NEW ZEALAND HOME BIRTH ASSOCIATION
P.O. Box 7093
Wellesley Street
Auckland
Auckland Branch Newsletter No. 22 November 1983

H.B.Assoc. SUMMER PICNIC

Kaitarakihi

4th December, midday, half hour's drive from Auckland on a good road. At Titirangi take road to Huia.
Kaitarakihi is the beach, left just before Huia.

Titian *The Garden of Love* Madrid, Prado

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FUND RAISING

It has been some time now since the Auckland Branch embarked upon active fund-raising schemes. The committee feels that it is time we raised funds to improve the scope and depth of our support activities and to assist midwives currently in domicilary practice or those contemplating taking it on.

The committee felt that a priority would be for the Branch to purchase sets of midwives' equipment which would be the property of the Branch but available for use to practising domicilary midwives. Not many people realise that domicilary midwives, unlike other public health professionals, have to supply all their own equipment from cord clamps to motorcar!

For many years now we have been trying unsuccessfully to get some Trust Body to donate funds to our organisation for a film projector. It is time we got money together ourselves as such a piece of equipment would be very valuable for use at support group meetings, seminars and conferences. Our libraries are another area which could well use an injection of funds. Updating books and journals, which is a continuing expense, and with the increasing availability of relevant films it would be good to establish a modest film library.

The committee has been trying to think of and organise fundraising activities and invites/begs suggestions and assistance from our members.

So far we have arranged to have a stall in the Eden/Epsom Jaycees Village Fete to be held on Sunday November 20 at Potters Park Balmoral. This will be an information stall as well as a sales table. We need donations of plant cuttings, herb plants, preserves, produce, babywear, etc. If you have anything you would like to donate to this please phone Brenda Hinton 866-643.

We have also been given a stall in the Avondale Flea Market on Sunday 27 November. If you have anything saleable, clothes, furniture, bric-a-brac, please arrange to drop it off at the collection depot in your area:

Western Districts	Carolynn Mitchell	832-4053 after 6pm
North Shore	Tina Hoyle	439-228
Central City	Jenni Churton	768-245

Other fundraising ideas that the committee came up with were :
Sausage Sizzle/Picnic Bottle Drives
Piecework
Restaurant Dinner - Block Booking/ set menu / set price
If you are in a position to implement any of these or other ideas, or if you have any other suggestions for fundraising please phone Brenda Hinton 866-643.

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More shame to Auckland Branch. The Self-Development Workshop was cancelled due to lack of interest ! !

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WANTED 2 interested Homebirthers who would be prepared to devote some time and effort to presenting the Home Birth Association position at National Council of Women (NCW) Auckland branch monthly meetings. Please contact Auckland secretary, Brenda ph. 866-643.
*see article on NCW report.

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A BIRTH - Rosa McNeilage

After spending the day cleaning up the yard we spent the evening quietly at home. 9.30pm I remarked to Mark that it felt as though I was about to have a period, slight ache in the lower back, and slight watery discharge.

We decided that seeing as yesterday had been her due date perhaps we should look up to see what the first signs were. I was sceptical as she was my first baby and I was mentally prepared for her to be late. However it seemed as though period pain was indeed the first sign that labour was about to begin. We were fairly unprepared for this, and so there was a flurry for a couple of hours; a table was made ready in the sitting room with a rubber mattress and plastic cover, old blankets and sheets, the room was fairly spartan as we'd only just moved in. I put my great gran's picture on the wall, thinking of her 17 children, and asking her to watch over us. About 10pm I rang Alison the doctor after feeling a cramp which I though might have been a contraction. The advice was to get as much rest as possible and not to worry about getting things ready yet. So I took myself to bed with a hotty.

At about 11.30 I woke with a start, heavy cramp like a period pain, and feeling as though I wanted to vomit, piss and shit all at once, I rushed to the toilet and sat there holding my hotty, bless the toilet! As I sat I tried to remember what to do, and realised that the breathing was the key. So I just leant back against the cistern and filled my body with air, as each contraction came I chanted to myself Lisa's mantra, 'Expand the pelvic floor.' It seemed to be happening very quickly, I thought I'd have time to read, sit down or at least walk around between contractions, so I'd get up and walk through to the divan, try to lie down, only to have to rush back into the bathroom again. By about 12.30 I was feeling quite cold and at one stage got the shakes. This made me feel quite panicky as the breathing was difficult to continue with, so I leapt into a giant bath, I can still feel the bliss as the water relaxed me and the shaking came under control. Such a relief to be in control again. By now things were really speeding up. Mark thought we should time the contractions, they were 40 seconds long and one and a half minutes apart. At one thirty we rang Joan, who said she'd be there soon.

When she arrived I was 4cm dilated. So this was it! Mark helped my onto the table and sat up behind me holding my tummy. There we were working away, breathing and resting. Joan used acupuncture, which left me feeling deliciously relaxed between contractions. At about 4.30 the contractions were long and it really felt as though you were working hard, I was still chanting over and over in my head 'Expand the pelvic floor" and asking the baby if there was enough room there for it.

Mark sat behind me breathing with me, in fact it was his steady breathing which helped us ride up and over the contractions. I could feel the warmth of his heart on my back almost like a radiant heat. Joan had a look to see how we were getting on. Just a tiny rim of skin holding the baby's head behind the cervix. One massive contraction like a giant wave, and it was gone. Paula my flatmate rang Alison.

Now I could feel different muscles working. A tight grip from the sides of the stomach, extremely powerful though not painful. I wanted to adjust my position from sitting to being more upright, and leaning forward more but there was hardly time to move much as Joan told me to feel the baby's head. I couldn't believe that she was going to be here so soon. Now it was time to push. Soon the baby's head was born. I could see a tiny black haired roundness. Great cheers from Joan and Alison and exhortations to push harder and more. I wasn't very keen as I found this quite sore, a certain amount of bellowing helped.

Alison and Joan cheered with every push, and then suddenly after half an hour there she was with a great woosh and a tiny mewing cry. Joan picked her up and put her on my tummy. What a delicious feeling, a tiny wet warm little girl looked up at us, as Joan held her to my breast. Soon she began to suck. While Mark and I gazed at her, Alison and Joan delivered the placenta and put in a few stitches, and saw to a small bleed with a dose of Joan's cayenne pepper.

I'll never forget it. It was a wonderful experience, thanks to Liese's yoga breathing classes, Daphne's encouragement and the Homebirth support group, to Wendy for being so determined about going swimming every day in our last month, and to Alison for being brave enough to have confidence in a 'senile primagravida' in spite of the Medical establishment. Thanks to Joan for her care of me before the birth - acupuncture treatments for 3 days turned the baby from a posterior position, and her nutritional advice - hooray for brewer's yeast, raspberry tea and puha salads. Thanks most of all to Mark for spending his scarce dollars on Bluff oysters when I was pregnant and for holding me in his arms for 3 hours with cramp in his leg! I couldn't have done it without their support.

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NEWS FROM THE SUPPORT GROUPS

Thoughts from Waiheke Island

Having decided on Home Birth simultaneous with decision to get pregnant my dilemma was whether to travel to town for the birth or stay in my island community 7-10 mins by sea-plane or helicopter to Auckland. Obtaining the services of a domicilary midwife and supportive doctor I opted for birth at my mother's home in town.

As my baby was due in January risk of emergency plane/helicopter couldn't fly (eg. fog) was minimal. The real deciding factor was lack of support from the island's doctors and no domicilary midwife available. Staying put meant calling the PHN (also a midwife) and doctor during labour (late enough to avoid early transfer) or finding a "lay midwife'. To me this increased the risks with no antenatal records being available. Also, the calm congenial family atmosphere associated with Home Birth is upset by compelling a birth attendant to be present.

Happily, the way went smoothly for me. I travelled to town on the last ferry to start labour that night and deliver the following afternoon. I went home and missed the support of a midwife and mother during the following week.

The experience was a wonderful one and my heartfelt thanks to Sian and Rhonda for their skill and care. Finally, facing the decision again I would stay at home with the support of a domicilary midwife or other competent attendant as available. After all, there's no place like home!
Allison Barton, 18 Matapeuna Road, Palm Beach, Waiheke Island, WH 8557.

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SOUTH AUCKLAND desperately needs to see new faces, or old ones returned, because our group is fading fast. (We had an attendance of three at our last ante-natal class - that was including a speaker, it's no better at the support group committee meetings!)

