NEW ZEALAND COLLEGE OF MIDWIVES
WELLINGTON REGION - OCTOBER NEWSLETTER

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Last Meeting

The last COM meeting was well attended with 27 midwives and 5 students present. Guest speaker was Dr Jane Zuccollo, Perinatal Pathologist, who gave a most interesting talk and informative presentation (with slides). Jane spoke of the importance of pathological findings and how they will effect change of practice for practitioners. For parents the huge questions of "Why did my baby die?", "Will it happen again?", "How can I prevent it?", "What can I do in the next pregnancy?" can often be answered.

The purpose of pathologists is to 1) determine the cause of death (in the case of abnormalities this is very important as the abnormality may not be the cause of death, 2) if an abnormality is detected antenatally, it confirms diagnosis, 3) gives quality control for Obstetricians, care givers and neonatal units, 4) ensures accurate national statistical data.

To do a postmortem, a signature of consent first has to be obtained and a death certificate. Jane said that most parents want to know that the death of their baby was not useless. A pathological examination will show, amongst other things, 1) Normal anatomically, 2) whether well grown and well nourished. There will be an indication from the examination of whether death was "possibly preventable", or "probably preventable" which has implications for audit for practitioners.

It is important to note that all coroners cases require a post mortem to be performed.

- all deaths where a death certificate cannot be signed (i.e. no obvious cause of death)
- any death related to invasive procedures
- any death following instrumental delivery
- in most cases where birth asphyxia is the diagnosis to be seen to be "above board"

Jane fielded many questions and those present were fascinated with the information she presented. Thank you Jane.

Next Meetings

14.October 1997, Kenepuru Hospital, Women's Health Room (near the Maternity Unit). The meeting will start at 7pm. At 7.30, Valmaye Dawson from Health Services Welfare Society will discuss a health care plan designed for Health Professionals. At 8pm Kate Clarke from CYPS will come and talk specifically on adoption but may answer questions in other areas too.

The November meeting will be a special midwives forum. It will be held on the 11.11.97 at 11am. Guest speaker will be Dr Cheryl Benn from the Department of Midwifery at Massey University. Cheryl is one of the midwife representatives on Nursing Council and she will speak on "Keeping oneself safe".

There will be time for discussion. This meeting includes a luncheon - please bring a plate. Venue is Rose Garden Lounge, Hutt Hospital. All are welcome and an indication of numbers would be good. Ph Sandra on 04 528 2092 and leave a message.

Cord Blood
At the recent NZCOM Exec meeting, the issue of cloning was discussed. NZWW (28.7.97) carries an article calling for establishment of a national cord blood bank. Supported by MP Peter Dunne and Dr Lochie Teague (Starship) it is estimated to cost $3 million. US Biocyte Corporation has a patent giving it complete control over the extraction of cord blood cells and any therapy developed. This was recently endorsed by the European Parliament under the European Convention - although in 1995 it rejected legislation to patent genes.

This was done due to pressure from the agrochemical and pharmaceutical industries to 'harmonise' EU's patenting rules with the US and Japan. This Directive has now gone back before the European Council of Ministers for approval before going back to the Parliament. (NZH 23.7.97)

The patent holders can charge for the cells and techniques and can refuse anyone unwilling to pay. The RHA's should be aware of this since Starship has already brought two units of cord blood from New York at a cost of $35,000 per unit. And while 'American women donate their cord blood', no consent form from the donor is required.

If the patent was enforced, cord blood cells sold for transplantation, would transgress the International Society of Transplantation which established that "no part of the human body should be commercialised and that donations of organs or cells should be free and anonymous". (Eurocard Medical Assoc, July 1996)

Cord blood is rich in bone marrow stem cells: 100mls of cord blood contains as many marrow cells as 10 litres of adult blood. To be viable, the placenta must not be frozen and has to be delivered within 24 hours. Physiological third stage leaves insufficient blood for this type of collection. (ASIM Communique, v7, no3, Winter 1997)

