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NEWSLETTER OF THE NEW ZEALAND HOME BIRTH ASSOCIATIONS.
P.O BOX 7093 . WELLESLEY STREET . AUCKLAND .

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Bruce Coyaghan
4 Grange Rd
Mt Eden

introduction ...

This newsletter is put together by a collective of women whom are also responsible for most of the information and articles appearing within it. We are hoping to change the format soon, and to start producing a small magazine which will be available for sale to the wider public .

I am taking over from Shaneen Moloney as editor, (Shaneen is kindly showing me what to do), and I'm looking forward to the job. I would like to see more communication between us as mothers (and fathers) than the relaying of messages from the HBA to subscribers.

Since the theme of this years conference is "Change through Consumer Action" , it seems appropriate for this newsletter to be a wider-reaching louder-speaking voice for the changes that we wish to see in our society. It was my experience with hospital post natal care that has motivated me to want change, and the louder we speak the better we shall be heard.

The biggest shock to me in my transition to motherhood was the newfound depth of my vulnerablity . I felt soooo open, and open to criticism with regards my daughter and my mothering. I saw that it was more than birthing the way I wanted to, it was rearing my child in the way I wanted to. Issues that had not touched me before now were very relevant, and information seemed sparse. Things like homeopathy and conservative medicine, immunization and plunket nurses , median lines and breast feeding...New mothers need support - and information. I welcome letters, photos, opinions and your experiences as a mother, father parent - or well-informed person.

I believe that my new vulnerability can work for me. That it is the depth of our caring that will effect change.

Daniella Aleh .

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This issue was compiled by Shaneen Moloney, Brenda Hinton , Joan Donley and Daniella Aleh. Issue No. 36 is due out in June so the deadline for letters, articles, reports etc is the LAST WEEK OF MAY.

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NEW ZEALAND HOME BIRTH ASSOCIATIONS - ADDRESS LIST

Dunedin Home Birth Assn.
P.O.Box 6124
DUNEDIN

Timaru Home Birth Assn.
c/- 7 Ranfurly Street
TIMARU

Southland Home Birth Assn.
c/- 87 Melbourne Street
INVERCARGILL

Christchurch Home Birth Assn
P.O.Box 2806
CHRISTCHURCH

Nelson Home Birth Assn.
P.O.Box 59
NELSON

West Coast Home Birth Assn.
c/- Willie & John Clews
89 Omapere Street
DOBSON - West Coast

Wellington Home Birth Assn.
P.O.Box 19-011
WELLINGTON

Manawatu Home Birth Assn.
c/- 44 Ada Street
Palmerston North

Gisborne Home Birth Assn.
c/- Kathie Ufton-Roberts
10 Riverside rd
Gisborne

New Plymouth Home Birth Assn.
c/- Louise James
14 Julian Place
NEW PLYMOUTH

Tauranga Home Birth Assn
P.O.Box 2370
TAURANGA

Thames Valley Home Birth Assn.
c/- L. Gilmore
Boundary Road
WAIHI

Waikato Home Birth Assn
P.O.Box 6090
HAMILTON

Auckland Home Birth Assn
P.O.Box 7093
Wellesley Street
AUCKLAND

Whangarei Home Birth Asnn.
c/- Judi Strid
P.O.Box 183
RUAKAKA

South Hokianga Home Birth Assn.
c/- Carly Judd
R.D. 1
RAWENE

Northland Home Birth Assn.
c/- Micky Harrower
Fern Flat Road
Peria
R.D. 3 KAITAIA

**Please address all articles, letters etc for the newsletter to ; Daniella Aleh , 15 Wellpark Rd , Grey Lynn. Auckland.

BUMPER STICKERS | WINDOW STICKERS

We have good supplies of both Bumper Ans Window stickers. These stickers are made from a durable plastic material.red print on white or clear background. Cost $1 each - includes postage. Please send your order stating which slogan you want and whether you want bumper or window . Slogans available ;

HOME BIRTH NATURALLY

I HAD MY BABY AT HOME NATURALLY

HOME SWEET HOME BIRTH

EINSTEIN WAS BORN AT HOME

WELCOME HOME BIRTH

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ENVELOPE RECYCLING LABELS

Lick 'n Stick Labels promoting Homebirth
Cost:- $2 for 75 or $1 for 35

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BUTTONS/BADGES

We have just had some new buttons made. One for parents,one for children. Cost :-$1 each

*For all orders please send a stamped ,self-addressed envelope with your order to:AHBA P.O.Box 7093 Wellesley Street Auckland.

N.B. Reproductions reduced to half actual size .

NZHBA BRANCH REPORTS.

Branches throughout N.Z. report imaginative and successful Homebirth Week (27 Oct-2 Nov) activities in their Newsletters. Some of these reports arrived too late for our December National newsletter; others are from Jan/Feb newsletters.

CHRISTCHURCH had a display board in Ballantynes, a radio interview featuring domiciliary midwife Maria Ware and homebirth mother Sue Battle, a film festival on two evenings and participation in Women on the Move, sharing seminar time with hospital midwives. An "overall success".

NELSON launched a "ritzy" homebirth pamphlet, mounted a display in the BNZ window, while domiciliary midwives Chris Voaden and Bronwen Pelvin were on local radio.

TIMARU organised a window display in the local health food shop and gained publicity in the local paper.

DUNEDIN had a display at the local library and good media attention - TV South Tonight featured the Dunedin homebirth scene; ODT carried an article about domiciliary midwife Feliz Barnette and the domiciliary midwife situation. There was also an interview on RadioOne FM.

KAPITI-WEST COAST celebrated at a picnic to meet their new midwife Mary Garner of Raumati South. Mary and the event were reported in the Kapiti Observer and the Dominion.

RAWENE, a small group publicised homebirth with an information and cake stall in Kaikohe, raising $50.

WHANGAREI had a publicity stall raising $131.96 and gained some new members bringing their mailing list to 55.

The Newsletters also outline the struggles and the successes.

SOUTHLAND HBA, Invercargill reports less resistance to home births from doctors and two mothers awaiting home births.

