IN THIS ISSUE:

SAVE THE MIDWIVES: a magazine by and for people interested in childbirth

OUR NEXT MEETING: MON JULY 16, 8pm.
24 ASHTON RD MT EDEN

SAVE THE MIDWIVES ASSOCIATION SUBSCRIPTION FORM

NAME: _____

ADDRESS: _____

mother _____ midwife _____ or _____

post to the secretary, STM, 24 Ashton Rd., Mt Eden, Auckland. sub: $2 p.a.

SAVE THE MIDWIVES

volume one

number three

winter 1984

special topic:

MOTHERING

COSTS - for Marion.

CONTENTS

IN THE NEXT ISSUE :

" just imagine...

an acute post-natal ward in a busy consultant hospital in England with 4,000 births per annum.The midwife is in sole charge with the help of one nursing aide and one nursery nurse to care for the babies. There are 25 mothers and babies in this ward, all of whose deliveries were not normal; that is, forceps and caesarean sections; patients with medical problems such as diabetes, epilepsy and asthma; and those with obstetric complications such as post partum haemorrhage.

On this particular day eight patients were recovering from C-sections requiring the total nursing care involved in intravenous infusions , Redivac Drains, catheterization, aseptic care of wounds and removal of sutures.One patient is diabetic requiring careful monitoring of blood sugars and insulin regime and another patient is receiving an intra-venous infusion of blood to correct post-partum haemorrhage".

...this is an account of the work of a direct-entry midwife, sent to us in response to a statement made by midwife Maureen Lawton in the last issue of Save The Midwives, that" (the direct-entry midwife) is not necessarily unsafe, but she lacks a depth of knowledge and understanding that will enable her to give the highest quality of patient care". This account will be published in full in our next issue, Spring 1984.

Also in the next issue ;

Amniotomy

Ultrasound

the Effect of Emotional Disturbance on Labour

Maternity Hospitals in Auckland- Policies and Practice.

An open invitation is extended to any member to submit articles for selection for the Spring issue - the special topic for that issue is CHILDBIRTH.

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NEWS & EVENTS

■ the Mental Health Foundation he granted Save The Midwives $200 towards the cost of the next newsletter.The newsletter could not have been printed without it, as the $2 sub charged has been too low to cover costs,so we are very grateful to the Foundation for this assistance.

■ Due to lobbying by the Midwives Section of the NZNA, support for midwifery training within the Advanced Diploma of Nursing (the technical institute course) has been withdrawn.At the NZNA conference in April this year the following remit was put : "that the course of study, in a technical institute, leading to the Advanced Diploma of Nursing and midwifery registration, be retained" & was defeated. This is enormously encouraging to those who believe that midwifery should be taught in a separate course.Continued lobbying will be necessary to ensure that it actually eventuates.

■ Auckland Parent's Centre is holding the following functions in June/July: Cottage evening, Preparing For Another Child, June 28, 7.30 pm, at the Mt Eden Methodist Church Hall, cnr Mt Eden Rd and Ngauruhoe St.
:Discussion Evening,Preparing Your Child For School, June 27, 7.30pm at 35 Henley Rd, Mt Eden.
:Antenatal class, July 12,Meadowbank Family Support Unit.
:"Early School Years", a 4-week course, to be held on Wednesdays at 7.30. Starting date and venue are yet to be finalised.
For more information phone Bobby Wakenell on 606 467.

■ The Auckland Home Birth Association is holding a seminar on Parenting on July 8, 2pm, venue 56 Ranfurly Rd,Epsom(the Manukau Rd end of the street) This will take the form of a panel discussion, with a single parent, a home birth father, and a mother participating. Creche available.Teaandcoffee.

■ The Otago Childbirth Education Association has been formed by Dunedin midwife Adele Birkbeck.Their first meeting was attended by Sheila Kitzinger. For more information write to Adele at 25 Selkirk St, Dunedin.

■ Auckland's La Leche League is feeling very post-natal, as it were,after their very successful area conference on Pakatoa Island, where they had so many participants that they booked out the entire island! The Christchurch area conference will be held on 23 August, and the contact person for that is Jillian Somerville, 31 Belmont St,ChCh 7, ph 880 041.

...editorial

The Nurses Association is a union which acts in the best interests of nurses. As the support of the Association for the Nurses Amendment Bill clearly showed, this does not include midwives. The apparent intention of the NZNA is to eventually eliminate the midwifery register and relegate the care of women in childbirth to obstetric nurses, reducing maternity care to a medicalised model, as is the case in the U.S.A. and Canada.

In both these countries there are strong parent protest groups working to restore the midwife to her former status; that of an independent, highly valued, professional caregiver. In this country, too, parents and midwives have begun to realise the eventual consequences of accepting the replacement of the midwife by the obstetric nurse.

In order to effectively counter the intention of the Nurses Association we need to offer Health Care planners a reasonable and financially viable alternative; midwifery cannot be afforded sufficient protection while midwives remain without an independent organisation to promote their professional interests. Formation of such an organisation would not necessitate withdrawal from the Nurses Association, rather, midwives could belong to both, as the Australians do. The Australian organisation comments on training and conditions of service, while the nurses' union negotiates on their behalf for salary increases, for example. An independent midwifery association could very effectively promote change to the health care system that would be of great benefit to both parents and midwives. However the formation of such a body depends on the committment of midwives to unity and to change.

