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MATERNITY ACTION FOCUS:

1. To oppose the unnecessary medicalisation of childbirth
2. To emphasize & facilitate the partnership between consumers and health professionals
3. To highlight the need for and availability of birth options and choices (ie.homebirth,small hospitals,birthing centres)
4. To encourage families to participate fully in their pregnancy, birth and parenting
5. To share information & ideas; and to explore alternative patterns of care

MATERNITY ACTION

Save The Midwives

MARCH/APRIL 1994

NUMBER 29

PROTECTING PARTNERSHIPS, OPTIONS AND CHOICES

Women and midwives have herstorically achieved a great deal through working together in a partnership that has acknowledged and responded to the symbiotic nature of women needing midwives and midwives needing women. But like all partnerships this one also needs ongoing nurturing and maintainance. The collective action of working together is proving to be an important part of protecting the options women have for maternity care so each woman is able to choose the options that are most appropriate for her and her baby.

The passage of the 1990 Nurses Act has resulted in a period of transition as women, midwives and other practitioners get used to the implications of the change in legislation. The timing for the restructuring of the public health system has been most unfortunate, complicating what could have been a relatively smooth transition. Midifery autonomy has essentially been restored amidst major shifts in government policy and changes to the view of public health as a right for all.

The current 'window of opportunity' market view of health services encourages an approach to care that is opportunist and entrepreneurial. This has created disturbing distractions for midwives who are now having to grapple with contracting, service specifications and collaboration versus competition. In many areas, active discrimination by CHEs against midwives has effectively undermined midwifery practice and compromised women's choices.

Women continue to experience the fallout from territorial issues and an increasing number are commenting on the presence of birth politics as a part of maternity care. Birthing options for many women are still being censored by GPs with a number of Obstetricians taking a position of refusing to work with independent midwives.

Women are often overlooked in the middle of the debate over safety, roles and budgets - yet maternity services must be women-centred and consumer-driven to meet women's needs.

The need for women and midwives to work together is very compelling.

Thanks once again to those of you who have contributed information and articles for this newsletter. Your input is always welcome.

Judi Strid

abnormalities, detecting the problem before birth did not make any difference overall, researchers reported in the New England Journal of Medicine.

CHILDREN'S ASTHMA LINKED WITH SECOND-HAND SMOKE

Tests of nearly 200 children with asthma have uncovered strong evidence that second-hand smoke causes or worsens the condition in children.

Although doctors have suspected a connection between asthma and second-hand smoke for years, the link has been circumstantial based on studies in which people were asked to estimate how much youngsters had been exposed to cigarette smoke from others. But such estimates may have been inaccurate.

The new study, published in the New England Journal of Medicine, was far more direct. A team of doctors from the state of Maine measured children's exposure to smoke by looking for telltale chemicals in their urine.

The doctors discovered that youngsters exposed to the most second-hand smoke in a year had 70 percent more attacks compared with children with little or no exposure.

The evidence that the smoke from someone else's cigarette causes asthma-related illness is sufficiently strong, and the amount of illness it causes is sufficiently severe that "systematic efforts to reduce inhalation ... are warranted for children with asthma," the doctors concluded.

BIRTH DEFECTS FROM ACNE DRUG

The Ministry of Health have formally acknowledged the link between birth defects and acne treatments containing a vitamin A derivative called tretinoin. The Ministry advises women who are pregnant or intending to become pregnant not to use the preparations. Skin preparations containing tretinoin are sold in New Zealand as Retin-A (gel, cream or liquid form) and Airol (lotion). Retinoid capsules taken by mouth as acne treatment should only be prescribed to women who are using effective contraception. They also carry strongly worded warnings.

Breastfeeding Research Information Available
From La Leche League International

La Leche League International's (LLLI) Breastfeeding Reference Library and Database houses more than 9,200 published studies in 200 subject categories covering all aspects of human milk and breastfeeding. References are added monthly to reflect the most current research available.

Services of the Breastfeeding Reference Library and Database include telephone consultations, bibliographic lists and full studies. Access is available to media representatives, health care providers, governments, educators, breastfeeding counselors, medical students, researchers and parents.

Trained staff search and interpret research data, answer questions, send published studies and refer callers to other sources of information. LLLI consults members of its Health Advisory Council on challenging medical problems and evaluation of conflicting research. The organization is additionally supported by the many doctors throughout the world who serve as Medical Associates of La Leche League International.

For more information about services and fees of the Breastfeeding Reference Library and Database, please call LLLI at 708/455-7730 or write to LLLI, Breastfeeding Reference Library and Database, PO Box 1209, Franklin Park, Illinois 60131-8209 USA.

CVS RISKS TO BABIES

CVS is used to collect cells from the developing placenta which, when analysed, can reveal whether a fetus carried one of a number of genetic or chromosomal abnormalities.

A woman who gave birth to a child with a deformed limb after having a chorionic villus sampling (CVS) was so convinced there was a link that her persistance prompted geneticist Helen Firth to conduct a study that forced the medical profession to think again.