Our antenatal sessions will still be running on every third Thursday, omitting January. The topics and the venue will be the same (see previous newsletters).

Please ring Clevedon [redacted] for details of committee meetings. If you have any bright new ideas or if you want to be involved in any way, we would love to hear from you!

Does anybody have a VHS video camera? We have an empty tape that we would like to fill with birth and related films. Please also ring the above number.

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Auckland Central & East Support Group

We are currently holding meetings at Anne & Barry Sharplin's home, 59 Selbourne Street, Grey Lynn. Held on Tuesdays beginning 7.30pm. The topics and dates until the end of the year are :

Nov 15	Antenatal exercies and relaxation
Nov 29	The Birth - what you need. The Father's Role - Sian White
*Dec 6	(put forward - was Dec 13). The First Few Days. Discussion with parents who've had a recent home birth. Post-natal exercises and relaxation.

Any enquiries phone Rachel Power 603-410, Daphne Mitten 764-991

Library Books - please check your home for library books. Return to 59 Selbourne Street, Grey Lynn.

RECYCLE! If you enjoyed attending support groups, please consider being involved next year. The more people helping - the better the group. Phone Marie Macky 799-109 Daphne Mitten 764-991.

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West Auckland Support Group Report

The next series is to be held at Carolyn Young's house, 36 Larnoch Road, Henderson, the first being :

	Feb 6th	Prenatal nutrition and care during pregnancy
then	March 5th	Requirements for delivery. The father or support-person's role and general equipment and preparation
then	April 2nd	Awareness and sensitivity of the newborn with Dr Hilton, and Breastfeedings
& on	May 7th	Videofilm of a home birth This fourth meeting will be held at 256 Titirangi Road.

West Auckland is holding a social for all people who had recent home births on 26 November. Bring a plate for a light supper & BYO refreshment. This is to be held at Carolyn Young's house (36 Larnoch Road, Henderson). For further details contact Adrianne phone 836-1537 or Cheryl phone 818-5248.

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RECENT BIRTHS

Joan Donley

10.8.83	Fiona McKenzie & Brett Hoggatt	daughter, Jemima, 6lb 1oz, transfer
16.8.83	Anne & Barry Sharplin	son, Joseph Rata, 8lb 9oz, transfer
22.8.83	Jean & Peter Drummond	daughter, Jennifer, 7lb 14oz
28.8.83	Kuini Keanrs & Patrick Minty	daughter, Julia Elizabeth, 7lb 10oz
29.8.83	Jane McCartney & Mark McNeilage	daughter, Rosa, 7lb 3oz
29.8.83	Michele Fill & Scott Wilson	daughter, Kate, 8lb 10½oz
3.9.83	Jane McAllister & Bud Hooper	son, Perry, 7lb 3oz
9.9.83	Karen Newman & Don Haeata	son, Ra, 7lb 7oz
19.9.83	Wendy Harrex & Hartley Pattinson	daughter, Isabella Sophia, 7lb 15oz, transfer
20.9.83	Terry Healey & Rique Higgins	daughter, 7lb 8oz, third homebirth
3.10.83	Julia Perawiti & Greg Chalmers	daughter, Pare Hinu, 6lb 15oz, second homebirth
8.10.83	Jude Hollins & Jo Gubay	daughter, 8lb 3½oz, delivered by Irene
8.10.83	Maureen Wylie	daughter, Chloe, 6lb 13½oz
19.10.83	Jenny & Kerry McCurdy	daughter, Holly, 7lb 10oz
26.10.83	Fiona Johnston & Ralph Paine	son, Cato, 10lb 1oz
30.10.83	Raewyn & John Braggins	son, Christopher John, 6lb 8oz third homebirth

Early discharges

24.8.83	Mary Egan & Gerard Reid	daughter, Anna Rebekah, 7lb 9oz
27.8.83	Jillian & Anthony Gerritson	daughter, Anneke Jane, 7lb 12oz
20.9.83	Lee Hutchison & Allan Booth	daughter, Kelly Anne, 6lb 8oz
13.10.83	Kay & Tony Rennell	daughter, Dominique, 7lb 14oz
20.10.83	Daphne Gledhill & Mark Munkowits	son, 7lb 2oz

Rhonda Evans

5.9.83	Sian White & Murray Feather	daughter, Rhiannon
3.10.83	Tish & Andrew Bell	son, Jake
7.10.83	Libby & Grant	daughter, transfer

Carolyn Young

25.8.83	Pauline & Ross Thomson	daughter, 7lb 4oz
31.8.83	Liz & William Beattie	daughter 7lb 7oz, third homebirth
5.9.83	Sandra & Trevor Johnson	son, 8lbs
6.9.83	Miriam & Geoff Clarke	son, 6lb 15oz
6.9.83	Brenda & Bob Willering	daughter, 10lb 2oz
23.9.83	Maureen & Graham Tearle	son, 7lbs 10oz
26.9.83	Pat & Alan Budden	son, 8lb 10oz
29.9.83	Maria & Rod Henson	daughter, 9lb 9oz
8.10.83	Jannie & Phil Allen	daughter, 8lb 8oz
14.10.83	Joanne & Kerry Edgar	daughter, 7lb, 11oz, hospital
20.10.83	Margot & Ian Power	son, 6lb 13oz
21.10.83	Evelyn & Mahon Houldsworth	son, 8lbs
23.10.83	Bev & John Bailey	son, 6lbs 15oz
26.10.83	Rowena & Geoff Blunt	son, 8lb 5oz
27.10.83	Sue & Bill Bosman	daughter, 7lbs
3.11.83	Tina & Geoff Hoyle	daughter, 7lbs 11oz

Irene Hogan

midwint.	Verner & Tom	daughter
Sept.	Stephanie & David	son
Oct.	Karen & Brian	daughter, transfer
26.10.	Debbie & Joseph Heays	daughter

NEWSFLASH FROM AUSTRALIA

In Australia a registered midwife called Terri Stockdale has been charged with professional misconduct. She went to a lady in labour and when she listened for the foetal heartbeat, found it had stopped. The woman said she would rather deliver her dead baby at home and Terri agreed to this. The local hospital has laid a complaint against Terri for not calling in a doctor. The case is now before the Tasmanian Nurses Registration Board, Public Building, Dazey Street, Hobart, Tasmania. The Australian Homebirth movement is asking for international solidarity. This solidarity is very important in any of these cases against Home Birth as the movement against Home Birth by the Obstetricians and Gynaecologists, and Hospitals is international.

The Auckland domicilary midwives branch has sent a telegram of support as has the Auckland branch of the NZ Homebirth Association and as has D. Stewart of Napsac.

Any messages of support to Terri would be sure to be appreciated :

Terri Stockdale, C/- S. Roper,
Lone Star,
Golkonda 7254,
Tasmania.

NEWSFLASH

There is a rumour that "obstetric clinical material", ie. women having babies, is to be redistributed within the Auckland Hospital Board Area. More than half the patients in National Women's at the moment are private patients so there is not enough clinical material for training obstetricians and gynaecologists. The suggestion is that clinical patients from St Helen's will be shunted over to National Women's, no matter if it is further for them to go. Parents should get in touch with their local Hospital Board members and question them closely about this.

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"One of Nelson's two domicilary midwives, Ms Pelvin says a woman has to push very hard to have her baby at home."

Tribune 12/10/83

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MORE FUND RAISING

The Home Birth Association, Auckland Branch, needs funds to purchase aids for our domicilary midwives eg. sonicaids, and resource material such as books and films, etc.

Please enclose your donation however humble in the attached envelopes. All and any help is great appreciated!

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NEXT HOME BIRTH COMMITTEE MEETINGS

January 17th 10 Henley Road, Mount Eden

February 21st 39 Wood Street, Ponsonby

March 20th 11 Manapau Street, Meadowbank

starting at 7.30pm.

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NEW ZEALAND HOME BIRTH ASSOCIATION

NATIONAL NEWSLETTER November 1983

Membership

We are having a membership drive!

Whenever we approach politicians especially Aussie Malcolm with requests for better conditions for domicilary midwives and greater availability of Home Birth, we are told that we are too much of a minority to warrant additional taxpayer/government monies. Similarly the medical establishment tend to dismiss us and our demands for equal recognition in the Health System because we are a minority 'lunatic fringe'.