As parents, we are interested in changes that will improve the quality of the birth experience for the mother, the baby, and the family. Proponents of medicalised childbirth often claim that improvements (in safety) for the baby must be at the expense (in emotional satisfaction) of the mother. This is not so. There are countless studies that show the outcome of pregnancy to be both safer and more emotionally satisfying when maternity care is provided by midwives rather than doctor/nurse teams (see Doris Haires paper in this issue, for example).

offspring benefit from a policy of nonintervention unless there is a clear medical indication for such intervention.

I appreciate the skills of the neonatologist in saving very premature, ill, and defective infants. However, there is no doubt in my mind that ultimately the midwife will be recognized as the health professional most capable of improving the outcome of pregnancy throughout the United States. It is obvious from the good infant outcome of infants delivered at the North Central Bronx Hospital and other midwifery services in the United States that we could reduce the numbers of newborn infants requiring intensive care by increasing the number of midwives and expanding the services offered by them nationwide.

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thanks to the American Journal of Nurse Midwifery, Vol 26 No 1, for this article.

A VOTE OF THANKS

Dear Save The Midwives,

Having received my first copy of Save The Midwives, I feel indebted to write to congratulate the people who have obviously put in so much time, commitment and caring.

In 1983 I experienced an induced labour, which initially set me off track and left me rather frightened and unable to cope. However a natural birth ensued (i.e. no pain relief) which my husband and I feel was due largely to the intense, undivided, caring support received from the midwife Sian White - Waitakere. We gained sufficient confidence to plan for a home birth for the next baby.

I would wholeheartedly opt for a "real" midwife to deliver my baby, rather than a (male no doubt) obstetrician.

yours sincerely,
Glenda Jenkins.

WHERE'D IT GO ?!

I attempt to edit this newsletter, and answer STM correspondence, with the intermittent assistance of two active preschoolers. Due to occupational hazards inherent in the latter activity some mistakes have no doubt been made. If you haven't received your newsletter, or have got two, or anything else (anything's possible) please let me know. Judy Larkin, Sec., STM.

propriate medical consultation, essentially run the obstetric service. The care of high-risk mothers and at-risk mothers is essentially the same as for low-risk mothers unless there is a medical indication for intervention. If a mother or infant requires medical attention, it is provided by a board-certified obstetrician rather than by a resident. If a premature, low birth weight or sick infant is anticipated, the chief pediatric resident and a first- or second-year pediatric resident are in attendance at delivery. The intensive care nursery is under the direct supervision of a board-certified neonatologist 24 hr a day.

The midwives practice nonintervention obstetrics in keeping with the latest scientific research. The results of their efforts refute the premise that it is the mother alone, not the management of her pregnancy, labor, and delivery, that determines the infant outcome of her pregnancy.

A review of the records of approximately 2608 births carried out from January 1 to December 31, 1979 at North Central Bronx Hospital reveals the following enviable statistics:

Every mother admitted to the obstetric service, whether low-risk or high-risk, and regardless of age, was cared for by midwives. With the exception of severely Rh-sensitized expectant mothers, obstetric patients were not transferred to another hospital.

Eighty-eight percent of the deliveries were normal, spontaneous vaginal deliveries (without fundal pressure).

Eighty-three percent of the total population of mothers were successfully delivered by midwives.

Ninety-three percent of the infants over 1000 g born in the obstetric service had Apgar scores of 7 or above at 1 min of life; at 5 mins, the rate was 98.3%.

Analgesia and anesthetic drugs were used in fewer than 30% of all labors.

Unless there is a specific medical contraindication, mothers are encouraged to walk around during labor to shorten labor (by 2.5 hr on average) and reduce the discomfort of contractions.

The incidence of instrumental delivery was 2.34% (low forceps 1.57%; mid forceps 0.5%; vacuum extractor 0.15%.)

The neonatal mortality rate among infants 1000 g or over was 4.2/1000; at 750 g or over it was 7.6/1000.

The perinatal mortality rate among infants 750 g or over was 14.5/1000. (The overall rate for New York City was 15.9; for all other municipal hospitals in the city the rate was 20.6. Statistics are not available for more than 1000 g.)

The overall cesarean section rate was 9% (7% primary and 2% repeat).

All mothers who had experienced a previous Cesarean section were allowed to experience spontaneous labor. Of these, 37% gave birth vaginally.

There were no elective inductions of labor.

Uterine stimulants such as oxytocin were employed in only 3% of mothers' labors and only when there was a medical indication.

Vaginal examinations are kept to a minimum (three to five times) during labor to avoid causing the mother unnecessary discomfort, to avoid the inadvertent rupture of the mother's membranes, and to avoid an increased likelihood of maternal infection.

Great care is taken by the midwives to avoid the inadvertent or intentional rupture of the mother's membranes during internal examinations of the mother during labor.

Fewer than 50% of mothers (including the 30% who were high risk) were monitored electronically. Many of the mothers who are monitored are monitored only intermittently to minimize the fetus's exposure to the potential risks of ultrasound.

To avoid maternal exhaustion during labor, mothers who are not high risk are allowed to eat and drink during labor. This practice has not resulted in a single case of aspiration of vomitus in the 2 years since the institution of the practice.