In December 1992, a small group of eminent obstetricians, geneticists and epidemiologists met to take stock of research findings since Frith's study. The evidence, they concluded, strongly suggests that CVS carried out in the first nine weeks of pregnancy can cause limb defects. They made the following recommendations:

1. CVS should not be carried out before nine and a half weeks' gestation
2. more research is needed into the damage done to the placenta

(From New Scientist, April 1993, reprinted in CHF, Australia Newsletter No.26)

ULTRA-COSTLY PICTURES

ULTRASOUND, the widely used imaging technique that allows doctors to view a baby in the womb, may be a waste of money during routine pregnancies, a United States report has found.

The study - the largest conducted of ultrasound examinations - found that the procedure did not increase the chances of having a healthy baby among more than 15,000 women who had low-risk pregnancies.

Even when foetuses did have

DEM UPDATE

Approval by the Minister of Education for further intakes into the direct entry midwifery programme has resulted in a third group of students commencing training as midwives at Otago Polytechnic and the Auckland Institute of Technology.

Funding for these intakes is dependent on approval from the Minister because of the experimental status of direct entry midwifery in NZ. Intakes will continue until the formal evaluation of the courses is completed. The timeframe for this to be completed is by the end of 1995.

Considerable collective effort was made by women and midwives around the country to emphasise the importance of the courses and MPs generally were made well aware of the strong community support for direct entry midwifery to continue.

The first graduates from the 3-year direct entry courses in Auckland and Dunedin will become registered midwives at the end of the year. Not surprisingly, demand for places on the two courses continues to be high.

FROM THE COLLEGE OF MIDWIVES

NZCOMI EDUCATION WORKSHOP

Manuwatu Polytechnic, Palmerston North 18-20 May 1994. Observers are welcome to attend the National Committee meeting which will be held from 10am-6.30pm on the 17th, the day before the workshop begins.

Workshops will be held on education and research issues; the direction of the College; midwifery scope of practice; independent practice; development of competencies; standards review; quality assurance and legislative issues.

The workshop will be followed by a seminar involving Prof. Murray Enkin, Joan Donley, Bronewn Pelvin and Karen Guilliland.

For further information, contact your local branch of the COM.

PUBLICATIONS

The NZCOM Breastfeeding Book is a must for both women and midwives. Called Protecting, Promoting and Supporting Breastfeeding the book provides up-to-date and accurate information. The cost of the book is $19.95 or $22 including P&P.

The NZCOM Handbook for Practice is available for $5.

Maternity Action/Save The Midwives - Number 29 - 1994

It is something every midwife should have and is relevant to consumers as well. It outlines the scope of practice of the midwife, standards for practice, guidelines for referral and the complaints mechanism.

To order these publications and to join the College of Midwives (there is a special rate for consumer membership) write to the Board of Management, PO Box 21-106, Christchurch.

PUTEA O PUA

The Tamaki Makaurau (Auckland) based Maori Midwives Collective is an independent collective which brings together a wide range of skills and expertise both cultural and professional.

They are supported by whanau, hapu and iwi and the wider community and have a shared vision to reduce the health risks of Maori women before, during and after birth.

The midwives have double registration and their collective experience spans the plunket, public health, practice nursing services. Some have additional post graduate qualifications and others have been founding members of the National Council of Maori Nurses and the Maori Health Foundation - He Puna Ora. Some members also have research experience and have intentions to pursue this further in order to enhance their practice.

The Maori Midwives Collective provides consultancy and professional links with other organisations and agencies involved in the management and delivery of pregnancy and childbirth services, such as other independent midwives, parents centres, maternity action groups, independent nurse practitioners, GPs, obstetricians, home birth associations, health promotion agencies, kohanga reo, marae trusts, runanga, maori health centres, maori training centres, cultural groups, maori women's organisations, and others.

The Collective offers:

* Continuity of care for Maori and other women antenatally, intrapartum and postnatally.

* Twenty four hour, mobile, seven days a week coverage.

* Individualised, customised and culturally safe material and midwifery services.

* Antenatal and parenting education.

* Delivery at home, hospital, on a marae, clinic or centre.

* Appropriate follow-up, referral and other support services.

3. Central nervous system dysfunction: including mental retardation, irritability, short attention span, hperactivity, developmental delays and long-term learning and behavioural problems.

Foetal Alcohol Effects occurs when there are some, but not all, of the symptoms required for a FAS diagnosis. Symptoms frequently include low birth weight, and behavioural and learning problems.

INCIDENCE AND RISK FACTORS

- Prenatal alcohol exposure is one of the leading known causes of mental retardation in the Western world, yet it is entirely preventable.

- Based on overseas statistics, between 20 and 114 babies may be born with FAS in New Zealand every year. (Worldwide incidence rates for FAS range from 0.3 to 1.9 per 1000 live births.) FAE is more difficult to diagnose, but it is far more common than FAS.

- New Zealand has the highest rate of teenage pregnancies in the developed world. Alcohol is a major factor in many teenage pregnancies.

- One in four women aged 18 to 24 drink more than four drinks on one occasion. They drink at this level at least once a week.

- The probability of having a child with FAS or FAE increases with the amount and frequency of alcohol consumed. Stopping or reducing drinking during pregnancy increases the chances of having a healthy baby.

BITS & PIECES

BREASTFEEDING BENEFIT

Infants who are breast-fed for the first four months have half the number of ear infections as those who are not. The American Academy of Paediatrics recommends that exclusive breastfeeding should continue at least 4-6 months after birth.

