NEWSLETTER OF THE NEW ZEALAND HOME BIRTH ASSOCIATION

MARCH 1979

NEWS

The N.Z.H.B.A. membership now stands at 142. This figure includes 66 couples, 3 other Home Birth groups, 3 Medical Practitioners, 9 Midwives and 14 Nurses. Around the country there are domiciliary midwives in Christchurch (1), Nelson (1), Wellington (2), Napier (1), Tauranga (1), Te Aroha (1) and Auckland (4).

Our new midwife in Auckland since July is Irene Hogan, who has spent time doing V.S.A. in Malaya.

Articles on home birth have recently appeared in the Auckland Star, N.Z. Woman's Weekly, Western Leader, North Shore Times and Parent Centre Bulletin. As well, the Association had one hour of talk back on ZB radio.

N.Z.H.B.A. held a fundraising cake stall at the Women's Electoral Lobby's mass protest rally at St. Heliers and raised $103.10c. Chris Reynolds with Sue Bremner's help organized a "Good as New" stall at the Glen Eden Community Fair raising $78 in 1½ hours!

WORKSHOP AT NAMBASSA

A Home Birth Workshop was taken by Dr. John Hilton at Green Bay and Joan Donley, Domiciliary Midwife. About 200 people attended and good audience participation was experienced. Four midwives indicated interest in joining the domiciliary ranks - one from Kaitaia, one from Tauranga, one presently residing in Whangaparoa, and one other who still has young children.

The Workshop was poorly organised - there being no programme to advise interested people when and where it was; also midwive(s) from the Tenessee Farm were present, but were not present at the Workshop, which was a pity.

La Leche League had a tent at Nambassa. A large percentage of the books they sold were on home birth.

Michael Adams, our treasurer, spoke about the Home Birth Association and enrolled several new members.

A letter is being prepared to the new Minister of Health, Hon G.F. Gair pointing out the difficulties midwives have in registering and how the very low rate of pay means that there is such a shortage of midwives. It would add weight to the Association's letter if you would write your own personal letters to the Hon G.F. Gair.

We invite your contributions to the Newsletter. Articles, case histories, quotations or just any ideas will be gratefully received at P.O. Box 7093, Wellesley Street, Auckland 1.

Any members interested in co-operative bulk buying of Brewer's Yeast please phone 584 336. Fresh goat's milk is available from Health Food shops at St. Heliers, Greenlane, Papatoetoe and Karangahape Rd.

BARBECUE * * * * B A R B E C U E * * * * BARBECUE

Diaries out because this time, rain or shine, it's definitely ON! Bring all your family to the Home Birth Association Barbecue Party on MARCH 11th at TITIRANGI BEACH. Your chance to meet, talk with and enjoy the company of what makes the Home Birth Association - its members.

We've arranged music and we are trying to get a puppet show to go with the barbecue and the beach. The Association will be supplying free sausages and barbecue cooking facilities - just bring the rest of your food and any grog. And bring sandles for the kids - the grass has those nasty prickles in it. Directions are: - Carry on up Titirangi Rd; near the top look out for Park Rd on the left; turn left down Park Rd, and turn left again at the next intersection; carry on merrily down to Titirangi Beach. If it rains, don't worry, we've hired the hall at the beach. Bring your friends. TIME 11 p.m.

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A combined A.G.M. and Workshop is planned for May 20th, so pencil in this date in your diaries.

AN EXHIBITION OF PHOTOGRAPHS

A B I R T H

Kevin Donovan

OUTREACH 1 Ponsonby Road. 19th Feb - 3rd March

Jill Wittmer, a member of N.Z.H.B.A. has written this summary of an article called "A place of safety : an examination of the risks of Hospital delivery" by Dr. M.P.M. Richards. This article appears in a new book by Kissinger and Jones. "The Place of Birth", Oxford University Press, 1978.

Most arguments used against domiciliary confinements are based on the assumption that the hospital is always safer. However evidence to support this is not convincing. Dr. M.P.M. Richards, in 1978 examined the risks of hospital deliveries in Britain. He believes that for the 40% of mothers who are low risk and elect a home delivery there is no justification for insisting these be confined to hospital.

Dr. Richards analysed the British perinatal mortality rates, he states that this is largely determined by the incidence of low birthweight and congenital malformations. The place of delivery however, has no influence on congenital malformations and only a slight effect on low birthweight. He concludes that the place of delivery then, will have only an indirect relationship to perinatal mortality. Since the place of delivery may affect the survival of these babies it is reasonable to suppose very small babies (under 2000g) are better off in a special care unit, but the "larger prems" (2000-2500g) can be and are successfully nursed at home.