The mother's pelvis and perineum are not "prepped" (shaved and washed with an antiseptic solution). Enemas are not given.

Throughout their labor and delivery mothers are accompanied by one or two companions of their choosing.

Sixty-four percent of the mothers gave birth in their labor beds in the labor rooms. Twenty-one percent gave birth in labor beds that had been moved to the delivery room because of indication that the mother may need an assisted delivery or that the assistance of a pediatrician may be required. In only 15% of births were mothers moved to the delivery table for delivery.

Eighty-five percent of mothers gave birth in the semisitting position without stirrups.

Almost half (45%) of the mothers gave birth over an intact perineum. Episiotomy was performed in only 26% of births. Twenty-six percent of the mothers experienced first or second degree tears. Most first degree tears did not require sutures and all healed without complication. Three percent of the mothers experienced third degree lacerations, and 1% experienced fourth degree lacerations. These lacerations were extensions of episiotomies and occurred after the application of forceps by the obstetrician.

Premature and low-birth-weight infants are delivered over an intact perineum unless there is insufficient stretch to the mother's perineum.

The midwives at North Central Bronx Hospital have demonstrated that even high-risk mothers and their

In Germany and Holland, midwives work as truly independent practitioners. They run their own antenatal clinics, contract with hospitals for a certain number of beds per month, and attend births at home. They also provide post-natal care. Such a system of independent midwifery could well be considered for New Zealand. Among the advantages would be continuity of care for mothers, an improvement in fetal/maternal mortality and morbidity statistics, greater job satisfaction for midwives, more community involvement in maternity care (with antenatal clinics located in the community in much the same way that Plunket clinics now are) , less costly maternity care, and most important of all, greater involvement and satisfaction of mothers in their own health care.

We would like to open the subject of independent midwifery to discussion and welcome your criticisms and comments. Information from midwives and parents who are familiar with the European systems is especially welcome. New Zealand parents need to develop and promote a system of maternity care that best meets their needs, rather than leaving such policies to medical and nursing personnel - parents use the service and foot the bill, two very good reasons for being involved in policy making.

- Judy Larkin.

SAVE THE MIDWIVES' POLICY

We would like to canvass members opinions on several topics in order to develop a national policy that accurately reflects the attitudes of the membership. To this end we have designed a short questionnaire, and we would be grateful if you would fill it out and post it back to us by August 7, when we will compile the answers for the next newsletter.

Save The Midwives opposed the Nurses Amendment Bill on four major grounds; support for midwifery as an independent profession; support for direct-entry midwives; support for domiciliary midwives; and support for the right of parents to choose the kind of birth experience they wish. These remain fundamental parts of our policy. This questionnaire is designed to provide guidelines for change within these areas, change that is both necessary and desirable, and we need input from our members as to the direction in which change should be made. Please take the time to answer the questionnaire, and return it to Save The Midwives' Spokesperson, Barbara McFarlane, 11 Manapau St., Meadowbank, Auckland. (All replies are, of course, strictly confidential.) Thank you.

SAVE THE MIDWIVES POLICY QUESTIONNAIRE : MIDWIFERY.

1. Why did you join Save The Midwives Association?

2. If you are a midwife, are you satisfied with the representation you receive through the New Zealand Nurses Association?

Comment?

3. Would you support the formation of an association for midwives along the lines of the English Royal College of Midwives?

Comment?

4. Should such a College of Midwifery undertake full responsibility for midwifery training?

Comment?

5. What is your attitude to direct-entry midwifery training in the light of the 3 year U.K. course?

6. Do you think that the current midwifery training in N.Z. is the best that it could be?

Comment?

have not developed or have lost their skills to perceive and interpret human factors and their contribution to the intricate checks and balances which comprise human parturition. Residents and practicing physicians have increasingly turned to electronic and ultrasonic devices to determine the status of the fetus. Yet the F.D.A. has recently cautioned that

> Increasing concern has arisen regarding the fetal safety of widely used diagnostic ultrasound in obstetrics. Animal studies have been reported to reveal delayed neuromuscular development, altered emotional behavior, EEG changes, anomalies and decreased survival. Genetic alterations have also been demonstrated in in-vitro systems.[2] (For more details on diagnostic ultrasound see *Federal Register*, Tuesday February 13, 1979, part 3, pp. 9542–9545.)

Amniotomy (the artificial rupture of membranes), which is frequently carried out to insert the monitoring electrodes into the fetal scalp, is a procedure shown by Caldeyro-Barcia, Gabbe, and others to increase the risk of umbilical cord compression,[3] cord prolapse, and increased pressure on the fetal brain.[3] Amniotomy causes the baby's head, rather than the intact amniotic wedge, to serve as a battering ram to open up the birth canal.

I recently attended the Tokyo Congress of the International Federation of Gynecologists and Obstetricians. The research data presented by Doctors Caldeyro-Barcia, Flynn, and others demonstrated that American obstetric practices are frequently detrimental to maternal and infant outcome.

Doris Haire is the President of the American Foundation for Maternal and Child Health. In addition, she is the Chair of the Committee on Health Law and Regulation of the National Women's Health Network. She also serves on the Advisory Board of JNM, representing Consumer Affairs.

