NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

March 1996

Section 51 Update

Giardia Lamblia

MPO Update

Sender : **NEW ZEALAND COLLEGE OF MIDWIVES (INC)**
P O Box 21-106 Edgeware Christchurch

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

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TO : 12 months Subscription to the New Zealand College of Midwives (Inc)

TYPE OF MEMBERSHIP (Please indicate in Box)

☐ Self Employed $350
NB : Your membership is deemed Self Employed if you claim from the Maternity Benefit Schedule

☐ Employed	$175	☐ Associate with Indemnity	$155
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☐ Student	$ 50	☐ Affiliate	$ 30

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☐ Automatic Payment } (contact details at foot of this page)

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REMINDER : *Professional Indemnity Insurance is included with NZCOMI membership for financial members who are self employed, employed, unwaged, student and associate with indemnity.*

Your membership to the NZCOMI will expire 12 months from the date of this payment being received. When your membership is due for renewal we will send you an invoice one month prior to the due date.

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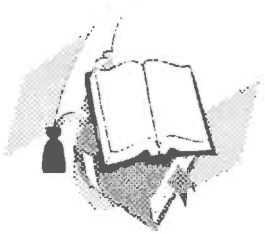

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P O Box 21106 Christchurch

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   The Handbook of the New Zealand College of Midwives
   Cost - $19.95 + 80c Postage = $20.75

2. New Zealand College of Midwives **MIDWIVES HANDBOOK FOR PRACTICE**
   Cost - $5 + 80c Postage = $5.80

3. **THE MIDWIFERY PARTNERSHIP**. A model for Practice by Karen Guilliland and Sally Pairman
   Cost - $15 + 80c Postage = $15.80

4. **PRESCRIPTION PADS**
   (Please make cheques payable to NZCOMI, Canterbury/West Coat Region)
   Cost - $5 each + 80c Postage = $5.80

5. **JOURNALS** (A supply of back issues)
   Cost - $5 + 80c Postage = $5.80

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   Cost - $25 + $4.50 Packaging & Postage = $29.50. Pinards are posted separately.

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..... TOWN/CITY: .....

PLEASE SEND ME: .....

.....

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Cheque Enclosed : $ ..... **A receipt will be enclosed with your purchase/s**

CONTENTS

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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:

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NZCOMI
P O Box 21-106 Christchurch
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PLEASE NOTE

NZ College of Midwives
National Office
Christchurch
has a new Fax Number :
(03) 377-5662

DISCLAIMER

The articles and reports printed in this newsletter are the views of the authors and not necessarily those of the NZCOMI

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Editorial

"HELLO"

Welcome to the first newsletter of 1996. Hopefully the next issue will be in a greatly improved, more professional and easier to read format. We are presently looking at quotes for an A4 sized publication.

Although I know you are all increasingly busy, please do send any articles of interest, newspaper articles etc to share with us all; after all, this is your forum for disseminating information.

The Conference Committee is in full swing and need your support. Don't forget to send back "expressions of interest" and you could start off your Autumn wardrobe and support conference by buying some of the specially designed clothing.

With the increase in the prevalence of Giardia, you will be keen to read Joan Donley's informative article.

Regards,

Barbra Pullar

1996 MedSpec Catalogue

Editor's Note: Enclosed with this issue is a subscription to MedSpec Catalogue which is a comprehensive directory for Medical Equipment and Supplies. The next edition will provide Midwifery advertising .

This is a Special Introductory Offer and is available at 50% off the normal subscription price.

Situations Vacant

LAKELAND HEALTH
MAI MAKETU KI TONGARIRO

CLINICAL MIDWIFE CONSULTANT

- We have developed a new Midwife Consultant role for our Maternity Service.
- The CHE provides a Midwifery Service in two sites, Rotorua and Taupo with birthrate of 1,750 births per annum.
- We require a Midwife who has completed a minimum of three years Midwifery experience, who has completed or is working toward a post graduate degree.
- The Key tasks of this Clinical Leadership role are to:
  - ensure clinical best practice through a Continuous Improvement Programme
  - implement the Midwifery Professional Development Programme
  - lead a transdisciplinary secondary service team toward accreditation in 1997

We intend to build a new birthing facility ready for occupation in early 1998 and the Consultant will be involved in this project team.

Salary Scale : $42,000-$45,000
Hours : Monday - Friday 0800-1630

APPLICATIONS CLOSE 19/04/96

Commencement Date: May 1996
For further information contact:
Lucy Dawson, Operations Manager Maternity
Ph 07-349-7903 Fx 07-349-7983

Northland Health

STAFF MIDWIFE
Kaitaia Hospital

Are you looking for a more relaxed lifestyle?

Situated in the far North, Kaitaia offers a sub-tropical environment, beautiful beaches and a wealth of recreational opportunities. Kaitaia's population is growing and the town is served by good schools, clubs and sporting facilities.

We are looking for someone to fill the position of Staff Midwife in our friendly maternity unit, working full time rostered shifts, although part-time would be considered. Experience is essential. An opportunity to develop extended midwifery care.

Applications to: Caroline Vasmer-Diecks, Maternity Nurse Manager, Kaitaia Hospital, PO Box 256, Kaitaia. Telephone 09 408 0010, Fax 09 408 2357.

A PLEA FROM THE NATIONAL CO-ORDINATOR

RE THE BIRTH OUTCOME SURVEY

REMINDER

Could all midwives participating in this survey please return their completed forms as soon as possible. There are still some 2,000 forms to be returned and it's definitely not too late to do so.

Many thanks,
Karen Guilliland

NOTICE OF SPECIAL GENERAL MEETING

MEMBERS ARE GIVEN NOTICE OF AN SGM IN THEIR REGION TO VOTE ON THE DECREASE TO THE SUBSCRIPTION RATES. PLEASE NOTE ON PAGE 4, THE DATE FOR YOUR REGION'S MEETING

REMIT:

THE NEW ZEALAND COLLEGE OF MIDWIVES (INC) DECREASES THE PROPOSED NEW SUBSCRIPTION RATE TO THE FOLLOWING:

	Current New Rate	Proposed New Rate
	$	$
Self employed	700	630
Employed	350	315
Associate with Indemnity	310	279
Associate	60	54
Affiliate	60	54
Student/Unwaged	100	90

NATIONAL CO-ORDINATOR'S FORUM

This edition's Forum is dedicated to NZCOM business. As the six years since incorporation fly by, we as an organisation continue to develop and expand at an incredibly rapid rate. The days of meetings in back bedrooms of midwives homes, sleeping bags on the floor, bringing a plate and doing a week's work in one day trip to economise, all on a voluntary basis are over. Midwives are autonomous, well paid and respected members of the community. Their professional association also needs to reflect this position. The College has moved from a totally voluntary organisation to an employer and asset holder. The College now has an office and equipment which can service all members. It employs a National Co-ordinator, a Legal Advisor, a Secretary and a Finance Clerk to manage the business of the College. As an employer the College must face its obligations both statutory and ethical, to be a good employer and equity based. The regions remain largely voluntary and the new rates will allow an honorarium system which goes some way to recognise the work of local committees. The impact of indemnity demands have accelerated the College's workload and Jackie, our one Legal Advisor already fully if not over employed acting for members in this new environment. In the UK midwives must pay individually for this cover (some 4,000 pounds sterling) as the Royal College of Midwives can no longer absorb the costs. Indemnity issues affect all midwives both employed and self employed and we expect claims to continue rising over the next years as both CHEs and Government shift responsibility further and further onto the individual. These changes to how the College operates were inevitable and essential but bring with them financial consequences. At last year's AGM, the membership recognised this and approved a substantial increase in subscriptions which recognised the demands of the organisation. As with all changes of this nature the increase in fees has caused some concerns amongst individual members. Subsequently the National Committee has listened to these concerns and have examined the budget position at some length to see if some reorganisation of subscription funding would enable a lesser fee for the next financial year.

The recent National Committee Meeting unanimously agreed to support the concept of reducing the fees. The proposal which will allow this is to reduce the amount of the subscription which now goes to each region from 30% to 20%. This ten percent decrease will come off the subscriptions and is set out as follows:

	Current New Rate	Proposed New Rate
Self employed	$700	$630
Employed	350	315
Associate with Indemnity	310	279
Associate	60	54
Affiliate	60	54
Student/Unwaged	100	90

The 20% breakdown of the subscription to regions will vary according to the number and category of midwives and consumers who join. The range from Northland through to Southland is predicted at $2,800 to $24,700 for regional funds. These amounts were reviewed by all chairpersons as equitable and adequate for the work envisaged for their local members, ie, newsletters, meetings, networking and information. The restructuring of subs in this way also meant the National funding of the expense accounts for Midwifery Standards Review Committees and Complaints Committees. This does not change the local autonomy of these committees in any way but does give them a better financial base.

In order to make these changes, regions will need to hold a Special General Meeting for their members to approve the decreases officially. The dates for these meetings are as follows and members are urged to attend so they better understand where their subscription money goes.

Region	Meeting Date
Auckland	Monday April 15 at NZNO, 1 Symonds St at 8.30pm
Bay of Plenty/Tairawhiti	Friday April 26, Tauranga
Canterbury/West Coast	Thursday 4 April, MRC Centre at 7.30pm
Central	Saturday April 13, Wanganui Hospital
Northland	Monday 15 April Antenatal Clinic Whangarei Hospital 6.30pm
Southland	17 April, A/Natal Room, S'land Obstetric Unit at 7.30pm
Taranaki	Tuesday 9 April at 7pm.
Wellington	Tuesday April 9

Waikato, Nelson and Otago Regions have been advised of their SGM via their local regional newsletters so that 14 days written notice may be given. Please read local notices for times and venues.

Report on the Hui and National Committee Meeting Orongomai Marae, Upper Hutt, 1 - 3 March 1996

Nga Maia O Aotearoa Me Te Waipounamu joined us for the first National Committee Meeting ever to be held on a Marae. The National Committee Meeting was preceded by a Bicultural Workshop. The impetus for this weekend came from a recognition that the National Committee needed to address its own issues relating to partnership so that this could be modelled to the wider College. Nga Maia proposed that the most appropriate place for this negotiation to occur was on a Marae. Estelle Marment of Nga Maia was the linchpin to the success of this Hui and must be congratulated for her incredible organisation which resulted in a very smoothly run Hui. Tino pai rawa Estelle.

It was felt that the Workshop should be facilitated and so bicultural co-facilitators from TEC Consultancy worked with the Committee to help guide us on this journey of discovery and recognition of each others cultures. This co-facilitation between Maori and Pakeha in partnership is a new way of working and it was hoped it would mirror the commitment by all of working together towards a mutually beneficial and equal partnership. It was also an opportunity to apply similar principles in examining and reflecting on the way in which the National Committee conducts itself and its processes.

On the Saturday evening the MSRC and Resolution Committees joined with us to socialise and network. They then went into their own forum next day while the National Committee Meeting continued.

Two major events occurred as a result of this weekend. Firstly, the bi-cultural funding was formally handed over to Nga Maia to facilitate the development of a structure for Maori Midwives in partnership with the College. Secondly, Wharemawhai Timu Timu and Joan Donley graciously offered themselves as Kaumatua to guide the College in its bi-cultural journey, to ease our path and to help us avoid the pitfalls of ignorance or insensitivity. To them we give our grateful thanks. We are extremely fortunate to be lead by women of such mana.