No NZ hospital has yet managed to meet the standard required to become a WHO recognised baby-friendly hospital. There is a need for:

- all hospitals to formulate policies that ensure the WHO criteria is met;
- the establishment of a process to monitor the above
- all maternity units to employ a lactation consultant to provide all maternity staff with up-to-date, accurate and valid information on breastfeeding.

AUSTRALIA

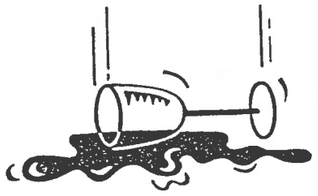
Congratulating Henny Ligtermoet

The Rockingham Woman of the Year Inaugural Award was presented to long time birth campaigner and writer Henny Ligtermoet on the 8th of March 1994. The award was given by the Women's Health & Information Centre in recognition of the services of a local woman to the community.

Community Based Midwifery Pilot Project

The Community Midwives of Western Australia and the Birthplace Support Group have negotiated with the Health Department of Western Australia to obtain a grant to run a 12 month pilot project. The project will provide community midwifery services to women who wish for a home birth, subject to meeting defined criteria. The service is to operate in such a way as to enhance access by women from non-English speaking and Aboriginal backgrounds.

The Birthplace Support Group are to be the administrators of the project, which will be run from the Midwifery & Natural Childbirth Centre in Leederville. The Health Department require a large amount of statistical data and extensive quarterly reports from the project.



ALCOHOL-RELATED BIRTH DEFECTS

Prepared by Alcohol Healthwatch

Drinking alcohol during pregnancy may cause permanent birth defects. All alcohol passes freely across the placenta to the foetus so that the blood alcohol levels in the foetus are similar to those of the mother. Although not all babies are harmed by prenatal alcohol exposure, it is impossible to predict which babies will be affected and which babies will not. Many women, however, are not aware of the potential dangers of drinking during pregnancy.

The effects of prenatal alcohol exposure exist on a continuum. Foetal Alcohol Syndrome (FAS) can result from heavy alcohol use throughout pregnancy, while Foetal Alcohol Effects (FAE) may occur from either heavy or more moderate levels of alcohol consumption.

<u>Foetal Alcohol Syndrome</u> is characterised by a cluster of birth defects that include at least one feature from each of the following categories:

1. **Prenatal and postnatal growth retardation:** Babies are typically underweight, small in body length and lack 'catch-up' growth.

2. **Characteristic facial malformations** such as small head circumference, flat midface, small eyes, thin upper lip, short upturned nose and indistinct philtrum.

COMING EVENTS

This year is also **The International Year of the Midwife** as well as the International Year of the Family. **International Midwives Day** always falls on the 5th of May.

PRIVACY ISSUES FORUM
Organised by the Office of the Privacy Commissioner - 12 May 1994. University of Auckland. The fee of $395 includes GST and covers attendance at all sessions, morning and afternoon teas, business lunch, conference papers and the evening cocktail function at Old Government House. A number of overseas speakers are included on the programme which deals with privacy laws; public attitudes to privacy; family information issues including adoption; assisted reproduction and child abuse; privacy and disability; workplace privacy and the handling of privacy complaints.

MURRAY ENKIN TOUR
Professor Murray Enkin - Obstetrician, Epidemiologist, Researcher, co-author of **A Guide to Effective Care in Pregnancy & Childbirth** and Director of the Cochrane Centre (Pregnancy and Childbirth Database) will be visiting a number of places in NZ.

18 May - Auckland
21 May - Palmerston North
24 May - Wellington
26 May - Christchurch
28 May - Dunedin

Contact the College of Midwives for further details.

NATIONAL WOMEN'S HOSPITAL SATURDAY SEMINAR SERIES
The next seminar on the 28th of May will have a special focus on VBAC vaginal birth after caesarean. Held at the NWH Floor 1 lecture theatre 8.30am-10.30am.

WHANAU FAMILY HEALTH
A national conference organised by the Manawatu-Wanganui branch of the Public Health Association (PHA) on generational cultural and gender issues in health. To be held on 31 May to 3 June 1994 at the Palmerston North Conference Centre.

MIDWIFERY TODAY
1st Annual East Coast Conference
8-11 September 1994
New York, USA

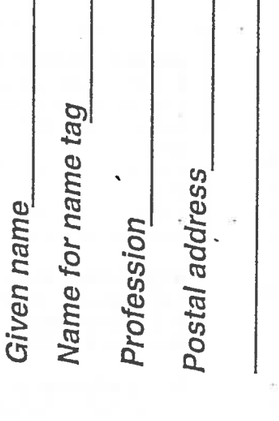
For information write to:
Midwifery Today
PO Box 2672
Eugene
Oregon 97402
USA

INTERNATIONAL YEAR OF THE FAMILY CONFERENCE
To be held in Auckland on Dec 1-3. To go on to the mailing list and for more information contact:
Moira Ransom, IYF Committee, Private Bag 21, Wellington ph (04)473-5872 Fax (04)474-3426.