For example, several researchers showed that merely confining a mother to bed during labor tends to significantly[4]

1. Prolong labor by 2.5 hr
2. Increase the mother's need for pain-relieving drugs and uterine stimulants
3. Increase the need for forceps extraction of the infant
4. Increase the incidence of abnormal fetal heart rates and poor Apgar scores in the neonates.

Despite evidence that ambulation during labor improves the mother's comfort and the immediate and probably the long-term outcome of the pregnancy, the vast majority of obstetric patients in the United States are routinely confined to bed.

Drugs are used frequently as a substitute for quality care. Yet neither physicians nor other hospital personnel appear to be fulfilling their legal obligation to inform their obstetric patients that

1. There is no obstetric drug that has been proven safe for unborn children
2. The drugs offered to them during labor and delivery can depress their infant's cardiovascular, respiratory, and thermoregulatory mechanisms
3. No one knows whether the brain circuitry of the infant may be permanently affected by the drugs offered to them during labor and delivery.

Perhaps some mothers would not care about this, but their indifference does not remove the health professional's legal obligation to inform the patient of the risks involved in the treatment and of alternative treatments that do not involve those risks.

The improvement in the outcome of pregnancy resulting from the greater use of well-trained midwives was made evident in 1971 by Levy, who reported that during a 2-year medically directed nurse–midwifery program in California, the number of prenatal visits doubled and the incidence of infant deaths decreased significantly.[5]

Across the continent, the success of the California nurse-midwifery program in improving infant outcome has been essentially duplicated by the Frontier Nursing Service in remote Leslie County, KY, one of the poorest counties in Appalachia; in Su Clinica Familia, located in the Mexican border town of Raymondville, Texas; and at the North Central Bronx Hospital in New York.

NORTH CENTRAL BRONX HOSPITAL

I recently obtained data from the obstetric service at North Central Bronx Hospital in New York that demonstrates clearly that educating mothers for the childbearing experience, permitting one or two of the mother's loved ones to provide her with strong emotional support during labor and delivery, and avoiding unnecessary intervention in the birth processes can significantly improve the outcome of pregnancy, even when two-thirds of the obstetric population would be considered high risk or at risk.

It is appropriate to this discussion to describe the obstetric service of the North Central Bronx Hospital because it is a city hospital, serving one of the more sociologically depressed areas of New York. The mothers cared for at North Central Bronx Hospital are primarily black and Hispanic, with a smattering of whites. Thirty percent of the mothers are clearly medically high risk. An additional equal percentage of mothers would probably be considered at risk in most institutions.

The maternal and infant outcome at North Central Bronx Hospital in 1978 and 1979 is outstanding by any criteria. Given the 30% incidence of high-risk mothers it is truly remarkable. This good outcome is the result of the skilled and tender care of certified nurse-midwives who, with ap-

IMPROVING THE OUTCOME OF PREGNANCY THROUGH INCREASED UTILIZATION OF MIDWIVES*

Doris Haire

ABSTRACT

Current research makes it obvious that aggressive management of human parturition is not, in general, in the best interests of the vast majority of mothers and babies. Practices such as enforced confinement of the mother to bed during labour, amniotomy, administration of drugs that depress the central nervous system of both the mother and her newborn infant, forceps extraction, etc., are potentially detrimental to both mother and infant. If the outcome of pregnancy is to be improved, the number of nurse-midwives must be increased and their services expanded. Efforts aimed at reducing infant mortality by concentrating on the expansion of neonatal intensive care units are secondary, not primary.

During my years as President of the International Childbirth Education Association, the National Women's Health Network, and the American Foundation for Maternal and Child Health, I have visited hundreds of maternity hospitals throughout the world: in Great Britain, Western Europe, Russia, Asia, Australia, New Zealand, the South Pacific, the Americas, and Africa. During my visits I was privileged to observe obstetric techniques and procedures and to interview physicians, professional midwives and parents in the various countries. My companion on many of my visits was Dorothea Lang, C.N.M., Director of Midwifery for the New York City Department of Health and Past President of the American College of Nurse-Midwives. Miss Lang's experience as both a midwife and former head nurse of the labor and delivery unit of the New York Hospital-Cornell Medical Center, made her a particularly well qualified observer and companion. As we traveled from country to country, certain patterns of care and infant outcome soon became evident. For one, in those countries that enjoy an incidence of infant mortality significantly lower than that of the United States the major proportion of family planning services and obstetric care is provided by highly trained midwives. In these countries the medical expertise of the physician is called on only when the expectant mother is ill during pregnancy or when labor or birth is anticipated to be, or is found to be, abnormal. Under this system the high-risk mother, the one who is most likely to bear an impaired or stillborn child, has a better opportunity to obtain in-depth medical attention than is possible under our existing American system of obstetrical care, in which the obstetrician is also called on to serve as both midwife and physician.

Evidence is accumulating rapidly that our basic system of providing obstetric care is not in the best interests of normal pregnant and parturient women and their offspring, nor, in many cases, in the best interests of high-risk mothers and their offspring.