With increasing assaults on the availability of the Home Birth option and a general election next year it is vital that we increase our membership, especially in marginal seats like Eden.

We seem to lose many members after their children are born or between babies. Annual membership is very reasonable, please see that you are currently paid up. If you know anybody who had had a homebirth(s) ask them if they are still members and if not, ask them to rejoin.

A number of our members feel that we are becoming too political rather than being a more support and education oriented organisation. Since 1982 three 'political events' have seriously threatened the availability of the Home Birth option to parents all over New Zealand. Firstly the Wage/Price Freeze, which has given the Minister of Health an excuse to deny domicilary midwives a much needed increase in remuneration. (Despite the fact that the Trade and Industry Department approved the increase on grounds of hardship.) The Maternity Services Committee Report currently being studied, if implemented will aggravate the shortage of midwives by imposing lengthy training prerequisites plus annual refresher courses and annual assessment by obstetricians and doctors on those wishing to undertake domicilary practice. It also recommends more stringent selection criteria for mothers eligible for Home Birth.

Most recently the Nurses Amendment Bill which implements many of the suggestions relating to the practice of domicilary midwifery in the Maternity Services Committee Report if passed will severely limit the availability of domicilary midwives.

Whilst the Home Birth option is so severely under attack by the Medical Establishment, supported by the Government, we are forced to become a politically active organisation. Once our legal right to choose Home Birth is seen to be upheld and supported we will be able (and more than willing) to concentrate our efforts on support activitities and education. In the meantime we need numbers to prove that we are a significant voter population. Please help to ensure the continuing availability and growth of the Home Birth option by retaining your membership and encouraging friends and neighbours who support the right of parents to choose the birthplace of their children, to join the Home Birth Association.

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E.G.:

We wish to join the NZ Home Birth Association, Auckland Branch,
P.O. Box 7093 Wellesley Street, Auckland.
Enclosed is my $5.00 subscription

PLEASE USE

Name

Address

Phone number

Useful skills/ Access to equipment, etc.

N.B. Number of adults in family (ie. votes)

THE NURSES AMENDMENT BILL

The Nurses Amendment Bill was introduced to Parliament on September 1 by the Minister of Health, Aussie Malcolm, and quickly became controversial. The Bill contains provisions that will not only (once again) restrict the practice of home birth in NZ, but will lead to the end of all midwifery in this country, a situation which came about some time ago in the USA as a result of the same kind of pressures and tactics. To quote from the USA :

"The dramatic disappearance of a centuries old profession, almost to extinction, was no accident. It was not due to objective scientifically based health care planning seeking to improve the quality of maternity care. It came about by a conspiracy on a grand scale, spanning more than a century and continuing to the present day, on the part of medical doctors seeking to eliminate their economic competitors.

"Their tactics included two major forms: 1) the waging of a propaganda campaign to discredit the practices and reputations of midwives (to gain public support); and 2) the enactment of legislation and licensing regulations which granted them a monopoly and gave them regulatory powers over midwives." [1]

In New Zealand we can see the first tactic beginning to be used by the Nurses Association and the Minister of Health who claim that midwifery is simply an extension of the profession of nursing, not a profession in its own right. This is further evidenced by the fact that the Midwives subsection of the Nurses Association (which is their union) wished to send in a submission opposing the Bill to the Parliamentary Select Committee but was declined the opportunity to do so by the Nurses Association Executive AFTER the Executive had seen what was in it! The midwives clearly need their own union in order to survive professionally.

One can see the second tactic being used in the Nurses Amendment Bill :

Clause 15 (Section 54) (1) gives doctors total control over childbirth in New Zealand by specifying that all obstetric care must be supervised by a medical practitioner, with a fine of $1,000 for any person not so qualified who assumes responsibility for a birth. To quote the Bill -

Clause 15 (54) "Every person commits an offence and is liable on summary conviction to a fine not exceeding $1,000 who carries out obstetric nursing in any case where a medical practitioner has not undertaken responsibility for the care of the patient."

So if you decide to deliver your own baby you can expect to pay the Courts $1,000 for the privilege. In what other field of health care is one required by law to seek the services of a doctor? In what other area of health care is one prosecuted and fined because one does not choose to engage the services of an orthodox health practitioner? Not only does this regulation assert by implication that pregnancy is a disease to be treated by a doctor, it also carries the assumption that a woman is not sufficiently responsible to provide for her own maternity care. So the (male) legislators wish to dictate that the (mostly male) doctors will have 100% control over childbirth. Women should be well aware of the deeply sexist implications of this clause.

The Bill contains 3 other new restrictions of interest to home birth :

HOME BIRTH MIDWIVES

It restricts domicilary midwifery to nurses only. (Clause 15 Section 54 (3)).

This clause will have a dramatic effect on the number of domicilary midwives available, since several women are at present training in England in the 3-year direct-entry course (for which you do not need to be a nurse first) so that they can return to NZ to do domicilary work. If this Bill becomes law they will be unable to practise here, and the present direct-entry domicilary midwives will lose their jobs.

POWERS OF SUSPENSION

The Bill gives the Health Department's Medical Officer of Health the powers to suspend a domicilary midwife from practice if he "suspects" her to be practising "in an

unhygenic manner". Clause 16 Section 58 (2). He does not need "reasonable grounds for suspicion", nor does he need evidence. He can suspend her for a month at a time, and to challenge the suspension the midwife has to go to the High Court - an expensive process.

The present Act allows the M.O.H. to suspend a domicilary mideife in order to "prevent the spread of infection" and that is quite enough protection for the consumer. Apparently the above clause is designed to be used against water births; that issue aside, one can easily see how a prejudiced M.O.H. could use it to effectively eliminate the homebirth midwives in his area. One Auckland M.O.H. has already been overruled by the Ombudsman for stepping beyond his powers concerning home birth. What could he do with Clause 16?

MIDWIFERY TRAINING

The Bill also makes it impossible for a nurse to become a midwife unless she trains in a technical institute. Clause 5 Section 17 (3) states that "Every person shall be entitled to be registered as a midwife who satisfies the (Nursing) Council that he (sic) has completed the nursing course and
a) has passed the exam . . .
b) has been assessed . . .

This ostensibly offers a midwife two ways to gain registration - either she passes an exam, or she is "internally assessed" on the value of her course work. However, note that the clause specifies a nursing course as a requirement; elsewhere in the Bill a nursing course is defined as one undertaken in a Polytechnic, Community College, or Technical Institute. Hospital-based training courses are defined as "nursing programmes" in this Bill. So the legislators have, with this clause, eliminated the possibility of midwifery training being returned to the maternity hospitals, where the midwives would very much like to see it. It presently is held in the Technical Institutes, as a one year couse called the "Advanced Diploma of Nursing" which has a sub-option in midwifery. One must train as a general nurse for 3 years and then do 2 years practice before one can enter this course; this means that New Zealand is now requiring 6 years full time committment to train as a midwife. This will effectively reduce the number of our midwives - Maori and Pacific Island women, and women with children to care for, will be much less able to afford to do the course, and how many homebirth midwives will come out of a training course that keeps them 6 years in the system?

Note also that last year NZ registered 171 midwives of which 86% trained overseas, nearly all in programmes [2]. NZ trained 14% of the midwives it needed; if this Bill becomes law, 14% is all we'd get.

CIVIL RIGHTS

One other decidedly nasty provision of the Bill is the one that removes the legally protected confidentiality that presently exists between a doctor and his/her patient if the patient happens to be a currently employed nurse. (Clause 9 Section 34 (3)).

This means that no nurse can see her G.P. about serious emotional or physical problems without putting her job on the line - if the doctor considers her unable to do her job (nursing) satisfactorily, then he is required to give notice of this in writing to the Nursing Council. He is not required to tell his patient that he is doing this. Aussie Malcolm considers that "the interests of the public outweigh the legal privilege that exists between a medical practitioner and his patient." [3] The Mental Health Foundation considers it a "grave breach of a nurse's civil rights". [4] The Nurses Association initially supported this clause, but now that a great deal of attention has been drawn to it, has mildly opposed it. Any Home Birth Association members who are also nurses should let the Nurses' Association, the Minister of Health and their M.P.'s know how they feel about this one.

DEFENCE OF THE BILL

Defence of the Bill has come from 1) the Minister of Health; 2) the Health Department's Director of Nursing; and 3) the Nurses' Association. Reasons cited include a desire to "tighten the standards of domicilary midwifery" and an apparent wish to curtail water births. These things, between them, however, are going to throw the baby out with the bath water.