The earlier EU rejection of human cloning was based on the fear of fixing the genome in its present state with the loss of genetic diversity. Already, American embryologist, John Gearhart, claims to have grown long-lived cultures of human embryonic cells that have the capacity to develop into a wide range of tissues. They could also be used to create genetically engineered humans. Such mice (oncomouse) have already been produced. (New Scientist 19.1.97)

Complete annulment of this patent is being sought by Australian Thomas Schweiger of Global 2000 and No Patents for Life Campaign, Zoe Elford or Ricarda Steinbacher, Womens Environmental Network, 87 Worship St, London EC2A 2BE.
(The above was reproduced from the September edition of Midwives News, Auckland)

CPR Updates
CPR sessions have been going really well so if you are interested in attending the next one (to be held on October 24th) for your annual update, contact Lynley Davidson - Ph 04 8010206

Section 51
The NZCOM has recently completed yet another submission regarding this thorn and in the next newsletter will be a summary of issues covered. Needless to say that the latest draft is significantly different from the original and the College has done a wonderful job in representing the interestsof both CHE and self employed midwives and the women we work with.

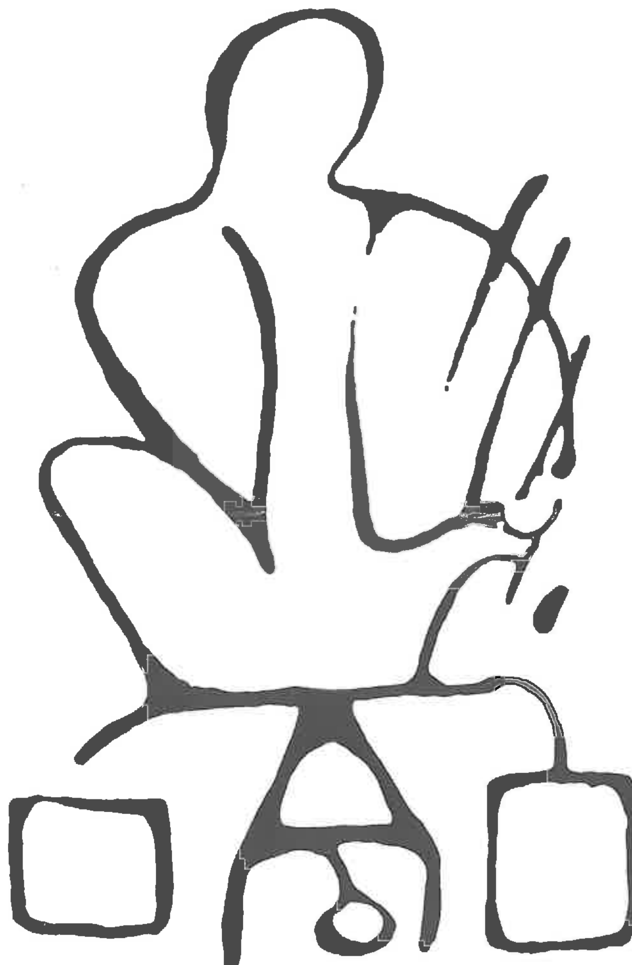
Summary from Questionnaires

Thank you to all the people who returned the questionnaire included in the August Newsletter. The main reasons for non attendances at meetings were; place, time, day, birthing women, other prior commitments, lack of professional interest and not enough social involvement. Reasons given for others not belonging to the NZCOM included, lack of interest, cost, opinions of others incongruous with own, politics, belief that they don't have anything to contribute, relevance and NZCOM there only for self employed midwives.

We hope to address some of the issues where possible to encourage greater attendance at your professional body meetings.

Midwifery Resource Centre

The Department of Nursing and Midwifery at Victoria University of Wellington has now grown to incorporate buildings at 81, 76 and 78 Fairlie Terrace to house our ever expanding numbers of students and staff. As part of that expansion we are also in the process of setting up a Midwifery Resource Centre and we are pleased to invite the Wellington NZCOM members to use the space for small group meetings or to house archival material which may be of benefit to current or future Masters of Midwifery Students at VUW. Bookings for the room can be made with our secretary , Sarah, on 471 5363.



