21 106
Edgeware
CHRISTCHURCH

Dear Ms Guilliland

Thank you for your letter of 19 December 1994 regarding the article on maternal deaths in the *Sunday Star Times*, 18 December 1994.

I am advised that officials in the Ministry of Health have spoken to Professor Aickin about his comments quoted in this article and are confident that the Maternal Deaths Assessment Committee (MDAC) does not claim a direct association between independent midwifery and maternal deaths. Neither does Professor Aickin claim that difficulties between doctors and midwives were responsible for any maternal deaths which appear in published statistics.

Professor Aickin's comments on the relationship between doctors and midwives were apparently in response to a question on what general issues need to be resolved to improve the quality of obstetric care in this country. He also noted that a key issue was the need for high risk groups to seek specialist care during pregnancy.

I am advised that a number of Professor Aickin's comments were not reported in the *Sunday Star Times* article, for example, the difficulty in making comparisons on maternal death rates from country to country, due to differing measures of maternal mortality.

Thank you for writing with your concerns.

Yours sincerely

Hon Katherine O'Regan
Associate Minister of Health

OPEN POLYTECHNIC OF NEW ZEALAND

Midwifery Programme

The Open Polytechnic of New Zealand has requested the College forward names of midwives interested in marking Midwifery papers for the distance learning courses currently offered.

If you are a member of the NZCOMI, hold a current practicing certificate and have experience in continuing education, please contact the

NZ College of Midwives
P O Box 21-106
Christchurch

If you would like to discuss the expectations, workload and renumeration, you could ring the Open Polytechnic directly on

(04) 566-6189

and ask for

Trish French

ICM SPONSOR A MIDWIFE PROGRAMME

For the 23rd Triennial Congress of the International Confederation of Midwives held in Vancouver in 1993, the Midwives Association of British Columbia inaugurated a most successful 'Sponsor a Midwife Programme' that enabled 25 midwives from many developing countries to attend and participate in the Congress.

New Zealand sponsored a midwife from Fiji at this conference largely through the generous donation of a self employed midwife.

Due to the programme's success, the ICM is now calling for donations to sponsor midwives to the next ICM Congress in Oslo, May 1996.

As the Pre-Congress Workshop theme of 'Safe Motherhood' focuses on developing countries, it is vital midwives from these countries are involved. The estimated cost to sponsor a midwife is three and a half thousand Pounds (£3,500).

If you or your organisation would like to support this programme, please send your donations to
The National Treasurer - NZCOMI
P O Box 21-106
Christchurch.

Thanks!

Reprinted from Home Birth Whanautanga No 62 Spring 1994

Maternal Serum Screening

A pilot programme for the introduction of maternal serum screening (also called "The Triple Test") in pregnancy for Downs syndrome, neural tube defects eg spina bifida, and abdominal wall defects, is about to commence at National Women's Hospital.

This screening test has been available for some time overseas and it is intended that it will become a routine part of antenatal care here in New Zealand.

What is Maternal Serum Screening?

Maternal Serum Screening (MSS or The Triple Test) was developed by doctors at St Bartholomew's Hospital, London. A blood sample is taken from women, usually at when they are about 16 weeks pregnant. The test involves measuring the levels of three substances, or "markers", in the mother's blood: these are alpha-fetoprotein(AFP), unconjugated oestriol (uE3) and human chorionic gonadotrophin (hCG).

Lower levels of AFP and uE3, and higher levels of hCG, can indicate a higher risk of that a woman is carrying a baby with Down's syndrome; high levels of AFP may indicate an increased risk of open neural tube defects, such as spina bifida.

The results from the blood tests are combined with the mother's age to give an individual risk factor. Women who have a risk of 1:250 or more are called "screen positive" and offered amniocentesis to find out if the baby is abnormal. Those whose risk is less than 1:250 are "screen negative".

Screen positive women may be offered an ultrasound scan to check the gestational age of her baby before scheduling an amniocentesis, because the levels of the different market in the blood vary as the pregnancy advances.

The Auckland pilot will use the same technology as a programme which has been offered in Adelaide, Australia for some time. The results from this programme show that MSS has detected 95% of spina bifida (in conjunction with their concurrent ultrasound programme) and 65 - 70% of chromosome abnormalities[1]

Problems associated with Maternal Serum Screening

Most parents find it hard to distinguish between screening and diagnosis. MSS is NOT a diagnostic test, it is a screening test which puts a numerical value on your level of risk. "Kypros Nicolaides, director of the Harris Centre for Foetal Research at King's College Hopsital, London argues that labels such as "positive" and "negative" can be misleading. "If your risk comes back at 1:249 you are positive, yet if it's 1:251 you are negative," he points out. "In reality there is no natural break in risk, just a rising curve."[2] Because risk is determined by combining blood test results with maternal age women who are older will almost always score higher.

Another problem with this test is the level of "accuracy". Although most neural tube defects are diagnosed (95% in combination with ultrasound) approximately 35% of chromosome abnormalities are not detected - that means that there is a high false negative result. There is also a 5-6% rate of false positive results i.e. most women who screen positive are, in fact carrying normal, healthy babies. Most of these false posi-

good idea!

2. We do not advise GPs that their client had been to the clinic if the client so requests. It is hoped that the client will eventually agree to their GP being informed but it is not compulsory.
3. When we take cervical smears, we do not record the client's home address on the pathology form. The laboratory has agreed to use the clinic address for results.

Advertising

We use posters, fliers and adverts in the local Trust newspaper. However, most young people visit the clinic having heard of its existence from a friend or peer.

Further developments

The first clinic opened in May 1991. We now have 5 sessions spread across the Trust, together with a telephone help-line, a drop-in service in one clinic, and a pager number for staff to ring in an emergency.

Two of the sessions are run by a doctor, two nurses and two clerks. Three sessions are run by a nurse practitioner, a nurse and a clerk, with access to a doctor should it be necessary. The doctor comes to the session once a month, with the nurse practitioner holding prescribing protocols.

The help-line is covered by a school nurse, the sister-in-charge of the genito-urinary medicine clinic, a health visitor, and the nurse practitioner. All have a qualification in family planning. The busy 'drop-in' service is also run by these nurses from Monday to Friday, 9.00am to 5.00pm. The pager is mainly carried by the nurse practitioner, so that emergencies from across the Trust can be dealt with immediately.

We have developed a list of GPs who will prescribe emergency contraception.

Successes

We knew that we would need to evaluate the service if we wanted funding to continue and increase. The evaluation would take into account: the number of attenders and re-attenders, a client and staff satisfaction questionnaire, an analysis of conception rates.

At the end of the first year the conception rate among the under 19s in the Trust had been reduced by 16% (85 fewer conceptions). This 16% is much greater than that in conceptions in all women. It also compared favourably with the under 19 conception rates in a similar health authority.