The tone of poroporoaki (or farewells) seemed to indicate that participants were leaving with renewed hope and commitment for our future growth and with considerable excitement for the partnership which has been forged.

Tapawera mother says rural midwives' services essential

Losing the services of rural midwives will be another nail in the coffin for rural communities, says Tapawera mother Sarndy Scott.

Mrs Scott had problems during her last pregnancy earlier this year when, at 25 weeks, she thought she was going into labour.

No one was around to help, except her toddler, but Tapawera-based independent midwife Jill Bonny was on the scene in 10 minutes.

"I or the baby could have died," she said. "Fortunately it was just stomach troubles and nothing tragic happened. It could have been tragic, and what if Jill hadn't been around?"

"When you're pregnant, it's stressful enough without losing that personal touch and having to go all the way into town for check-ups in a sterile atmosphere," Mrs Scott said.

For the past five years, Mrs Bonny has provided 24-hour antenatal and postnatal care at home for rural women in Murchison, St Arnaud and Tapawera areas.

She has helped delivered more than 100 babies and helped many families.

Mrs Bonny said on average she travelled 45km a visit, but the Central Regional Health Authority's proposed funding changes would only cover vehicle running costs within about 15km of her Tapawera home.

She said the authority's goals were to provide a choice of maternity care for mothers-to-be. But under the proposed changes the three objectives would no longer exist for rural women.

Mrs Bonny said no other midwives would be able to stretch their resources to help women formerly on her "run" and if the women's GPs did not deliver babies they would have to rely on an obstetrician.

Rural home births might no longer be an option, as two midwives needed to be present but might not be available.

"I expect a reasonable number of women will get less than optimum care because they'll have to travel so far to get it."

"I would really just like to get on with helping out mothers and babies, and not have politics interfere with my job."

Mrs Bonny said women would lose the chance to have help and encouragement with breastfeeding, and this could prove unhealthy for the baby.

"For years women have fought to have this type of service, but now it could be whisked out from under them." ■

Nurses attack post-natal subsidy plan

- NZ Herald, Nov 1995

By Fiona Barber
medical reporter

Midwives and nurses are condemning a move to use public money to subsidise post-natal care for new mothers in a private Auckland hospital.

They said the scheme would prop up the private sector while the largest maternity hospital, National Women's in Auckland, struggled with insufficient funds. This week, the northern regional health authority confirmed that it was holding talks with the Auckland Adventist Hospital, in St Heliers, about a scheme to offer new mothers subsidised care in the private facility for $80 a night.

The proposal aims to relieve pressure on National Women's Hospital and to provide women with an additional choice for post-natal care.

North Health said talks were also being held with at least one other private hospital in the city, although free post-natal care in public hospitals would remain.

The Auckland Adventist Hospital usually charges between $315 and $395 a night.

The Nurses Organisation said yesterday that the scheme would shore up the private sector while the public system was being run down.

The national director, Brenda Wilson, said National Women's Hospital had not been receiving the amount of money it needed to run its services.

When news of the scheme became public this week, the National Women's Hospital general manager, Mr Gary Henry, said the hospital had yet to sign a funding contract for this financial year because it was being offered $5 million less than services cost.

The Nurses Society national director, Mr David Wills, said channelling money to a private hospital was the worst solution for the increasing demand placed on National Women's.

It would seriously aggravate problems for National Women's by taking scarce funds away from that hospital and seriously reduce the prospect of services being properly funded and expanded.

The Auckland chairwoman for the College of Midwives, Mrs Sandy Grey, said the move was the first step in the privatisation of maternity services.

She said private healthcare should be the domain of health insurers. "National Women's is underfunded yet they [North Health] can find money to subsidise the private sector." ■

- STOP PRESS -
SECTION 51 UPDATE

The NZMA has had a day meeting with the RHAs to discuss their concerns with Section 51. The NZCOM is to meet with the RHAs to talk on our submission on Friday 15th March. Following these talks all parties will convene to discuss the outcomes.

Contact the National Office or your local Region for further updates following these Meetings.

Many thanks to all the midwives and regions who sent in such comprehensive feedback on the last draft.

NEW ZEALAND
COLLEGE OF
MIDWIVES
NATIONAL OFFICE
has a new Fax number
(03) 377-5662

SECTION 51 UPDATE

20 February 1996

JOINT RHA MATERNITY CONTRACTING STRATEGY AND PROPOSED CHANGES TO SECTION 51 NOTICE - DRAFT

This submission reinforces the points the New Zealand College of Midwives raised with the Joint RHA Maternity Committee at the Meeting of 20th December 1995. The notes of that meeting are enclosed for your reference.

NZCOM has had an overwhelming response to this draft, yet again identifying the issues as already raised with the RHAs at the December 20 Meeting. The notes of that meeting are therefore the substantive part of this submission.

The outstanding issues which are a priority for midwives continue to be:

1. **Mileage Subsidy**
The recognition of the actual miles midwives travel in order to deliver the service required under Section 51. The principle of being paid for actual mileage travelled is still strongly supported. This is particularly so for midwives and women who live in rural areas. These midwives have no access to swings and roundabouts as all their clients are geographically spread.

2. **Rural Care**
Recognition of the service needs of rural women as different to urban women. Professional and personal isolation, lack of easily accessible backup, poor economic status of many rural families, no transport and extended time demands, all impact significantly on the midwife's ability to practice safely and earn a reasonable income. Under the proposed schedule most rural and small town midwives feel the prospect of continuing to provide their current service daunting. For some midwives providing the service according to need will cost them more than they actually earn. Most rural midwives already have to modify the number of visits they do to less than urban women receive because of travel time requirements. We look forward to the RHAs proposals for a rural supplement.

3. **Continuity of Midwifery care**
Continuity of midwifery care is not spelt out clearly enough in the document to reassure midwives that this is in fact the RHAs objective. The vision statement itself no longer includes the phrase "continuity of carer" which was of major concern. In all our negotiations it was continuity of carer that was to be the cornerstone of the new system. The current focus on a poorly defined LMC (mostly in relation to the actual birth rather than the whole experience) does little to reassure midwives that women-centred care will be the outcome. Several midwives point out that under these payment incentives when a GP is the LMC the following will be the norm:

- Antenatal care provided by GP.
- Core CHE staff provide labour and birth.
- Self employed midwife provides minimal postnatal care.

This recreates the system of old in which so many women had unsatisfactory experiences. The women's health lobby was specifically aimed at changing this fragmented impersonal type of service.

3.1.3.4 Requiring all LMCs to continue to provide care following transfer is fraught with problems.

1. To continue care or not must be an individual decision of judgement in relation to each individual's parameters of practice, eg, skills, level of tiredness, women's choice.
2. GPs do not need to continue, as the midwife is still there if there is shared care.
3. Many CHEs expressly forbid the continuation of midwifery care in their access agreements.
4. The often restrictive and punitive criteria involved in getting an access agreement excludes many practitioners and ostensively denies them a livelihood. If the RHAs make it mandatory to have an access agreement many women will have access to no midwife at all.

The emphasis should be on the midwife's right to carry on care if appropriate for her and her client. This requirement to carry on when transferring care is the only real reference to continuity of care however.

3.1.34
Surely all providers are expected to exercise wise clinical judgements.
3.4.4
The establishment of labour is a clinical judgement and HBL are not required to define it.
3.4.4.5
Remove "on site" as not viable. This had been agreed to previously.
7.4.1
Midwifery enquiries to the RHA midwifery not medical advisor.
8.0
Complaints
There is a growing concern related to the proliferation of complaints procedures. Any independent practitioner may find themselves being investigated by:

HBL
CHE complaint processes
RHAs
ACC
Professional Disciplinary Bodies
Ombudsman
Patient Advocates
Privacy Commissioner
Health and Disability Commissioner

Often several investigations are triggered by one complaint. If there is a complaint against an independent midwife NZCOM has 10 Complaints/Resolutions Committees throughout New Zealand. Access to these is via the Regional Chairperson, the National Office or the Midwifery Standards Review Committees Co-ordinators. The role of these Committees is one of mediation and resolution and the complainant is offered a process of facilitated discussion.

If there is no resolution, the complainant is given all other options available. It is an expectation that if a complaint is made to another health professional rather than to a body that they approach the first and discuss their concerns with her. This is seen as a professional courtesy.

In light of the above NZCOM would question the appropriateness of the RHA investigating complaints involving clinical practice and would request the RHAs urgently review this.

Mums happier with midwives

By CATRIONA BONFIGLIOLI in Sydney

PREGNANT women given continuous care by a midwife team used less drugs, were happier and were as safe than those given conventional care, a study published in the Medical Journal of Australia has found.

The study compared 405 randomly selected pregnant women given continuous care by a team of six midwives and an obstetrician with 409 women cared for conventionally with no effort made to ensure a midwife known to the woman would be present during labour.

Women receiving team care were 73% more likely to attend antenatal classes, two-thirds less likely to use pethidine during labour and 73% more likely to labour and deliver without intervention, the study based in Newcastle, New South Wales found.

However, the midwife team lost three babies from premature twin pregnancies, including two babies who were extremely underweight, a finding which could be attributed to chance.

Also in the journal, University of Melbourne obstetrics and gynaecology professor Roger Pepperell commented that these deaths did not make a statistically significant difference between the two groups.

The study also found the midwifery team service cost 4.5% less than the conventional care team.

"This is the first Australian study to demonstrate the feasibility of this model of maternity care and to include high risk women," Ms Rowley and her co-researchers wrote in the journal published by the Australian Medical Association.

The co-authors were University of Newcastle professor of medicine Michael Hensley, Clinical associate professor of reproductive medicine Maxwell Brinsmead, and statistician John Wlodarczyk.

Ms Rowley said the teams were quite hard to organise under current industrial awards but were also available at Sydney's Westmead Hospital and were backed up earlier studies which found women were much happier and needed less pain relief when a woman known to them stayed with them through labour.

"Women are looking for continuity of care," Ms Rowley, now a nursing lecturer at University of Newcastle, said in an interview.

"It probably won't cost any more, it might cost less, it's certainly as safe and women prefer it."

Ms Rowley said nationwide industrial change was needed to give women the kind of delivery services they clearly favoured because continuous care was hard to provide while midwives were paid hourly instead of getting an annual salary linked to the number of women they cared for.

The study found that for mothers having a single baby, the stillbirth and neonatal death rates were the same, with three deaths in each group.

However, the midwife team lost three babies from premature twin pregnancies, including two babies who were extremely underweight, a planned for Royal Women's Hospital Melbourne and Royal Women's Hospital Brisbane.

Professor Pepperell said doctors had a responsibility to recognise the professionalism of midwives and support their endeavours.

"Only then will we be able to regain the respect that many of them no longer show for their colleagues in obstetrics.

"Both groups need one another, if not for the care of all pregnant women, then certainly for the care of women whose pregnancies become complicated, who are identified as 'high risk', or who have unexpected problems arising during labour.

"In these situations, the survival of the baby may be compromised if a harmonious, competent working relationship does not exist between both groups of professionals."

Ms Rowley said although some obstetricians were disturbed by the midwifery revival most were very supportive.

AAP

Midwives say cost cuts put women at risk

- Northern Advocate Tues 12/12/95

By Mike Dinsdale

Northland's independent midwives are fuming over plans to cut their mileage allowance for visiting expectant and new mothers.

The chairwoman of the Northland branch of the New Zealand College Of Midwives, Jane Fox, said the Government planned to reduce the amount of mileage midwives could claim in April or May next year.