Roberto Caldeyro-Barcia, President of the International Federation of Gynecologists and Obstetricians (F.I.G.O.) from 1976 to 1979, commented on the adverse effects of obstetric intervention on maternal and infant outcome by saying:

> In the last 40 years many artificial practices have been introduced which have changed childbirth from a physiological event to a very complicated medical procedure in which all kinds of drugs are used and procedures carried out, sometimes unnecessarily, and many of them potentially damaging for the baby and even for the mother.[1]

Obstetric residents and practicing physicians have been so pressed to keep up with technology that they

* This article was adapted from the author's testimony presented at a Public Hearing sponsored by the Mayor's Blue Ribbon Commission on Infant Mortality, Washington, D.C., February 14, 1980.

.....cont'd :SAVE THE MIDWIVES POLICY QUESTIONNAIRE : MIDWIFERY.

7. Are you a) personally and b) generally satisfied with the current role of the midwife in N.Z.?

Comment?

8. The WHO's definition of a midwife is

"a midwife is a person who is qualified to practise midwifery. She is trained to give the necessary supervision, care and advice to women during pregnancy, labour and the post natal period, to conduct deliveries on her own responsibility and to care for the newly born infant. This care includes preventive measures and the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the parents but also within the family and the community. The work should include antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care."

Does your work experience place you within that definition?

Comment?

SAVE THE MIDWIVES was formed in response to a crisis in midwifery. The crisis looks as if it may be permanent. We would like your suggestions on the role and future of Save The Midwives.
Comment:

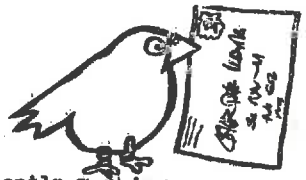
PLEASE RETURN TO:Barbara McFarlane, 11 Manapau St., Meadowbank, Auckland

Name: _____ Are you a midwife ☐ parent ☐

are you employed in a base hospital ☐
small hospital ☐
domiciliary ☐

retired ☐

letters to the editor



The Editor,

I have recently emigrated from England and am presently working as a midwife at Base Hospital, Wanganui.I am interested in subscribing to the "Save the Midwives" Association since I see that the role of the midwife is deteriorating rapidly here in N.Z.
It would seem that not enough midwives feel strongly motivated enough to stand up for what they believe. I have already written to the NZNA Midwives Section to say how surprised I was to learn that the midwifery training is "tagged on" to the advanced nursing diploma!When I think that the English training is now 18 months, I wonder how much can be covered in the New Zealand 40 week course. There are also financial and social drawbacks to the training which have to be borne in mind.
I would be interested to know how many midwives presently subscribe to your organisation.

Yours faithfully;
(Mrs) Barbara Lawton.
(There are approx. 70 midwife-members of Save The Midwives. -Ed.)

The Editor,

I read of the plight of N.Z. midwives in the International Childbirth Education Association newsletter.It was very distressing particularly since the role and registration of midwives is under review in our country.There is a lot of debate about the role of domicillary midwives at present.
I wish you all luck and support in your move to save midwives.I would appreciate any further information that you could give me.
We are at present striving to have domicillary midwifery covered by our National Health fund.

Best regards and support,
Pauline Murray,
Home Birth Co-ordinator,Coffs Harboub, N.S.W., Australia.

The Editor,

Many thanks for the copy of your Magazine. I congratulate you on the efforts you have put into producing it. . It has reinforced both my highest expectations and also my worst fears of what it may have contained. Dealing with the negative sides first, I really find it difficult to take seriously any Magazine which throws around statistics relating totally different situations to each other. The slightly hysterical, anti-Obstetrician parts also displays a

(a) base hospitals be encouraged to second midwives to outside units to provide short term relief

(b) midwives in smaller hospitals be encouraged to spend a regular period in base hospitals updating their skills

(c) hospital boards should provide more inservice retraining courses

(d) policies concerning part time work and job sharing should be re-assessed

(e) there be a rationalisation by hospital boards of the use of beds and staff in maternity hospitals which cater for under 100 births a year.

4. It is recommended that the Department of Health have a more flexible approach to funding and bonding of midwife trainees, that hospital boards should be able to be more flexible in how they fund employees undertaking midwifery training,and that consideration should be given to a specific midwifery funding scheme within each board, to help alleviate the problem of finance.

5. If there is any sign of a decline in the number of midwives coming to N.Z. from overseas, a shortage is likely to occur and urgent remedial action will need to be taken.

6. It is recommended that there be a public reaffirmation of the N.Z.N.A. policy statement on the role and function of the midwife within the nursing service.

7. A further specific review needs to be undertaken of the role, supply and conditions of employment of the domiciliary midwife.

****

POSITIVE NOTES FOR MIDWIFERY

A further investigation into the technical institute course will be welcomed by many midwives and parents, and it seems that the Hospital Board's Association recognises the inadequacies of the programme.The need for greater practical content in the course, the reason given by many midwives for choosing an overseas course instead, is noted,as is the relative unavailability of the course,both geographically and financially.The great dependence of N.Z. on overseas trained midwives is also recognised, but whether any effective urgent remedial action could be taken in the case of a severe shortage is debatable.

A public reaffirmation of the NZNA Policy statement on the role and function of the midwife will only serve to further alarm many parents and midwives; it is the NZNA's insistence that a midwife also be a nurse that has caused so much concern .This is seen as self-interest on the part of the NZNA and has been justifiably criticed by both parents and midwives.

a shortage of midwives ?