Between 1991 and the end of 1992, the conception rate fell by 20%. Pregnancies were down by 16%. Terminations were down by a very encouraging 27%.

" To reduce the rate of conception amongst the under 16s by at least 50% by the year 2,000." (Health of the Nation, 1992).[4]

Ongoing evaluation

We are continually evaluating the clinics. We know that some young people will not come and consult with us so we are investigating how we can use peer-led work to reach these young people.

The young people in the surveys related how pleased they are to have a service of their own. Many of the Health of the Nation targets relate to this group or need to be started at this age if they are to be effective.

This service is school nurse led but I hope there is food for thought in this article to stimulate other professionals to initiate similar work. The work is proactive and very cost effective.

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3. Brook Advisory Centres. *Annual report*. London: Brook Advisory Centres, 1991.
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*This project was included in the Government's **Health of the nation** document, as an example of good practice. Valerie Dodds is willing to discuss it with anyone interested in starting a similar project and can be contacted at the Foord Road Clinic, Folkestone, Kent. Tel 0303 251504.*

Dodds V. MIDIRS Midwifery Digest, vol 4, no 4, Dec 1994, pp 421-423.

Original article written for MIDIRS by Valerie Dodds, school nurse/practitioner. © MIDIRS, 1994.

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SAFE MOTHERHOOD NEWSLETTER Issue 16 Nov 1994-Feb 1995

A race for survival: community-based transport for safe motherhood

For too many women the decision to go to hospital is made too late – after labour has begun and when problems are already apparent. This story from Nepal describes just such a case, and the race that followed to save a woman's life.

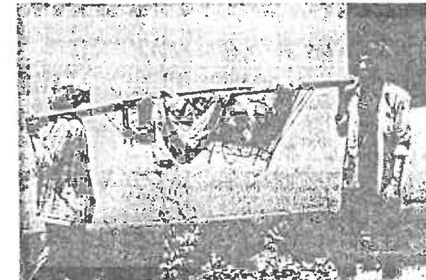
The young woman was just 17 years old, expecting her first baby. Her husband was 18. The couple lived in a mountain village, accessible only by steep and narrow paths.

As a child, the mother-to-be had been burned and she had scars around her genital area. Her pregnancy was normal but problems started when she went into labour. The scar tissue of the perineum just would not stretch sufficiently to allow the baby to be delivered.

After several hours of labour the young woman asked to be taken to hospital. It was 03.00 – the middle of the night. The husband woke the neighbours to help him take his wife to a health facility. People agreed to help but persuaded him to wait until morning because "she would probably deliver normally." At 08.00 they set off for the district hospital 25 kilometers away.

There was actually a health post nearer than the hospital, but in the other direction. The villagers decided (correctly) that the health post would not be able to give the woman the help she needed. In any case, the hospital was downhill, the health post was uphill and the woman would have to be carried.

The woman was carried in a *doli*, a reclining seat fixed to a pole, that is used to take a bride to her wedding and then to her husband's home. This was her own *doli* in which she had been taken to her wedding a year before. The *doli* is carried between two men but in this case, because of the distance, 12 men went with her. Six teams of two men took turns to carry her, running the 25 kilometers to the hospital in only four hours over uneven mountain paths. The husband's mother followed later because she could not keep up.


Phil. Fortney

The road to survival is not always easy: 25 kilometres in this *doli* saved a mother's life.

At the hospital the young woman was delivered vaginally with an episiotomy. Sadly it was too late to save the baby which was stillborn. The woman's genital tract was badly damaged by the obstructed labour but it was repaired, apparently satisfactorily, by the physician in the hospital.

After a week's stay the woman returned to her village (on foot). The physician advised her to go to hospital before delivery the next time she became pregnant.

Lessons learned

People will go to great lengths to reach a hospital (or other health facility) if they believe they can be helped. And communities will use whatever transport they have available to take sick people for help. In Nepal, wheeled vehicles are of little use where paths are narrow and extremely steep.

Delay increases the likelihood of poor outcome. The young mother asked to be taken for help at 03.00. Setting off down the mountain in the dark was probably ill-advised, but first light during the summer months is at 05.00 and setting out at daybreak rather than at 08.00 as they did might have saved the baby's life.

This young woman had no prenatal care. She lived some distance from the health post. In any case, pelvic examinations are often not included in prenatal care at this level.

District hospitals in Nepal (and many other developing countries) do not have obstetricians assigned to them. In Nuwacot District Hospital, where this young woman was taken, there are three physicians. The one who dealt with this case is actually a chest specialist although he spent a year working in a maternity hospital in Kathmandu. He did a fairly complicated repair alone, though with verbal encouragement from a visiting obstetrician-gynaecologist.

This is mostly a success story – a mother's life was saved. Nevertheless, the baby's life might also have been saved and the mother might have been spared much pain and trauma if the difficulty had been recognized earlier and acted on more promptly.

This article is published with thanks to: Vijaya Manandhar, National Operations Officer for Safe Motherhood, Ministry of Health, His Majesty's Government of Nepal; Rajendra Pant, Trisuli Hospital, Nuwacot District, Nepal; Judith Fortney, Family Health International, North Carolina, USA; Friederike Wittgenstein, School of Public Health, Harvard University, Cambridge MA, USA (formerly with the Safe Motherhood Programme of WHO's Division of Family Health); Hari R. Koirala, Nutrition Officer, Ministry of Health, His Majesty's Government of Nepal; Keshab Dhungana, District Health Officer, Ministry of Health, His Majesty's Government of Nepal.

Sex Disease clinic logs 10,000 visits a year

by Anna Price

More babies are being born in Christchurch with painful eye infections traced directly to a parent with a sexually transmitted disease.

About 12 babies a year are being diagnosed with opthalmia which produces sore eyes and a discharge. The cases have been sourced to a parent with chlamydia or gonorrhoea, Gordon McKenna, medical director of Christchurch Hospital's sexual health clinic says.

"You're only as safe as your partner," he said.

The clinic is logging close on 10,000 visits a year from patients aged from 14 to 70 seeking treatment or investigation of all types of sexual diseases.

Dr McKenna said historically, more men than women would seek health checks for sexually transmitted disease but recent years had brought a reversal.

"There is a general feeling that women are more aware of the implications than their partners and rather than trust the men they are seeking help themselves," he said.

Women were more likely to take the brunt of the long-term effects, he said.

Any sexually transmitted disease impacted both on a woman's ability to conceive and on the development of the baby in the womb, he said. It also affected the newborn, erupting in conditions such as ophthalmia.

An estimated 2000 men and women in the city have chlamydia, a bacterial infection of the genital tract which can impact on newborns as pneumonia, Dr McKenna said.

The clinic treats more than 12% of all known affected adults in Christchurch for the disease which is linked with "unsafe" sex and multiple partners.