Ms Fox, from Okaihau, said Northland's 19 independent midwives were unhappy about the plans and said the care given to pregnant women and mothers with new babies could suffer.

Independent midwives currently bill for mileage clocked up for visits to women during pregnancy and for six weeks following birth.

Ms Fox said the Northern Regional Health Authority (North Health) planned to give midwives $150 for visiting mothers in rural areas, which would mean midwives had to pay for house calls out of their own pockets.

"Even though we will only get a limited amount for mileage midwives are a dedicated bunch and will still visit these women after the RHA money has run out," Ms Fox said.

However, in the long run service and care offered to women in outlying areas could suffer, she said.

In the days of user pays the plan meant that the midwives, the providers, would have to pay for the service they were delivering.

"This will hit women in Northland particularly hard. We have a large population living in rural areas and the public transport system is nonexistent.

"The reality of providing care for women and children in Northland is that we have to travel long distances. Women in rural areas will be disadvantaged by this," Ms Fox said.

She said, for instance, if she had to visit a woman in Umawera, the money would be used up in three visits. She would normally make up to 20 visits to a woman during the pregnancy and after the birth.

Women needed a lot of support and care, particularly after birth, which could be a very dangerous time for mother and baby.

Some women in isolated areas of Northland did not have telephones and had no access to visiting a doctor. Midwives were the only medical professionals they could readily see, Ms Fox said.

The plan could mean women would not see midwives as often. Because of that illnesses could go undetected and that could lead to the mother or child ending up in hospital.

Women might also decide to stay in hospital longer after giving birth because they were worried about fewer visits from their midwife.

"Both would cost hospitals more money in the long term in patient care and cost the woman's family who have to travel to visit them.

"Midwives and women see this as an important issue and we are very disappointed by it.

"This is not an economic issue. It's about something that may affect the services delivered to a woman and her baby at home," she said.

North Health maternity manager Sam Denney said the plan was designed to improve the service offered to women.

Mrs Denney said the draft plan was to pay midwives under a modular system in which they were funded for a period and type of care, similar to a bulk-funding system.

The modular funding included a mileage component, but women in rural areas got extra mileage funding, she said.

Women living more than 30 minutes from a birthing facility got an extra $150 while women more than 60 minutes away got $225. Women who were already receiving care from a midwife when the policy was introduced would not be affected by it.

Mrs Denney said while midwives were unhappy with the plan, discussions were continuing.

"It's all about improving the quality and safety of care of the service and managing our purchasing of services," she said.

Mrs Denney said midwives currently received $1 per kilometre mileage expenses.

4. **The Underfunding of Postnatal Services**

Current services cannot be maintained on the proposed prices by either self employed or CHE midwives, especially if home visits are to continue. The DRGs that are available would indicate home visits are cost effective compared to in-patient care. They are also an effective primary health intervention. Not least, the women and their families report high levels of satisfaction for home-based services. We appreciate you are investigating ways of increasing funding to this area and we look forward to hearing the results.

There was also major concern with the 70/30% split in module payments when transferring care which was seen clearly as highly disadvantageous for the midwives who provide most of the service. We look forward to your amended proposal.

5. **Access to Facilities.**

There is major concern at the absence of the access principles in Section 51. Each practitioner needs to know the conditions under which they have access to CHE facilities. The current longstanding highly restrictive and even obstructive criteria put forward by CHEs for access has not abated. NZCOM urges the RHAs to take a more directive approach to solve these issues and give women back their right to accessible hospital facilities. Some private facilities, eg, Winton and Rawine will not give midwives access.

We draw your attention to the Buddle Findlay opinion where the practitioner not the CHE remains responsible for his/her actions (Appendix III).

6. **Laboratory Tests (Part G)**

No midwife considers this list acceptable or even workable for safe practice. Restricting the tests to one only makes a nonsense of many of the tests, eg, SBR, vaginal infections, haemoglobin.

Without the ability to investigate, a midwife is forced to refer everything regardless of actual need. This is a very non cost effective way of practising and very inconvenient to women.

7. **Second Person Attending Birth (see Appendix I)**

There are serious inequities to the $70 sum. Under Section 51 a reason for requiring the availability of a second person at a birth, is resuscitation of the newborn.

In a CHE or city environment there is access to paediatricians who are paid $76.80 just to be present for 1/2 an hour. They may not be required to "do" anything but if resuscitation for example is required are paid $76.80 for each additional 1/2 hour. If requested urgently (and 2nd persons may well be in this position for home and birth unit births) paediatricians are paid $129.70. If you are saying the second persons may be needed for resuscitation, why isn't the second person paid similarly to the paediatrician?

Compare the two scenarios:

a) Paediatrician called at night to well lit, known hospital. She/he probably doesn't live far away and the women is fully dilated before paediatrician is called. All hospital emergency backup services are freely and instantly accessible. The baby is a little flat and needs a little oxygen, some stimulation but stable in 10 minutes. Paediatrician goes home. The mother who sustains a PPH is cared for by midwives. Fee $76.80 for 30 minutes plus $129.70 for urgent attendance making a total of $206.50

b) Midwife/GP called at night to a house some 20kms away to attend a pending birth. They may or may not know the house, there may or may not be adequate lighting and house numbers. On arrival the woman is only 8cms dilated and had been progressing well, however progress slows and it is 2 1/2 hours until the woman reaches full

dilation. Second stage progress slowly and the baby is born some 2 1/2 hours later. The baby's a little flat and needs oxygen and stimulation. The mother starts to bleed and needs active emergency measures. The second attendant assists the LMC and keeps a watchful eye on the baby. Some 2 hours later it is safe to leave the LMC to finish writing up notes etc. Fee $70 (less GST) for 7 hours work and responsibility plus travel.

8. **Referral Guidelines**

Midwives still find the lack of research base to some of the criteria unacceptable.

The most controversial and universally objected to as a "must consult" are referrals for:

- maternal age over 37 and under 16.
- prolonged rupture of membranes after 24 hours.
- large baby.
- prolonged labour (2 hours first stage and 1 hour second stage).
- jaundice in term infant.

- Referral for epidural is to an anaesthetist not to a GP or O&G then to an anaesthetist. This is clumsy and causes unnecessary delays. Maternal distress and request does not require another medical opinion and should be a 1.

- A must refer for an SBR of 250 at any time is not necessary in a term infant and is easily managed by a midwife practitioner. Phototherapy is not recommended under 290 in a 4 day old baby and even this level is conservative nowadays.

9. **Claim Forms**

The proposed claiming forms are unacceptable. They exhibit a phenomenal increase in bureaucracy which is unnecessarily laborious and repetitive. Each client's claim form measures 3mm in depth! Consider in particular, the LMC's storage problems when this is added to the client's midwifery obstetric notes.

The data entry is excessive, surely integration and carbonisation is possible. As proposed, the LMC is required to enter their:

ID No.	-	7 times
Reg. No.	-	8 times
HBL No.	-	3 times
Name	-	8 times
Woman's Name	-	8 times
Woman's NHI	-	8 times
Woman's Address	-	8 times etc

Practitioners are increasingly burdened by data entry requirements and midwives generally (hospital and self employed) are expected to enter the data not only for their own practice but that of others. This is not a midwifery competency or responsibility and removes the midwife from the woman. It is a pointless waste of a midwife's registration. Consider the claims 14 pages, the midwife/woman's own case notes, CHE case notes (if appropriate), the midwife's birth register, professional review/audit data requirements and the CHE demands for increasing amounts of information about each client. There will be little time left for client contact after everybody else's demands for information are met.

We have enclosed the actual forms with corrections together with Appendix II which expands some of the logistic problems with their content.

MEDIA WATCH

Rural mums face tough journeys

Maternity changes alarm midwives

- The Northern News Tuesday January 16. 1996

by TRACY DALTON

Rural pregnant mothers could be drastically affected by proposed changes to funding of maternity services that could reduce the quality of midwife services.

Maternity services are being reviewed by a joint regional health authority committee which includes members of the College of Midwives, College of General Practitioners, and College of Obstetricians and Gynaecologists which will make recommendations to the government in April.

The present draft suggests midwives be paid a set amount for attending births regardless of mileage and time spent with mothers.

Although it is hard to prove, midwives strongly believe good antenatal services reduce birth mortalities, and cost cutting could mean an increase of undesirable birthing situations.

The rural midwife has long been a key figure in the lives of rural women. She is part doctor, part counsellor and an important confidence inspiring person at the time of childbirth.

Okaihau midwife Jane Fox said the payment option could have major impact on rural women who have no transport and live in remote areas.

"If time and distance is not taken into account then midwives will be forking out of their own pockets, which is neither professional or desirable," she said.

Midwives could also expect to pay a second health professional (another midwife) a nominal amount of $70 to attend a birth with her.

She said it was not an economic issue but the continued erosion of antenatal services that was of concern."

"Government has a commitment to Maori health, and many of the women we work with are Maori who will quietly put up with the changes.

"Many women and their families already have to travel large distances to birthing centres. And the stopping of surgical backup at Bay of Islands Hospital has also placed a horrifying strain on general practitioners and ambulance staff as well as the birthing women."

Under the present system midwives claim retrospectively for mileage, and when needed, refer patients to specialists. This could also be destroyed by the review.

Ms Fox urged people to contact their MP's and express their concerns at the proposed changes to maternity services.

'Witch-hunt' on for midwives

- Daily News 10/10/95

DOCTORS are staging a global witch-hunt against midwives in an attempt to drive them out of business, a World Health Organisation expert alleged yesterday.

Marsden Wagner, a doctor specialising in maternity services at the WHO, said many in the medical establishment felt threatened by midwives.

"There is a global witch-hunt in progress — the investigation of health professionals in many countries to accuse them of dangerous maternity practices," he wrote in the Lancet medical journal.

"This witch-hunt is part of a global struggle for control of maternity services, the key underlying issues being money, power, sex and choice."

Marsden said he had been asked to consult or testify in 20 cases in 10 countries in which maternity professionals had been brought up before public courts, medical review boards or health insurance review boards. Seventy percent of those being investigated were midwives and 85% women. "What they do is not what the local doctors in authority most commonly do," he wrote.

Competition was also a major factor, Marsden alleged.

"As birth-rates fall, the competition for pregnant patients increases, especially in countries largely reliant on private medical care; and as more and more countries move towards pluralistic healthcare systems with private practice, maternity care becomes more competitive."

But, he added: "Another issue is the 200-year-old struggle of doctors to control midwifery."

Many obstetricians in the United States and Britain had been sued by parents but they were rarely brought before review boards, he said. The opposite was true for midwives.

Reuter

Valerie Ann Worwood
Leading Aromatherapist to visit New Zealand

Valerie Ann Worwood, who is acknowledged as one of the world's leading aromatherapists, will be visiting New Zealand at the end of April this year.

As an aromatherapist, a reflexologist, a member of the London & Counties Society of Physiologists, and an active member of the International Federation of Aromatherapists, Valerie is eminently qualified in the study of aromatherapy and other forms of holistic medicine. She was awarded a Doctorate in Complimentary Medicine in 1990, and runs her own clinic in Romford, Essex. Valerie's constant research on aromatherapy and its effects on endometriosis and infertility is well regarded, and she lectures all over the world on these and other subjects linked to aromatherapy.