ABSTRACTS FROM RECENT LITERATURE

- Olsen O. Meta-analysis of the safety of home birth. *Birth* 1997; 24:4-13.
- Macfarlane A. Commentary: the safest place of birth - is there a better analysis than meta-analysis? *Birth* 1997; 24:14-16.
- Waldenstrom U, Nilsson C-A. A randomized controlled study of birth center versus standard maternity care: effects on women's health. *Birth* 1997; 24:17-26.

Three recent studies in the journal *Birth* examine the issue of the safest place for birth. A paper by Olsen uses meta-analysis to examine the safety of planned home birth (backed up by a modern hospital system) with planned hospital birth in six controlled observation studies of 24,092 low-risk women in the Western world. He found home birth to be an acceptable alternative to birth in hospital for these selected women, with fewer medical interventions. In a commentary on Olsen's article, Macfarlane questions his use of meta-analysis because of the great differences between the settings for birth and suggests the alternative approach of a critical structured review describing both similarities and differences. She raises the problem of comparability in undertaking any study of home vis-a-vis hospital births because of the need to recognise the wide spectrum of settings for both home births and hospital births. Nevertheless, she concludes that Olsen's review is "a valuable contribution" to the documenting of information on birth outcomes in different settings. While these two papers focused primarily on infant outcomes, Waldenstrom and Nilsson's randomised controlled study in Stockholm compares the effects on women's health of birth centre care and standard maternity care, again in a Western setting. This study found no major differences between the two groups in women's health, despite fewer antenatal visits and tests, fewer medical interventions during labour, longer labours and a shorter postpartum stay in mothers in the birth centre group, and concluded that birth centre care is as safe as standard maternity care.

Birth Issues Vol 6 No 2 June-July 1997

Compiled by: - Virginia Thorley OAM, IBCLC

The stress of tests in pregnancy - *women's experiences*

ROSEMARY DODDS & MARY NEWBURN

During 1995/96 the National Childbirth Trust (NCT) carried out a survey of the views and experiences of pregnant women, in terms of antenatal screening.[1] The survey was conducted using a postal questionnaire in *Pregnancy Plus*, NCT's newstand magazine and in *New Generation*, a journal which is sent to NCT members.

Completed questionnaires were received from 2,722 women. As anticipated, they were not a representative sample, being older and more highly educated than the national population of women having babies, however their responses shed light on the problems associated with antenatal screening.

Key findings

- 57% of women in the study said that they had all the information and support they needed, 36% would have liked more information and 19% would have liked more support.
- The right of parents to choose not to have antenatal screening was undermined by some health professionals who made assumptions that screening and termination of pregnancy if the baby had a disability was in the parents' best interests.
- A small number of women (n=11) said that amniocentesis was only offered to them on the condition that they agreed in advance to a termination of pregnancy if their baby had a disability.
- Women do not have equal access to screening services. For instance, some trusts offer serum screening to all whereas others only offer it to women over a specific, although variable, age. Also there tends to be more choice in centres which are developing new screening methods, although these are sometimes unevaluated techniques.

Conclusions and recommendations

- Women have the right to choose or refuse each test or scan.
- Detailed information, including the difference between screening and diagnostic tests, their accuracy and possible outcomes should be provided by appropriately trained staff.
- Health professionals should not make assumptions about what is in the best interests of parents, nor put any pressure on parents.
- NHS trusts should consider providi[ng] a dedicated telephone helpline for women with enquiries or worries about screening tests. Helplines should be staffed by people trained to give unbiased information and support.
- The use of confusing and insensitive terminology - 'positive' for a higher chance of carrying a baby with a disability and 'negative' for a lower chance - should be stopped

Reference

1. Dodds R, Newburn M (1997) Support during screening - an NCT report. *Modern Midwife* Vol 7 No 6.

A report of the survey and recommendations for purchasers, prov' ters and parents are available from the Maternity Services Committee, National Childbirth Trust, Alexandra House, Oldham Terrace, London, W3 6NH. Please send an A5 size SAE with two first class stamps.