Close on 1000 adults were tested for HIV by the clinic last year — roughly 200 more than in 1993, but only one man, without obvious signs when he turned up at the clinic, tested positive.

One in five sexually active adults in Christchurch has the viral infection, genital herpes, Dr McKenna said.

And one in 10 has genital warts.

Confirmation of a sexually-transmitted disease is rarely taken lightly by the patient, Dr McKenna said.

•Turn to page 3

PROTEIN TEST PICKS BIRTH

NZ DOC 17/3/95

With a simple test, doctors soon may be able to predict whether a pregnant woman will give birth within 48 hours.

The test screens for the protein fetal fibronectin that appears in the vagina of women who are about to deliver, according to a study published recently in the *American Journal of Obstetrics and Gynecology*.

Regine Ahner of the University of Vienna in Austria suspects that fetal fibronectin is released into a woman's cervix and vagina after imperceptible uterine contractions begin. The weak contractions may cause fetal tissue to separate from the uterine tissue, releasing the protein.

The researchers followed the pregnancies of 100 women who had passed their due dates and collected mucus samples from the women to look for traces of fibronectin.

Within 48 hours of the time the samples were collected, 41 of the women gave birth. Four of these women were excluded from the study because they either had a Caesarean section or had labour induced. Of the remaining 37 patients, 30 had positive tests for fibronectin.

A total of 59 patients delivered later than 48 hours after sampling and three of these women were excluded from the study because they required Caesareans. Of the remaining 56 women, 51 had a negative fibronectin test, while five produced positive tests.

MTNS

What's the difference between a Midwife and a terrorist?

You can negotiate with a terrorist.

Sex clinic logs 10,000 inquiries

•From P.1

Grief and frustration in the knowledge that it was avoidable were common, he said.

"People usually get upset. It is vexing to find one is an unnecessary victim," he said.

The herpes figure aligns with world-wide trends indicating the disease affects about 20% of the adult population.

"It remains the most common viral sexually transmitted disease and is the most problematic because of its complications," Dr McKenna said

Genital herpes is treated with anti-viral preparations but cannot be cured.

The virus lies dormant and erupts in times of stress on the surface of the genital area.

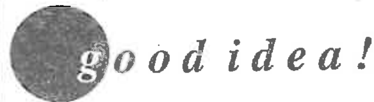
Genital warts cases have climbed steadily from 734 in 1991 to 800 in 1993.

The 1994 statistics have not yet been collated.

A rare case of syphilis which manifests at genital ulcers and can ultimately destroy the entire system was treated in Christchurch last year.

The woman made a good recovery on antibiotics.

Unlike the United States where syphilis tends to affect the poor blacks and hispanics, the disease is virtually unknown in New Zealand.



Before opening the service it was decided that if parents complained about the service, or called to see if their child had been to the clinic, we would invite them to come in to discuss the work and purpose of the clinic and to explain to them how the law relates to young people.

Young people refrain from attending clinics because they do not want to be examined, especially by a male doctor. We discussed at the planning stage whether all clients needed to see a doctor and if it was essential for clients to have a vaginal examination at the first visit. We decided that this was not necessary, since it would deter clients from coming to see us.

Venue

Our Trust covers 400 square miles. The sessions are held on Trust premises near to secondary schools. The team did consider other options for the location of the clinics, including youth centres, GP surgeries, village halls, and a mobile unit. We decided against these options due to lack of privacy, inadequate facilities, or the cost.

Time

The timing of the sessions needed careful consideration; not all schools allow pupils out at break times. Young people said that they could not always attend evening sessions, as they were not allowed out, or did not have the fare or transport to attend a clinic. The sessions are mainly held immediately after schools close. We do however hold one lunch time session in a clinic in a rural area as the children are bused to school and could not reach a clinic in the evening, nor reach home after the buses leave. Most sessions run all year round, with the exception of bank holidays.

Staff

School nurses with family planning training were chosen to organise the clinics. They have the skills and knowledge to work with young people and the ability to organise contraceptive clinics. The school nurses also have the opportunity to follow up clients in school should the need arise. Doctors, family planning nurses and clerical support working in the clinics have the skills and desire to work with young people.

We ensured that all the staff were conversant with the law relating to young people and issues of sexuality.

Appointments

We have an appointment system but we also see anyone who turns up to a session. The appointment system enables us to judge if we need extra staff. Attendance at the initial sessions was just 3-4 but we now see as many as 30 young people at a session.

Contraception

The most requested contraceptives are condoms and the pill. Most of our clients ask for the pill with condoms; "Double Dutch". This is something we encourage. We also dispense emergency contraception, mostly hormonal.

Very few intrauterine devices are fitted and we issue very few diaphragms or Femidoms (female condoms). The doctors make referrals to the hospital for the now diminishing number of terminations requested.

What's on offer

- We provide a highly confidential service.
- We offer a pregnancy testing service.
- We offer counselling, advice, help, and contraception.
- We find that young people often need lots of time. This time is provided, especially at the first visit.
- We endeavour to work closely with other agencies, but always obtain clients' permission before passing on information.

In the clinic we have health promotion videos, music, leaflets, and magazines, all designed for young people.

Who comes?

We mainly see under 19s and encourage both boys and girls to attend. If parents or guardians wish to bring a young person or want help and advice about their child we offer them appointments at the end of sessions.

Although most clients come about a sexual health issue, some of these and others attend about a variety of health problems from acne, to relationships, to abuse, from problems about their own health to problems about their friends' and parents' health.

Communication

At the outset we discussed client confidentiality at the steering group meetings and the outcome of these discussions were:

1. Clients can choose where to have mail sent, ie not necessarily to their home.

good idea!

Unwanted teenage pregnancies: making a difference

An innovative project which offers advice, counselling and practical help to young people is having a dramatic impact on the rate of unwanted teenage pregnancies. Valerie Dodds, school nurse in South East Kent Community Healthcare Trust (SEKCHT), describes how the project works.

The aim

To reduce the number of unwanted pregnancies in the under 19 age group.

How and why

The sessions have been developed to complement the health promotion work already undertaken by school nurses.

The clinics were set up in response to:

- research into the perceived needs of the young people.
- concerns of school nurses that the sexual needs of young people were not being met.[1]

The problem

The SEKCHT school nurses have been involved with health/sex education in the local schools for many years. Throughout this time young people had been telling the school nurses, and the nurses themselves realised, that the young people needed their own services.

During the late 1980s local, regional, and national statistics were revealing an alarming rise in the number of conceptions in the under 16 age group.

"In the 1980s the total conception rate in women under 16 years, in England and Wales (Rate: per 1,000 women) increased from 7.2 to 10.1. and in 1990, 50% of the conceptions to under 16s led to abortions."[2]

Whilst some of the young people were happy to attend family planning clinics and general practitioner surgeries, others were not. Reasons given included: bumping into friends and relatives at the clinic or surgery and their immediate locality, embarrassment at consulting a male GP, and the reluctance by some staff to see young people.