Valerie 's latest book, "THE FRAGRANT MIND" (available only in Doubleday hard-cover) is a pioneering study in the field of aromatherapy, exploring the emotional, psychological and mood-changing effects of essential oils. It is the first study to offer a comprehensive guide to the subject of natural mind enhancement, based on the latest research, and the first text to provide a programme for the whole person - body, mind and spirit.

Valerie now has a range of essential oils and specifically blended oils available under the "Essentially Yours" label. These are available in New Zealand from Essentially Yours (NZ). Valerie Worwood will be in New Zealand from 2nd April, to give two workshops - a one day workshop of female reproduction disorders which Valerie calls "The Female Principle, and a two day "Aroma genera" workshop.

For further information, please contact Megan Walsh on phone (06) 758-9599

Valerie's three books are available from all good booksellers, nationwide, or phone Tranworld Publishers (NZ) Ltd (09) 415 6210 for further details

PLEASE NOTE :
NZ College of Midwives
National Office Christchurch
has a new fax number
(03) 377-5662

The perinatal database information required poses several questions:

- Why does the CHE also require this information from access holders?
- Where does the national perinatal database proposals fit in with this or is this it?
- If or when there is a national perinatal database do these requirements come off the claim forms?

As a database for clinical assumptions, trends and correlations, the information required is minimal and not particularly useful for describing practice and makes the midwifery skills other than physical outcome invisible. Could you provide the rationale for the data you have decided to collect?

10. **Lead Maternity Carer**
The proposals still allow for LMC gatekeeping and excluding midwives or other maternity qualified GP until late in the pregnancy. There needs to be a statement which clearly states that if the LMC is a midwife; specialists, laboratories, pharmacies etc must accept referrals, requests and prescriptions. The current access problems, the restrictions to prescribing and investigating obstruct the midwife LMC and place her in a dependent position which is not in line with the legislation which gives midwives the ability to practice autonomously. This is an area which needs immediate clarification and sorting to make the Section 51 requirements of LMCs possible. It also raises equality questions under the Fair Trading Act if not addressed immediately.

General Comments

- Ultrasound is now an open cheque book and midwives predict an upsurge in costs as a result. There was little support for 1st trimester scans as the fee for service when it is the 2 trimester which requires it more.
- How are these requirements going to be monitored and from when? How will RHAs ensure care plans are done and adhere to?
- The longstanding and increasingly urgent need is for women to have easy access to the options available to them. It is not acceptable that the provider only provides that. Where is the RHA information leaflet and why has advertising not already started?
- There is major confusion in the document over discharge. Is it 2 weeks, 28 days or 6 weeks? As there are no payment differentials the likely outcome is that women will be discharged at 2 weeks regardless. The requirement in 3.4.5.7 in Services Following Birth for referral to the well child carer within 2 weeks encourage duplication of services and often conflicting advice. Should be "notification" required with referral at discharge.
- Miscarriage rates disadvantage midwives who provide the labour care in second trimester miscarriage. This sometimes involves many hours. GPs and O&Gs transfer care to hospital midwives but the independent midwife can continue providing care. Birth needs to be redefined in this context.

3.4.5.15	Promotion of immunisation awareness.
3.1.2.7	Women need information on what informed choice and consent is.
3.1.3.2	All women do not need to be booked at a secondary facility. This is overly bureaucratic. Consider National Women's Hospital rejecting 1500 women who wish to book as they facilitate them. It needs stating that the booking in information is for administration purposes not clinical judgement on client and chosen caregiver.

MPO Update

1.0 Background

During 1995 the New Zealand College of Midwives (Inc) prepared feasibility reports for three of the four RHAs on the establishment of a commercial organisation which would contract with each RHA for the provision of midwifery services within that region. These reports were funded by the Transitional Assistance Grants approved by North, Midland and Southern RHAs. Central RHA did not take up the College's application therefore we were unable to conduct a feasibility study in the Central area.

The NZCOM's Constitution does not permit commercial activity as it was established as an organisation which would promote the professional image of the midwife to consumers, healthcare professionals, and potential students by increasing understanding of midwifery practice, evaluating and promoting midwifery education programmes, and maintaining and enhancing the quality of midwifery care. Therefore, the reports focused on the creation of Midwifery Provider Organisations (MPOs) as the appropriate commercial vehicles to contract with the RHAs on behalf of members.

The RHAs initial responses to the feasibility reports were disappointing and it became quite clear they would not support the national data collection and payment systems proposed. It has been the MPO's contention that a central administration structure was the most cost-effective, particularly in light of the RHAs reluctance to provide for ongoing administration costs.

The MPO Steering Committees have accepted they will now have to establish four separate payment administration systems if talks with the RHAs are to progress. This is likely to mean additional costs to the individual midwife in the long term.

2.0 Progress towards the Establishment of the MPOs

Southern MPO An amended proposal based on the above was placed before the Southern RHA by the MPO Steering Committee recently.

There has been agreement in principle by the SRHA to approve funding for the establishment of a Southern MPO. This is our first of hopefully four establishment grants and is an exciting start to yet another direction for midwifery. The SMPO Steering Committee will be meeting shortly to plan and implement the setting up of the MPO. Southern members will be receiving an update after this meeting. It is hoped the establishment of this MPO will demonstrate to other RHAs the advantages of having a single contractor providing midwifery services in each region.

The SMPO and the medical IPA "Pegasus", have also been successful in attracting funding for a midwife/GP joint venture for Christchurch City. This consortium will hopefully be able to provide a role model in the management of "shared care" for other MPO areas if successful

Northern MPO Northern initially sent the NMPO Steering Committee back to the drawing board to reappraise its costings and reconsider the proposal without the central data collecting agency. North Health also indicated their transition

Yet for many women, squatting closes the pelvis, makes muscles contract and places added stress to the soft tissue. I am not going to talk about these things, instead I'd like you to experience another way the big hip bones moves and more important how our internal tension or relaxation can effect their ability to do so.

First, let's feel a commonly promoted technique in our more pro-actve birthing. Women are encouraged to stand with their legs at shoulder distance and circle their hips. This is promoted because women are upright and in a gravity positive position, they are also "moving" their hips. Please do that now. Stop after a few moments and tighten up inside the sacrum and the rectum. Now circle your hips. Although it may be a bit more difficult many women can still do it even though they are tense inside. No one outside can see the tension, only you know. But if you don't know about yourself, then you can not make changes. The reason that it is possible to still circle the hips and to hold tension inside is that you are moving the pelvis as a whole unit from the waist. When we need to make room for our baby, we need to move the inside of the pelvis and to really know whether we are tense inside. It can't just look good to others, we must be aware of ourselves. And we need to separate the bones in the pelvis so that we can effectively work with the inside of us.

Here is one exercise that both separates the bones and when we tense can stop us from being able to make the movement. Stand on one leg with the other foot lightly resting on the floor but not weight bearing. Place your hand on the hip of the lightly rest, non-weight bearing side and move the hip up and down. Most people can do this quite easily. Stop moving your hip, but keep that side non-weight bearing and tighten up inside the sacrum and rectum. Try to bring that hip up. It's very hard. Now relax and you can do it quite easily.

WHAT IS THIS INFORMATION? There is a huge amount of information ranging from lower back work which helps to relieve tension and make certain the inside of the pelvis is in alignment; 'couples work' which uses non-verbal, non-confrontation exercises which teach people to work together effectively; preparing the birth canal (this is vastly different then perineal massage); 'sacral work' - by far the most important bone in birth; breast exercises to reduce tension and prevent engorgement; abdonimal and cardiovascular work as well as all the pelvic awareness which helps women separate and work with the areas involved with birth - the pelvic bones, the top of the vagina and cervix and the birth canal.

Workshops are available and also the training of people who will teach this to others. ■

Wintergreen 11 Strathmore Place Whakatane Phone 07-308-0378

Abstract

Aims. To examine whether the high proportion of Polynesian women giving birth at Middlemore Hospital contributes to its low interventional delivery rate.

Methods. A study of a one-year cohort of women delivering at Middlemore Hospital. Delivery suite records were scrutinised to determine ethnicity and mode of delivery. Statistical comparisons were made.

Results. In Maori, Pacific Island and European women the caesarean section rates were 6.5%, 9.5% and 11.5% respectively. Maori women have a significantly lower rate of caesarean section than Pacific Island women and both groups have a significantly lower rate than European women. The spontaneous vaginal delivery rates in Maori, Pacific Island and European women were 89.0%, 87.4% and 74.8% respectively.

Conclusion. The high proportion New Zealand Maori and Pacific Island women contributes to, but does not fully explain, the low interventional delivery rate at Middlemore Hospital.

NZ Med J 1995; 108:511-2 **6/12/95 NZ Med Journal**

We recognise that we are dealing with very intimate information. Childbirth educators and midwives can be just as shy. So how do we get this information out? For the past 20 years I have tried to teach it directly in many countries. The not-for-profit association Common Knowledge that I formed is seeking funds to produce a multi-media kit - a booklet, video and audio which will present the "pelvic work". The "couples work" will become another book and the "back work" will become a second video in time. While in New Zealand I hope to interests some people in really becoming skilled so that they can teach and work with all of the above skills.

A SHORT COURSE OF EXPERIENCE : This is body work. Explaining it on paper or through direct conversation is hard. Showing it and feeling it is easy. There are two things that you can do.

KNOW HOW "OPEN" YOU ARE : Stand with your legs together. Pay attention to where your vagina is (it's between your legs). That is the very front of your bony pelvis. Pay attention to the tip of your tail bone. There is a distance that you can perceive ("front to back" dimension). Also pay attention to the distance between the bones you sit on (for all you professionals, the ischial tuberosities). When you are standing they are under your bum. The distance between them is your "side ways" dimension. So you are now paying attention to your "front and back" and "sideways". And your legs are together. Notice two things : first, all of the hole in the pelvis is toward your back, not toward your belly side at all. Second, ask yourself "do you feel open down there" standing with feet together? It's only relative to you. Now move so that your legs are a shoulder width apart. How does this affect your sense of "being open down there?" If you're not certain go back and forth until you can feel the change. Many women "feel more open" when their legs are apart. Now find a chair. Put one leg on the chair. Do not face your raised knee, rather your raised leg is to the side and you are facing front. How do you feel down there now - open or closed? Now turn to face the raised leg. What happens? Now turn back to facing front again. Notice the difference?

There are as many positions that women take in labour as they can think up. If you spend time going through each position and noticing whether you are open or closed, you will notice that some positions are "right" for you. They might not be right for someone else. By knowing this, the positions we choose giving birth are no longer "instinctive", they come from our self knowledge. If we put this information together with the way the baby is, whether our muscles are also relaxed and how tight the soft tissue is, then we can be much more effective in choosing positions. And yes, it's easy to hold it all in your head if you know. Although there are some women who find the "instinctive" positions, as a care provider you have seen women choose positions which make them feel better but seem to hold the baby in. Pain causes women to do this, with the best intent, it just hurts too much. Our knowledge eases our fear and gives us courage to work with pain.

DO THE BONES MOVE? In the change occurring in birth, women are often told by their care providers that the birth hormones will soften the bones and that they actually can move and open up in labour. Squatting is often chosen as a position where the bones are more open.

funds applications were all turned down by the Ministry of Health in the last round so there may be added difficulties for the NMPO getting this funding.

NRHA has indicated it still wishes to negotiate and thought the amended establishment grant application had gone some way towards meeting their concerns. The NMPO Steering Committee is to meet again with NRHA in the near future. Northern members will be kept informed of progress via their Newsletter.