NEW ZEALAND DOCTOR
3/9/97

Midwives picked as top caregivers

Robyn Sinclair

Midwives have taken the gold star in a random survey of 3000 people by North Health to gauge patient satisfaction from specific services.

AC Nielson McNair completed the $250,000 study, aimed to help the THA division better target spending.

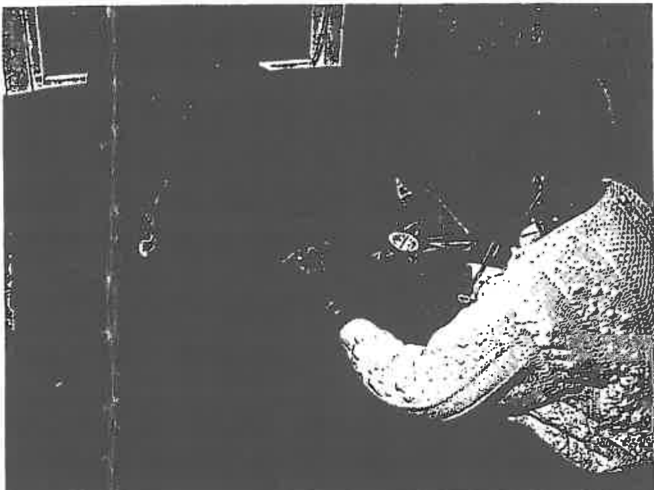
Midwives polled 61.4 per cent on the scale for extreme satisfaction from patients' last visit to specific health services, followed by occupational therapists and then disability support services.

GPs and practice nurses polled tenth, with 46 per cent.

On an extreme dissatisfaction scale, mental health services stood out a mile from the rest, on 22 per cent.

Patients also express a high confidence in the health-care system if they or one of their family become sick or need an operation.

Regarding satisfaction with their last visit to the doctor, most were happy, especially in terms of being treated with respect, understanding the doctor and having questions answered. Cost was the biggest reason for any dissatisfaction .



High patient satisfaction with midwives

The results also reveal young adults aged 15-24 years are the least likely age group to have seen a GP in the past month, have the highest injury rate (28.7 per cent) and smoke the most (29 per cent). Male young adults were less likely to visit their GP.

Meanwhile, European women aged between 15 and 44 lead the charge for cervical screening in the past three years at 75 per cent, while Pacific Island women over 45 years have the lowest rates. Prevalence of breast screening is rising with age among European wome but decreasing with age among Maori and Pacific Islanders.

Thirty per cent of under sixes have had an illness or injury in the past month and nearly 29 per cent have seen a doctor or GP.

Transport is the major barrier getting under sixes to the doctor.

10 THE DOMINION, TUESDAY SEPTEMBER 23 1997

Hutt doctors run into trouble over maternity fees

SOME Lower Hutt doctors have run foul of the Commerce Commission for setting the fees they pay midwives for maternity care.

The General Practitioners Association said yesterday that the price problems showed that new maternity scheme arrangements had become an administrative nightmare.

The commission said yesterday that the Lower Hutt doctors' attempted collective agreement to pay midwives specified rates was a form of price-fixing and risked breaches of the Commerce Act, which prohibited people getting together to agree on prices.

Doctors had agreed that when a doctor was responsible for a woman's maternity care and the woman used a midwife, then standard fees set collectively by the doctors would be paid to the midwife.

Commission chairman Alan Bollard said, "We've advised the doctors that under the act it is up to the doctor and midwife involved to agree on the fees. For groups of either doctors or midwives to get together and agree on standard prices is ... price-fixing."

Under present maternity arrangements a pregnant woman chooses her lead maternity carer, and that carer gets the government maternity subsidy. If other health professionals are involved, the lead carer pays them from the subsidy.

Dr Bollard said the commission was focusing on the $7 billion health industry this year — "and our involvement with it shows that its awareness of the Commerce Act is poor".

The commission's Commerce Act manager, Jo Bransgrove, said the commission was alerted to the Lower Hutt doctors by two complaints.