"In 1991 it was estimated that 52,000 15 year old girls in England had sexual intercourse but only 18,000 under 16 year olds visited family planning clinics. Statistics for the attendance of under 16 year olds at general practitioners are not available. It is highly unlikely that 34,000 under 16s visited their GP for contraceptive advice. It is estimated that 40% of 16 year olds have experienced sexual intercourse. 50% not using contraception."[3]

From left to right, Eveleen Feasley, school nurse; Rena Davies, sister-in-charge; Valerie Dodds, school nurse; Janet Featherstone, clinic secretary.

The first clinic

After much campaigning by the school nurses and with support from our line managers, the Director of Public Health Medicine and many other agencies and authorities, funding of £9,500 from the AIDS budget was given by the Regional Health Authority to run one clinic for a year.

A working party was formed, with a school nurse as the chairperson, to plan and implement the clinic. We took time to do this and believe that this detailed planning has contributed to the success of the service.

The planning

The factors we considered in planning the clinics included the following: venue, timing, staff, appointments, types of contraception, service offered, communication, advertising and evaluation.

Previous caesarean section and the rising incidence of placenta praevia and placenta accreta

Out of a total of 25,551 deliveries, the diagnosis of placenta praevia requiring a caesarean section was made in 124 patients (0.48%). The risk of placenta praevia with an unscarred uterus was 0.42%. The risk increased with the number of previous caesarean sections to 22.2% in patients who had 4 or more sections. Patients who had placenta praevia and an unscarred uterus had a 3% risk of having placenta accreta. With previous caesarean section and placenta praevia, the risk increased linearly with the number of previous sections to 50% in patients who had had 4 or more caesarean sections.

Khouri JA, Sultan MG. Journal of Obstetrics and Gynaecology, vol 14, no 1, January 1994, pp 14-16.

Author abstract. © Journal of Obstetrics and Gynaecology, 1994.

Active management of labour: current knowledge and research issues

Objectives

To review evidence that the package of 'active management' of labour which is comprised of strict diagnosis of labour, early amniotomy, early use of oxytocin and continuous professional support reduces rates of caesarean section and operative delivery. This review studies data from 4 separate overviews of relevant randomised controlled trials from the Cochrane Collaboration pregnancy and childbirth database.

Background

Since the 1970s the use of amniotomy and oxytocin has become widespread. This was part of the active management of labour movement originating at the National Maternity Hospital in Dublin. Other components include rigid criteria for the diagnosis of the onset of labour, restriction on the duration of labour and the continuous presence of a supportive companion. Proponents claimed it reduced the caesarean section and instrumental delivery rate and was safer for mothers and babies. Maternity units elsewhere have adopted some or all of these components of active management.

Methods

The evidence for this review is based on a meta analysis of previously conducted randomised controlled trials (RCT). There have been no randomised trials of the total package of active management. The various components were analysed separately and consisted of amniotomy alone (6 RCTs), early oxytocin (4 RCTs), amniotomy and oxytocin together (3 RCTs), and the presence of a continuous companion (10 RCTs). The final component, of correctly diagnosing the onset of labour, has never been the subject of a randomised trial.

Findings

The evidence from these meta analyses is that amniotomy and oxytocin separately or as a combined package has no statistically significant effect on the caesarean section rate or on the maternal or fetal outcome. Amniotomy resulted in a slight reduction in the duration of labour but this did not have an effect on maternal or fetal outcomes. Studies investigating the effect of a companion in labour explore the psychological component of active management. Meta analysis supports the idea that psychological support reduces analgesia requirements, reduces the incidence of caesarean section and improves fetal outcome. Therefore the only component of active management which has been shown to have a beneficial effect on the outcome for mother and fetus is the continuous presence of a supportive companion. The authors conclude that "Delivery units should endeavour to provide continuous professional support in labour, but routine use of amniotomy and early oxytocin is not recommended".

Abstract writer's comments

This is a highly significant review for all midwives and obstetricians as it challenges the value of 'active management', aspects of which have characterised care in labour for the last 25 years. While this review provides support for the theory that active management of labour reduces the rate of operative interventions for delivery, the element which achieves this is the presence of a companion in labour rather than the effect of amniotomy or oxytocin.

Thornton JG, Lilford RJ. British Medical Journal, vol 309, no 6951, 6 August 1994, pp 366-369.

Abstract written for MIDIRS by Liz Floyd, midwifery lecturer. © MIDIRS, 1994.

Lucid Breastfeeding

One by one, a host of breastfeeding misperceptions are falling by the wayside. Reports issued about a year and a half ago indicated that mothers who breastfeed nine months or longer exhibit bone loss at 12 months postpartum. Reports released more recently take a longer range view and show that the bone lost during lactation is recovered after weaning. Moreover, at least three studies correlate breastfeeding with ultimately *higher* maternal bone mass. Increased bone mass is reported for breastfed children as well. According to earlier evidence, infants absorb 67 percent of the calcium in human milk, as opposed to 25 percent of that in cow's milk. A new study shows that the average bone mineral density of young adults who were breastfed as babies is significantly higher than that of young adults raised on formula. (*New Beginnings*, July/Aug 1994, pp. 110–111)

A study published in June 1992 cautioned mothers against nursing after exercising. The researchers' methodology has since been questioned, and at least one subsequent study on the impact of aerobic exercise on breastmilk volume and composition shows that exercise does *not* adversely affect breastfeeding. (*New England Journal of Medicine* 330, 17 Feb 1994)

Murky lenses have also been wiped clean on the question of relactation. Two recent studies show that women who have stopped breastfeeding and adoptive mothers who have lactated in the past can produce milk for their children. Successful relactation, according to one research team, is fostered by regular counseling. (*BFHI News*, Sept 1994, p. 4)

The effective initiation of breastfeeding, meanwhile, has been shown to hinge not so much on intent, as is often believed, but on birth factors—namely, the absence (or timing) of labor analgesia. A team of university researchers has found that healthy term infants who receive no labor medication prior to an hour before birth and who initiate breastfeeding within an hour of birth demonstrate effective rooting and suckling reflexes significantly earlier (6.4 hours after birth) than those who experience longer durations of analgesia and later initiation of breastfeeding (62.5 hours after birth). (*Journal of Nurse-Midwifery*, May/June 1994, pp. 150–155)

On another front, opposition to breastfeeding took a dramatic about-face this past June when New York State passed what has been coined "the country's toughest law" in defense of nursing mothers. It is now a civil rights violation to prevent a woman in New York from breastfeeding in any public or private place—whether or not her nipple is exposed. Violators are subject to fines of $1,000 to $5,000 or prison sentences of one to five years. Florida's weaker law, instituted in March 1992, protects a woman's right to nurse in public, yet imposes no penalties. (*The Bergen Record*, 19 May 1994, p. A-12)

As of September, 1994, the medical community's support of breastfeeding took a positive turn. More than 3,000 physicians had signed and returned UNICEF Executive Director James Grant's Physician's Pledge to Protect, Promote and Support Breastfeeding. Pledges will be collected from physicians worldwide. For copies to distribute locally, write to James P. Grant, Physician's Pledge, 3 United Nations Plaza, New York, NY 10017; or fax 212-303-7911.