One is reminded of the three witches of Macbeth, hunched over a boiling cauldron, "Bubble, bubble, toil and trouble" - policymaking by panic as they end midwifery in New Zealand with the Nurses Amendment Bill.

ACTION

1. The Bill is presently before a Select Committee, who are considering submissions from the public on it. When it is returned to the House, probably in November, the M.P.'s will vote on it clause by clause. You can obtain a copy of the Bill airmail from your M.P. Write out your objections to the undesirable clauses and then go to see your M.P. (or post this to him/her). Leave your written summary behind, after asking your M.P. to let you know which way he/she will vote on each of the clauses to which you object. If your M.P. needs time to think about it ask for a written answer to be sent to your home address when the matter has had time for due consideration.

2. Write letters to newspapers and magazines about clauses in the Bill to which you most object. Make them short, punchy, to the point. If they're funny as well they're more likely to be published. This is one of the best ways to let other people know what's going on.

3. Join "Save the Midwives", an association of midwives and consumers that has been set up in Auckland to fight the Bill. The membership fee is $2 p.a., which you can send to the Secretary, 24 Ashton Road, Mount Eden, Auckland and you will be sent in return a brochure on the Nurses Amendment Bill, plus 3 more newsletters on Midwifery, Mothering and Childbirth, as they are published (every 3 months).

References :

1. The Five Standards for Safe Childbearing, David Stewart, Napsac International, 1981, Marble Hill, Mo. p.112
2. Report of the Nursing Council for the Year ending 31.3.83 to the House of Representatives
3. Speech, Notes for the Hon. A.G. Malcolm, Minister of Health, for the first reading of the Nurses Amendment Bill
4. Submission of the Mental Health Foundation, PO Box 37-438, Parnell, Auckland, October 1983, to the Parliamentary Select Committee on Health & Welfare.

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LATEST HOME BIRTH STATISTICS

The home birth figures have now been entered onto computer, and statistics are presented below. The forms received were from March 1982 onwards, with a few in 1982 prior to March. In addition eight forms were received for births which occured in 1981.

The figures below for 1980-81 and for 1981-82 are taken from the National Newsletter, where they were published in newsletter number seven and number four. The 1980-81 period was from May 1980 to May 1981, and the 1981-82 period was the financial year from March 1981 to March 1982.

The 1982 figures below do not include births analysed earlier, and are of all births in the 1982 calendar year for which forms were received. Giving the figures by calendar year has the advantage of enabling better comparison with government figures which are compiled by calendar year.

Where information was missing for particular items, the percentages are of those births for which the information was known.

		1980-81	1981-82	1982
Number of births analysed		169	253	127
Variable		%	%	%
Para (previous live births)	0	26	28	25.4
	1	41	36	33.3
	2	24	23	24.6
	3	7	9	10.3
	4	0	0	4.8
	5	0	0	1.6
Stable relationship		92	93	96.0
Smoker		5	7	5.7
Anti-D given		12	14	12.1
Iron tablets taken		19	23	21.2
Raspberry leaf taken		84	90	76.2
Maternal transfer to hospital (intra- and post-partum)		8	11	12.2
Pain relieving drugs used		5	5	5.6
Acupuncture		19	20	18.5
Ecbolics		19	20	10.3
Blood loss:	less than 300 mls	83	82	85.8
	300-600 mls	15	15	12.5
	more than 600 mls	2	3	1.7
Episiotomy		5	8	5.7
Sutured laceration		27	28	22.9
Membranes ruptured spontaneously		74	72	73.4
Resuscitation needed (for baby)		4	4	3.3
Sex of baby -	boys	50	50	54.8
	girls	50	50	45.2
Breast feeding established		99	99	97.6
Infant transfer		3	3	3.3
Maternal conditions -				
hypertension during labour		2	2	1.6
uterine dysfunction		3	1	4.7
cord prolapse		0	0	0
malpresentation		0.6	1	2.4
op. delivery		4	3	3.1
shoulder dystocia		1	3	3.1
retained placenta		3.6	0.4	2.4
mastitis		7	6	7.9
other maternal infection		5	0.8	3.1
post natal depression		1	4	0.8
Foetal conditions -				
foetal distress		2	3	2.4
meconium staining		7	8	10.2
dysmaturity		1	0.8	0
foetal abnormality		2	3	1.6
birth injury		1	2	0
infection		9	12	7.9
jaundice		32	28	34.6
pleasure responses		43	34	53.5
Apgar score, at 1 minute: 9 and 10		79	73	78.7
at 5 minutes: 9 and 10		98	97	97.5
Maternal transfer to hospital of mothers having first baby (para 0)		16	26	20.0
Maternal transfer of mothers having subsequent babies		5	3.4	9.1

STATISTICS continued:

Variable	1980-81	1981-82	1982
Average age of mothers (years)	28	27	28.7
Minimum age of mothers (years)	20	19	19
Maximum age of mothers (years)	38	39	39
Average length of -			
first stage of labour (hours)	10	9.6	6.9
2nd stage of labour (hours)	1.25	0.9	0.5
3rd stage of labour (minutes)	15	12	13.4
Average birth weight of babies (gms)	3574	3454	3589
Average discharge weight	3854	3856	3856

For further information contact Stan Gillanders, phone 673-747 Wellington.

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THE BONHAM WAY TO A SUCCESSFUL BIRTH!

Professor D.G. Bonham, Head of the School of Obstetrics & Gynaecology, Auckland University Medical School, presented a paper to the 1982 graduating class of the Diploma in Obstetrics detailing the future of NZ obstetrical services as he saw it. He states that family doctors will do 10-50 deliveries a year (leaving the rest of obstetricians), that the management of labour will include routine rupture of membrances unless there is specific contraindication, free use of intravenous fluids, episiotomy, low forceps, mandatory use of an oxytocin agent in the third stage and routine echograms at 16 weeks. The following patients will be considered high-risk: All women having their first babies, all women aged 30 or over, all those with a medical complication, a history of obstetric complication, still birth, neonatal death and any woman with a complication developing during the current pregnancy. All these women will be delivered by obstetricians.

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THE OVERUSE OF TECHNOLOGY

From 5 standards for safe childbearing, David Stewart, Napsac Public, pp.211-213.

While hospital technology is there to be used, most of the time it is used because it is there. It is used as a cover-up for lack of manual skills on the part of physicians. It is used because doctors find it time saving and convenient. It is also used because that is the way doctors have been trained.

For whatever reasons there are no scientific or valid medical reasons for the rampant way hospitals make use of IVs, oxytocin, induction of labour, aminocentesis, ultra sound, x-rays, analgesics, anaesthetics, forceps, episcotomies, bilirubin lights, intensive care, nurseries, caesarian surgery etc. Over-technicalisation of birth is a serious problem. While technology has refined its art such that more problems can be treated successfully than ever before, at the same time the gross overuse of technology is the major cause of the problems it treats. For example, prematurity no longer results in the mortalities it used to (thanks to today's technology). Yet the major causes of prematurity today are the elective induction of labour and the rampant use of caesarian surgery - both of which are applications of technology.

The four obstetric procedures correlating most closely with bad outcomes for babies were :

1) Oxytocin (a uterine stimulant)
2) Analgesia (pain killers or tranquilizers)
3) Forceps
4) Amniotomy (artificially breaking the bad of water).

The four of these are interelated. Oxytocin stimulates uterine contractions and speeds labour - more convenient to doctor and hospital, but more painful to mother and

harder on baby. Amniotomy is another means to induce or accelerate the rate of labour - but it too prduces a stressful labour for mother and unborn child. The greater stresses call for pain relief usually given in the form of analgesia. Analgesic drugs can depress the baby, compromising its vital signs before and after birth. Analgesic drugs can also reduce the mother's ability to push, thus creating a need for forceps. Forceps are also another means of hastening the final stages of labour - a convenience to the attending physician but a real danger to the baby as qell as potentially traumatising to the mother's birth canal. Once oxytocin and/or amniotomy are used there follows an increased use of analgesia and forceps both of which pose additional dangers to the foetus and newborn child.