24th TRIENNIAL INTERNATIONAL CONFEDERATION OF MIDWIVES (ICM) CONGRESS
Held every 3 years, the next ICM congress will be in Oslo, Norway 26-31 May 1996. For further information write to
Team Congress
PO Box 6
N-6860 Sandane
Norway

UNIVERSITY OF AUCKLAND
DEPARTMENT OF OBSTETRICS
with the
NEW ZEALAND COLLEGE OF MIDWIVES
AUCKLAND REGION

presents the



Wednesday 18 May

Music Auditorium
College of Education
Gate 2
Epsom Avenue Epsom

$50.00 students $35.00

PROGRAMME

0830 Registration

0900 Professor Murray Enkin*
"Taking the Guesswork Out of Maternity Care"

1015 Morning Tea

1045 Panel Discussion
"What is Effective Care of the Low Risk Woman in the Nineties ?"
Professor Gillian Turner
Midwife Sarah Hodgetts
Midwife Carolyn Young
Professor Enkin
Professor Mantell

1300 Finish

*MD FRCS (L) FACOG
Outstanding critic and author of many publications including co-editor of "Guide to Effective Care in Pregnancy and Childbirth"

Registration Form

Surname_____Title___

Given name_____

Name for name tag_____

Profession_____

Postal address_____

_____

_____

Telephone (STD)_____

Fax_____

Please complete and cut off registration section enclosing $50 before May 14 1994
Send to: G. E. Stimpson
3/28 Findlay Street
Ellerslie
Phone (09) 525 3437

calculated that if the rate in 1991 had been 15 instead of 23.5, the number of caesareans would have decreased by 349,000 resulting in savings of more than $US1 billion in physician fees and hospital costs.

The US government has set a goal of reducing the number of caesarean births to 15 or less per 100 by the year 2000.

The CDC also described caesarean birth as the most common major surgical procedure for American women and accounts for about one million births in that country per year.

Health `Reforms' and Maternity Care

A recent Midwives Association of Washington State newsletter reports on how the health `reforms'are likely to affect midwives. After July 1995, the uniform benefits package and supplemental benefits will only be offered by certified health plans. All maternity care will be provided through managed care systems. Many insurance companies, hospitals and provider groups are creating managed health care plans that will evolve into the certified health plans.

A managed care system integrates insurance, finance and health services delivery. Instead of the fee-for-service system where a practitioner is paid for services provided, practitioners in a managed care system are employed or contract with an organisation which provides care. The reimbursement level is set by the organisation. Most managed care systems use primary care providers, usually a GP as the `gate-keeper'. The primary provider is paid a set amount of money to provide care to a set number of people each year. The expectation is that the practitioner will provide the most cost-effective care.

The transition to managed care is underway. Medicaid has contracted with managed care plans in 13 countries to provide care for eligible clients. Hospitals are making arrangements with provider groups to develop their own Certified Health Plans. Providers are organising specialty and multi-disciplinary groups to gain more power in contracting with Certified Health Plans. MAWS notes that no one is quite sure what this new system will look like - but everyone is very uneasy.

Midwives are collectively working together to monitor what is going on and to collect information about health plans. A basic plan has been developed for the establishment of an Independent Midwives Association that could contract with Certified Health Plans.

(This all sounds very familiar despite being assured we are not going the American way!)

The main conclusion of a Health Action International (HAI) study on research into contraceptive `vaccines' is that it should stop because it entails serious risks to women's health and rights.

Judith Richter, author of Vaccination against Pregnancy, describes the methods as working in a totally new way by tricking the body into attacking a natural part of reproduction in the same way it would attack a germ. This type of reaction would normally be considered an auto-immune disorder. The long term health risks for women, and for children accidentally exposed before birth are unknown.

The book Vaccination Against Pregnancy: Miracle or Menace? is available from Health Action International - Europe, Jacob van Lennepkade 334T, 1053 NJ Amsterdam, The Netherlands.

(From CHF, Australia No.26 & 27 newsletters)

START SMART CAMPAIGN

The drug company Schering is sponsoring a campaign to reduce the country's high number of teenage pregnancies. Each year over 10,000 NZ women under 20 become pregnant, a rate second only to the United States in the Western World. The campaign features a freephone service for teenagers who are becomming sexually active, and a series of counselling aids for doctors.
The 24-hour freephone provides general contraceptive information, as well as alerting teenagers to the dangers of sexually transmitted diseases.