The doctors had changed their practice of setting fees and were now negotiating individually with midwives and the commission was not taking further action.

Medical Association chairman Brian Linehan said doctors would take note of the commission's warnings and in some cases might seek legal advice.

Understanding Female Genital Mutilation

With the increasing number of North East Africans settling in New Zealand, Female Genital Mutilation (FGM) has been introduced into our public health services. **Nikki Denholm**, FGM Project Co-ordinator at National Women's Hospital, discusses the implications for primary health care workers.

Primary health care workers are often the front line professionals dealing with genitally mutilated women and need to be aware not only of the clinical effects and complications of FGM, but also how to provide sensitive and effective care.

FGM is the collective term for a number of procedures involving cutting or removal of the female genitalia. The procedures vary from removal of the prepuce of the clitoris, to removal of the clitoris and labia minora, to infibulation—removal of the clitoris, labia minora and labia majora.

Sexual health screening and health promotion are important areas for primary health care workers to focus on. Most of the women affected by FGM in New Zealand are refugees and have been on the run or living in camps for the last six years and have had little or no health screening or health education. A recent survey with 81 genitally mutilated women over 16-years-old in Auckland identified that only 6% had received a breast check and only 31% had received a cervical smear.

Women with FGM can have health problems in the following areas:

- **Difficulty with urination and menstruation:** The average time for an infibulated virgin to pass urine is 15 minutes and it can take up to 30 minutes in young girls (performing an MSU can therefore take some time). Recurrent UTIs and severe menstrual pain are very common, particularly in virgins.
- **Sexuality:** Most single women require their scar tissue to be cut open prior to marriage before penetration can occur—this can be done through referral to hospital gynaecology services. Many women complain of pain associated with intercourse and may require topical lubrication. Some types of contraception, for example, diaphragms and IUDs, may be precluded in women who have not had any previous children.
- **Pregnancy and childbirth:** There are specialised needs surrounding pregnancy and childbirth. A primigravida requires incision of the scar tissue to allow exit of the fetal head and childbirth care should be provided by a skilled and experienced midwife or doctor. (All the Somali women are Muslim and the majority say that they prefer female doctors.)
- **Cervical smear testing:** This may be difficult with women who have never had a vaginal delivery. However, most women who have had children (and who have not been sewn up again) are able to receive a cervical smear. Most of the women affected by FGM in New Zealand are Muslim and great sensitivity and respect is important when taking smears. The women may prefer a female smear taker and may wish to have a friend present.

It is also important that primary health care workers have a good understanding of the cultural issues surrounding FGM. FGM is upheld in the genuine belief that it brings a girl many benefits and is a very 'normal' practice. Many Somali women in New Zealand have said that they have encountered negative and condescending reactions from GPs and practice nurses, and are consequently quite apprehensive about seeking gynaecological advice. ■

New Informed Choice Leaflets

ANN THWAITES

The second series of Informed Choice leaflets has now been launched by MIDIRS and the NHS Centre for Reviews and Dissemination.

The new titles are:

- Epidural analgesia for labour
- Infant feeding
- Screening for congenital abnormality
- Management of breech presentation
- Place of birth

Like the first series of leaflets, the titles come in pairs, one for maternity service users and one for health professionals. The woman's version makes explicit the options available for care, thereby supporting women in making informed choices during pregnancy and childbirth. The professional's version provides busy clinicians with easy access to succinct summaries of research evidence, to help them as they move towards research based practice.

Over 70 NHS trusts throughout the UK have ordered titles from the first series of leaflets which were launched in January 1996. In some trusts the leaflets have provided the research evidence to enable midwives and obstetricians to update hospital policies and procedures.

The NHS Research and Development Programme has funded a major study to evaluate the impact of the Informed Choice leaflets. This work will begin during 1997.

Information packs and samples of the new titles have been sent to all midwifery managers in the UK.

Ann Thwaites is Marketing Manager at MIDIRS. For further information contact: Informed Choice, PO Box 669, Bristol, BS99 5FG.

BreastFeeding Health Initiative

B F H I

YOU can help a group of committed organisations to restore a breastfeeding culture in New Zealand.