Hospital based doctors/people accuse homebirth couples of "a mindless rejection of technology" but homebirth parents justly question what appears to be "a mindless acceptance of technology". Homebirth couples don't reject technology. They just want to see it applied in an appropriate manner. It has been said that the principal danger of homebirth is the absence of immediate technology. It can also be said that the principal danger of hospital is the presence of immediate technology.

IT IS TIME THAT WOMEN BECAME MORE AWARE OF THE SUPERIORITY OF CARE THAT IS PROVIDED BY MIDWIVES IN NORMAL CHILDBIRTH.

The training of obstetric residents and the requirements for their certification focus almost entirely upon complications and their extreme treatments. Hence their training does not suit them for normal births. By practising such techniques as IV management, electronic foetal monitors, forceps deliveries, etc, routinely on women, whether they need it or not, such doctors have no discrimination to know when to use their techniques and when not to use them, and thus through inappropriate interventions are, themselves, the major cause of most of the sudden crises they see in their practices. Also the majority of such specialists do not attend women in labour. She is generally cared for by an overworked nurse/midwife. Electronic foetal monitors are often used to cover up the fact that women are not watched during labour, but a continuous monitor without a continuously watching birth attendant still adds up to a woman being neglected in labour.

Midwives have considerably fewer crises because they do not cause them by inappropriate intervention. Midwives watch mothers in labour closely so that problems are detected much sooner than under the care of most physicians. A well trained and skilled midwife can handle most complications without a doctor.

HOW GOOD ARE MIDWIVES?

This study compares the patient care given by family physicians, midwives, and obstetricians in a poor area of California, over the years 1960-1966. It was reported in the American Journal of Obstetrics and Gynaecology.

Before 1960, only family phsycians (G.P.'s) delivered babies in Madeira County, California. It is a poor county, with most of the workers employed in agriculture, and the number of high risk pregnancies was greater than average for the U.S.A.

In 1959 the neonatal mortality rate was 23.9/1000
the prematurity rate was 11%.
In 1960 California State funded nurse-midwives to deliver babies in Madeira County Hospital. They were employed until June 1963, by which time the neonatal mortality rate had dropped to 10.3/1000
and the prematurity rate to 6.4%.

One could argue that this improvement in statistics was solely due to improved environmental factors, such as nutrition, housing, etc. If this was so, one would expect the figures to continue to improve. However in June 1963 the Californian Medical Association sought termination of the funding for this project and had the nurse-midwives replaced by obstetricians. From January 1964 until June 1966 the neonatal mortality rate was 32.1/1000 and the prematurity rate was 9.8%.

For ease of reference these results are tablulated below :

	NMR/1000	PREMATURITY (%)
Family Physicians	23.9	11.0
Nurse-midwives	10.3	6.4
Obstetricians	32.1	9.8

The quality patient care provided by the midwives speaks for itself.

In New Zealand, the domicilary (homebirth) midwives have collated the following statistics :

NMR = 3.5/1000

Resuscitation = 2.5%

Foetal distress (heartbeat 120 or 160) = 4.1%

Forceps deliveries = 0.6%

Maternal infection = 2.1%

Pain relief = 5.4%

Post-natal depression = 0.8%

Intra partum transfer = 7.5% (during birth)

BABIES with 1 minute Apgar scores of 7, 8, 9, 10 = 91%

BABIES with 5 minute Apgar scores of 9 and 10 = 97.4%

A more complete statistical analysis is available from the N.Z. Home Birth Association, Auckland Branch, PO Box 7093, Wellesley Street, Auckland.

Dr David Stewart, an international authority on the statistics of homebirth and midwifery, and Executive Director of NAPSAC (The International Association of Parents and Professionals for Safe Alternatives in Childbirth) International, has commented on the existing statistical support for midwives, pointing out that not even one technical or scientific publication favours doctors over midwives. "All existing published studies support midwives," said Dr Stewart, "there are no exceptions."

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NEWS FROM AUSTRALIA

Dr John Stevenson of Melbourne has been charged by the Victoria Medical Board with negligence and with using lay midwives. The charges arose out of a TV interview. His defence will cost at least $5,000. The Homebirth Group, Melbourne, and Homebirth Australasia have launched an appeal to assist Dr Stevenson. Contributions can be sent to the Homebirth Group, Melbourne, Jika Jika Community Centre, Northcote 3070, Victoria.

Melbourne's other homebirth doctor, Peter Lucas, was also before the Board - because an article about him with a photo had appeared in a Queensland newspaper. He was charged with advertising. Since Peter did not even know about the article the charges were dropped and the Board assured him that they had nothing against homebirth!!

In discussing these cases Henny Ligtermoet quoted from the latest NAPSAC. "First they will knock off the sympathetic doctors. Then they will pick off the midwives. Last they will go after the parents." NAPSAC says that those who oppose homebirth base their position upon "the sands of falsehood. Our position rests upon the rock of immutable truth . . . Therefore, we cannot fail . . . We of today's generation may not live to enjoy it, but we can know for a certainty that it is there for our children and grandchildren. Our efforts today guarantee it. We have the truth and we will never give up. The midwives of today are the daughters of time whose destiny is secure for the ages."

Henny also advises that both NSW and S.A. have formed domicilary midwives groups. She has suggested that the domicilary midwives 'down under' should set up a domicilary midwives alliance similar to the Midwives Alliance of North America. Good idea! (J.D.)

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BREAST MILK SUBSTITUTES

Homebirth mothers establish and maintain breastfeeding with a minimum of problems. However, all women are not so fortunate. One member of the Monitoring Committee for the International Code of Marketing of Breast Milk Substitutes feels that medical and nursing staff in hospitals should be better educated to support any woman who chooses to breastfeed. Chairman of the Committee, Dr Collins, Department of Health appointee and some members feel this will be difficult to implement. However, Sue Neal, member of L.L.L.N.Z., Y.W.C.A., Corso and the Coalition for Trade & Development would appreciate hearing from people who agree with her stand. She would also like to hear from women who have been subjected to anti-breastfeeding attitudes from hospital staff: such staff who persist in giving baby a formula when the mother specifically requests that this is not to be done, or who make such comments as 'colostrum is of no advantage'. Please send your complaints to the Secretary, Mrs Burgess, PO Box 5013, Wellington. Forward a copy to Sue Neal, 12 Hayward Road, Papatoetoe (phone 278-2683).

Armed with a copy of the W.H.O. Code on Breastfeeding (available from the Government Bookshop or Sue Neal, visit your local maternity unit and speak to the Principal Nurse there. Discuss with her the staff attitudes on breastfeeding in relation to the Code.

Currently, the Committee is dealing with infant formula labels as NZ manufacturers have made no effort to meet the regulations set out in the Code, available since 1981. They are waiting for the Committee to adjudicate on the labels first. Two manufacturers are represented on the Committee: Glaxo by Mr E. McKenzie; NZ Co-op Dairy Company by Mr A. Webber; and the Chemist's Guild is represented as well.

Some people feel that the manufacturers may want to use their representation on the Committee to restrict the Committee's activities, thereby watering down the WHO provisions. Some Committee members feel the Code should not apply in its entirety in NZ since NZ is not a Third World country. Sue feels it should. Her experience has shown that in our deteriorating economic climate, women existing on the DPB or food vouchers tend to use any milk product (sweetened condensed milk, milo, skim milk, etc) in their belief that if it's 'milk' it must be okay. Sue would appreciate information on the misuse of any milk product given to infants (children under six months of age).

The Plunket endorsement on the Karitane Milk Products labels should be challenged. Karitane Products Society is a commercial company established by Truby King in 1927. It makes generous grants to the Plunket Society.

The Code states the labels should have no attractive pictures of babies and should not idealise bottle feeding. Labels should also have clear, conspicuous, easily readable messages which include a) the words 'important notice' or equivalent; b) statement of the superiority of breastfeeding; c) statement that the product should be used only the advice of a health worker as to the need for its use and proper method of use; d) instructions for appropriate preparation and a warning against the health hazards of inappropriate prepartion. The words 'humanised', 'maternalised' etc should not be used.

Article 5:1 of the Code states "there should be no advertising or other form of promotion to the general public of products within the scope of the Code." But manufacturers' representatives on the Committee tiried to protect the right of a chemist to advertise infant formula "specials' in newspaper advertisements in the early stages. Fortunately this has been overruled.

So, you see Sue has a pretty lonely job on this Committee. Get in there and give her all the support you can by letting the Committee know your feelings and by providing instances of contravention of the Code.