OVERSEAS

USA

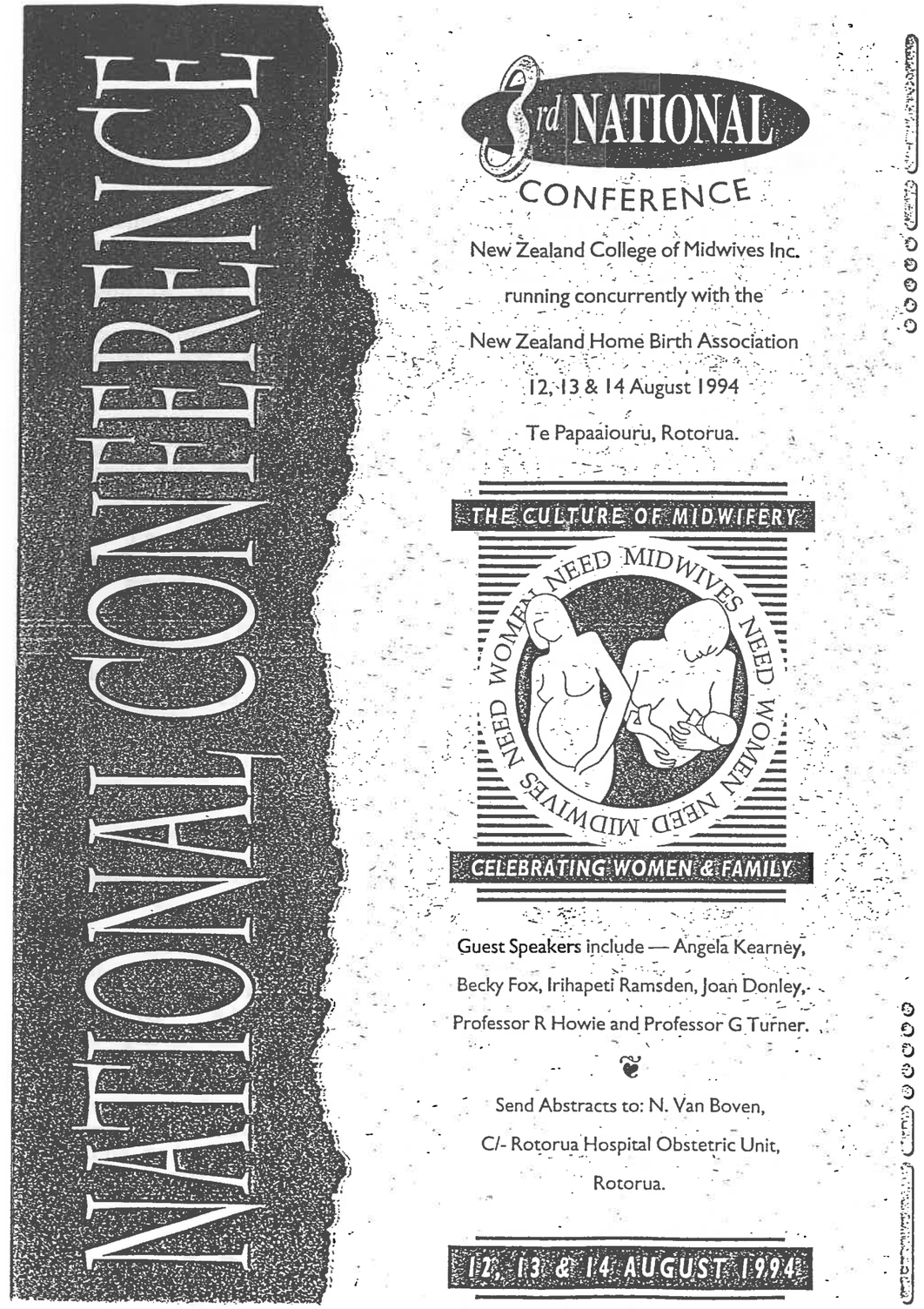
Seattle Midwifery School

The Seattle Midwifery School has become the first midwifery school in the USA to be accredited by a national accreditation body. The Accrediting Council for Continuing Education (ACCET) granted a 2-year accreditation after years of lobbying and effort. This is seen to be a significant step towards putting midwifery back on the map in the USA.

Unnecessary Caesareans

A US health agency has stated that at least 349,000 caesareans carried out in 1991 in the United States may not have been medically necessary. This amounts to a direct cost to the US health system of more than $US1 billion or $NZ1.82 billion. (The indirect costs associated with the trauma of a caesarean and the subsequent increased likelihood of having repeat caesareans were not considered in this report.)

The Centres for Disease Control and Prevention (CDC) have stated that 23.5 births out of every 100 were caesareans. They have



Maternity Action/Save The Midwives - Number 29 - 1994

INTERNATIONAL YEAR OF THE FAMILY (IYF)

New Zealand's IYF Committee has developed four themes for the International Year of the Family and these are to guide the year's activities.

1. **`Home, Family and the Community'** covers the status and diversity of the family in modern society; roles and contributions to family life, issues such as violence and the role of the family in the neighbourhood and the community.

2. **`Families Valuing Learning'** involves parenting and family skills; creating a learning environment in the family as well as valuing education and learning for all family members.

3. **`Families and Fun'** focusing on making quality time for family recreation as well as activities for whole families and across generations.

4. **`Reaching Families'** has the aim of identifying services and service gaps; encouraging positive attitudes to seeking help and communicating with families.

At the official launch of the IYF, the Director of UNICEF programmes described this focus as an opportunity to develop a fuller understanding of the rights and responsibilities of todays families: and a clearer sense of the actions needed from governments and employers, from non-government groups and communitites, to strengthen the best of family structures in a rapidly changing world. His 5 points for priority action are:

1. Promotion of more equitable partnerships between men and women
2. A more active role for fathers in child-rearing
3. Encouragement of communities to develop effective means for supporting families
4. Development by governments of comprehensive family support programmes which include parental leave, high-quality and affordable child-care, support for breast feeding mothers, stronger measures for enforcing child support entitlements and special provisions for poor families
5. Encouragement of international organisations and governments to view families as among their most important partners, the first line of defence and protection against all obstacles to human well-being and the building blocks for communities.

facilities. Like the Waikato situation, midwives working for the CHE are denied access contracts even though obstetricians in the same situation are not. To qualify for an access agreement, a midwife must first have worked for the CHE. This condition does not apply to doctors. Existing contracts are being renewed on a bi-monthly basis which is a bizzare approach considering pregnancy lasts about 9mths! A woman could discover her midwife no longer has a contract when the time of birth arrives.