DUNEDIN's midwife Feliz went to Christchurch during December to help Maria with her heavy case load. She is now back in Dunedin "precariously/indefinitely hoping for a dependable promise of solidarity and effort". The Branch advises its members to "Go Forth and Advertise.." (not multiply?) Dunedin is also concerned about their Branch. With only 17 paid up members, the Newsletter says "the Association will collapse (after a long illness) unless YOU at least pay your sub".At their quarterly meeting they planned to discuss a more formal structure. "Lack of cohesiveness with our relaxed approach to Association business unfortunately requires that we revert to a more formal structure - a key working group."

TAURANGA cheers the arrival of Anne Sharplin and family. Together with the Thames HBA Anne has put a lot of energy into having the home birth option reluctantly accepted in the difficult Thames area. She

is shifting to Tauranga to be near family.

TARANAKI is finally to have a domiciliary midwife after much political opposition which blocked the first midwife that registered with the Health Department. Now Lynley McFarland is in New Plymouth until March to do home births and to help Anne Brown who is in the process of getting registered, get under way. Lynley was Palmerston North's domiciliary midwife and has just returned from several years in Vanuatu. Lynley writes, "Home birth families have been responsible for widening my experience of childbirth and teaching me the joy of being an autonomously practicing midwife."

Taranaki received a $600 grant from COGS for administration.

MANAWATU organised a temporary, subsidised home help and child care scheme to provide help for home birth families. The cost was $2 per hour and was to operate from 1 Dec to 27 Feb. Hope we hear more about this at Conference!

During 1986, 24 women booked for home births - double the 1985 figure. Of these two were transferred antenatally for post maturity, three were transferred during labour for failure to progress and two of these had c/s. There was one postpartum transfer - phototherapy for the babe. One of the successful homebirths was the arrival of Lucy for domiciliary midwife Fiona Barnett and husband Simon. During a 36-hour posterior labour Fiona leaned that despite her years of studying books on birth, nursing training and practical experience, she still had to go through it herself before she really understood what an experience it was - "a lot of hard work, but very positive". (Evening Standard 3.11.86).

NELSON: A new 'home-like' maternity unit was opened here on 29 November. Prof Bonham was invited down to cut the cord - oops ribbon - hope he waited for it to stop pulsating! Homebirths were anticipating a big promotional exercise to 'tart-up' the obstetricians' flagging image. (What did happen? Did it have any noticeable effect on home births?)

CHRISTCHURCH is conducting a national survey on cot deaths among home birth babies as suggested by Jacqueline Steincamp who is researching myalgic encephalomyelitis (ME). Steincamp refers to The Bitter Pill by Dr Ellen Grant who argues that the most damaging effect of the contraceptive pill is its overall depression of the immune system in both mothers and babes, and speculates that the increase in cot deaths sice the sixties could be linked to the use of pills and other hormones administered before or during pregnancy.

Such a survey should ask about contraceptive use in any case of home birth cot death. (It might also enquire about immunisation). Please sen any information to Gaylene Hansen, Christchurch HBA, Box 2806, Chch.

At this point, while Wendy prepared to fight the suspension in the courts , the consumers took up the battle, much to the surprise and discomfort of the medical establishment who referred to them as the "rabble".

Besides their contempt for the consumer, what comes across clearly is the 'colleague's' arrogance and self-righteousness. Also they failed to do their homework, their evidence was contradictory, but, of course they never expected their cozy enquiry to be challenged in the High Court! The Court "heard no evidence of sufficient weight that Mrs Savage's criteria for safe practice are unreasonable ..." Nor did it hear "evidence of sufficient weight to indicate that Mrs Savage's general standards for safe obstetric practice are lower than those of anyone else at the London Hospital."

Wendy was fortunate that there were a number of well known and respected obstetricians and paediatricians prepared to give 'expert witness' on her behalf. Looking back to the deregistration of Dr John Stevenson of Melbourne, although there was strong consumer support during his challenge through the courts, the collegial support was sparse. As in New Zealand the Australian O&G specialists speak publicly with one voice while dissenting voices are quickly and effectively silenced by peer pressure. We, in Auckland are well aware that secret audits are kept on those GPs most supportive of home births. But, as Wendy pointed out, the action of her colleagues at London Hospital "were not significantly different from those taking place every week in other hospitals and medical academic units in (the U.K.)" (p xvii)

Wendy hopes her battle "will help us to go forward and make changes which will be of benefit to both women and the medical profession. Ultimately these issues affect everybody, because the way a society deals with birth affects the whole fabric of that society and sets the scene for the next generation." (p 182)

Congratulations Wendy - for your courage and your victory!

J.D.

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BOOK REVIEW

A Savage Inquiry - Who Controls Childbirth? is Wendy Savage's documented account of her suspension (for "incompetence") in April 1985 as Honorary Consultant in Obstetrics & Gynaecology to the Tower Hamlets Health Authority, the subsequent High Court enquiry which cost the taxpayer £100,000 ending in acquittal in July 1986 and a reinstatement into her position in October 1986.

Anyone who imagines that witch hunts were confined to the Middle Ages should read this book, which also has lessons in it for New Zealand. Fundamentally, the issue was power! 'My case', writes Wendy became 'a focus for a countrywide debate on the future delivery of maternity services'. (p 71) with women realising 'that they have the right and the power to see that the health services they get are the ones they want'. (p 73). However, Wendy points out that involving the woman in decisions about care means that the obstetrician must relinquish some of his/her power.

Wendy's 'crime' was that she and Peter Huntingford who held the Chair of O&G at London Hospital & St Bartholomew's Medical Colleges set out to do just that. They tried to offer women a choice in childbirth services by sharing antenatal care with GPs and by encouraging the midwives to regain their autonomy and take on home deliveries. 'What our colleagues appeared to dislike most is that we offered the GPs choice. They felt that the consultant should take the decision about the woman's delivery'. (p 23).

Huntingford gave up his post in 1981. Two years later it was filled by Jurgis Grudzinskos from Australia, with the approval of the dissenting colleagues. Meantime, Wendy concerned about providing a good service for women in a deprived working class distirct while the budget shrank, established community based antenatal clinics in GP surgeries, sharing care with the family doctors and the community midwives. This further dilution of obstetric power was attacked by Grudzinskos as 'misuse of medical college funds'.