At the Hospital Boards' Association's conference held in March 1983 the following remit concerning the shortage of midwives in New Zealand was carried;

> "That this conference expresses concern at the shortage of midwives in N.Z. and requests the Hospital Boards' Association to establish a working party to research the reasons and to advise on ways the retention of midwives in employment might be improved".

Our Summer newsletter carried an article about the specific objectives and constitution of the working party, and we have now received a copy of the Report that it compiled.The complete Report can be obtained from A.R. Grigg, Secretary to the Working Party on the Shortage of Midwives, Hospital Boards' Association of N.Z., P.O.Box 714,Wellington.

We have summarised the conclusions and recommendations as follows;

1.The new midwifery courses have not been running long enough to allow the prediction of a possible future shortage of midwives.A further review, to be undertaken in 3 years time, is recommended.Matters to be examined in such a review should include;

   (a) the midwifery prerequisites
   (b) the location of the courses in 4 metropolitan areas only
   (c) the possibility of part of the course being undertaken in a smaller centre to allow the students the experience of working in a smaller hospital and community.
   (d) the availability of adequate clinical experience
   (e) the number of nurses undertaking the midwifery option compared with other options within the advanced diploma courses and the limited number of places available.

2. It is recommended that employers be advised not to expect a new graduate to accept sole responsibility in any setting until that graduate has had a period of supervised experience.

3. There is a midwifery shortage in some provincial areas but not in N.Z. as a whole.Small maternity hospitals are often difficult to staff. However these hospitals are an integral part of the hospital service and are important to the local community.It is recommended that;

regrettable lack of knowledge of the history of the development of Midwifery and Obstetrics in the Western world, over the last few centuries. It was not until Doctors such as Smellie and Chamberlain, in Britain, started intervening with the role of Midwives that improvements started to be made. Further progress, of course, was made possible in the 1950's by an ex-patriate New Zealander, Sir John Stallworthy, who organised a very efficient maternity service in Oxford, based on Midwives for normal deliveries. Further technological progress, initiated by Obstetricians, but subsequently largely taken over by Midwives, has resulted in a dramatic improvement in safety of pregnancy for Mother and child. Paradoxically it is these technological and medical advances which have made normal Midwifery so much safer, and have enabled us to make such tremendous strides on the humanitarian side of childbirth. The bogey of the Doctor's handmaiden should also be buried. We have different areas of expertise and different areas of responsibility.

The Hospital based system of delivery which has developed in New Zealand, was largely made possible by the work of Dr. Doris Gordon, and Sir Truby King, and the Plunket Nurses, and was a tremendous step forward in improvement in Maternity care. We are still faced with a very low population density, which has its own problems. Even Auckland would be regarded as hopelessly rural by most European and North American standards.

On the positive side, however, I agree that Midwifery should have a separate organisation. I should expect that most Midwives would continue to belong to the New Zealand Nurses Association (Voluntary Unionism), but also support an independent body which has the ability and right to negotiate on their own behalf. I also agree with you that the current training of the Midwives needs re-examination, and one point which needs to be more closely explored is the maintenance of clinical expertise by the teachers. I understand that most of the current Midwifery Tutors are making efforts to maintain their clinical experience, but I should like to be reassured that this is compulsory. There is no point in spreading our resources even more thinly by creating a totally separate system for direct entry Midwives. The direct entry Midwives I have worked with, are very competent, but as in any field of endeavour, the broader the background, the better, and I can see no advantage in promoting direct entry training.

The New Zealand system is often compared with the Netherlands. Colleagues from the Netherlands (Medical and Midwife), emphasise the entirely different social infra-structure and historical basis. I am hoping to see Professor Kloosterman later this year, and to get a direct view of the system in the Netherlands to see whether there is anything we can really learn from it.

A summary of the system practised in Hawke's Bay may interest you, as most of our demand for Home Births here comes from people who are disillusioned with the services received in metropolitan centres. They almost invariably prefer the experience locally, and are reasonably happy to continue with a Hospital based

system. We essentially have four Hospitals - two serving rural areas, (each doing less than 300 deliveries a year), and two "Base Hospitals" only 14 miles apart, but each doing close to 1000 deliveries a year. This is inefficient in many ways, but does help us to maintain individuality. A deliberate attempt has been made to continue the General Practitioner involvement in the Obstetrics, right through to the highest risk cases, and the number of people who elect to have full Specialist care is very much smaller than in the major centres. If an emergency caesarean section is necessary, it is the rule rather than the exception to have the General Practitioner accompany the couple to Theatre. From the time I first arrived 13 years ago, I have actively encouraged the presence of spouses in Theatre, despite considerable opposition from Hospital Boards, (and initially Midwives). The very active local Parent Centre started its operations using Hospital Board facilities, and maintains a good rapport with Obstetricians and Midwives. Real attempts have been made to keep the Parent Centre classes and the Hospital based classes, as genuine alternatives, rather than in competition with each other.

Recently, a considerable step has been made towards decorating the Obstetric Unit in Hastings, in a more homely fashion. The initiative for this came largely from the Midwives, and indeed they raised a large amount of the money, but with active support from the local Doctors. Health education films have been funded by Parent Centres, by local subscription, and by Midwifery and Obstetric staff.