Otago
Queen Mary Hospital in Dunedin have announced their intention to charge women who have independent midwives for antenatal classes and lactation consultancy. These services were previously available to all women at no cost. Hospital postnatal beds and services are no longer available for women who have an independent midwife.

West Coast
Coast Health Care CHE have denied access to a domiciliary midwife for use of facilities at Grey Hospital because she lacked experience working at the hospital!

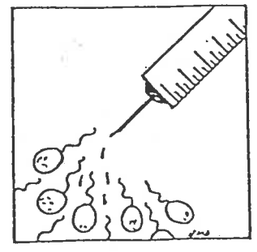
Paraparaumu
Women who have a midwife as their caregiver are being denied postnatal facilities at Paraparaumu Hospital.

Christchurch
St. Georges Hospital in Christchurch excludes all independent midwife practitioners from using their facilities.

The College of Midwives has expressed increasing concern at the number of other hospitals that are also planning similar restrictions. Two CHEs are reported as saying they are developing strategies to halt independent midwifery practice and reduce competition for funding. Most CHEs are taking the position that a CHE bed no longer belongs to the woman who brings her chosen provider with her, but as beds which belong to the CHE business structure.

IN THE NEWS

VACCINATION AGAINST PREGNANCY
A new contraceptive is currently being researched. It works through immunisation of women against pregnancy. Women in developing countries are the main target for this vaccination. Tests have been carried out on women in India, Finland, the Dominican Republic, Chile and Brazil and are soon to commence in Sweden. Researchers estimate that a product will be ready for marketing in 5-10 years.



midwife run the risk of being intimidated by doctors from the only medical practice in the area. Doctors have rung women at their homes to hassle them and have threatened to withdraw services to the whole family if they choose a midwife instead of the doctor.

Of equal concern has been the attitude of the RHA, North Health. Instead of using their authority, which is presumably part of being a funder, to insist the medical practice meet certain standards of behaviour, the RHA chose as their initial response to side-step the issue. They even had the audacity to suggest that a complaint be made, by the women, to the medical practice so the practice could investigate the matter! If this didn't prove worthwhile, the RHA suggested trying the Medical Practitioner's Disciplinary Committee. So those of you who thought the RHA and their contracts would bring these sorts of problems into line need to think again!

CHE RESTRICTIONS ON MIDWIFERY PRACTICE

A number of CHEs have been in the news over their attempts to place restrictions on midwifery practice, which obviously impacts on options available to women. The College of Midwives has taken steps to inform the Ministers of Health and Crown Health Enterprises; the Human Rights Commissioner; and the Commerce Commission about the active and very blatant discrimination going on. Complaints have been lodged with both the Human Rights and Commerce Commissions.

Waikato

In the Waikato, independent midwives (and only midwives) attending births at Waikato Women's Hospital in Hamilton are being charged for using the CHE facility. Established midwifery practitioners are being prevented from renewing their contracts if they are also employed part-time by the CHE, and no new access contracts are being granted. It is interesting to note that most obstetricians are employed and have practices as well, yet they are not denied access or forced to resign like midwives are. Midwives are also denied car parking at the hospital which provides this service for doctors.

Auckland

Private obstetricians in Auckland are refusing to work with independent midwives. This means that `at risk' women requiring specialist consultation can only obtain this through a public hospital clinic with whoever is on duty. Many women prefer to have their consultation with a selected obstetrician so they know the person they are dealing with in advance if specialist input is required at or before the birth.

Gisborne

Tairawhiti Health Care, the CHE responsible for Gisborne Hospital have refused to issue any new contracts for midwives to access their

THE CAMPAIGN FOR PARENTAL LEAVE DURING THE UNITED NATIONS INTERNATIONAL YEAR OF THE FAMILY

Working Women's Resource Centres around the country are organising collective action on parental leave to coincide with the 1994 International Year of the Family. There is no statutory entitlement in New Zealand to paid parental leave. In this regard NZ lags behind most of the world where some form of paid leave is now taken for granted.

The Department of Labour is about to embark on a review of the Parental Leave and Employment Protection Act. The report is due out in the middle of the year so there is a need to highlight the importance of this issue as soon as possible.

The Present Situation on Parental Leave

Parental leave is unpaid leave from the workplace to care for a child. Both men and women are entitled to this leave before, during and after the birth or adoption of a child. Parental leave may last up to 52 weeks and includes maternity leave, paternity leave and extended leave.

Maternity leave is unpaid leave of up to 14 weeks for pregnant and adoptive mothers. This leave can be taken from 6 weeks before the birth, or earlier in some situations.

Extended leave can be taken by either or both partners to care for a child after birth or adoption. This leave is also unpaid and may last up to 52 weeks inclusive of maternity leave.

Paternity leave is unpaid leave of up to 2 weeks available to the male partner about the time of the birth or adoption of a child.

Special leave is additional unpaid leave of up to 10 days available to the pregnant woman only for reasons directly connected with the pregnancy. These could include antenatal appointments or childbirth preparation classes.

The Parental Leave and Employment Protection Act 1987 defines the minimum conditions. Some employment contracts include special provisions for parental leave.

Eligibility

* if you are pregnant
* if your partner whom you live with is pregnant
* you are adopting a child under 5
* you will have been employed by the same employer for at least 12 mths at the expected date of the birth
* you have been employed to work at least 10 hours per week

What happens to your job?