In the summer of 1984 a secret enquiry into Wendy's practice was commenced following a perinatal death. Over a period of 13 months four other cases were added to the secret dossier. These were related to clinical management, i.e. differing opinions between the conservatives who wanted to maintain control - and play god - and Wendy who listened to women. On the basis of these cases she was suspended. An appeal to the High Court for an injunction against the suspension was lost.

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Reports/3

WELLINGTON's FEbruary Newletter tells of a caesarian section for a primigravida footling breech in Wellington Women's hospital. This was to have been a home birth but the baby wouldn't turn! The significance of the story is the changing attitudes in hospital (as a direct result of consumer pressure). Not only did this woman have a 15-hour trial of labour, her husband accompanied her into the theatre, the baby was given to her immediately after the birth and her husband roomed-in with her for her three day stay in hospital. A bed was set up for him beside hers and he was able to look after the baby. She writes: "Throughout my stay at WW and during the labour and birth I had felt absolutely confident in the hands of the staff. They went out of their way to be sensitive to our feelings."

Wellington's midwife Jenny Johnson has taken on a job (until November) as relieving nursing tutor at Wn Polytech teaching maternity nursing to third year students. While still available for antenatal classes and the occasional home birth during week ends and holidays, the Wellington practice will be in the hands of Mary Garner. There is a possibility that a domiciliary midwife from Melbourne, Barbara Hasslacher, may reinforce the midwife numbers.

Wellington also reports that Jane Syles who works at the Masterton hospital has started doing home births in that area.

RAWENE would like som birth photos for their display board if you have any to spare. This group was arranging a meeting with their domiciliary and hospital midwives to discuss such issues as mothering and child care and health care during pregnancy and birth.

WHANGAREI is still struggling with the newly formed Northland Area Health Board (NAHB). Following some 'positive' recommendations re home birth, three HBA members met with Chief Nurse Elizabeth Lee to discuss provision of equipment/facilities and the home help service. The 'procedure' was published in the January Newsletter and created an explosion, with the NAHB demanding a retraction. The crux of the problem was that the HBA is not to be involved in any arrangement. Only a 'licensed practitioner' will be permitted access to equipment/facilities after negotiating "access to what".!

Whangarei Newsletter says, "We can't help wondering why they are so reluctant to involve consumers...It is interesting to note the public relations consultants to the Board share our sentiments over communication and community involvement." This consultant report (Northern Advocate 7.10.86) says that a cross-section of people involved with

the board "feel distanced and do not see any change in the traditional approach to health administration since the area health board was formed 13 months ago....Senior hospital executive staff seem to dislike and distrust the media....Some executive staff told the interviewer that they thought the board was sometimes not in touch with new developments and trends in health care. There was a feeling the board tended to intrude on their territory....Many of those interviewed seem to be saying, nothing has changed, except the name, the report says."
THis situation is of relevance to all areas which have formed or are about to form an area health board. In the Whangarei instance the board's senior obstetricians "do not favour the conduct of home births". hence are opposed to let the consumer in on the decision-making - the gp can be more easily pressured to conform through the Obstetrics Standards Review Committee which monitors the doctors' hospital board contracts. (It's called 'peer pressure') The Report of the Health Benefits Review Choices for Health Care is aware of such conflict, saying, "decisions on local health priorities...probably reflect the power of various factions in the area....Improvement may still come if greater emphasis is placed on structures which can be responsive to the needs and desires of the community. Such suggestions are part of the philosophy of the area health boards." (p 57).
The NAHB has appointed a Community Liaison midwife, Val Meiklejohn - to follow up mothers and babies after early discharge and also after home births supervised by gps only. This service is available for six days post partum, MOnday to Friday and only within the Whangarei city limits and preferably if the mother is on the phone.
Whangarei is looking for a domiciliary midwife!.
AUCKLAND tells of a confrontation with the Obstetrics Standards Review Committee (OSRC) over their policy of booking all home birth women into N.W.H. as private patients so that in case of transfer they can continue under the care of their gp rather than becoming clinic patients, eg clinical material. Earlier last year the OSRC arbitrarily decided that the legal right of women to the doctor of their choice would no longer apply to home birth transfers. This was challenged by the home birth doctors and domiciliary midwives who hold combined meetings. The Auckland HBA paid for a legal opinion and the matter was taken up by Maternity Action, a coalition of 16 consumer organisations. It was established that the OSRC is merely an advisory body and its recommendations have to be approved by the Board. Their order, aside from being illegal had not been approved by the Board. Consequently,

Gabrielle said one useful thing to me , and that was ; She would prefer that if a mother and baby find themselves in an incompatible situation due to routine hospital procedures - that they should make an appointment for her to see them A.S.A.P . A friend of mine whose support person was wonderfully disbelieving of the hospital's right to treat their baby ,did manage to see her (needs persistence) and retained more control over their baby. By no means ideal , nor does it resolve the issue of a mother's right to her baby - but it is an improvement .

Daniella Aleh .