Several of our Midwives, all of our Specialists, and many of our General Practitioners, have had experience of domiciliary Obstetrics and Midwifery, some a considerable amount, and we are all very conscious of the need within our limited resources, to reproduce the advantages of the home birth in our institution, as we really cannot afford to divest our resources any further. The advantage of General Practitioner involvement throughout the pregnancy is, of course, that he will be the Doctor who will care for that Mother and child for many many years, and it is a part of practice which seems to give great satisfaction to both Doctor and the family involved.

Over the last thirteen years our perinatal statistics have gone from the worst in N.Z. to equal to the best, despite having very considerable geographic and social problems. (Hastings has a high unemployment and Gang problem). This has been achieved by excellent co-operation between Specialists, Midwife, and General Practitioner, and you will therefore understand my distress at seeing extreme statements which would tend to separate the groups, rather than to improve their degree of co-operation. I look forward to seeing your next Magazine. If I receive any useful information from my trip to Holland later in the year, I shall be delighted to let you know.

Yours sincerely,

D.H.C. DAVIDSON.

Consulting Rooms
305W Lyndon Road,
HASTINGS, N.Z.

HOME BIRTH MIDWIFE

On February 1, I became Hamilton's new domiciliary midwife. I did general and paediatric nursing training in Holland and midwifery at St. Thomas' Hospital, London. I am married to a New Zealander and have 3 children - a boy 8 years old, and two girls aged 7 and nearly 5. We settled in Hamilton 2 years ago after living in London, Holland, Indonesia, Nigeria and Libya.

I work part-time in delivery suite and the newborn unit in Waikato Women's Hospital. Reading and talking to various people I became aware of the strange situation in which domiciliary midwives in N.Z. find themselves. My decision to join their ranks was mainly influenced by the fact that the Minister of Health seems to think that not providing a reasonable amount of money to fund an existing and legally provided service will phase it out. I love delivering babies in a relaxed environment and sharing in the unique experience of new life starting and I am in the fortunate position that I don't have to exist on the money I earn. So I decided to apply via the Department of Health in Hamilton for a licence.

The difficulties (for me) of being a home birth midwife are in the hours and hours of my time I spend trying to get some sort of organisation set up for myself, and in trying to work in with the many already existing services (Home Birth Association, District Nursing Service, general practitioners, CSSD, Supply Office, etc).
This seems to be happening quite well now , and I am thinking of ways to make home birth more acceptable to all parties involved and make them as safe as possible, keeping Holland and its well developed system in mind and "borrowing" ideas from the English system under which I trained.

In conclusion I would like to say that I do enjoy all parts of this new job!

Regards,
Clare Hutchinson.

DIONY YOUNG

august 19
WAIKATO UNIVERSITY

Parent's Centre are bringing out Diony Young, a childbirth activist, (author of CHANGING CHILDBIRTH), well known in the U.S.A., from America as guest speaker for the Sunday of their August Conference. Other speakers on that day include the Ritchies and Jenny Phillips (Mothers Matter Too) There will also be new films from the U.S.A. and workshops on such topics as lobbying, stress management, support groups, etc. Fee for the Sunday is $15 (includes lunch). Send to: Registration Sec., 39 East St, Hamilton.

If the fees paid to domicillary midwives were doubled, the cost of a home birth would still be just over half that of a normal hospital birth.

Family centred maternity care is best (and most economically) provided by midwives and general practitioners. To maintain, let alone increase, the number of G.P.'s undertaking maternity care and the number of midwives undertaking home births, we need to change the fee structure by which they are reimbursed.

We would like to open this topic for discussion, and welcome letters to the editor, or articles from members, to be printed in the next issue [The deadline is August 15.]

australian expenses

In a recent paper presented to the Royal Australian College of General Practitioners,Dr, Hugh Carpenter, State Director,RACGP Family Medicine Programme, Tasmania, has calculated the relevant costs of home and hospital births in Australia.[4] They are as follows;

HOME BIRTHS Antenatal care,Confinement,Post-natal care;

Doctor	$240
Midwife	$400
	$640

Hospital BIRTHS Antenatal care, Confinement,Postnatal care;

Doctor	$295
Labour ward and Lying-in(7 days)	$850.
*Intervention factor	$504
	$1,659

*Intervention factor; the average additional cost, per birth,of the sum of current costs for induction (12%),forceps (40%), spinal anaesthetic (36%), Caesarean section (5%).Percentages reduced to allow for home birth intervention.

- Judy Larkin

REFERENCES : 1.Bonham,D. "Whither Obstetrics".Post-graduate School of Obstetrics and Gynaecology.University of Auckland Medical School.
2. Clinical Services Letter No 202 , obtainable from the Director - General of Health, P.O.Box 5013, Wellington (29 May 1981 issue)
3. Appendix 5, Report on Medical Graduate Needs in N.Z. 1968-2000, Wellington May 1970. 4."Domiciliary Obstetrics",Dr. Hugh Carpenter, presented 3 March 1984 (copy held by Editor).

we need you!