Midland MPO The Midland MPO submitted its feasibility report to the MRHA at the end of last year. The initial response from the RHA was disappointing but the MPO Steering Committee will be meeting to discuss these issues with the RHA as soon as possible.

Central MPO Because NZCOM had had virtually no response from the Central RHA to its second application for a feasibility study grant in March 1995, the Central RHA was re-presented with an application for an establishment grant in October 1995. The Central MPO Steering Committee wrote further to CRHA in mid-December 1995 requesting a response. There have also been telephone conversations on the subject.

A Meeting finally took place between the CRHA and CMPO Steering Committee on 2 March in Wellington. It was clear from these discussions the CRHA's lack of response was based on a misunderstanding about what was proposed. Once the CMPO Committee explained that a regional MPO for the Central RHA area was the option, progress was made. There will be another meeting soon to discuss how the process of funding and setting up will proceed. It is still early days but there is a commitment by all parties to working out a viable solution.

3.0 Role of the MPO

The MPO is an administrative organisation which will have the following functions:

(a) establish an administrative base with a computerised system to process, analyse and make payment on the claims of members midwives.

(b) negotiate contracts with RHAs for the provision of midwifery services on behalf of member midwives.

(c) take on the role of Lead Maternity Carer (LMC) to ensure women get continuity of high quality midwifery care.

(d) to negotiate conditions for fair and equitable access to CHE facilities on behalf of midwife member.

(e) to act as a business interface with general practitioners, CHEs, Royal New Zealand Plunket Society and other health professionals who provide maternity and well child services.

(f) to explore collaborative and joint venture arrangements with other maternity and well child service providers.

(g) to develop service specifications and negotiate issues of payments for shared care, as well as transfer provisions, to ensure that all arrangements put women's needs before financial considerations.

(H) to negotiate additional funding for the provision of quality services to rural women and to identify groups of women who require a more intensive level of midwifery care.

Initially the MPO's role will be concentrated on paragraphs (a) and (b).

4.0 Structure of MPO

The MPO will be a separate legal entity from the NZCOM. As there is an inherent risk factor in any commercial venture, the most appropriate structure for the MPO is a limited liability company. However, it is not intended that the MPO will be a profit making venture as its role is to act on behalf of member midwives.

Membership of the MPO will be through holding shares in this Company. The shares will be issued at a value sufficient to cover the Company's initial costs of incorporation, registration of shareholders etc. After that time the administration will be funded by the RHA.

To qualify as a shareholder, a midwife must have current membership of the NZCOM as self-employed; ie, claim from the Maternity Benefit Schedule. If a midwife no longer qualifies as a shareholder the shares are repurchased by the Company.

Midwives do not have to become shareholders of the MPO to continue to practice independently but will need to be aware that this will mean that they will have to contract individually with the RHA for provision of Lead Maternity Carer (LMC) midwifery services. If midwives wish to offer shared care with a doctor and are not or do not wish to be the Lead Maternity Caregiver they will be unable to claim directly from Section 51. Claims will be made through the LMC doctor by the individual midwife concerned. Midwife members of the MPO would make all their claims through the MPO which would in turn invoice or pay the appropriate amounts to other providers involved.

Regardless of where the MPO administration centre is to be based, area representatives will be appointed to liaise with local midwives to enable local shareholders to easily contribute and comment on actions that directly affect them; eg, the need for a birth centre in a specific area, proposed joint ventures.

5.0 Conclusion

The NZCOM has supported the concept of the establishment of MPOs in the four regions as the appropriate structure for the commercial aspects of independent midwifery. Whilst disappointed at the initial response received from the Central, Midland and Northern RHAs, the NZCOM is optimistic that negotiations will eventually produce funding for all four MPOs.

THESE PARTS OF OUR BODY..... A PREPARATION FOR CHILD BIRTH

by Wintergreen

A SHORT HISTORY: With no intention to create a larger understanding of pregnancy, preparing for birth or working with labour; women came to me because I worked with disabilities and pregnancies. They often had something in common .... bad backs. Many women who came arrived after a birth that had been difficult. The women who came were of diversified ethnic, religious and philosophical backgrounds. They didn't have much in common except that they had trouble getting their babies out of their bodies. So we worked with bodies, fully clothed and gently. I passed on what knowledge we had accumulated and was encouraged to teach workshops. The information is a vast collection of body knowledge so that each individual woman can get what she needs. There is no philosophy nor "do this" techniques or methods.

The information resides best with birthing women and their partners. Each woman need only work with her body. For example, if she doesn't have a long tucked under tail bone, then that information isn't important. It may be vital to the woman who does. A woman with strong belly muscles may not need to tone them, however a woman with weak ones whose last birth (5th one) was 36 hours because the baby would not come into the pelvis could change not just her next birth outcome but her self image, her back problem and her fatigue by strengthening the belly muscles.

All the exercises are simple and effective. Women will spend zero time on things that don't work. Getting the information to women has been a problem. When childbirth educators learn the information they tell me "As a woman I need all this information however I have only 6 weeks to get lots of information to these people. They are strangers, the information is often intimate and I don't feel skilled to teach the body work, and I don't work with people on a one-to-one basis". The midwives have had a similar response except they work one-on-one yet "I don't have time. I'm not confident to do body work at this level". Compounded with these difficulties is the expectation that women have. They fully believe that in the change from doctor care to midwifery care, that midwives are there to "teach them how to birth". Midwifery in western countries has been promoted as a return to "historical" birthing situations, however the "professional" midwives of today are not like the traditional women working within their communities.

This work is a direct statement by women that the ante-natal education did not prepare them for birth and that they did not "instinctively" know what to do. They had often tried the "breathing", the "walking", the "squatting", even the "why are you holding back" techniques. As birth continues to move toward midwifery care, the ante-natal education needs to change. We can support the right to have choice, however, if we don't have the skills and tools, choice can be meaningless. It's neat not to want an episiotomy however if you really don't know how to EFFECTIVELY prepare "down there..." a tear or episiotomy, or a long second stage which can compromise the baby, or long term trauma to the bladder, vagina or rectum may occur.

Everyone benefits from women and their partners knowing more. Not knowing more intellectual things, but the real things like: mapping the pelvis to know your shape; how different positions can effect that shape; how you can feel your muscles relax or prevent movement of the pelvis; how to feel, separate and directly work with the bones, top of vagina and birth canal. Birth is enough of a mystery without us having to be ignorant.

terms of birth weight. My own research showed that the VBAC rate in upstate New York in 1989 was 23.0% and only 18.0% in New York City (King 1994).

The influence of non-clinical factors will also, at least partially, explain the variation in hospital cesarean delivery rates since these rates will reflect the practice patterns of the physicians admitting mothers into these hospitals. McKenzie and Stephenson (1993) studied the determinants of hospital cesarean delivery rates in Washington State and found that proprietary hospitals had rates in the range of 29.2-42% while church-owned hospitals had rates that ranged from 8.3-29.5% even though the patient population of the proprietary hospitals was generally of lower risk. New York State vital statistics data for 1989 shows that hospital VBAC rates can vary from a low of 5.3% to a high of 43.3%.

These variations, especially those that do not correspond with obstetric risk, show that we can reduce the cesarean delivery rate without sacrificing the health and safety of mother and child. Aggressive and successful programs at healthcare institutions show that cesarean delivery rates can be reduced if the institution is willing to make the commitment. The University Medical Center of Jacksonville in Florida was able to reduce its cesarean delivery rate from 28% to 11% in 1989. During this period of time neonatal mortality rates declined and morbidity rates were stable. This program included trial of labor for women with a history of cesarean delivery. The proportion of women having repeat cesarean delivery dropped from 8% to 3%. It was felt that the higher morbidity of elective repeat cesarean delivery outweighed any perceived benefits the physician or patient attributed to repeat elective cesarean.

Women as consumers of healthcare services can sometimes replace a physician bias with their own preferences through education and peer support and achieve the birth experience that is right for them. Through the early to mid 1980s the VBAC rate in the United States remained below the potential the medical literature and national organizations thought reasonable. In the late 1980s the VBAC rate increased dramatically. Women of higher socioeconomic status were at the forefront of this increase. Women with graduate education had a VBAC rate of 28.6% while women without a high school diploma had a VBAC rate of 19.2%. Higher education gives these women the resources to study, attend conferences and childbirth classes, and make an informed decision. Only through continued education can we achieve a birth experience that is right for all.

■ *Dale King is a PhD candidate at the University at Albany, State University of New York. He is currently completing his dissertation on the effect of clinical and nonclinical factors on the odds of cesarean delivery.*

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SCREENING FOR DIABETES IN ASYMPTOMATIC INDIVIDUALS

Which test? It is recognised that no screening test is ideal. Universal screening for diabetes in pregnancy with the 50 g polycose at 24-28 weeks with a follow up 2 hour OGTT is the 1 hour result is ≥ 7.8 mmol/L is currently the recommended practice. There is some debate concerning the value of such screening in woemn at low risk of diabetes in pregnancy (eg, nonobese Europeans with no family history of diabetes and a normal obstetric history).

Table 2. - Recommended interpretation of the screening tests in symptomatic individuals.

	Test positive (Diabetes likely)	Equivocal	Test negative (Diabetes unlikely)
Fasting venous plasma (mmol/L)	≥7.8	5.5-7.7	≤5.5
Random venous plasma (mmol/L)	≥11.1	7.0-11.0	≤7.0
Fasting capillary whole blood (mmol/L)	≥26.7	5.0-6.6	≤5.0

From Consensus Statement, NZ Society for the Study of Diabetes. NZMJ 10/11/95 pg 464

National Committee Minute Summary

Notes from the NZCOM National Committee held on 3pm Saturday 2 March and 9am Sunday 3 March 1996 at the Orongomai Marae, Upper Hutt, Wellington commencing at 3pm.

Midwifery Promotion

On Air Productions presented the Committee with video and TV options for promoting midwifery. The video option is expensive but could be a widely utilised resource kit for women, midwife educators, schools etc.

Treasurer's Report

The demand for services continues to rise rapidly which has serious financial implications. This year NZCOM will most likely face a deficit and the increase in subscriptions continue to be a priority if midwives are to have their needs met. The current structure and position of National Treasurer as a voluntary one is untenable at this stage of the College's development. It was decided the National Co-ordinator and the Finance Clerk will manage the day to day budget/treasury issues in conjunction with the NZCOM Accountant and that the Treasurer will revert to an audit or monitory role.

The Board of Management proposed restructuring the subscription breakdown by reducing capitation to the regions by 10% and allowing 10% reduction in fees. This still leaves the regions enough funds to meet local needs if managed well (please read the National Co-ordinator's Forum for further information).

The principle of reducing fees by this method was supported by the National Committee. The SGM will be held regionally before the end of the financial year on May 1st to get membership approved or otherwise.

Section 51

Affirmation that this is a foundation document for midwifery services and will shape future midwifery practice for all midwives employed and self employed. Karen reported a wonderful response from midwives and regions to her request for feedback on the last draft. This enabled a submission to go to the RHA which was truly representative of midwifery feelings on the document and was very supportive of the Negotiating Committee's direction. Julie Richards has resigned from the Committee for workload reasons and Sandy Grey (Auckland, self employed) nominated and elected as her replacement.