29 NOVEMBER 86 'FATHERING - THE IMPLICATIONS!'

*Commitment. Ideally your commitment to the mother is permanent and to the child before birth. Get to know your child before birth by touch, talking etc from as early in the pregnancy as possible.
*First night. The best part of a homebirth for most fathers is the first night together as a family in bed. Those fathers whose partners were transferred to hospital shared their feelings of frustration,loneliness and the disruption the separation caused. Don't panic and say something unflattering or negative if you don't feel 'romantic' about the baby immediately. Give love plenty of room and positive support to blossom in. Give time to bonding as a priority.
*Personal growth. Fathers felt that pregnancy and birth had been opportunities for immense personal growth. The changes that were inevitable could be faced together and in ways that ensured compatability. Education seen as key to this compatability. Remember, love can't be divided, only multiplied!
*Sensitivity. This really could be enhanced and worked at. Fathers should be sensitive to their partners vulnerability. Being informed and interested in progress essential.
*Education. A vital component. One father was thrown out of his complacency by the videos. He realised that what was happening was real and imminent and that he had to take responsibility. Attending homebirth classes was considered essential, and reading at least one book. Going to Drs visits . Organising helpers' meeting. Some husbands tended not to get around to reading whole books but would happily listen to sections read out and discuss them.
*Hospital. Fathers needed to get to know and work as team with midwife in case of hospital transfer. In this case you must really know what your wife wants and be assertive (not aggressive) to ensure she gets the ultimate birth she can in the circumstances. You can ask for and get your placenta to take home and bury under a tree if you want.
*Subsequent children. Remember, love can only multiply! A new child brings something of its own to the family. Spend time bonding with your baby and previous child/children as well as your wife. Your family has permanently changed for the better! Don't let everyday things get on top of you, call in support troops to take care of meals /housework if possible, without getting in the way of your new family and their privacy. Don't get all stirred up about the dishes and forget to love and compliment your wife and family. Don't let it all get on top of you. Seek some solitude when others are there to support, and give yourself time to process this immense experience.
Some quotes: "A father is neither an anchor to hold us back, nor a sail to take us there, but always a guiding light whose love shows us the way." **George Webster Douglas.**
"When I was a boy of 14, my father was so ignorant I could hardly stand to have the old man around. But when I got to be 21, I was amazed to see how much he had learned in 7 years - **Mark Twain.** "Wondrous is the strength of cheerfulness and its power of endurance - the cheerful man will do more in the same time, will do it better, will preserve it longer, than the sad or sullen." **Thomas Carlyle.** "Perhaps the reward of the spirit is not the goal but the exercise" **E.V. Cooke**

FROM THE CANBERRA HOME BIRTH ASSOCIATION NEWSLETTER

Report back from Nat. WOM.

The last HB newsletter carried a copy of the complaint I had made to Dr Gabrielle Collison of National Womens Hospital, after the birth and subsequent neo-natal treatment of my daughter.

I was invited by Dr.Collison to visit the hospital and discuss the issue with her and the relevant people, so. accompanied by my daughter and support person I went back to NAt.Wom. and met with Gabrielle , Dr Tony Nott (the resident pediatrician who had assumed responsibility for my daughter) and another resident pediatrician who had read my daughters file and written me out a report detailing and commenting on her treatment.

" Comment:

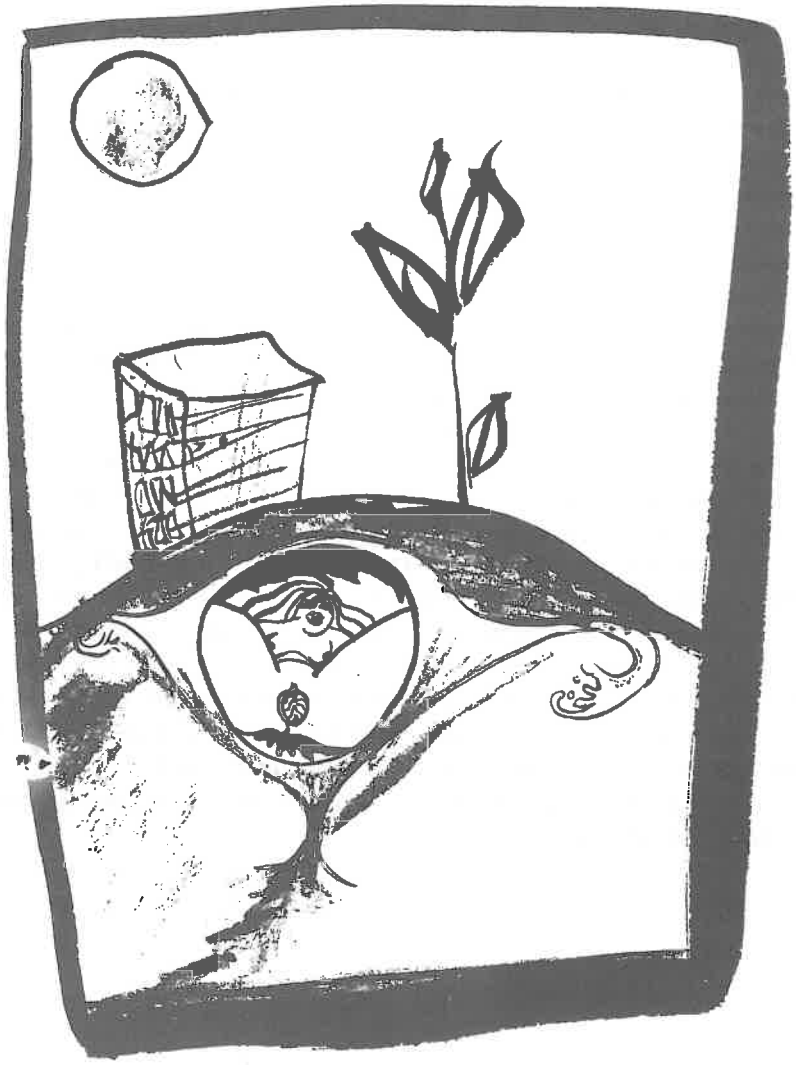
i Reviewed because of detailed complaint from mother
ii Certainly needed admission to neonatal unit
iii Respiratory distress treated appropriately. Antibiotics were indicated in a preterm infant with PROM and respiratory distress.
iv Breast feeding established early and well by a very motivated mother.
v Discharged from 11A earlier than we normally would: the baby was still in an incubator under P.T. IV fluids were kept going because of the jaundice and the need for IV access for antibiotics. The baby did well on Ward 8 but this could not be predicted. SBR subsequently increased to a rather high level in a preterm infant.
vi I consider that laboratory investigations carried out were indicated and were not excessive.
vii Discharge at nine days when no weight gain had been recorded and at the baby's minimum weight would be criticised by some but I consider to be appropriate in the circumstances.
viii The emotional aspects of the complaint are not addressed in this review but have been by others who were involved in the baby's care and knew mother.

Dr D.B. Knight "
Neonatal Paediatrician.

I found the "Comment" basically irrelevant, not addressing my complaint at all. I found that Tony Nott was more upset by the carbon copy indications at the bottom of the letter than by anything else. This realization gave me back some personal power which had been usurped following my daughters birth. And I saw the fallibility of hospitals as places for birth, and pediatricians as neo-mothers.

home birth transfers to hospital continue under the care of their gp and/or specialist of choice. Furthermore, transfers from level 0 and 1 hospitals to level 2 or 3 hospitals also have the legal right to continue under the care of their gp if they so wish, and the Board is not entitled to act unreasonably so as the nullify the "right to select".