Join the BreastFeeding Health Initiative network to push for the Government to demonstrate its commitment to the Innocenti Declaration, the Baby Friendly Hospital Initiative and uphold the International Code of Marketing of Breastmilk Substitutes.

Your support will ensure that breastfeeding rates rise and the Public Health Commission's breastfeeding targets are met. Your contribution to the movement will improve the health and nutritional status of New Zealand children.

Your subscription will ensure you get reports of meetings, up-to-date information and enable you to participate in strategising meetings.

Send your $30 subscription to BFHI, c/- NZCOM, PO Box 21-106, Christchurch

YES ! Please enrol me as a member of the BreastFeeding Health Initiative
I enclose $30 to support this initiative.

CONTACT NAME ....

ORGANISATION ....

ADDRESS ....

....

PHONE.......................................**FAX**.......................................

TEN LINKS FOR NURTURING THE FUTURE
ACTION FOR THE 21ST CENTURY

❖1❖
Food Security

All women should be enabled to practice exclusive breastfeeding and all infants should be fed exlusively on breastmilk from birth to 6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age and beyond.

❖2❖
Women's Empowerment

Develop innovative social support systems for mothers working in the informal sector and to ensure adequate maternity legislation is implemented for women working in the public and private sector.

❖3❖
Community Participation

Encourage the development of community infant feeding support groups, including mother to mother support groups, women's groups and mother-and-child groups.

❖4❖
Baby-Friendly Health Care

Ensure that the practices recommended in the *Ten Steps to Successful Breastfeeding* are implemented in all health care facilities offering maternity services.

❖5❖
Baby-Friendly Environment

Expand the Baby-Friendly Hospital Initiative to antenatal clinics, primary health care and community facilities, including mother-friendly workplaces and baby-friendly communities.

❖6❖
Capacity Building

Make sure that every health worker, including primary health care staff, nurses, midwives, general practitioners and specialists, has adequate training in breastfeeding and young child nutrition to be supportive.

❖7❖
Beware of Subversion

Refuse any form of sponsorship of medical education or of health workers by manufacturers of infant feeding products and accessories.

❖8❖
International Code

Implement the International Code of Marketing of Breastmilk Substitutes and related WHO Resolutions, or legislation based upon these, as a means of protecting consumers from misleading commercial influences.

❖9❖
Advocacy

Develop and implement a *National Infant and Young Child Feeding Policy* which includes the appropriate use of complementary foods.

❖10❖
Networking

Support the creation of national networks of organisations, individuals and government departments working on infant and young child feeding and broader issues of child care, and to integrate these in regional and international movements.

Ten Links for Nurturing the Future
Action for the 21st Century

The World Alliance for Breastfeeding Action (WABA) believes that the promotion, protection and support of breastfeeding and healthy infant and young child feeding practices require a holistic approach that encompasses science and ethics, theory and practice, and policy and action.

An action plan to protect, promote and support healthy infant and young child feeding practices requires comprehensive action at many levels. A framework for such action is provided by the attached document ***Ten Links for Nurturing the Future.***

WABA links, coordinates, inspires, nurtures, cultivates and supports such actions, and helps to translate consciousness into concrete programmes and aspirations into activities. Our agenda is guided by the following framework. WABA urges you to:

- continue to place breastfeeding within the larger human rights, environment and sustainable human development struggles;
- engage women's organisations in creative dialogue to address the issues of harmonising reproductive and productive roles of women;
- work with human rights groups to consolidate the concept of infant and young child nutrition as a basic human right and to identify forces that interfere with breastfeeding and sound young child nutrition as human rights violators;
- work with development organisations to promote the recognition of the contribution that breastfeeding and sound young child feeding make to family and national economies and the preservation of our environment; and
- work with health professionals to continue stressing the protective power of breastfeeding to promote immunities in communities.

WABA invites you to join in the global campaign in nurturing the future through protecting, promoting and supporting breastfeeding and sound infant and young child feeding.

NOON
5 OCT

40c
New Zealand