The Revival of Homeopathy

IN 1900, ABOUT 15 PERCENT OF PRACTICING PHYSICIANS IN THE US WERE homeopaths. Homeopathic hospitals numbered well over 100 and medical schools, 22—most of which, in response to pressure from the American Medical Association and drug companies, were closed by 1922.

In the 1970s, there were less than 200 homeopathic practitioners in the US. Presently, there are at least 2,500. Based on 1990 estimates, about 2.5 million Americans a year now use homeopathy and about 4.8 million visits are made each year to homeopathic practitioners. In addition, homeopathic remedies are currently available in most of the 43 national drugstore chains, including Kmart, Payless, Thrifty, and Walgreen's. (Factsheet on Homeopathy, from the National Center for Homeopathy)

This past May, an American peer-reviewed journal published research for the first time ever on homeopathic medicine. The double-blind, placebo-controlled study, conducted by Jennifer Jacobs, MD, MPH, and researchers at the University of Washington and University of Guadalajara, evaluated 81 Nicaraguan children with acute diarrhea, the leading cause of pediatric morbidity and mortality. The children were between six months and five years of age. Those given 1 of 18 different homeopathic medicines were found to recover 15 to 25 percent more quickly than those treated with a placebo. (*Pediatrics*, May 1994, pp. 719–725)

Studies published in European journals document the effectiveness of homeopathy in the treatment of influenza, asthma, migraines, fibrositis, and hayfever. A research grant has just been awarded for a study on the homeopathic treatment of mild traumatic brain injury. (News Release from the National Center for Homeopathy, 9 May 1994)

One more milestone for this low-cost 200-year-old branch of natural medicine: Blue Cross coverage. On May 11, 1994, Blue Cross of Washington and Alaska announced a pilot program to insure the services of a select group of homeopathic physicians in the Seattle area. The AlternaPath Nontraditional Health Care Program, although available to all residents of Washington State, will be limited to about 1,000 subscribers for the first year. If successful, the program will expand, encompassing a larger provider base and more enrollees. For details, contact the National Center for Homeopathy at 703-548-7790.

be offered antenatal screening with detailed ultrasound by an experienced team at 18 to 20 weeks. Amniotic fluid alphafetoprotein (AFP) measurements could also be used.

Other Women

The recommendation, however, that all women planning a pregnancy should take daily folic acid supplements is one which, while easily made, is not easily implemented. Women who come to their general practitioner or to another health professional for general advice on planning for a pregnancy should now be advised to take folic acid daily on a regular basis. Neural tube defects occur some three to four weeks after conception, and will therefore occur before the pregnancy is diagnosed, so the prophylaxis needs to be in anticipation of a possible pregnancy. Indeed it can be stopped at about six to 12 weeks from the estimated date of conception.

Diet

Although it is logical that a diet with a high content of folate should also be protective, there is little direct scientific evidence of a benefit of dietary improvement, and to introduce a diet which would be equivalent to even the 0.8mg daily supplement would require the consumption of very large amounts of folate-containing foods such as green vegetables. This is partially because the bioavailability of natural folates in foodstuffs is considerably less than that of the pharmacological supplement.

Public Education

Many women do not seek professional advice in advance of pregnancy, and to achieve implementation of these recommendations for such women will require a much higher level of publicity and education than has been considered so far in New Zealand. In some other places, such as Western Australia, major publicity drives concerning prepregnancy care are underway.

Toxicity

Folic acid supplementation is cheap, about 10 cents per tablet (that is, $35.00 a year for regular use), and appears to be safe. The vitamin is water soluble and has no acute toxic effects. Potential toxicity includes the risk of making undiagnosed B_{12} deficiency anaemia worse, but this is a very rare problem in women of child bearing age. It may interfere with anti-epileptic drugs which act through an antifolate mechanism; this is not a contraindication to use as the frequency of neural tube defects is increased in women taking anti-epileptic drugs. The folate supplementation is important, but the dosage of anticonvulsants may require an adjustment in the pregnancy.

The current recommendation is for folic acid used alone. A case can be made for the use of multivitamin preparations containing the same quantity of folic acid, as long as they do not have vitamin A, which can be teratogenic (for the same reason, eating liver is not recommended as it is high is both folic acid and vitamin A). Several multivitamin preparations on the New Zealand market have little or no folic acid, and have considerable vitamin A, so the use of folic acid alone is presently the safest strategy.

Conclusion

The chances of benefit for women in the general population are admittedly small, as the frequency of these defects is probably around 1 to 1.5 per thousand births; and of these, perhaps 50% would be picked up on routine ultrasound screening. Thus the number of women benefitting from using folic acid prophylaxis is probably about one in 2000 or less.

On the other hand, successful prevention prevents either a catastrophic fatal abnormality, or perhaps a life-long disability which might be missed by antenatal screening.

Prevention is not complete; the large trial on high-risk women showed a 70% protection, so it is important that antenatal diagnosis and counselling is still offered to high-risk women who receive folate supplementation.

This is still an area of active research, and there is as yet little definitely known about the mechanism by which the folic acid supplement works.

There are also suggestions that some other defects, perhaps other defects of midline closure, like cleft lip and palate, might have a similar mechanism and might also be reduced by folic acid supplementation. On the public health front, the possibility of fortifying bread or other basic foodstuffs with folic acid is being considered in several countries, including Australia, as it is perhaps the only method of achieving high compliance.

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Folic Acid Prophylaxis of Congenital Defects

In 1991, the results of the Medical Research Council (UK) randomised trial of folic acid supplementation to prevent recurrence of neural tube defects were published.[1] This showed a 70% reduction in recurrence rate in pregnancies in women who had already had an affected birth, following a 4 mg/day supplement. The supplement was given from the time pregnancy was planned to the 12th week. Since then, it has become accepted practice to recommend similar supplementation for *women at high risk* of bearing a child with a neural tube defect. A 5mg folic acid tablet is available, without prescription from pharmacies, and is also fully subsidised on the pharmaceutical schedule.