J.D.



MINIMAL STANDARDS FOR DOMICILIARY DELIVERIES

The Thames Hospital Board Obstetric Advisory Committee (eg OSRC) established in 1982, has prepared a document entitled Domiciliary Deliveries:Minimal Standards of Patient Care (22.12.86) which sets out guidelines.

The guide to patient selection would require referral to an obstetrician for practically every woman. In addition to the legitimate medical and obstetric high risk factors, this is extended to include all primigravidae, all multiparae over 35 years and/or parity of 5 or more, women with 3 or more previous abortions, previous prem labours (37 weeks), perinatal death, damaged child, operative delivery, difficult or prolonged labour, p.p.h., retained placenta.

A new category has been added which should catch any stragglers. These are Social Risk factors for which 'the mother should be subjected to a social screening...at her first interview'. These include any woman 16 years or under, history of previous psychiatric problems, alcohol or drug abuse, parental violence or neglect, previous child abused or neglected, financial lack/mismanagement, unrealistic expectations of a child, low self-esteem, history of failure at school or work, social isolation, evidence of poor impulse control and/or personality problems, abusive/neglectful incompetence of partner, attachment problem/problem baby - all to be assessed together with home facilities (telephone, car, accessibility, family support, etc.)!

While it is heartening to see that this body of 'experts' is finally recognising that social factors play an important role in labour and birth, I have a strong suspicion that this is mere token recognition to camouflage ulterior motives. After all, a few days after being 'delivered' (rather than giving birth) in the 'safety' of the hospital, these mothers have to go back to their substandard homes and cope with their social and financial problems. Not only that, in all probability, because of interventions during birth, separation from their babies, they will have been deprived of their bonding experience, their mothering instincts and their self-esteem - all of which are recognised as a contributing factor in child neglect and abuse!

indicate this . The creche will be sited in some of the units.

An added attraction is the spa and sauna facilities. A relaxing end to the day.

The Saturday evening meal will be a smorgasbord ,followed by an informal get together.

Re transport : we anticipate having flights to Hamilton met, and people transported over by car. Please notify us if you will require this service.

* If your group has a video that they wish to have included in the Video/film session . please send it to; E.Tye
R.D. 3
Paeroa.

*** We feel that it was an advantage to have the annual reports included in the conference folder. I see that 7 groups contributed last year ;Northland,Auckland,Wellington,Manawatu,Timaru,Nelson and Thames Val. How about a 100% response this year.Send these to ; J.Tye
R.D. 3
Paeroa.

*** If your group wishes to hold a sales table please contact ;

Anita Peters .
P.O. box 6
Waikino (via Waihi)

**** Costings should be comparable to last years conference , plus GST

We will inform groups of approximate costs at a later date.

We hope that this information will encourage many of you to attend. The location will be very conducive to an "invigorating" conference.

Gay Tye / Anne Sharplin.

NATIONAL HOMEBIRTH CONFERENCE

May 8-10

at the CEDARWOOD MOTOR INN. WHANGAMATA.

Convenor: Anne Sharplin Co-ordinator; Gay Tye

You will noW be aware that Thames Valley are hosting the 1987 Homebirth Conference. As Whangamata is one of N.Z.'s most popular beach resorts we are hoping that families will take advantage of the fact that it is the first weekend of the school holidays.

As you can see by the brochures (sent out to each group), there are excellent family facilities within the Cedarwood complex, beside the many attractions that Whangamata itself offers. eg. beautiful surf beaches, harbour, estuary and bushwalks in the Wentworth valley.

The theme of the conference is " Changes in childbirth through consumer action." The opening address will be presented by Lynda Williams, (see preceding page). It was felt that last years conference did not have enough time for discussion in the panel/forum sessions , or for the Overview & Roundup on the Sunday , hence the two panel sessions this year. These will be particularly relevant as there is so much happening politically that needs to be presented and discussed. (see tentative programme.) On Saturday afternoon and Sunday there are groups of workshops dealing with a variety of topics and lead by very stimulating speakers. An indication of interest in the conference has been the willingness of speakers to travel long d stances to prese - nt these workshops.

The Cedarwood complex has a number of advantages for our conferen ce in that the dining , conference , and accommodation facilities are all on the one site, attractively set out around a central recreation area. We anticipate that this wil give ease of management for parents with young children. The spaciousness of the units will give privacy and be peaceful retreats. Please note that the units can accommodate 5-6 adults(plus children on floor) as all rooms are spacious doubles.

We visualize that there will be group bopokings dont forget to

If their concern is real, would they have had such 'difficulty in maintaining any other view than that the nominated practitioner should be an experienced obstetrician and should be present at the confinement. To accept responsibility for a patient in other circumstances would be most unwise'? For starters, the role of the obstetrician is to take charge of abnormal deliveries; next, how many obstetricians do you know who would cover for a home birth? The few who are sympathetic do not have the courage to withstand peer pressure.

If the obstetricians who are at the apex of the heirarchy are unable to withstand peer pressure, what hope have gps to run counter to these "safe and minimal standards of practice" which the Thames Hospital Board 'considers it has a duty to make....known widely' especially to private practitioners who work outside of public hospitals and over whom the Board admits it 'has no jurisdiction'. However, it claims the backing of the Health Department via circular letter 1986/43 to 'act as a peer review body where the general practitioner has no contact with the Hospital Board'. Rather unnecessarily the Committee acknowledges that it 'does not share this enthusiasm' (for domiciliary confinement) and devotes itself to making the process as difficult as possible. It endorses the Hospital Board Service Planning Guidelines issued by the Department of Health (May 1986) that 'a careful assessment of the home environment is required and should be undertaken by the domiciliary midwife'. Last year when the Auckland domiciliary midwives were asked to participate in such an assessment they declined to take advantage of their clients' trust to spy on them.

The Committee considers that the site of confinement should be within 20 minutes travelling time of both the medical practitioner and the base hospital, and within 1½ hours travelling time from the midwife.