Negotiating is still ongoing and it is envisaged that the implementation date will be further delayed. The Referral Guidelines are still very much a matter for negotiation as neither NZMA or College of O&G have responded to a meeting date with NZCOM to discuss consensus.

Laboratory and Diagnostic Services
Continuing problems throughout the regions with midwives scope of practice impeded and women disadvantaged as a result. Southern and Midland RHAs are reviewing the service and responsible for recommending the Lab and Diagnostic Tests for the Payment Schedule. Midland has not had a midwife on their Committee to date but now are required to do so by the Joint RHAs. Ann Hopkirk (BOP/Tairawhiti) nominated and elected. This midwife is seriously disadvantaged joining the Committee at this late stage and this has been accepted by the Joint RHAs. All recommendations from these Committees will go back to the NZCOM for comment.

Prescribing Rights
Increasing problems throughout the regions with midwives unable to access the Payment Schedule for their clients prescriptions. A working party has been set up by the four RHAs to review prescribing and the Pricing Schedule for midwives.

Nominated and elected onto this Committee as NZCOM representatives were:
Jane Fox (Rural Midwife Northland)
Anne Barnett (Urban Midwife Auckland)
Beryl Davies (Midwife Teacher Wellington)

The use of appropriate proxies was approved. Other members of the Committee will be a physician (Ray Naden) a member of the Pharmacy Guild and an RHA Service Manager.

MPO Progress
Each Regional MPO Steering Committee reported back on progress (these reported on Page 10).

Database
Inclusive Software to continue to the development of the midwifery database.

Bounty
Bounty publications continue to consult NZCOM and revise their booklet. Their commitment to ongoing consultation and changes as a result was appreciated. The video still needs refinement and in its present form is not satisfactory. The booklet is for reprinting in August and will reflect the changes consultation has required.

Variations in Cesarean Delivery Rates

by Dale King

Research Review - ICJE Vol 10 No 3

In an ideal world the decision to perform a cesarean delivery would be made solely on its benefits to both the mother and infant in each individual case. Unfortunately we do not live in an ideal world and physicians are human beings with conscious or unconscious biases that will sway the decision to either perform or not to perform the cesarean delivery. In a paper published in *Obstetrics and Gynecology*, Diane Gordon with other co-authors (Gordon, Milberg, Daling and Hickok 1991) found that older first-time mothers had 2.5 times greater risk of delivering by cesarean section, in absence of reported complications. The authors attribute this to the physician's perception that older women are at increased risk and treat these women more aggressively. This brings home a point that I try to make whenever I speak or write about cesarean delivery. Obstetrics is an art that requires judgment and experience, not a science where the physician knows exactly what to do in every situation.

Researches have shown that non-clinical factors can have a statistically significant impact on the odds of cesarean delivery. Vaginal birth after cesarean delivery (VBAC) is more likely to occur in larger hospitals. Randall Stafford (1991) reports that in 1986 California hospitals with more than 3,500 births annually had a VBAC rate of 16.6% while hospitals with less than 1,000 annual births had a VBAC rate of 5.4%. The type of insurance the parents have can also have an impact. In 1992 mothers with Blue Cross had a cesarean delivery rate of 25.6% and mothers with Medicaid had a cesarean rate of 21.9% (BIRTH 1994). Hospital ownership can also be a significant factor. Again in 1992, women giving birth in a private hospital had a cesarean delivery rate of 28.4% while the national average in that year was 23.6%. Using birth certificate data for Los Angeles County, Gould and his fellow researchers (Gould, Davey and Stafford 1989) were able to show that the incidence of primary cesarean delivery increased with income. The primary cesarean delivery rate in census tracts with median income of more than $30,000 was 22.9% while the primary rate in census tracts with less than $11,000 in median income was 13.2%. In his study Stafford states that "observed variations demonstrate the prominence of non-clinical factors in decision making and question the clinical appropriateness of current practice patterns."

Clearly the research shows that a physician's judgment can be affected by such factors as the mother's type of insurance, the size and ownership of the hospital where she will give birth, and even her level of income. Physician practice patterns will be influenced by these factors and this in turn will influence the cesarean delivery rate in the geographic area in which these physicians practice obstetrics. Zdeb and Logrillo report on the geographic variations in cesarean delivery rates by zip code that existed in New York State during the late 1980s. Cesarean delivery rates ranged from a low of 8.5% to a high of 40.1%. Interestingly, high cesarean delivery rates rarely corresponded with obstetric risk when obstetric risk is defined in

continued on page 32

Low back pain after epidural anaesthesia for delivery

Epidural anaesthesia is an effective method of pain relief during labour and delivery. However, two retrospective UK studies have indicated an increased risk to low back pain when epidural anaesthesia was used. A Canadian group has carried a prospective study of this problem.

In a cohort study of 329 women who were delivered of live infants and in whom half had epidural anaesthesia were examined 1 day, 7 days and 6 weeks after delivery. Patients with back pain before pregnancy or delivered by elective Caesarean section were excluded. Back pain was self reported, there was numeric pain score and an estimation of the interference with daily activities.

The incidence of low back pain in epidural v nonepidural group was at day 1 53% v 43%, at day 7 21% v 23% and at 6 weeks 14% v 7%. The relative risk for low back pain adjusted for parity, delivery, ethnicity and weight as 1.76 at day 1, 1.00 at day 7 and 2.22 at 6 weeks. There was no difference between the two groups in pain scores or frequency of interference with daily activities.

Low back pain is common after delivery at almost 50% at day 1 and 10% at 6 weeks. Most women do not seek medical attention. However, epidural anaesthesia was associated with a two to three fold risk of low back pain at day 1 and at 6 weeks. *Macarthur A, Macarthur C, Weeks S. Epidural anaesthesia and low back pain after delivery: a prospective cohort study. BMJ 1995;311:1336-9*

water-based drink. Since this may also temporarily reduce friendly intestinal flora, as a preventive occasional use is advised. (19)

HOMOEOPATHICS (20)

IPECACUANHA powerful amoebicide. For cutting pain around navel, green, frothy, slimy stools; nausea and vomiting.

CALCAREA PHOS for colicy burning pain around navel, heartburn, fetid flatulence, green, slimy, hot, sputtering stools.

ELATERIUM ECBALIUM (squirting cucumber) for griping abdominal pain, watery, frothy, olive green squirting diarrohea.

MAGNESIA CARBONICA for griping colicy pain, green, watery, frothy stool like frog pond scum.

Joan Donley, November 1995.

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Zee Films

This Company is producing a video on birth choices and wants midwives involvement. The current script and philosophy does not model true choices and Auckland Region will liaise with the Company to encourage a more balanced view of the midwife's role.

Consensus Statements

Not unexpectedly, consensus takes time to come together. Discussion continues on Breastfeeding, Ventouse, VBAC, Informed Consent, Gestational Diabetes, Cervical Screening. Regions to keep open discussion and bringing submissions forward to next National Committee Meeting. A pre-Meeting Workshop will finalise statements in May.

Parents Centre

A farewell letter from Sharron Cole, a dedicated health activist and long term member of National Committee representing Parents Centre:

..."*Consumer organisations such as Parents Centre benefit very greatly from the excellent liaison between our two organisations and certainly we would be very much in the dark over changes in the maternity services field were it not for the College of Midwives. My time on the National Committee always reinforced my belief that the College and consumers of maternity services are extremely fortunate in the calibre of women at national level in the COM. As is always the case however, the dedication, hard work and expertise is never adequately recognised. I would like to formally record my appreciation and recognition, on behalf of Parents Centre but also from a personal level*"...

National Newsletter

Approval given for revamping and updating the National Newsletter. Format to project a more polished publication. Cost implications to be offset in a reduction to the numbers of pages published. Board of Management to proceed with graphic artists, Incline Design for May/June edition if possible.

Midwives Brochure

A draft brochure on midwifery presented for discussion in regions. Parents Centres, Home Birth and Nga Maia to feedback also. All members to consider role and utilisation of this promotional material.

Conference Committee

Already marked interest shown. Pre-Conference Workshops very popular. Sponsorship is looking promising. A wide variety of abstracts already submitted. Overseas and other professionals interest higher than expected and Barbara Katz Rothman

would appear to be a major drawcard. Response to Conference clothing poor. Committee reminded this is a fund raiser to provide a cashflow for the Conference Committee to operate. Regions to market the designer clothing more widely. Every piece is unique.

NZ Society for Study of Diabetes
A meeting called by above Society to produce consensus guidelines on screening for diabetes. Bronwen Pelvin and Emma Wolfe (Waikato) to represent NZCOM at 6 June Meeting. Call for comments/submissions to these representatives please.

Nurses Act Review
Regional Working Parties to make submissions for a Special Interest Group to write up at the May National Committee Meeting.

Direct Entry Education Fund
The Committee received 14 applications of which 10 were successful.

ICM Conference
Decision made that NZCOM will not attempt group travel again as it requires a lot of work and no-one has taken up the group booking option.

Plunket Society
Karen and Sally to meet with the Plunket National Office to discuss issues of mutual interest. Several regions having difficulty with referrals and follow through by Plunket. Major concerns about the RHAs funding of Plunket as an antenatal educator. This move has had serious consequences for Parents Centres and other consumer organisations who have traditionally offered childbirth education. Regional feedback to National Office requested to prepare for this Meeting. ■

Nga Maia O Aotearoa Me Te Waipouamu Members, Harangi Biddle, Estelle Marment and Mina Timu Timu at the Whangai-u Hui.

(bacterial and amoebic) diarrhoea'. Betaine Hcl is also helpful in cases of persistent Candida (immune deficiency). The toxins produced can suppress Hcl production.

Back in pre-autonomy days I cared for a home birth P2G3 infected with giardia. Her doctor gave her Fasigyn 2G @ 14/40 which cleared the infection. Baby was born with tufts of hair on each ear. Her partner was severely infected and had repeated treatment which were only temporarily successful. He eventually tried glutamic acid with success. This case prompted my research into giardia.

Acid fruits eg plums reduce amoebic motility while hot spicy herbs eg cayenne burn them up. (10)

GARLIC - preferably fresh and purple skinned is effective against amoeba (as well as pinworm and hookworm). (11) Travellers are advised to eat raw garlic to avoid 'traveller's diarrhoea'.

BRACEA JAVANICA: (Simaruba Amara) seed is effective against amoebic dysentery, nematodes and as a douche for trichomonas vaginitis. Dose - 7 - 15 seeds with shells removed. Contraindicated during pregnancy, and for individuals with digestive weakness, nausea or vomiting. For children, use with caution. (12) (13)

Macrobiotic medicine suggests **umeboshi plum** juice (effective in neutralising amoeba) and **bancha twig** (kukicha) tea. Eat two ume plums every morning and drink the combined tea every two hours. Umeboshi are salted, dried plums (10)

GOLDEN SEAL root (Hydrastic canadensis: Ranunculaceae) is an effective treatment for giardia. Taken as an infusion - one teaspoon in a cup of boiling water - or a tincture - 10 to 30 drops - over 10 days. (14) Since it can weaken friendly intestinal flora take acidophilous yogurt.