A further randomised trial, and several observational studies, have shown beneficial effects in the much more common situation of a neural tube defect occurring without any previous history.[2] Accordingly, in September 1993, the New Zealand Public Health Commission issued a recommendation that *all women planning a pregnancy* should take a daily folic acid supplement of 5mg per day. As the studies suggest that lower doses would be effective, a 0.8mg folic acid preparation is to be launched as a pharmacy supplied non-prescription medication. This dose is regarded as sufficient for prophylaxis in women in the general population.

These recommendations are based on excellent scientific evidence that folic acid prophylaxis will prevent a high proportion of neural tube defects (spina bifida, anencephalus and encephalocele). The studies were reviewed in the *New Zealand Medical Journal* in December 1993[3] and a full review is also available.[4]

Salient Points

- High-risk women should receive 5mg folic acid daily in advance of conception
- Prevention of defects is not complete (70% protection). Offer antenatal diagnosis and counselling to high-risk women
- Supplements must be taken prior to pregnancy and can be stopped after 6 to 12 weeks following conception
- All women planning a pregnancy should receive 5mg folic acid daily (or a lower dose of 0.8mg when this becomes available)
- Vitamin A should be avoided
- There is little direct evidence of benefit from a folate-enhanced diet

Recommendations

High-Risk Women

The challenge now is in the implementation of this advice.

High-risk mothers, (most commonly, those who have had a previously affected child), should receive specialist advice and genetic counselling, and should be aware of their risk of recurrence in future pregnancies, which is around 2 to 3%. They should be advised to take folic acid supplementation (5mg daily) as soon as they plan a further pregnancy, and should also

INDEPENDENT MIDWIFE REQUIRED

Home Birth and Hospital Birth - Locum and Permanent -
West Coast South Island

Contact : Bev Olson
20 Kaniere Tram, Hokitika
Telephone (03) 755-7545

International Day of Action for Women's Health, May 28th, 1995.
Stop Terminisation of Poverty, Promote Women's Health.

CALL FOR ACTION

This year the CALL FOR ACTION is linked to the "180 days: 180 ways Women's Action Campaign '95", coordinated by the Women's Environment and Development Organisation.[2] 180 days between March 8, International Women's Day and September 6, International Day of Action for Women's Equality during the fourth Women's World Conference in Beijing. 180 ways to link this United Nations conference to the realities of women's lives and to all women's actions and campaigns to change and improve our conditions and our lives. May 28, International Day of Action for Women's Health is one of the 180 and more ways that women use for that purpose. Despite the worsening conditions for women all over the world, we are in no mood to give up, on the contrary! Everywhere women are active in their communities, at a national level, at an international level to push for changes which will benefit especially poor women and men. We put our trust in our combined strength and creativity in all different places at all different levels.

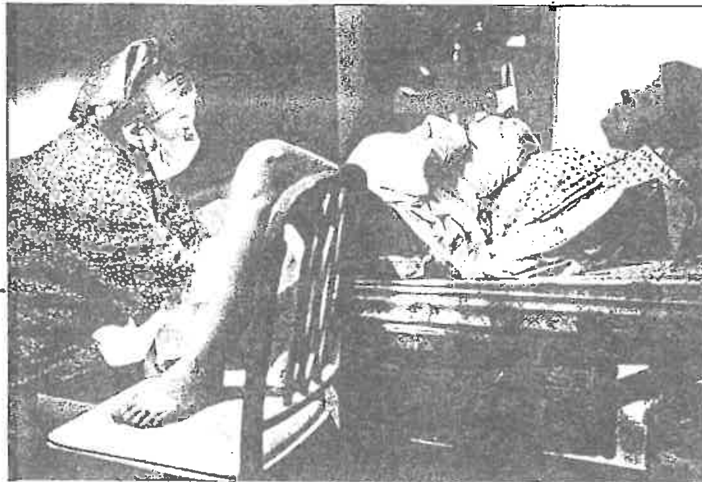
What you can do:

* Distribute copies of this leaflet in your country. Translate it into your local language;
* Use the International Day of Action for Women's Health to demand attention for the feminization of poverty and its devastating effects on women's health;
* Make the International Day of Action and the 180 days: 180 ways campaign knwon to the media;
* Denounce the poverty and ill health of people, caused by the global market economy and inequity;
* Demand an end to coercive birth control practices and population control policies which target and discriminate against women;
* Join local groups and join with all the women's groups around the world fighting poverty and sexism, which limit and deny women the power to self-determination.

During earlier Days of Action, women's groups organized radio programmes; forums with members of Parliament; discussions with health personnel; workshops; information stalls in public places; demonstrations; picket lines; street theatre. Please send newspaper clippings, leaflets, information sheets, posters, reports, photographs, letters and all other relevant information about your activities on May 28 to WGNRR or the Latin American and Caribbean Health Network. Please do so as soon as possible so we can use your material for an exhibition in Beijing.

2 WEDO, 845 Third Avenue, 15th Floor, New York, USA. Fax: +1-212-7598647

Midwifery on the Rise



AN ESTIMATED 50 percent of babies born in the US in 1910 came into the hands of midwives. In 1948, midwives numbered about 20,000; by 1976, about 1,800. (*Birthing*, no. 66, p. 7) At that point, midwifery's role in the provision of maternity care—having dwindled as the organized power of physicians increased—began a slow, steady comeback. In 1980, midwives attended 1.7 percent of all births, climbing to 3.9 percent in 1990 and 4.4 percent in 1991. (*Quickening*, May/June 1994, p. 28)

The results are glowing. A 12-year study of 30,311 nurse-midwife-attended births at the Normal Birth Center at Los Angeles County, University of Southern California Women's Hospital, reveals *no* maternal or fetal deaths and *low* rates of intervention and operative delivery (cesarean, forceps, and vacuum extraction). From 1985 to 1992, the operative birth rate was 4 percent, including a first-time cesarean rate of 1.8 percent. For pain relief, the midwives bypassed anesthesia in favor of showering, ambulation, positional changes, and emotional support from friends and family. For labor induction, they replaced oxytocin with breast stimulation. (*Journal of Nurse-Midwifery*, July/Aug 1994, pp. 185–195)

Perinatal outcomes, however, are not the sole criteria for evaluating the effectiveness of midwifery care, note homebirth practitioner Sylvia Borton and colleagues. Midwifery itself, they point out, emphasizes not only safety but "satisfaction, respect for human dignity, self-determination, cultural and ethnic diversity, family centeredness as defined by the woman, and health promotion"—factors that, although less studied, impact profoundly on the birth experience. Calling for a more inclusive view that embraces such qualitative measures as the influence of the birth event on relationships, the woman's sense of empowerment, and the initiation and continuation of breastfeeding, the authors invite researchers to examine childbirth in the home — the "center of family culture." (*Journal of Nurse-Midwifery*, May/June 1994, pp. 142–149)

Family-based maternity care will soon proliferate in homes, birth centers, and hospitals throughout Florida, where health officials have called for midwifery attendance at 50 percent of the state's births by the year 2000. To realize this objective, Florida will need 950 midwives, three times the number currently in practice. (*Santa Cruz Sentinel*, 11 Jan 1994)

In California, a bill signed in October 1993 grants direct-entry midwives the right to obtain licensing. Those who pass the licensing exam are required to work under the supervision of a physician. The legislation, although a giant step forward for the birthing community, falls short of providing access to care for all childbearing women and full freedom of practice for midwives, says Maggie Bennett, chair of the California Association of Midwives. A collegial or consulting relationship with physicians, she points out, is more fitting than a supervisory one, and more in keeping with the international definition of midwifery, which states that a midwife must be able "to conduct deliveries on her own responsibility." (*Special Delivery*, Fall 1993, p. 11)

In keeping with this resurgence of the traditional maternal care providers, the US Postal Service is proposing a stamp to commemorate the practice of midwifery. All in favor may send letters of encouragement to James Tolbert, US Postal Service, 475 L'Enfant Plaza SW, Washington, DC 20260-3122.