As for the midwife, the Committee considers the present system of registration of domiciliary midwives to be 'archaic'. (She has only to present her annual practising certificate and her equipment for inspection to obtain her contract from the Department of Health, albeit after long delays). This, says the Committee 'leaves the question of competence and standards of practice entirely in the hands of the licensee and hence offers no assurance to the public that minimum standards of safety in midwifery can or will be met'. The Committee would prefer 'that such licenses were the subject of routine peer review based on continuing knowledge and practical

competence in midwifery....(with) a constant updating of theoretical knowledge' to be demonstrated to any licensing authority.
Of course, the answer to this dilemma is to restore and upgrade the basic midwifery training in N.Z. so that when a midwife graduates she is a practitioner competent to practice in any setting. Her practice should be evaluated by an independent and autonomous College of Midwifery. Would the obstetricians buy into that one?

The Committee puts out feelers, in the interests of 'sufficient exposure' in the management of labour (it reckons there will be very few domiciliary confinements!) for the domiciliary midwife to become part of the hospital team working from the base hospital. That should eliminate the remnants quickly or convert them into obstetric nurses, handmaidens to the obstetricians. Imagine what options in childbirth women would have then! The Domiciliary Midwives Society Inc has consistently and vehemently opposed any such incorporation.
The Thames' views are not only of local concern, they have relevance for domiciliary confinements throughout N.Z. because they are supported by the Department of Health and are based, in part, on the Hospital Board Service Planning Guidelines, which, when commenting on home births advise:

'Every effort should be made to ensure that women with identified risks are delivered in hospital'.

Although the decision to set down its views on domiciliary confinement was made in July 1986, in response to 'voluminous correspondence, most of which demonstrated enthusiasm for domiciliary confinements', this document endorsing such stringent measures was only released early this year when the Committee felt it was in a strong political position. This was following a home birth maternal death in Thames - of a woman who met all the criteria and was, in fact, the first home birth in that area to be officially sanctioned. She died on her seventh day postpartum. The coroner's report has not yet been released (7.2.87).
J.D.

introducing LYNDA WILLIAMS .

Lynda will be giving the opening address at the HBA conference this year, on the theme of 'Changes in Childbirth through Consumer Action' , and so I thought it appropriate to show how her personal experiences of her births had led her into the political arena.

Lynda is 37 y old, and mother to four children. Her eldest son was born in hospital, and Lynda had attended ante-natal classes at Nat.Wom. and had expected that the classes would prepare her for the experience of labour. While in labour she realized that she hadn't in fact been prepared at all for what she was going thr ugh. and this coupled with the then routine separation of mother and baby made her angry. Her second child is adopted and was a cæsarean birth .

Her third daughter was born two months premature and spent time in a neo-natal ward. For her second birth Lynda had attended classes at the 'Parents Centre', and while she felt the classes were better they still placed too much emphasis on 'experts', such as the doctor//midwife nurse - who by nature of their education 'knew' better than the mother. Then in 1978-9 while in Canada (accompanying her husband) she trained as a childbirth educator and began to teach on her returen to NZ in 1980.

Through teaching (home based groups for both home and hospital births.now dealing with mostly hospital births) .Lynda became aware of what was really happening with women and their births in NZ. and began to desire to change things. She was hearing a lot of stories from other women and sodecided to have a fourth child to experience a home birth and find out what she had missed. Her (now)3 yr old was born at home.- and while it was everything that her previous births weren't .she says that it in no way eased the pain /anger of those two hospital births.

Lynda attends 3-4 births a year as a su-port person to keep in touch with the birthing scene, both at hospital and at home.

As a childbirth educator Lynda is a member of the Auckland Child-Birth Educators Assn.,a support group for NZ childbirth educators which would like to see an officially recognized training programme for Child-Birth Educators established. Lynda is also NZ co-ordinator for The International ChildBirth Educators Assn.

Lynda is a long term member of the HBA,and in 1984 was a founding member of 'Maternity Action' - a political group which fought against the closure of the small hospitals and now has two members sitting on the 'Maternity and Neo-Natal Services Committee' which advises the Auck. Hospital Board on policy. More recently Maternity Action has helped preserve the right of homebirth mothers to their own GP on admissionto Nat. Womens.

Daniella Aleh.

Many of the more enlightened midwives are trying to keep the essence of midwifery alive, but find it difficult to "counteract the massive medical machine" and the extremely bureaucratic heirarchy.

Antenatal care is fragmented and in the hands of the OBs. Women are 'entitled' to three scans under their insurance but usually have anywhere from four to ten. They have four to six non-stress tests in the last month of their pregnancies.

Debbie spoke about the years of effort to have midwifery legalised in B.C. which is now threatened as a result of charges brought against two 'lay' midwives because of a perinatal death. The trial was used to divert the focus from midwives' real need for legislation to establish midwifery education, licensure and standards of practice. The Government now proposes to delay such legislation while it spends $900,000 to carry out a two to three year study to study their previous study.

Throughout the long trial which has seriously divided both the consumers and the midwives between themselves and each other, MABC has wisely maintained a neutral stance. The prosecution brought Fillippa Lutenburg to B.C. as an expert witness. The intention was to prove negligence by applying the midwifery standards of the Netherlands (which has a long tradition of midwifery practice) to B.C. which doesn't even know what a midwife is. This, in fact, is why lay midwifery has developed. Their ignorance about midwifery was exposed when Lutenburg was asked what standards of practice a nurse midwife would apply. She replied: "What is a nurse-midwife? I do not understand that term. That's like saying I am a carpenter-plumber."

The female judge opined that anybody holding themselves out to be a birth attendant needs at least the skills of a general practitioner. She seemed unaware that B.C. doctors can complete their medical degree without ever delivering a baby! She maintained that had the midwives possessed the skills of the intern at the hospital, the baby would have lived. Since the baby's head had been delivered it was defined as a person rather than a fetus thus enabling a conviction on criminal negligence causing death. The midwives were acquitted of causing bodily harm to the mother (episiotomy, fundal pressure) because they were found guilty on the first charge. They were each given a three-year suspended sentence with 200 hours of community service and forbidden to attend a labour or a birth during this period. They are appealing. They still face charges of practising medicine without a license.

J.D.