If any group would like copies of resolutions from this Committee, request this from the Secretary.

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NCW REPORT

Alison Jones and I attended the National Council of Women (NCW) Auckland branch monthly meeting on 26.9.83 to speak on the HBA letter concening the Nurses Amendment Bill.

The NCW wields a lot of influence in political circles. It was NCW that nominated the one lay member to the MSC. The N.Z.N.A. is affiliated to NCW.

I feel that HBA should concentrate more effort on their NCW affiliation. They set aside a portion of each meeting for a 'Members' Showcase'. At this meeting SPUC and the Widows' Association presented background information etc about their respective organisations. The HBA should make such a presentation soon.

They also have a special Information Table at each meeting where affiliated members can place background information and notices. We should regularly have relevant HBA and STM information on this Table as well as notice of any special activities.

Joan Donley

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NEWBORN JAUNDICE

(The 5 standards for safe childbearing, D. Stewart, pp.395-401)

Jaundice in the newborn baby is not well understood by most physicians. It is a condition seen as a yellowing of the baby's skin and the whites of the eyes. There are a few types of jaundice that can cause harm if left untreated, but the vast majority of cases are harmless and require no treatment. Physicians, in general, do not seem able to tell the difference. Hence they often hospitalise new babies for days of unnecessary treatment. In the process the baby is separated from its mother, usually denied the benefits of breastfeeding and submitted to therapies that carry risks of physical and psychological harm. Countless parents, following a perfectly good and natural birth, have found themselves a day or two later separated from their babies because of the inappropriate treatment of neonatal jaundice.

In general there are 4 kinds of jaundice in the newborn :

1) jaundice due to blood incompatibilties between mother and babe (Rh negative, ABO etc)
2) breast milk jaundice
3) normal physiologic jaundice
4) drug-induced or iatrogenic jaundice.

Only the first of these is clearly known to bring harm to the baby.

1) In blood incompatibility jaundice the symptoms show up immediately at birth or within the first 24 hours. With no treatment the prognosis in these cases is grim - severe brain damage or death. Treatment in these extreme cases usually consists of a complete exchange blood transfusion. However this kind of jaundice is very uncommon.
2) Breast milk jaundice is so rare, most physicians have never seen a case. It is caused by certain substances occasionally found in human breast milk that causes a reaction in the baby, resulting in jaundice. Temporarily removing the baby from the breast will cause the jaundice to disappear, but considering

the known harm of non-breastfeeding and the absence of any scientifically demonstrated risk from this sort of jaundice this does not seem advisable.

3) Physiologic jaundice is normal. The reason it occurs naturally and normally and is visible to some degree in most babies is this: the medical term for jaundice is "hyperbilirubinemia" which refers to the presence of high levels of bilirubin in the blood. Bilirubin is a yellow pigment, the principal colouring of bile and is formed in the breakdown of red blood cells.

While the baby is developing the womb, it cannot breathe for itself but must rely upon the mother to provide enough oxygen for both of them. In order to compensate for this the baby develops extra red blood cells as additional oxygen carriers until it is born and it can breathe directly for itself. Hence upon birth into an oxygen atmosphere it no longer needs those extra red blood cells and a certain proportion begin to decompose producing bilirubin. Since bilirubin is not soluble in water it takes a while for the bodily processes to excrete or decompose the substance, thus clearing up the resulting jaundice. Normal physiologic jaundice is easily distinguished from the pathologic jaundices caused by blood incompatibilities because it does not begin to show until 24-48 hours after birth.

The treatment most commonly prescribed in hospitals consists of separation from the mother and the placement of the baby under special lights, ie. phototherapy. The problem is this: separating a newborn baby from the security of its parents is a serious assault upon the baby - psychologically and physically. While all cases of physiologic jaundice will eventually go away on their own without any special treatment, if treatment is desired to hasten its disappearance it can be done at home with the use of ordinary daylight fluorescent lamps. These can be applied at night when the baby is asleep. In the daytime the baby can simply be placed near a window with natural daylight (but not direct sunlight with the risk of suburn).

In addition to natural daylight and fluorescent lamps at home the baby should be encouraged to drink lots of liquid as this will hasten the excretory processes, help pass the bilirubin, and hasten the disappearance of the jaundice. The best way to accomplish this is by total and frequent breastfeeding.

Besides the traumas of separation and the hazards of denial of breastfeeding, there are dangers from hospital phototherapy itself. Because of the harmful effects of these lights on the sensitive eyes of young babies they have to be blindfolded or have their eyes shielded in some way. This deprives them of visual stimulation, a form of sensual deprivation and is an additional source of trauma. If the blindfold comes off, as it occasionally does, the baby's eyes can be permanently damaged. The bili lights also dehydrate the baby, upset its metabolic process and can cause slower rates of early growth. Furthermore no one knows the long term effects of phototherapy and it has been suggested that prolonged exposure at such an early and vulnerable age to such radiation could, perhaps, sensitize the body's surface and result in higher chances of skin cancer later in life.

The thing that doctors fear that causes them to submit so many babies to this treatment is their belief that brain damage might result if left untreated. However, phototherapy is a relatively modern fad in medicine and there is no data to suggest that rates of mental retardation and infant death were higher in the past because of the lack of treatment for normal physiologic jaundice. There are no scientific data to prove that physiologic jaundice, per se, at any level causes brain damage.

The fourth kind of jaundice is drug-induced or iatrogenic jaundice. There are a number of scientic studies indicating that jaundice in the newborn can be caused, or its levels increased, by drugs taken by the mother eg. aspirin. They also include many drugs prescribed and administered by doctors. These include oxytocin, various kinds of analgesics and anaesthetics. Following birth, the Vit. K shots given routinely to hospital newborns have also been implicated as being a cause of jaundice. No one knows if these kinds of jaundice are harmful or not and at what levels there should be concern. One way to avoid having to consider such types of jaundice is to avoid all drugs in pregnancy, labour and birth, and to avoid the Vit. K. shot for the baby.

It is recommended that expectant parents obtain and read the publications mentioned below, and realise that a lot of physicians are misinformed about jaundice.

Articles :

1) La Leche League International has a reprint on jaundice obtainable by contacting LLLI.
2) Vol 4, No 7, issue of The People's Doctor by Dr R. Mendelsohn, entitled "Jaundice and Bilirubin Lights". It can be obtained by sending $2 (U.S.) to The People's Doctor, PO Box 982, Evanston, Illinois 60204.
3) "When your baby has Jaundice" by Penny Simkin RPT and Margot Edwards, RN. MS., available from The Pennypress, 1100 23rd Avenue East, Seattle, Washington 98112. Approx $1 (U.S.) a copy.

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The NORTHERN AREA REGIONAL CONFERENCE, hosted by Thames Coromandel Branch.

Auckland Branch should be ashamed that only 3 women, Joan, Anne and Barbara, were prepared to go to the Regional Conference at Waihi. It was without doubt the best organised and most productive conference yet held. The weather was good, the accommodation close to the beach and very comfortable, the delegates attending were all pleasant and friendly, the food absolutely magnificent.

Nobody mentioned the constitution, thank God. Joan Donley and Ruth Schell gave interesting talks and we all put our heads together at the workshops and came up with some good plans for action.

We would like to express our thanks to the Thames Coromandel Branch.

Barbara McFarlane

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LOOKING FOR THE WAY FORWARD

Yin and Yang, the female and male principles in Chinese philosophy, are said to undergird the world as opposites in balance. Where one predominates the other is in eclipse, yet each depends upon the other for its existence. Yang is the active, assertive principle, Yin the passive and yielding. In Western philosophy we have our opposites such as positive and negative electricity; mass (matter in its passive), and motion (matter in its active sense). It is useful to refer problems of personal, social, national and international significance to such broad abstract principles. For if an imbalance is detected it helps to indicate the corrective measure.

Yang in excess leads to aggression, Yin in excess to poverty, weakness and collapse. For poverty is at the heart of love which gives all and asks nothing. But then, Yang, the active principle, must discover love to be its own basis, and this is accomplished in the realization that human intelligence, which guides willful action, arises from, and so must return to, love as its source. For the human mind, through infancy and childhood, arises as a fire from its bed from the mother-infant relationship established by nature at birth.

The imbalance in the West today, indeed throughout the world caught up in the thrust of modern technology, is a surfeit of aggressive intelligence, that is, the application of technology beyond the constraining and moderating bounds of understanding and love. We see this in the aggressive campaign waged in the industrialised nations to force birth into the hospital making it a 'medical business'.