MALE FERN rhizome (Dryopteridis Crassirhizomae) - filicin is the active antiparasitic principle. Because of its action on the uterus it is contraindicated in pregnancy. (15)

PUMPKIN SEED & HUSKS are antiparasitic as a powder or decoction - 1 - 2 liang. (1 liang = 30G.) (16)

Jacqueline Steincamp reports several giardia herbal rememdies (17) - **ARTEMESIA ANNUA**, a Chinese malaria treatment, either alone or in combination with an extract of grapefruit seeds - paramyocidin - is promising. Bensky records that the Chinese malarial treatment uses A. Apiaceae Hance (wormwood) and Folium A. vulgaris (mugwort) both of which are anthelmintic. (18)

- **CAJEPUT** oil (Melaleuca leucodendron) made from leaves and twigs. Cajeput is a variety of the Australian Ti-tree (M. decussata, M. ericifolia) When under amoebic or candida attack take several drops to a maximum of one teaspoon once daily in a

Stool microscopy with detection of cysts is accurate in only 50 percent of those with established giardiasis. Accuracy depends upon the speed with which stools are examined.

A recent 'membrane based' giardia specific antigen test - ProSpecT/Giardia is now available @ $750 a 100 test kit for labs with a high volume of specimens as the colour reagent has to be used within one hour. It is not government funded.

Medical treatment is **FASIGYN 2G** stat (Tinidazole) Fasigyn is contraindicated during the first trimester of pregnancy and in nursing mothers. Use during the latter stages of pregnancy requires that the potential benefits be weighed against the potential hazards. Other contraindications are a history of blood dyscrasias, organic neurological disorders.

Adverse reactions are nausea, vomiting, anorexia, diarrhoea, metallic taste, dizziness, ataxia, vertigo, incoordination, skin rash, pruritis, transient leucopenia, headache, furry tongue, dark urine. Even a small amount of alcohol can cause a severe reaction.

Alternate treatment is **FLAGYL** (Metronidazole) 2G for three days. Side effects as above. According to Nader (The People's Pharmacy) Flagyl may have tumour-producing potential.

HERBAL TREATMENTS

ALOES extract is a vermicide (kills) and a vermifuge (expels parasites). Its astringency and taurine cause contraction of the intestinal mucosa and the bitterness causes the parasites to let go. The purgative action expels the stunned/dead parasites. Single dose: 40-50 drops can be repeated in three days to three weeks. It is not recommended for pregnant women because of its purgative effect.

Taurine is a sulphur amino acid derivative synthesised from methionine and cysteine. Vegetarians may have difficulty manufacturing taurine. Estradiol depresses formation of taurine in the liver. (7)

According to Dorothy Hall (8) aloes is effective against giardia, amoeba and even bilharazia. She reckons that the ancient Egyptian, farming in the rich alluvial mud of the Nile protected himself from intestinal parasites by drinking the diluted juice of aloe, and by eating garlic and onions which make the gut unattractive to parasites.

Parasites flourish in an environment created by eating sweet and refined starchy food which suppress secretion of gastric juices. Glutamic acid assists in the production of strong stomach acids - pepsinogen in the presence of Hcl (yin) becomes pepsin (yang). (9) Hcl is credited with inhibiting the proliferation of parasites. Hcl can be taken as **Betaine Hcl**. Travellers are advised to take two tablets after each meal to avoid 'traveller's

EVENTS CALENDAR

1996 CONFERENCE & ANNUAL GENERAL MEETING of the NZ LACTATION CONSULTANTS ASSOCIATION

Lactation Consultants : Meeting the Challenges Towards the Year 2000
29th - 31st March 1996
Latimer Lodge Conference Centre, Christchurch

Further information available from Conference Co-ordinator
Marcia Annandale Phone (03) 323-7124

BREASTFEEDING : REFRESH, RENEW & REVITALISE
PLUS
BREASTFEEDING UPDATE - IBLCE EXAM PREPARATION SEMINAR

9th - 11th March 1996 - Perth
13th - 15th April 1996 - Melbourne
18th - 20th May - Brisbane

Seminar to be conducted by Mary Lantry, Angela Smith and Ruth Worgan
Registration Fee : $185.00

Enquiries : *CAPERS, P O Box 567, Nundah, Queensland 4012*
Phone (07) 3266 9573 Fax (07) 3260 5009

ICM 24TH TRIENNIAL INTERNATIONAL CONGRESS OF MIDWIVES

Oslo, May 1996
Pre-Congress Workshop, 23-26 May
(TO BE CONDUCTED IN ENGLISH)

Experienced Midwives who wish to become Consultants/Advisors, primarily in developing Countries, are invited to attend this workshop.
Apply early - only 40 places are available. Registration fee : 125 Pounds
Further details from
ICM Headquarters, 10 Barley Mow Passage Chiswick London W4 4PH UK

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
1996 National Conference

28th August - Pre Conference Workshop
29th - 31st August - Conference
Lincoln Conference Centre, Canterbury, New Zealand
Theme : ***Midwifery : The Balance of Intuition & Research***
Keynote Speaker : Barbara Katz-Rothman
Contact: Judy Henderson Phone (03) 377-2732

NATIONAL HOME BIRTH CONFERENCE 1996

1st September 1996
Christchurch

DEADLINE *for next issue of the Newsletter is* 20 APRIL 1996

ARTICLES OF INTEREST

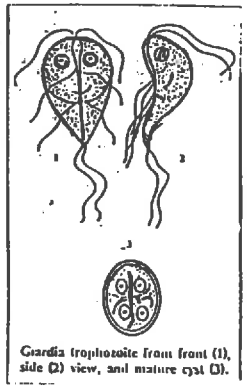
Giardia Lamblia

- Joan Donley, November 1995

Giardia lamblia is a motile flagellated protozoan closely related to trichomonas. It has been endemic for a long time having been recorded but not identified by Leeuwenhoek in 1681. This host specific parasite produces a tough chitin-walled cyst enabling it to survive for long periods in soil and water. (1) In fact it takes 10 minutes boiling to destroy it. It is not necessarily destroyed by chlorine. (Investigation of more than 80,000 live births, 1985-1988, found that chlorination of drinking water can cause birth defects and babies of low birth weight.) (2)

It is suggested that the crushed seeds of the **Indian moringa tree** (morinda citrifolia) will purify water. Bacteria and viruses adhere to the seeds and can be filtered off. (3) Whether or not it attracts parasitic cysts is not mentioned. **Eucalyptus** (E. globulus) oil - one drop in a 4 litres of water, left to stand overnight is credited with killing off potentially dangerous bacteria and parasites. (4)

Based on Auckland's recent laboratory figures of 1200 cases p.a. Professor Tim Brown of Massey University/Ministry of Health estimates the national incidence may be 3000 p.a. It is much more common in Northland and Coromandel. "It is a public health problem exacerbated by dispersed populations and a poor economic base." according to Brown. Hygiene is important. It spreads quickly in child care centres and kindergartens. Giardiasis is scheduled to become a notifiable disease in the near future. (5) Breast feeding babies are apparently protected by the fatty acids in human milk. (6)



Giardia trophozoite from front (1), side (2) view, and mature cyst (3).

This parasite sets up shop digging into the duodenum and proximal jejunum. Incubation ranges from two to 25 days - average 8-10 days. Symptoms are sudden onset of explosive, watery, foul green diarrhoea, distension, flatulence, abdominal cramps - mainly on the right side above umbilicus - accompanied by nausea and vomiting. Chills, fever, malaise and headache may or may not precede or accompany the acute stage which may last for 3 - 4 days. It then usually settles (1) into a chronic or recurrent syndrome of wind, distension and foul diarrhoea. (1)

Accompanying weight loss is due to malabsorption of fat, carbohydrate, vitamin A, thiamine, folate, B12 and iron. Asymptomatic infection has been found to exceed 75 percent.

Midwives take the plunge

With Mid Central Health and local GPs pulling out of Otaki maternity services, Otaki midwives are pushing ahead with plans to establish a "home away from home" birthing unit in the town.

Verbal approval from the Central RHA for transitional funding totalling $48,000 to purchase and set up a house as a birthing unit is now awaiting a Ministry of Health go-ahead.

Otaki midwife, Jane Stojanovic, says setting up a birthing centre reflects a continuing commitment to childbirth choices for women and a midwifery endeavour to fill the gap in women's health in the area.

"The project represents a midwife package offering women fertility monitoring, breast-feeding advice, antenatal care, and routine birthing and postnatal services."

With an expected rate of between 20 and 40 births a year, independent midwives running the birthing unit hope to offer 24-hour unstaffed stays for women, supported by a midwife on-call system.

Arrangements for relatives or friends to stay with women in a home-like setting may be expected although such details are yet to be negotiated.

In the event of maternity complications, effective access to emergency back-up services is part of the essential planning.

Five midwives live within five minutes of the proposed birthing unit site, and Otaki ambulance services are likely to be dedicated in cases of emergency obstetrical transfers to Levin or Palmerston North secondary maternity services. ■

ACUPRESSURE FOR NAUSEA AND VOMITING IN PREGNANCY

Reseachers at the Department of Obstetrics and Gynecology, California Pacific Medical Center in San Francisco, investigated the use of acupressure to help relieve the feelings of morning sickness — particularly nausea and vomiting — often experienced by pregnant women.

Sixty women were divided into two groups matched in terms of maternity age, fetal number and pre-treatment nausea and emesis scores. The women in one group received daily acupressure treatment, while the women in the other were given placebo. All the women completed an assessment sheet for 10 consecutive days describing the severity and frequency of symptoms. The first three days were monitored as pre-treatment scores and, from the fourth day, the women used acupressure treatment for 10 minutes four times a day.

The researchers discovered that, while there was no difference in the severity and frequency of vomiting between the groups, nausea decreased significantly in the treatment group. They concluded that 'Acupressure at the PC-6 anatomical site is effective in reducing symptoms of nausea but not frequency of vomiting in pregnant women.'[1]

REFERENCE
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Adam Jackson, LLB, LCSP (Phys), AMRSH, is director of the Alternative Health Information Bureau and a freelance writer

Current Issues

Editor's Note: The following is the reply to a request that we ask the NZNO about a dual membership for College members who also belong to the NZNO in order to reduce their (CHE Midwives) subs. CHE Midwives may like to make submission to NZNO via the remit process at the AGM.

Ref :

11 December 1995

NEW ZEALAND NURSES ORGANISATION

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

Dear Karen,

Thank you for your letter. Attached please find the information requested on cultural safety. I hope it is useful.

In regard to offering reduced subscription rates for NZNO membership to CHE midwives - this would really go against the philosophy of an industry based union - a philosophy which in the interests of 'collectivity' we are committed. In addition the NZNO offers a range of professional, industrial and indemnity services to CHE midwives. We appreciate that in the end the member will decide on the relevance of the services offered by each organisation and make a choice.

To offer an 'industrial' only option could see the fragmentation of clinical sections who may decide to obtain 'professional' services from sections or international clinical nurse groups. This could only lead to further fragmentation of New Zealand nurses and possible de-unionisation of the health sector.

Yours sincerely,

Brenda

Brenda Wilson
National Director

NZ DOCTOR **Sanya Baker** 10/11/95 NEWS

Cuts stall detection of deafness in children

Cuts to Plunket services are contributing to delays in detection of hearing impairment in children, according to National Audiology Centre manager and researcher Anne Greville.

According to the latest annual figures, the average age of detection of deafness is 27 months. The previous year, the average age for hearing loss detection was 26.1 months.

Ms Greville said there are two ways to remedy this situation - one is to improve well child care in New Zealand, the other is to introduce universal screening of newborns for hearing impairment. She said in the current climate, universal screening may be the better option although it does introduce some logistical problems.