(11)N

PRESS RELEASE FOLLOWING THE RELEASE OF THE MEDICAL BENEFITS REVIEW TEAM REPORT

The Domiciliary Midwives Society representing all New Zealand domiciliary midwives:

1. Applauds the thorough and honest appraisal of the current health care system in New Zealand, afforded by this report.

2. Fully supports the underlying appreciation that health spending needs to concentrate more on primary, community-based, preventitive care and away from secondary, curative health care as we have at present, or to use the analogy currently in vogue move to funding the fence at the top of the cliff and away from the ambulance at the bottom of the cliff.

3. Applauds the recognition by the review team of the unique position of the domiciliary midwife - who is at present restricted by law from practicing in her own right and who recieves a significantly lower level of income than other health professionals working in the area of normal childbirth and obstetrics. Both these factors considerably reduce the availability of the home birth option to healthy women expecting a normal childbirth who are thus forced into "medicalised" hospital birth where they become vulnerable to very expensive and unnecessary high-tech medical intervention.

4. The report also implies that the reason for the low level of payment is a reflection of the established medical profession's attitude to home birth as an "unsafe, second-best option" an attitude which flies in the face of the statistical facts, the ever increasing demand for home births and the high degree of consumer satisfaction evidenced by the formation of strong and ever growing numbers of regional home birth associations.

Specifically, the report has endorsed the home birth option and highlighted the need for a further review of the uneven pattern of maternity subsidies and further investigation into the status of the domiciliary midwife.

Such an review is already long overdue. The situation is a crisis one and the Government must now act urgently to raise the level of income to domiciliary midwives by which ever mechanism is considered most suitable, to one which fairly reflects their level of commitment, the quality of their service and their specialised training.

Home birth is an immediate and practical example of effective primary health care allowing parents to take more direct responsibility for their own health and which will prove cost-effective both in the short and long term.

The Government has voiced a commitment to the home birth option but the current level of benefit, notwithstanding the increase granted earlier this year, belies this. It must now keep faith with its commitment to keeping the options for maternity care open.

The Domiciliary Midwives Society will be presenting submissions to the Health Department immediately for an increase in the level of maternity benefit paid to them. This will be followed early next year with submissions on the future directions of midwifery training and a comprehensive code of practice that will ensure full accountability whilst seeking the necessary legislative changes to allow midwives to provide normal childbirth services in their own right.

(12) N

CHOICES FOR HEALTH CARE

REPORT OF THE HEALTH BENEFITS REVIEW.

This Report was released just before Xmas. The terms of reference were "to report upon the underlying rationale for state involvement in health and to recommend broad principles and directions for reform." (p1)

Although dealing with New Zealand's health care system in all its ramifications, it is encouraging to note the space accorded to maternity care and the positive endorsement of options in child-birth and domiciliary midwifery! This is credited to the "vocal home birth movement". Under Domiciliary Midwifery which is class-ified under "narrowly targeted services" which also inlcudes dentistry and physiotherapy, the Report says there being less than 40 midwives in the country claiming the domiciliary midwifery benefit "such a very small group of providers have little political leverage and are easily overlooked. However, there is now a vocal home birth movement that has spoken out for the midwives; the number of submissions we received in support of them bears witness to this. The issue of home birth is associated with the increasing notice taken of patient's rights and women's health issues. The ability of pressure groups in this area to make some headway against the medical establishment demonstrates their growing influence." (pp 55/56)

So, you see, all the hard work and numerous submissions are finally having an effect. Six Homebirth Association branches (Auckland, Nelson, South Hokianga, Southland, Wellington & Whangarei) sent in submissions. Also Save the Midwives and the Domiciliary Midwives Society of New Zealand Inc, as well as a number of individuals. In all there were 285 submissions. However, don't be deluded that now you can relax; the fact is that you are going to have to work even harder than ever!

While "a greater role for the individual" (p49) is envisaged, individuals are now expected to play an important role "in judging the quality and adequacy of health care services" (p14) while also defining their roles and needs.....before a path is chosen, the direction one wants to go must be clear" (p114) says the Report.

(17) N

needle inserted on admission although they are not hooked up to a drip until in advanced labour. The episiotomy rate is 90% and the c/s rate is 17%. All primip breeches are sectioned as are women who come into labour between 28 - 32 weeks. In the early stages of labour women are ambulatory and can do pretty much as they please. They wear their own clothes. Very little medication is used and the epidural rate is low. They have a non-stress test every two hours. Every woman has a student midwife with her throughout labour.

Debbie found the German midwives to be "incredibly caring and nurturing" if somewhat rigid and authoritarian, while the women were passive and submissive. Although early labour proceeded without too much interference, at about 8cm dilatation approx-imately 98% of women had internal electronic fetal monitors applied by the midwives, who also augment labour with syntocinon at their own discretion. Debbie felt that their use of augmentation was "indiscriminate". Birth took place in delivery rooms containing two or three tables separated by curtains. Anyone can wander in and watch a birth, even when the woman is a private patient. During the second stage women are strongly advised against pushing until the head is on the perineum. They are delivered in the dorsal position by midwives with the medical student. doctor or OB standing by with the scissors ready to do the episiotomy. Private patients are delivered by qualified rather than student midwives.

They have an 'improvement' on the episiotomy called a 'sphincter-otomy' or 'complete periotomy' generally used for a forceps delivery whereby the incision is made right through the anal sphincter - to prevent a third degree tear!

Delivery management is aggressive with manual restitution, down-ward traction, then holding the baby up by its head. The doctor suctions the baby with a bulb syringe. The cord is cut right away with the doctor rushing off with a piece to test the blood, gases. The baby goes to the mother, but on a blanket rather than skin-to-skin contact. Vitamin K and neomycin eye drops are routine. Babies go to the breast briefly and are then given glucose and water. They are kept in nurseries at night and fed glucose and water, the bottles being propped. Mother and baby go home at about six days with sample packs of formula.