For the doctor - if we see him as such - abstracting from everything except his medical qualifications, birth is simple the emptying of the uterus at term, an operation that begins and ends with technical competence. For him it is a question of mechanics. His whole training is directed to combatting malfunction and disease by active intervention. This remains his only brief and the only reason for his being

there at all. The other side of the contract is that he be paid for his services. It is easy to see how this viewpoint lends itself to the expression that birth is a medical business and should therefore be entirely under medical jurisdiction.

For the mother, birth is an expression of her female nature. It is through giving birth that she is a woman, and for her, birth is just as much a psychological, as a physical process. In birth nature reunites psychologically that which she (nature) separates physically (the mother and infant). This reuniting consists of the baby imprinting to its mother; and the mother bonding to her baby. It is a total, self-sufficient and closed process. This is the mystery and spirituality of birth - spiritual here simply meaning the inseparable unity of the physical and psychological process. For 'spiritual' means 'whole' and mystery refers to the self-enclosed nature of the experience, that it is not open to the observer except by inference, for nature has made the mother and infant 'sufficient to each other'.

Yin and Yang need to be balanced. It is because woman's work in the intimate sense is value creating - but not recognized as such, that the world economy is grossly distorted and unbalanced. For labour, measured by the hour, is the 'substance' of value (or we can say that value, in economic perspective is labour intensive), and there are two inputs of this 'economic substance'. One is the labour that creates the commodities; one is the labour that creates the labour. In other words, woman's work on the home front is productive of the 'labour-power' which is productive of the (valuable) commodities.

That brief digression was necessary to indicate that the problems besetting birth in the modern world have their origin at the deepest social level, way beyond the confines of the home and the hospital. By rights the surplus profits of industry belong to the workers on the home front. Only such could we have a balanced economy, a 'home front' consuming commodities and producing labour: an industrial front consuming labour and producing commodities. A tremendous diversion of funds needs to be channelled into the home front. This would create a great commodity and services market, and at the same time provide for a radically upgraded input of personal time spent by the adult and older generations in the close relation and care of the young.

As a first step the home needs to take back its own, namely birth. The hospital obstetric services should be upgraded to work in conjunction with an independently organised midwifery service. This in turn should be underpinned by the right of every mother to choose her own place and style of confinement, even to the occasional mother, perhaps in a religious group, who may prefer medically unqualified persons or none. The right of a woman to choose her attendants or associates in her pregnancy, labour and birth are the basic rights of womanhood. Only the collective mother, ie. the user of the services, is competent in the last analysis, to judge these services, and to be effective this sanctioning judgement must be free.

This, in my opinion, is the vital cause in the modern world; recognition of the rights, and the autonomy of the woman. Natural childbirth training, after Grantly Dick Read, is a well-researched subject. In its essence it is the training of the individual woman to a spiritual autonomy, and this autonomy alone, as it is reached, spells the difference between a natural and a cultural childbirth. To be successful it needs to be understood and practised within the wider understanding of the autonomy of women indicated above. This is knowledge we should be practising so as to preserve and pass it on.

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Octanary Publications continued:

The Theory of Mental Arithmetic $29.95
by Dr S.W. Taylor

Tuition available in natural childbirth training techniques

Infant education

Mental arithmetic and mind development.

If interested in any of the above contact Octanary Publications, as above.

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Report from CHRISTCHURCH BRANCH

The Christchurch branch has about sixty financial members with about another forty interested people. We have a committee of twelve who take the bulk of the workload, although all members are invited to attend committee meetings. However as with many small groups it usually falls back on the old faithfuls to get the work done. We see our work as being split into two fairly distinct roles. One is to assist women who choose home birth to exercise that choice more easily.

Couples planning home birth are encouraged to attend our monthly meetings, to meet other home birthers, and to attend our ante-natal classes run by the midwives. We encourage women to continue contact made in the ante-natal classes and meetings after their babies' births as a form of new mother support. Each woman is visited by another member in her area prior to the birth to find out if practical help is needed for the family after the birth. As we are not entitled to the services provided for early discharge mothers we have checked out other agencies providing home-help and childcare and we often arrange help for new mothers.

Our other function is political - to fight to return the right to choose home birth. To this end the group has recently been mostly concerned with the Nurses Amendment Bill. A submission was sent from the group as a whole and individual members have written submissions, letters to MP's and letter to the paper. We have had contact also with other interested groups including the midwives section of N.Z.N.A., the Family Planning Association and the Royal College of GP's. Much of our publicity leading up to Home Birth Week has been related to the Bill. We are holding a public meeting during Home Birth Week which will be a panel discussion with Ann Hercus, MP, and one of our midwives, a supportive GP and Denise Arps. We were pleased to hear that Ann Hercus asked to replace Michael Bassett (who will be away) on the Select Committee reviewing the Bill, as she has always been most supportive of home birth. We have organised radio interviews and newspaper articles and are generally enjoying a higher public profile than usual. It would be good if the moment could come where no one ever says after the birth of their child, that they would have chosen home birth if they had known about it.

It is difficult in our fortunate situation of having two midwives not to get complacent. Issues such as midwives pay, do not immediately affect us although we know that the situation for other groups is quite different. Perhaps this issue should be the next important one after we have repelled the concerted attack on our rights to choose, from the Nurses Amendment Bill.

As soon as Home Birth Week is out of the way the group will be working hard on the planning for next year's National Conference. We would like to hear from all branches on any topics they would like included. The issue of President or Co-ordinator as discussed in the last National Newsletter will we hope have been discussed locally and regionally by next May so that we can deal quickly with it and spend most of our time at the conference on external rather than internal issues.

Communication between branches seems to be improved this year with the circulation of branch newsletters as well as the National Newsletter, although after not hearing

from Dunedin through the winter we were convinced they were in hibernation from the cold.

Once again - your requests, suggestions, etc, are welcome for the Conference, also any offers to take workshops or lead discussions.

Alison Locke
Co-ordinator
Christchurch Branch.

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Report from WELLINGTON BRANCH

What's new in Wellington? A group effort resulted in information on domicilary midwives pay and the effects of the Maternity Services Report on domicilary services, being sent to candidates for the Wellington Hospital Board in the local body elections. Candidates were asked to respond to the material. Out of the 37 candidates sent the material, responses were received from 19, and ranged from supporting the home birth option being available to very supportive, and willing to take some action to improve the availability of a domicilary service, along with two pretty neutral ones.

Three Branch members had a meeting with Marilyn Waring to lobby her on domicilary midwives' pay and the Maternity Services Report, and also to have her advice on how to lobby. We found Marilyn very well informed about the present state of the home birth scene, probably because of a meeting she had with Hamilton home birth people. She led us to understand that she and Ruth Richardson would put some pressure on Aussie Malcolm to approve of the 17% wage increase for domicilary midwives. She said that the HBA letter writing campaign was having an effect both on Aussie Malcolm and other MP's. She advised us to try to get other women's organisations to lobby the Minister in support of HBA, and we have started to make contact with some.

Branch members have been working to get submissions to the Select Committee on the Nurses Amendment Bill. Some members will be attending a Committee meeting to present their submissions.

Wellington Branch will be hosting a regional conference on Saturday October 29th, which will be attended by members of Wellington, Nelson and Manawatu Branches.

That's about it for now - cheers.

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Report from WAIKATO BRANCH

Some of us have been working on an ante-natal programme suitable for sending to those people who live out of town so can't regularly attend HB functions.

We feel these people have been particularly disadvantaged ad they have not been able to learn by discussion with others. We hope this programme will be useful as a guide to their ante-natal education, especially for first-time mothers. We hope to have it completed in time to bring to the regional conference at Waihi Beach.

On the political scene, our group has :

1) Sent submissions re the Nurses Amendment Bill.
2) Written to the Minister of Health about it and Midwives' salaries.
3) We have sent letters to all our local MP's.
4) We visited I. Shearer and M. Waring and intend visiting Minogue and Upton.
5) We have sent copies of our submissions AND a letter of dissatisfaction over the way the M.O.H. has treated the matter.

Locally we have sent two representatives to the University of Waikato to speak to a group of students in a course on 'Women and Politics'.

We have many calls from trainee nurses, midwives, etc, from the Technical Institute who are doing projects on birth alternatives and they all seem to be converted by the time they have finished.