24 MOTHERING SPRING 1995

ARTICLES OF INTEREST

LOCUM ON THE WEST COAST

- Helen Jones (Midwife, Hamilton) -

Stunning West Coast beauty and hospitality plus the enriching experience of working as a locum in a smoothly run Midwifery practice, made up the bulk of my Christmas holidays.

I stepped in to a superbly organised independent practice based in Hokitika, covering a huge arc of the coast North and South as well as the inland areas.

I had read Bev Olson's advertisement in the NZCOM National Newsletter, in August, requiring midwifery cover over the Christmas holidays. This provided me with a chance to escape Hamilton's muggy summer and gain valuable work experience on the coast.

Bev made me feel very welcome and we maintained regular contact before I came down. Bev's practice consists of home births and hospital births.

Once there, our weeks were well organised so that I could meet all Bev's clients and familiarise myself with the local terrain. This naturally included sightseeing and locating the best cafes, picnic sites and local swimming holes, all imperative to a good midwifery practice.

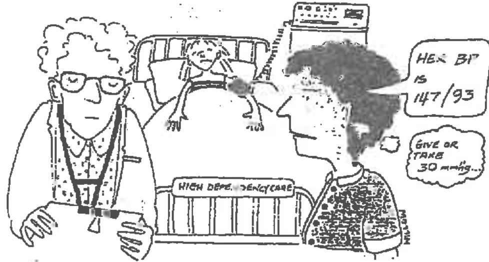
I was introduced to hospital staff and orientated to the hospital and all the other related medical services. I was even privileged to be at the inaugural meeting of the Homebirth Association covering the Coast. It was a pleasure to meet such dedicated and enthusiastic women. Bev gave me plenty of opportunity to familiarise myself with her practice and was always available to me if I had a problem.

I thoroughly enjoyed my seven weeks on the coast, the warmth and the hospitality was almost equal to the stunning scenery that surrounds Hokitika. There are so many outdoor activities to choose from like canoeing on the lakes, cycling, bush walks and of course long beach walks.

The West Coast women need more midwives and Bev would dearly love support from fellow colleagues. If anyone is considering a job move, consider the West Coast. There are so many opportunities to be had. It would definitely be enjoyable.

Automated blood pressure measurement devices: a potential source of morbidity in preeclampsia?

Objective: The purpose was to compare auscultatory and oscillometric techniques in the determination of maternal blood pressure in normotensive primigravid patients and primigravid patients with proteinuric preeclampsia (blood pressure > 140/90 on two occasions and proteinuria >0.5 gm/L).



Study design: A prospective comparison of systolic and diastolic blood pressure was made with an automated device using oscillometric principles and two observers using a double-headed stethoscope to determine auscultatory observations (phase I and phase IV of the vascular sounds) in normotensive primigravid patients (N=40) and primigravid patients with proteinuric hypertension (N=17).

Results: In patients with proteinuric preeclampsia the mean differences between auscultatory (phase I and phase IV) and oscillometric observations were 5.4 mm Hg (SEM 1.4 mm, $p<0.05$) and 14.8mm Hg (SEM 2.9 mm, $p<0.001$) for systolic and diastolic observations, respectively. In normotensive patients the mean differences between auscultatory (phase I and phase IV) and oscillometric observations were 2.4mm Hg (SEM 0.9mm, p not significant) and 7.5mm Hg (SEM 1.9mm, $p<0.01$) for systolic and diastolic observations, respectively.

Conclusion: Automated devices using oscillometric principles "underrecord" systolic and diastolic blood pressure compared with auscultatory observations (phase I and phase IV) in patients with proteinuric preeclampsia. In some cases the difference between observations exceeds 30mm Hg.

Quinn M. American Journal of Obstetrics and Gynecology, vol 170, no 5, pt 1, May 1994, pp 1303-1307.

Author abstract. © American Journal of Obstetrics and Gynecology 1994.

Grandmultiparity — not to be feared? An analysis of grandmultiparous women receiving modern antenatal care

Objective: To document the reproductive performance of grandmultiparous women receiving modern antenatal care.

Methods: A cross-sectional study of 2784 multiparous (882 grandmultiparous) mothers delivered in a base hospital obstetric unit staffed by western-trained midwives and consultant obstetrical staff.

Results: There were minimal differences in major antenatal, peripartum and neonatal outcome events, with the exception of a high rate of gestational and pre-existing diabetes.

Conclusions: This data supports the opinion that grandmultiparity *per se* is not necessarily a major risk factor for either mother or fetus. Similarly, the mature grandmultigravida in this population was not at significantly increased risk of the alleged associations of increased parity and advancing maternal age, with the exception of diabetes. Together with the combined prevalence of maternal anemia this requires further investigation and probable intervention, particularly in the light of recent speculation concerning the fetal and infant origins of adult disease.

Hughes PF, Morrison J. International Journal of Gynecology and Obstetrics, vol 44, no 3, Mar 1994, pp 211-217.

Author abstract. © International Journal of Gynecology and Obstetrics. 1994.

NZ Doc.

Maternity pilot flies into a provider storm

Southland correspondent and Lynne Laracy

GPs are being advised to steer clear of a "maverick" maternity contract drafted by Southern RHA.

The NZMA has lodged a protest with the RHA over the contract, though Southern is close to calling tenders from providers interested in piloting lead professional maternity care arrangements.

Earlier this month it distributed a 41 page model contract to potential providers.

"The lead professionals would be liable for the acts or omissions of other professionals they subcontract," said Southern GPA executive member Branko Sijnja.

"It's hazardous and something that should be looked at very carefully."

He said the RHA is planning to set "benchmark" prices, and that lead professionals could end up in trouble because of ensuing capped budgets.

"There will be a capped budget but the lead professional will have little control over what services, such as specialist referral, laboratory tests, home help, domicillary midwives, or after delivery care, will be needed."