Hospital delivery is said to reduce mortality from intra uterine asphyxia and from respiratory distress but in Britain although home confinements are being rapidly reduced, mortality figures stay unchanged over the years 1958 to 1970. Within those areas which do have a 100% hospital system there appears to be no reduction in infant mortality.

Clearly it seems that with an adequate selection of high risk mothers there is no strong evidence to suggest hospital confinements should include more than 60% of mothers.

REASONS TO SUPPORT DOMICILIARY CONFINEMENT

From the mothers point of view there are major differences between home and hospital confinement. Among other things relationships in the home environment result from the needs and wishes of the individuals concerned in the delivery, not the bureaucratic structures dominated by technical efficiency. A major disadvantage of the hospital is that the healthy mother is more likely to be exposed to unnecessary intervention. Richards suggests that intervention is the thing that must arouse serious doubts about the claims of greater safety in the hospital for "low risk" mothers.

A general feature of modern medicine is that techniques that do provide benefits for particular groups of patients tend to be given wider and wider use. When a technique is applied to a group of people who have nothing to gain they will be worse off if the technique carries any risk.

Induction and acceleration of labour (active management) can be life saving in a few specific situations such as maternal toxaemea and with very over due babies. In Britain induction has risen from 13% in 1963 to 40% in 1974 yet the expected level of complications that could be alleviated by this method is around 14%. No clear medical reasons exist for the use of active management above this level.

Complications arising from the use of active management cannot be stated with certainty but available research suggests it may be associated with more caesarean sections, forcep deliveries, maternal infections, more immaturity in babies, respiratory depression and jaundice. Consequently there are more admission to special care units for babies today than ever before.

Forcep deliveries are more likely to follow from the use of epidural anaesthesia rather than the induction/acceleration technique itself, but epidural anaesthesia is usually associated with the active management technique because of the intensity of the contractions this causes. Forcep deliveries have risen and probably account for a rise in the number of lacerations even though episiotomy is used almost as a matter of routine. Because active management produces stronger and more painful contractions higher levels of painkilling drugs tend to be used. Most of these have the effect of depressing the baby's breathing at birth and inhibiting sucking during the first week. Depressed sucking makes it more difficult to establish lactation and consequently the initial relationship between mother and baby may be made more difficult.

As hospital deliveries have risen the use of drugs has also gone up. Since 1958 the use of Pethidine has risen from 56% to 68% in 1970. This is despite the more frequent use of epidurals which might well act as a substitute for other drugs.

The most common technique of active management is the artificial rupture of the membranes and the use of intravenous oxytocin, a combination which is shown to produce three times the rate of depressed babies than that found in noninduced babies. Admittedly some of these babies were already at risk but this cannot account for such a high proportion of problem babies. Undoubtedly the combination of a greater use of pain killing drugs and the more violent contractions of accelerated labour can produce more depressed babies. Foetal monitoring is used to follow the infants heart beat. This is necessary because the induction/acceleration process carries risks. The monitoring device too can give rise to complications.

Jaundiced infants have become more common in recent years, reasons for this are uncertain but it does seem that jaundice is associated with the use of oxytocin, epidurals and forceps. The rate of admission to special baby care units too are rapidly rising. Part of this can be explained by problems associated with induction. It is now reasonably well established that the separation that follows admission to a special care unit may have harmful consequences for the mother's relationship with her baby for many months after delivery.

Why is there such a rapid increase in the use of the induction/acceleration technique? Probably this happens simply because it is readily available in the hospital setting. The technology once used in life saving situations now is used so widely that it is applied to those who gain no benefit from it. The induction technique carries significant morbidity for both mother and infants yet we know that for many mothers the induction is not performed for medical reasons.

Perhaps when the complications which are created by induction, acceleration and the unnecessary admission to special care baby units are more widely known there will be a more selective use of the techniques. It is interesting to note that some of the obstetricians who were most closely involved in the pioneering of the techniques are now urging caution to their colleagues. Prof. Mantelle has stated "that birth can no longer be seen as a normal physiological process". With the facts now coming to light it is not hard to see why doctors are now viewing so many "abnormal deliveries" it appears that in many cases abnormal outcomes of the birth process have been problems created by the doctors over use of some technology. The temptations for over enthusiasm are probably greater in the obstetric side of medicine because complicated and uncomplicated cases are treated side by side while at the same time we are viewing the hospital as a place where intervention is normal. There appears to be a need for our medical profession to be more self critical in its use of certain techniques, especially with those people who stand to gain only potential risks to themselves and their babies. For this reason some women are, it seems, safer in a domiciliary confinement than in a hospital confinement. It seems there is a need for a basic change in traditional attitudes.