Currently babies with identifiable risk factors for hearing loss are screened after birth and Ms Greville said many deaf babies are missed because risk factors are present in only 40 percent of them.

A project looking into the practicalities of hospital based screening of all newborns was initiated last year by the University of Auckland department of physiology in collaboration with the National Audiology Centre and National Women's Hospital.

Senior lecturer in hearing science Peter Thorne said the researchers tried out a new method of hearing testing, known as oto-acoustic emission screening, for its practicality and effectiveness when conducted at the bedside of mother and baby.

According to Dr Thorne, the healthy, functioning ear produces a little bit of sound energy when its sensory cells are stimulated by incoming sound. He said the presence of this oto-acoustic response can be detected by placing a small microphone in the ear canal while the baby is asleep or very relaxed, thereby reducing confounding noises.

Dr Thorne said about 300 babies were tested this way during the trial and, with a number of practical problems sorted out, the team believe the method could be put into place in maternity hospitals with the minimum of expense and disruption.

The problem, besides persuading the government to fund the programme, would be in reaching babies born outside hospitals and testing babies who are discharged after only a short time in hospital, he said.

Anne Greville agrees. She said the average hospital stay after birth is now 2.3 days, leaving little time to reach each newborn.

While severely affected children tend to be identified earliest, Ms Greville said late detection can have a serious impact on a child's ability to learn language or to speak properly.

"The greater the [undetected] hearing loss, the more devastating the consequences can be."

Once hearing impairment is picked up, a hearing aid can be fitted, surgery may be applicable in a few cases and an adviser will be allocated to each child to help develop strategies for language improvement.

"It is very important to young children to encounter language in one of its forms, not necessarily speech.

"There is now quite a bit of evidence that sign language is also more easily picked up during the critical learning period for language which is up to the age of three." ■

Advice for GPs under audit

■ Call the NZMA, which is currently negotiating with HBL on a protocol for dealing with audits and investigations.

■ Where there are grave concerns, it may be adviseable to approach your medical defence association or contact a lawyer.

■ A GP is not legally entitled to refuse access by funders or their agents to practice records. However, the nature of information which GPs are obliged to hand over is still being negotiated. If personal patient details are held separately from financial information, for example, it may be possible to retain it.

There is some disagreement as to whether GPs should contact their patients in the first instance, but this issue is to be clarified in the negotiations between HBL and the NZMA.

If patient files are to be duplicated patients have a right to be there when this occurs and further, they have a right to say they do not want their files copied.

However, there are concerns that GPs who inform their patients of this in advance of an audit may be seen as intentionally frustrating a statutory purpose as well as causing alarm.

■ One legal expert said GPs should inform their patients of possible access to their records by outside agencies as a matter of course, long before any audit or investigation is about to start. **- NZ Doctor**

Editor's Note: *This advice is also pertinent to Midwives. If you have any concerns related to audit, please contact HBL or Jackie Pearse, Legal Advisor, NZCOMI.*

Depo Provera and breast cancer Reprinted from 'Reproductive Health Matters, May 1995

An analysis of pooled data from two case-control studies, a WHO multicentre study and a New Zealand study, of the relative risk of breast cancer in women who have used Depo Provera (DMPA) for contraception included 1,768 women with breast cancer and 13,905 controls, most of whom were younger than 55 years old. The relative risk (RR) of breast cancer in women who had ever used DMPA was 1.1. There was no increased in risk with increasing duration of use, but RR estimates were higher in some subgroups of women. Recent (or current) use was thought to be the key factor. Women who had started using DMPA within the previous five years were estimated to have a relative risk of 2.0. The increased risk in recent (or current) users could be due to enhanced detection of tumours in women using DMPA or the acceleration of the growth of pre-existing tumours. Women who had used DMPA for more than five years had no increase in risk of breast cancer, regardless of the duration of use. This latter finding is reassuring, but factors underlying the increased risk in the sub-group of recent (or current) users need further research.

HRC FUNDS 17 NEW STUDIES ABOUT WOMEN'S HEALTH

- Dec 1995

The HRC funded $13,529,000 million (excluding GST) in health research grants and career development awards in the last 1995 grand round, to be carried out over the next three years.

This includes 46 new project grants, 17 clinical research limited budget grants, 7 public health limited budget grants, 23 Maori health grants and awards and 10 non-Maori career development awards. Seventeen of these grants went to researchers investigating women's health topics.

Existing programme grants received $211,000, project grants $11,021, Limited Budget Grants: Clinical Rsearch $581,000, Limited Budget Grants: Public Health Research $236,000, Maori grants and awards $700,000 and non-Maori awards $780,000.

Ultrasound alert

- New Scientist

Widespread antenatal ultrasound screening was introduced in Britain despite lack of evidence of either its efficacy or safety ("Screening without meaning?", 19 March). As a consumer group we started lobbying ministers of health from 1981 onwards for adequate research. We have highlighted many problems which have not yet been addressed.

Two studies have suggested an increased rate of miscarriage following ultrasound scans, but the subject is inadequately researched. In 1992, a randomised study of 2500 pregnant women receiving either two Doppler studies of blood flow or not, found that four times as many scanned babies died. This result is still unexplained. There are animal studies which have shown "delayed fetal lethality" in scanned groups.

The Australian findings that insonated babies were smaller have been repeated in many animal studies, including monkeys. Even more worrying are the major behavioural changes in infant monkeys who had many scans in the womb. A recent study from Northern Ireland has shown that 46 percent of pregnant women at one hospital had 5 or more scans, and 10 percent had 10 or more.

Ultrasound equipment is getting powerful, and the new vaginal probes deliver greater ultrasound exposure to the fetus than most abdominal scans. In many published research studies on fetal behaviour, babies have been scanned for an hour or more.

With every female examined, we expose the ova for the next generation.

Beverley Beech and Jean Robinson
Association for Improvements in the Maternity Services. Iver, Buckinghamshire

Domestic violence in pregnancy

How much domestic violence there is to women is a matter of speculation but few would deny that it is much commoner than reported. One particular form of abuse which is of particular concern is that to pregnant women. American experience suggests that 30% of married women experience at least one violent episode in a lifetime. A survey from the Royal Women's Hospital at Brisbane has identified the physical and psychological abuse of pregnant women in the local population.

Over a 4 week period in 1992 all women attending the public antenatal clinic at the hospital were interviewed and completed a self reporting questionnaire. Of the 1014 women almost 30% (301) reported a history of abuse with 59 of these being abused during pregnancy. Abuse became commoner as pregnancy advanced to 8.9% at 36 weeks. Abuse was less frequent in women with tertiary education compared with secondary education. Thirty one percent of those abused in pregnancy sought medical treatment.

The commonest form of abuse was pushing and slapping followed by emotional abuse including being kept away from money and friends. Other frequent forms of abuse were kicking, biting, punching and throwing things. Some women reported a serious threat to life and weapons were used on occasion. Being pregnant did not stop gynaecological injury.

Married women or those in de facto relationship were less likely to seek help than those in other relationships. More women in the lower educational groups sought treatment for abuse in pregnancy than those with higher education. Uncommonly did the abused women seek help from a doctor rather than from friends, police or welfare agencies.

The staff of the hospital were greatly shocked at the extent of this problem of abuse to which they were previously unaware. Further, some women had become so desensitised to violence that it was minimised or denied.

Reprinted from NZMJ Apr 20,1995

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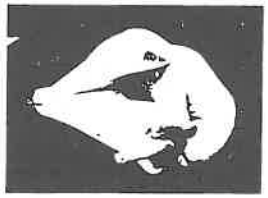
Pregnant women aware of choices



Investigative reporter GEOFF CUMMING examines Auckland's maternity and infant health melting pot — and health service planners' latest remedies. This final part considers the maternity service changes which have women's groups on the offensive.

Changes to nationwide maternity services will make pregnant women more aware of their choices, says project manager Sam Denny.

Women will get better information about pregnancy care options while management of their needs will be co-ordinated by a "lead maternity carer" — a delivering GP, midwife or specialist.

Another key change is the introduction of paid home help for women who choose early discharge after giving birth.

The new system, delayed for several months, will be phased in for newly pregnant women from April.

Sam Denny says the present maternity service allows unnecessary duplication, sometimes involving GPs and midwives who may have no wish, or need, to work together.

"We are paying twice for some aspects of care," she says. "It also allows providers to share care in a very theoretical way — we want them to share care in a practical way."

She says introducing care co-ordinators will not necessarily cut out any provider — "it will just make clearer who is responsible for providing each service."

Critics claim carers will have an incentive to minimise spending on normal pregnancies so they have enough left for more expensive cases. But Sam Denny says budget limits will be confined to midwifery and non-specialist consultations.

A complicated schedule of fees will apply. "It's not as simple as picking a figure and saying 'all women get this'. We are not saying all women are the same."

She says the total pool for maternity and neonatal care will be at least as big as the $323 million a year now spent nationally.

The changes would usher in a service which women have long asked for: free home help for women who go home early after birth. This involves a paid worker helping with domestic chores such as washing and cleaning in the early weeks.

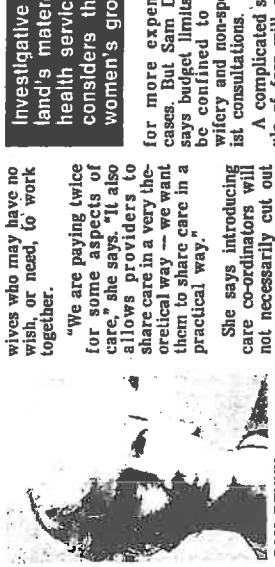
Project planners have yet to settle on a cut-off point for qualifying for home help: discussion is wavering between 36 or 48 hours for normal births. Women recovering from caesarian deliveries will be able to stay for five days under current plans.

Sam Denny says women will still be able to stay in hospital as long as they need to after birth. The key word is "need" rather than "want."

Home help meets a demand from women who do not need to stay in hospital.

"Maternity hospitals are not able to meet social needs."

The new service will be additional to the existing visiting midwife service covering mother and baby's health needs.



SAM DENNY

Early discharge incentives 'smack of paddy field'

Incentives for early discharge "smack of paddy field stuff" says Lynda Williams, co-ordinator of the Maternity Services Consumer Council. She says the council represents 90 groups.

"They're saying the woman is ready to pick up the pieces and responsibilities two days after having the baby. If she wants to stay in for more than two days it's apparently for social rather than medical needs."

Staying in hospital gives new mothers access to 24-hour midwifery care, Lynda Williams says. "If something happens to the baby in the middle of the night, if there's trouble with breast feeding or stitches — there's always someone there while the woman is adjusting to something new and feeling vulnerable."

Hospital staff already subtly encourage women to go home early because of a shortage of post natal beds, she says. "If the woman is asked every shift-change when she's planning to go home she feels pressured."

The offer of paid home help will add to the pressure, encouraging women to go home before they are ready.

A director of Women's Health Action, Sandra Coney, says early discharge increases the risk of nutritional and feeding problems being missed, Sandra Coney says.

The lobbyists have other concerns. Lynda Williams says the amount of home help each woman will be entitled to is too small, particularly for those recovering from difficult births or who have other children to care for.

"The payments they are talking about are not going to get you much home help," she says.

Co-ordination of services by a lead maternity carer will narrow women's choices, she says. "We can't see how it will give more choice if women have to choose between a GP and a midwife during pregnancy. I don't think women know enough about their options and what they are entitled to."

LYNDA WILLIAMS