1. Your job must be kept open (except if you are being made redundant) for leave of less than 4 weeks if it is the first leave taken for this pregnancy or birth. The employer must prove that the job is too important to keep open for longer periods of leave. A replacement worker can only be hired on a temporary basis and must be told that the job is temporary.

2. If you agree that your job cannot be kept open when you leave, your employer will give you a preference period of 6 months after your leave finishes. During this preference period the employer must offer you any job, similar to your old job which becomes vacant. You must take up the job within 7 days of the starting date set by the employer.

3. If pregnancy prevents you from doing your job properly or safely, your employer may temporarily put you in another job. If no other suitable work is available you may be asked to start your leave early. If this happens, you are still entitled to 8 weeks leave after the baby is born. In this situation the extended leave will not be reduced.

You cannot be dismissed from your job if you are pregnant, intend to take parental leave, or while you are on parental leave.

Giving adequate notice
Parental leave must be applied for in writing giving the employer 3 months notice. Extended leave can be shared between both parents and can be applied for at any time during your child's first year, even after the baby is born.

You must give 21 days notice of any change to what you have stated in your application. At least 21 days before your leave ends, write to your employer, giving the date you intend to return to work or start your preference period. You should also give 21 days notice before the end of your parental leave if you decide not to return to work.

Returning to work early
If you miscarry or your baby is stillborn or dies or is adopted, you are entitled to return to work or start your preference period early. Write to your employer giving 21 days notice. of your attention to return to work. Your employer may agree to you coming back to work earlier in other circumstances too.

Complaints
The Act sets out procedures for dealing with complaints relating to Parental leave rights. Contact your employees' organisation, if you belong to one, or the labour inspectors at your local office of the Department of Labour for

establishment of an environment where providers can work together. As well as providing no indication as to how this might be achieved, such a suggestion is contrary to the notion of competition and contestibility which is supposedly being promoted by RHAs! Possible consumer-centred recommendations have been overlooked in place of setting up protocols and guidelines that ensure equity of access for all women!

RISK LIST HEARING
RHAs have been presented with the responsibility for paying those practitioners who currently receive the maternity benefit, as payment for maternity care provided. The RHAs do not favour the present mode of payment which is fee for service and have an objective of controlling expenditure growth. They plan to put a ceiling on the amount spent on maternity services and are presently exploring ways of doing this. One strategy which has come under considerable criticism is the development of a maternity risk list which details when and with whom consultations and referral should take place.

The promotion of risk lists is a threat to women's choice and in conflict with the whole notion of informed consent. A risk list categorises women rather than recognising the uniqueness of each labour and birth and promoting individual assessment. Such lists also undermine professional education and training. Midwives and doctors are trained to recognise when there is a deviation from the norm and to consult or refer (hopefully in consultation with the woman concerned) when the situation is beyond their scope of practice.

However, despite opposition from women, midwives and GPs, the joint RHA project team have proceeded with the development of such a list and a hearing was held in April to determine the particular areas of difficulty with an itemised list of 248 risks.

Further drafts of the risk list are expected and although core health service and RHA personel have made assurances that the list will be a guideline only - women's groups and practitioners fear the list will become policy and the basis for payment. If these fears are realised, a woman who has had a previous caesarean section, for example, could have trouble getting midwife only care. The present risk list draft insists VBAC women see a specialist. There are fears the options could end up with women having to pay for their midwife if the risk list prevents the midwife being paid for care to such a `high risk' woman. Alternatively, midwives could find themselves not being paid for care provided to `high risk' women.

MONOPOLY CONTROL IN WELLSFORD
Pregnant women in the Wellsford area who want to book with an independent

informed consent.

The recommendations are often very general and vague. For example, one recommendation states `..promoting policies which allow for positive health impact.' It is disppointing that although the report notes difficulties for geographically isolated women, the only recommendation is that the RHA pay attention to their needs.

Although the report supports continuity of care and recommends that contracts specify how continuity will be meet, there is no definition of what continuity actually means. The document implies that co-ordination by the `contracted principal practitioner' means continuity criteria has been met.

The report does reflect widespread concern about the lack of balanced information so women are in a position to make informed choices. It doesn't mention how `balanced' will be defined and doesn't acknowledge the support for consumer groups to be funded to provide this information or the strong consumer call for an 0880 maternity information hotline.

One recommendation has implications for homebirth services and other services that provide specific rather than general maternity care services. The recommendation advises the RHA to purchase services from providers who can meet a range of needs. The irony of squeezing out the home birth option is that it is one of the few existing ways of achieving continuity of care.

A statement that there was consensus amongst consumers and providers for all women to be entitled to the option of one ultrasound scan at 18 weeks is blatantly untrue. A number of the groups consulted by C&L voiced their opposition to the routine use of ultrasound, recommending it only be carried out when there is a justifiable medical indication. Some groups also made reference to the position of the World Health Organisation which recommends the use of ultrasound only where medically justified. Groups who participated in the process have reported that when they raised concerns about the wasteful use of maternity funding on ultrasound without any medical indication, C&L interviewers stated they were hearing such comments all the time.

This false statement on ultrasound raises issues of credibility for the rest of the report. It is also a failing that the report does not provide some direction on the inappropriate use of technology such as ultrasound scanning.

The report documents the territorial battleground going on amongst the different groups of maternity practitioners. The report then goes on to recommend that RHAs support the

information about complaints procedures.