(16) N

DEBORAH FARNSWORTH is a direct entry midwife and a member of the Midwives Association of British Columbia (MABC), Canada. In 1985 she graduated from the underground midwifery school which she helped to establish. She was one of 16 students, the majority of whom were already practising 'lay' midwives. During their one year of intensive academic study they had to exercise caution about disclosing details about their school as the Medical Act in B.C. is so broad that anybody teaching medicine, surgery or midwifery has to be approved by the College of Physicians & Surgeons. At the end of their course the midwives spent two days being examined by two midwives from Seattle and by Fillippa Lutenburg, president of the International Confederation of Midwives. Fillippa praised 'the high standard and quality of learning the students had done under the supervision of a handful of dedicated, visionary teachers.' The school was financed by the students who each paid $2500. This year the cost has risen to $3600.

In October 1986 this B.C. School of Midwifery obtained accreditation with the Washington (USA) State Midwifery Licensing Board. This necessitated increasing academic study and clinical experience to 27 months, i.e. three academic years, and requires the midwife to do 50 births and witness a further 50. While 35 births and 35 witnesses can be from their previous practice, the remaining 15 of each have to be under supervision in a country where midwifery is legal. Debbie was hopeful that she could arrange for some of their students to obtain their clinical experience here. What a hope when our 'midwives' graduate with 18 weeks of 'obstetric component'!

Debbie went to Tuebingen, West Germany for a month to complete her clinical experience - to a hospital which does 2500 birth p.a. and offers a three year direct entry midwifery programme. Students work on the wards after six months of theory so that they can integrate theory with practice. She found their midwifery practice to be a combination of the progressive and the archaic, with the midwifery students eager to learn alternative ways but stifled by the medical machine.

The majority of women are shaved and receive a large enema. They are allowed nothing by mouth during labour and have an intravenous

Lugtenburg.

(13) N

The main emphasis will be "on long-term changes which offer much greater hope for achieving the goals of improved efficiency and equity". (p118). In the area of Maternity Services (pp 120/21) we are expected to consider both short- and long-term arrangements - and it is essential that we do so. The Report puts forward a number of suggestions.

The first suggestion is "various contracting arrangements....(for which the consumer would make a part payment). For instance, midwives could offer competing services for straightforward childbirth, although this would require some legislative changes." (Although the Report says that domiciliary midwives "operate as private practitioners" (p55) this suggestion would require more than legislative changes; it would also require major changes in the professional status of the midwife and in her training, both of which are essential in any event if midwives are to play a meaningful role in the maternity services. It is also the basis for long-term options in childbirth).

The Report adroitly sidesteps this first suggestion by favouring an alternative to the above, i.e. "to encourage "firms" of midwife and doctor combinations to tender for providing a range of services." The reason given for favouring this option is because "it emphasises teamwork". (At the moment it is also in line with the legal requirement that every pregnant woman must have medical coverage. However, midwives as independent practitioners would still refer women to doctors whenever necessary - eg teamwork).

Other areas requiring further examination (and expression of opinion) are "questions about hospital care, early discharge and the domiciliary midwife benefit in the short-term". In the long-term they are uncertain as to how and where to fit the domiciliary midwife into the health care system. Suggestions include:

(1) to incorporate her into the established hospital community-based service. (This the DMS has consistently resisted as it would place us under the tender loving care of the Obstetrics Standards Review Committee, i.e. obstetricians plus a token midwife or two. How we would fare under an area health board is a moot question. In view of the problems being experienced in Northland and Nelson where members of the old hospital board automatically became members of the area health board and continue to jocky to maintain the status quo and their sectional interests while denying consumer participation

which is supposedly the philosphical basis of area health boards, should make one reluctant to jump into this one.)

(2) to employ her on a salary like public health nurses.(Area health boards are a grouping of hospital boards, the Board of Health and consumers, so whatever happens to public health nurses would also happen to domiciliary midwives. It feels more comfortable to be under this wing, but this possibility requires further investiagtion.)

(3) the present benefit being further - and regularly reviewed and increased. (Currently our professional negotiators Trott, Grovehills & Associates are working on a long-term contract. As a gentle reminder we still need $1500 to finance this.) It is interesting to note that the Report recognises that "domiciliary midwives offer a service which is frowned upon by a large section of the medical community who consider home birth as an unsafe second-best option which is best discouraged. The low rate of pay may not be entirely unrelated to this attitude." (p56)

(4) a degree of part-charge being introduced. In the short-term the Board of Health seem likely to "leave untouched the 100 percent maternity benefit that is paid for general practitioner obstetrics. A reason often given for treating this service differently is because it concentrates on preventive care and there would be considerable concern that fewer women would consult their doctor during pregnancy if a part-charge was introduced." (Whether this benefit is paid in the long-term would depend on how important the future health of mothers and babies is to the nation; whether or not maternity care is to be dominated by the medical profession; and whether midwives, who offer much cheaper care, are made autonomous.) The argument for part-charge is that this would "support and encourage high-quality service - while also allowing women choices about who provides care and where it is provided" making various contracting arrangements possible eg competing midwifery services.

Cost effectiveness is an important aspect of future decision making.
During 1985/86 expenditure on doctors' maternity benefit amounted to $40.2m.
During 1985 public maternity hospital care cost 8.1% of $1311.7m

i.e. $106,247,700. In 1985 there were 51,798 live births in New Zealand, plus 254 stillbirths making a total of 52,052 births. Deducting an estimated 300 home births and a further 100 births in the 38 private maternity hospital beds (51,652) puts the cost of each phblic hospital birth at $2057. The 1985/86 domiciliary midwifery subsidy was $0.2m.

With the inflationary nature of the N.Z. economy the costs of hospital births can only increase. "It is important for health planners and politicians to note that studies have shown, not surprisingly, that home birth, if occurring in sufficient numbers, is less expensive than hospital birth for the government, although it may be more expensive for the family. Birth in a primary care setting is also cheaper than birth in a secondary or tertiary setting...." Those words of wisdom are from a 1985 W.H.O. publication Having a Baby in Europe, (p88)

Not only is it cheaper and with better outcomes for mothers AND babies, having babies at home places maternity care back into the hands of midwives. This would require restoration of the autonomy of the N.Z. midwife, which would cut the costs of the amounts now paid for doctors maternity benefits!

These are all topics which should be seriously considered at our Annual Conference, Cedarwood Motel, WHANGAMATA, MAY 8,9, & 10.

Please come prepared to discuss these important issues. Our future depends on it!

Joan Donley.