As from December we won't have a domicilary midwife as Jenny is going to Wellington (lucky Wellington!!!) and Thelma is at present working full time at the hospital to get some money. We are very upset about this as both our midwives have been very special. I suppose you have to be to be a domic. midwife anyway. It's unfortunate that we can't get a good doctor support because this is the reason we aren't getting trade for the midwives.

Glenys Wood, Secretary.

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REGIONAL HOME BIRTH ASSOCIATION BRANCHES

Auckland	PO Box 7093, Wellesley Street, Auckland
Northland	M. Harrower, Fern Flat Road, Peria, Northland
Waikato	34 Bettina Road, Hamilton
Tauranga	PO Box 2370, Tauranga
Manawatu	2 Cornish Place, Fielding
Wellington	PO Box 11-412, Wellington
Nelson	PO Box 59, Nelson
Christchurch	PO Box 2806, Christchurch
Timaru	21 Hobb Street, Timaru
Dunedin	PO Box 6124, Dunedin

National Secretary	Denise Arp, Christchurch
National President	Henriette Kemp, Wellington
National Treasurer	Angela Selwood, Tauranga.

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QUESTIONNAIRE

We would like as many replied as possible to the questions set out below. Information of this sort can be useful when dealing with the media and will also enable us to see how the various regional home birth groups are reaching potential parents. Please jot down your answers and send them to the Secretary, PO Box 7093, Wellesley Street, Auckland.

1. Why did you choose to have a home birth?

2. Where did you get your first information on the possibility of a home birth? eg. Family Planning, Doctor, Home Birth Association, etc.

3. Was your home birth all you had hoped for?

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This issue was edited by Jenni Churton and Dorothy Fitzgerald of Auckland.

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REPORT ON REGIONAL CONFERENCE AT WAIHI BEACH NOVEMBER 5 & 6

Approximately 50 adults present on Saturday.
Approximately 32 adults present on Sunday.
Support was not good but those who attended thought it worthwhile.

Saturday morning started off with short reports from all areas. Joan Donley followed this - reading a paper on Political Developments of Home Birth in New Zealand. The Nurses Amendment Bill being the most recent development - Barbara MacFarlane spoke briefly about "Save the Midwives" campaign.

Saturday afternoon, Dr Ruth Schell from Te Aroha spoke on 'Normal/Natural' Birthing.

notes from Ruth Schell's talk :

Management to keep birth normal
Ante Natal

* correct date of last period to know when baby is due so there isn't pressure to induce if baby suspected overdue
* clinical skills can equal Altra Sound data
* 12 week examination and frequent observation - is development size normal?
* parents looking at home birth must have responsibility to look after their own nutrition and no smoking. Eat a wide variety of food, cut out sugar then follow your own appetite = drinking milk, cordial and fruit juice is calorie and food intake; = iron - higher count if concentration on diet, iron pills have side effects of constipation, piles and vitamin E dificiency, molasses for vegetarians, fresh fruit eaten with iron source helps absorption; = folic acid, leafy green vegetables, kelp powder added to salads and bread making, can be disguised in a lot of meals and cooking; = calcium increased absorption while pregnant from grains and dried fuit, no need to drink a lot of milk; smoking a NO NO! results in premature and/or small babies for due date, H.B. midwives will not deliver mother who smokes
* exercise and fitness - squatting and unladylike postures should be encouraged even for young girls as pelvic floor muscles are strenthened, essential to know what these muscles feel like
* have some pain relief plan, talk to doctor and hospital, husband needs to enforce this at the delivery.

Early Labour to 5cm Dilation

* distraction and activity
* women need to be standing up - gravity
* lots of fluid in and out
* energy foods needed to help blood pressure
* no going into hospital too early
* fast labours are no problem
* stress hormones initiated with a long stay in hospital in a still postion eg. lying.

5-10cm Second Half of Labour

* need to concentrate on the labour more - get comfortable for good relaxation
* support team comes into action to create a happy joking atmosphere
* husbands need to be most active with much more potential than is realised. There are unspoken limitations on husbands in society. The couple are having this baby. Husbands can be used a hormone stimulant - sex hormone
* eye contact, talk and massage help mother at this stage
* loosen mouth with kissing, blowing raspberries
* energy foods
* frequent changes of position
* likes to know what she is achieving, knowledge of persecptive of how much longer it will last
* length and strength give a gauge of how much longer, assessing situation for the patient heldps to see the way

* tell the patient it is the 'hard work stage', Ruth calls the contractions pains

Transition

* it is a set time and doesn't last too long
* don't go against gravity
* good cooperation gives effectiveness in pushing

Third Stage

* present practices aimed at convenience and time saving
* variations on standard practices create fear in medical profession, thinking the lady will bleed to death in 10 minutes if she isn't given an injection
* injections give a false sense of comfort to doctor, suckling on breast is better
* not necessary to give injections at the time it is given, if needed at all, before the baby is born

Alternatives to Technology

* must get back to the "Art of Midwifery"
* doctors must ask themselves "We do it because . . . ?"
* nothing should be routinely, doctors should aim for what they want to achieve, there should be no side effects
* failure to progress in the early first stage in hospital is progressed with medical rupture of membrane and Drip
* Ruth asks herself if the patient is really in labour!
* the "Time Clock" starts ticking from the rupture of membranes
* hormone upset from surroundings: fight or flight response in humans causes problems here
* is she tired from lack of fluids and food?
* go for walk in pleasant places
* women are best left at home for as long as possible

Second Stage

* is he making some progress?
* how is she managing the pushing?
* a mirror is a morale booster
* hands pressed on back wall of vagina encourage the urge to push and widen the birth canal

Situations with Alternative Approaches

Older mothers - 35-90 slowly rubbished as a risk. Professional women are having babies later. Problems at this age bracket are nutrition related :

Meconium - does it really mean a distressed baby? Some studies show the baby is capable of recovering from stress. Small 26-week gestation babies have passed meconium after stress period. Important to keep meconium away from face as it irritates lungs, etc. Lighter green colour when it is older. Excellent nutrition has lowered rates of meconium being present in water.

Stuck Shoulders put mother on side to bring baby's back lower.

Unexpected Breach-experience is needed to deliver if head is stuck in cervix, discourage from pushing as long as possible to help dilation, delivery is easier on all fours, important to create an air passage

Haemorrage - find out girl's, mother's history. Is there a large uterus, big baby, not fit, tiring labout? Need studies of P.P. Haem. (A Chicago study showed no women died under 1½ hours). Is only a result of lack of attention after birth. 600 mls = P.P.H. Check if mother has had Anti-B's in last 12 months, give alalfa, there could be a vaginal tear or episiotomy tear.

report on Regional Conference, Waihi

Saturday evening - bonfire and fireworks for older children and parents.

Sunday Workshops :

1st session The Birthing Experience led by Jenny Johnson (Hamilton). Liaison with Hospital GP's led by Barbara MacFarlane. This discussion concentrated on problems in Thames area.

2nd session Family involvement in birth, Preparation of Children.

Recomended Reading :

Government Bookshops, papers on Health Care and booklets on N.Z. Policy, etc.

'New Life', Exercises for Pregnancy and Childbirth, Janet and Arthur Balskad (Sidwick & Jackson, London)

Unnecessary Caesarians, Ways to Avoid Them, Dione Young & Charles Mahon (International Childbirth Education Assn Inc, PO Box 20048, Minneapolis 55420 USA) by Whitcouls

Metric Tables of Australian Composition of Food, bookshops, about $3

Dr Greg White 'Emergency Childbirth' written for New York Police Force, R. Schell recommends this.

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THAMES/HAURAKI BRANCH REPORT

Nine families paid-up members. Four other families not financial (yet!). Have had four homebirths in our area this year - with the Waikato Midwife attending all births. One of our members travelled to Auckland for her home delivery.

Nurses Amendment Bill - Have made a submission to Parliament, as a group and as individuals - same to local MP G. Lee (Hauraki). Had article in local papers: Hauraki Herald, Waikato Times, Thames Valley Leader, Whangamata Flash. One of our couples (Gay & Walter Tye) meet with G. Lee (Hauraki MP) on political matters concerning Home Birth. Member of Opposition has also been contacted.

As a group we intend to take action against the Head Obstetrician of Thames Hospital Board Area following advice given to us from a workshop held at the Regional Conference.

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