Parental leave guarantees an unbroken service record with the employer. Further information about these entitlements are set out in the Parental Leave and Employment Protection Act 1987. Contact the nearest office of the Department of Labour for more detailed information.

UPDATE ON ORGANISATIONS

Auckland Maternity Services Consumer Council

The Auckland Maternity Services Consumer Council (MSCC) is a consumer based organisation made up of 78 community groups with an interest in maternity services provided in the Auckland region. Last year, the MSCC undertook to develop quality indicators for Auckland maternity services and produced a detailed report of the same name. Quality indicators are specific requirements needed to obtain a high standard of service.

The work was paid for through a contract with the Northern Regional Health Authority (RHA). The report provides a consumer perspective on the whole birthing continuum and includes quality indicators on:

- preconception
- pregnancy
- labour & birth
- postnatal
- policies, guidelines & protocols
- teaching
- research

The project involved extensive consultation with the MSCC member groups and a number of themes emerged. These were:

1. availability of maternity care
2. information & education (for children, women & health professionals)
3. continuity
4. respect for rights/informed consent
5. consultation & consumer input
6. cultural safety
7. flexibility
8. provision of services within the home and within the community
9. holistic approach
10. validation of procedures
11. co-ordination

Plunket Society

Plunket have established a free telephone service to offer parents advice on child health. The new service, available nationwide, is staffed by experienced Plunket nurses from a Wellington base. It will operate 7 days a week, initially between 4pm-1am, extending to 24 hours in October.

FEDERATION OF WOMEN'S HEALTH COUNCILS AOTEAROA-NEW ZEALAND

The Federation is the only national women's organisation with a specific focus on women's health. To contact the women's health council or affiliated women's group in your area write to CPO Box 853, Auckland (ph 09 520-5175, fax 09 520-4152. Information papers are also available from this address.

Just released hot off the press.....

Using Medicines Wisely: A Guide for older people & caregivers (bound B5 size) $2 plus $1 p&p

Spiral bound copies of the following papers are also available:

Accident Compensation: A Women's Issue
Compiled by Sandra Coney $6

Ensuring the Cervical Screening Programme Survives the Health Changes $6

Consumer Consultation, Representation and Participation $5

Abortion Services and the Health Changes $8

In Recognition of Older Women
Compiled by Audrey Fenton $8

A Health Commissioner for New Zealand $8

T-shirts in mauve with the **WOMEN BE STRONG** pictorial logo are available in a range of sizes (S,M,L,XL,XXL) from the Federation for $25.

RESTRUCTURING OF THE HEALTH SYSTEM AND THE COST TO MATERNITY CARE

MATERNITY BENEFITS
From 1 July 1993 maternity benefit services became the responsibility of the RHAs. The RHA now use Section 51 of the Health and Disability Services Act to offer terms and conditions of payment to medical practitioners and midwives. The new scale of fees resulting from the recommendations of the Maternity Benefits Tribunal has been incorporated into RHA payment arrangements.

The RHAs consider this situation to be a very temporary arrangement and are presently involved in discussions with provider and professional groups for the purpose of developing a different funding system.

ACCESS AGREEMENTS
11 crown health enterprises (CHEs) have collectively commissioned a legal firm to provide them with a legal opinion on the range of options for dealing with independent practitioners. The report is a lengthy and detailed one that outlines the responsibilities that CHEs would legally be considered to have when independent practitioners use their facilities. It seems unlikely that the preferred arrangement for women and independent practitioners of access to facilities only, will be a CHE choice.

Midwives (and particularly student midwives) are becomming increasingly concerned that the CHE access agreements may require work in hospital for a set period of time and a mimimum number of births per year.

COOPERS & LYBRAND REPORT ON MATERNITY SERVICES
The Coopers & Lybrand report to the RHAs called `First Steps Towards an Integrated Maternity Services Framework' (November 1993) is regarded by the joint RHA working group to be the first step towards changing the way in which maternity care is provided and paid for. The report will have implications for future maternity services so you may wish to obtain a copy.

To receive copies of the Coopers & Lybrand report contact the RHA for your region.

The C&L report looks at maternity services RHAs should purchase to ensure quality birth outcomes, as well as some contractural requirements. Consumer views are not always properly represented and recommendations are not consumer-centred. The majority of those interviewed represented health sector providers. Some of the recommendations require providers to take on roles currently provided by community-based consumer groups.

Although the report does reflect most of the key issues, it is very general and provides only a framework. There is nothing new so the report has not provided any advance for maternity services. Some groups have been critical of the use of resources to state the obvious!

The report strongly advocates the need for a national perinatal database as an essential tool for maternity services. This sort of database could provide women and midwives with important and accurate information relating to maternity matters, although it is important that the `right' information is collected. It is interesting to see that the C&L report notes the differing views of maternity providers on principles and practices but without a database, there is no satisfactory way of assessing all the varying claims. Consumer groups have emphasised the need for appropriate confidentiality safeguards and for consumers to have easy access to the aggregated data.

Although C&L abandoned the task to develop a single protocol for good maternity care, the interest and intention in developing such rules and regulations is noted in the report. Although protocols are important for medical situations such as the proper way of carrying out a caesarean or giving an epidural they are not appropriate for normal pregnancy and birth and are likely to conflict with women's choices and right to