He is also concerned at the onerous administrative requirements of the contract, and the fact that the RHA would have access to a practice for audit purposes with 24 hour notice.

Both GPs and midwives see the contract as an attempt to push providers towards individual, rather than a national contract, and say that its sole purpose is to cut costs.

New Zealand College of Midwives national coordinator Karen Guilliland and Dr Sijnja both say the pilot is ill timed given the fact that many of the issues it encompasses are currently being negotiated by the joint RHA maternity project, which SRHA is also party to.

Mrs Guilliland said the scheme, as proposed, will also increase conflicts between doctors and midwives because it fails to recognise or compensate for the intensive, time-consuming nature of midwifery practice.

"It is nonsensical for the contracts to allow for the doctor to hold the budget and direct postnatal care, when historically, it has always been the midwife who provides this care.

"In effect it means the midwife now works for the doctor, where in the past she worked for the woman."

But the Southern RHA women's health manager for Otago and Southland Veronica Casey said the authority is obliged to start the pilots given the "significant provider interest".

Feedback on the effectiveness of the arrangements will be sought from both consumers and providers.

The SRHA is convinced the changes are in the best interest of women.

"Under the existing system women sometimes do not find out until well into the pregnancy what options are available to them for the delivery of their baby.

"Often women don't know where to contact a person who can care for them during their pregnancy."

Under the existing system women may not find out their options till late in the pregnancy

Drinks, contraception increase risk of UTIs

NZ Doctor 31.03.95

About half of all women experience a UTI by the time they are in their late 20s, usually because of sexual activity.

But a new study shows that other factors, such as the type of contraception she uses, her ethnicity or even whether she drinks soft drinks also can affect her risk of the painful infection.

Michigan researchers looked at 374 college students, 86 of whom had a UTI. They found that women whose partners used condoms were almost twice as likely to get a UTI, compared to women who used oral contraceptives.

Diaphragm use tripled a woman's risk of the infection.

Using deodorant, sanitary napkins or tampons also increased the risk of infection, as did drinking carbonated beverages. And black women were more than five times as likely as white women to get a UTI, according to the study which appeared in the March issue of *Epidemiology*.

The researchers speculated that condom use, especially without lubrication, could increase the trauma associated with vaginal intercourse, which could cause the symptoms of a UTI. And organisms that cause such infections may be more virulent in black women, they suggested.

The link between the infections and soft drink intake, however, remains a mystery. The researchers thought the caffeine in the drinks might be the culprit, but women who drank other caffeine-containing beverages, such as coffee or tea, did not have an increased risk of infection, says study author Dr Betsy Foxman.

"Some say soda consumption is protective. Others say it is a risk factor," said Dr Foxman, an assistant professor of epidemiology at the University of Michigan School of Public Health, Ann Arbor.

"It's a suggestive finding, but it is hard to know how soft drinks may be affecting women," she said.

"However, if a woman drinks 10 cans of soda in a day, as some women in the study did, and she has lots of urinary tract infections, it's not unreasonable to stop drinking it."

Women in the study who drank cranberry juice or took vitamin C regularly were less likely to get infections. Cranberry juice is a well known folk remedy for these infections, and several studies

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"In our society a woman needs the support of information to be able to resist, with confidence, the power of the big business that human reproduction has become and which many have vested interests in keeping that way. She must be able to recognise the ubiquitous misinformation for what it is: she must - having had her innate self-assurance destroyed - be re-assured that indeed she can give birth, by herself.

Medicalised delivery, a cultural norm in our society, is both physically and psychologically abnormal, an altered event altogether. The WHO acknowledges - but most people do not - that 'it is no longer known what normal (ie non-medicalised) delivery is' (1)."

Ref: (1) WHO, "Truly normal birth has virtually been extinguished".

Maire Reid

Extract from *The Disappearance of Homebirth; The Disappearance of Birth. Language versus reality in modern childbirth and maternity care.* Available in full from AIMS Publications.

AIMS Quarterly Journal Vol 1 No 4/5

NZ MEDICAL JOURNAL 22.03.95

Bed sharing and cot death

Based on research findings from the New Zealand and other cot death studies[1,2,3] health professionals in recent years have advocated that all babies sleep separately from their parents. We are not calling into question the accuracy of the findings from these studies in relation to bed sharing, but suggest that the consequent recommendations may need to be reconsidered in the light of research in the area of mental health.

With reference to babies sleeping alone or conversely, with their parents, a recent article reports research on the consequences for longer term personality development of infant and childhood sleeping location.[4] Beginning with the observation that "parent-child co-sleeping has been so prevalent throughout the history of humankind that it is more economical to identify the exception than the rule of children sleeping with parents" (p43/44), the researcher goes on to consider a number of personality correlates of such practice.

Based on an indepth study of 219 women using multiple data collection methods, Crawford draws attention to positive relationships between infants sleeping with their parents and consequences for positive long term mental health. Study in this field is not new but we suggest that it is an area which has largely been ignored by health professionals when giving advice on parenting practices.

Marion Pybus, Valerie Fleming
Department of Nursing and Midwifery, Massey University, Palmerston North.

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Smoking reduces the chances of becoming pregnant, according to the findings of a study supported by the National Institute of Child Health and Human Development (*Fertil Steril* 1994;62(2):257-262). Women who smoke are three times more likely than non smokers to have high levels of a hormone that indicates that they have fewer eggs available for conception. The investigators studied 210 infertile women 35 to 39 years, 65 of whom smoked and 145 had not. The infertile women had a "significantly increased risk of diminished ovarian reserve", an indirect measurement of the number of eggs remaining in the ovary. The evidence that smoking impairs fertility corresponds with other known risks of smoking to women, including irregular menstrual cycles and earlier than average onset of menopause.

BIRTH 22:1.3.95

FEELING IS BELIEVING

I am disappointed that women have to see their baby on a television screen to know that it is true - their baby lives! It is a sad state of affairs when it all comes back to seeing is believing - what about feeling is believing - the feeling of a living thing inside your body, turning, kicking, hiccupping has got to be more memorable, more joyful and more secure than lying flat on your back, with a bladder full of liquid, having someone put slime all over your naked abdomen and then press your bladder as hard as possible so you can see fuzzy black and white picture with images quite like those you see when the antennae has come loose...

We as educators have a role in helping women become more aware of their body, to get to know it without the aid of technology, touch their unborn baby through their belly, concentrate on it's movements and watch their belly move like the alien. We need to allow women the chance to daydream about their baby - imagine it's body, hands and face. Pregnancy is a chance to really feel and learn of the body's capabilities - let's help women do this without TV.

Dianne McKenzie, *Nat Assoc of Childbirth Educators Newsletter*, NSW, 1/94. AIMS Quarterly Jnl Vol 1 No 4-5