SAVE THE MIDWIVES is growing rapidly and the work load has already become too great for the small number of people who have put the last three newsletters together.We need another 4 to 5 people to help with these jobs;

secretary

we need someone to answer queries from members, and to take care of new subscriptions. The total work load would be about 2 hours a week, so if you have this to spare and would like to use it to promote midwifery and mothering, we would LOVE to see you at our next meeting. Many of our letters are from midwives so if there is a (temporarily retired) midwife out there who has the spare time, so much the better.

typist

we would like to have the newsletter professionally typed but cannot yet afford to have this done. It involves typing 28 - 32 pages every 3 months. If you can help, even doing just part of it, phone Judy Larkin on 602 301 or come along to our next meeting.

spokesperson

our spokesperson, Barbara McFarlane, prepares our press releases and liases with the media.On occasions the work load becomes heavy and an extra person or two to help carry the load in this area would really be appreciated.Its a very interesting and stimulating area - Barbara has done this for the Home Birth Association for the last 5 years so she knows the ropes . If you would like to help out, come along to our next meeting or phone Barbara on 502 396.

writers

suggested topics for the next newsletter are; Amniotomy, Ultrasound, the Effect of Emotional Disturbances on Labour, Maternity Hospitals in Auckland - Policies and Practice, Direct - Entry Midwifery. More will be suggested at our next meeting, no doubt.
We share many resources between us but what we need are a few more people to get all the information and ideas together on paper. Assistance with writing and editing is available - if you would like to try writing an article for the next newsletter, or if you have an idea not yet mentioned, come along to our next meeting.
As always, unsolicited articles and letters are welcome.

our next meeting

will be held at 24 Ashton Rd.,Mt Eden, on Monday16 July at 8 p.m.

TAKING ON THE HOSPITAL

My sister, who had just moved to the North Shore in Auckland, wanted a very simple birth experience. She was happy to go along to North Shore Hospital, and went along to book accordingly. She was due to give birth a few weeks later, when certain circumstances arose which made her last weeks in pregnancy an insecure, frustrating and unhappy time. She wished to have a relaxed, quiet birth in the company of her husband, her doctor, and myself.Although the arrangement to have me present was approved of by her doctor, her request was turned down flat by the booking-in sister and Matron. The reason given was " there is not enough room in the theatre" and "what do you want your sister for?".

After leaving the hospital in tears, she tried St. Helen's Hospital, (another hospital her doctor could deliver at), but was told that it was not their policy to allow an extra person at ANY birth. Further investigation showed that National Womens and Waitakere Hospitals both had a very flexible arrangement, where others were able to be present to support the mother. As this meant changing doctors with only a few weeks to go, and travelling further to give birth, my sister chose not to do this. Instead we wrote to the Ombudsman and the Auckland Hospital Board to explain our predicament.

The Ombudsman replied immediately saying he had " notified the Chief Executive of the Auckland Hospital Board of the terms of our complaint and had asked him to supply the Ombudsman with a report on the matter".

Another letter arrived a few days later, explaining that Dr. Honeyman of the AHB had spoken to both the Medical Superintendant and the Principal Nurse of North Shore Hospital, and he believed that my sister would now be SUCCESSFUL with her request.He wrote "it is my belief that the problems which you anticipate can now be overcome. I trust that this is the case.Should you have any problem while at the North Shore Hospital,please discuss any difficulties with the staff of the obstetric unit.I am sure they will be more than willing to help you. Should however there be any continuing difficulty, you should contact the Medical Superintendant in the first instance."

Although my sisters request to have me present at her birth was denied by the Matron, her refusal was over-ruled by simply writing to the Ombudsman with a complaint about our unfair treatment.

In researching this article,several anomalies became apparent, the first of which was that both G.P.'s and obstetricians are reimbursed by the Health Department but obstetricians are permitted to charge additional fees. One might surmise that the additional earning power of obstetricians is justified by their "specialist" status: i.e. they are being paid extra for extra training and greater skill.But are they? Does the G.P. not have greater skill in family medicine, in assisting the family to integrate its new member , to care for the baby as part of the family? A disquieting note is struck by a section of the 1970 issue of "Medical Needs"in which the Royal College of Obstetricians and Gynaecologists states that future "desirable trends" for the profession are

(a) a reduced number of G.P.'s doing obstetrics

(b) the introduction of specialist consultant benefits

and (c) greater demand for specialist supervision of normal birth.[3]

An effective way to reduce the number of G.P.'s doing obstetrics is to price them out of this area of health care - at $6 per consultation,and permitted to charge no more, how many G.P.'s will consider maternity care worthwhile in the future? (Fees to doctors have not risen since July '81).Obstetricians, however, receive their $6 plus another $300 or so that they are able to charge the patient,thus nicely keeping pace with inflation, and well able, financially, to supervise normal as well as abnormal pregnancies.

The second anomaly that presents itself is that (domicillary) midwives are paid a standard fee for every labour, however long, while doctors are paid by the half hour.

The answer to this question, as to the previous one, seems to be political- who gets what depends on the lobbying power and political clout of the organisation concerned. There are approximately 12 home birth midwives practising in the country - not much weight in numbers there! With a full caseload they are able to earn approx $8,000 per annum - no more because of the level at which the benefits are set, Both the Department of Health and the Dept. of Trade and Industry have agreed to a 17% increase on grounds of hardship, but this has been consistently held up by the Minister of Health, Aussie Malcolm.

Antenatal visits: 1st visit	$11.50
11 subsequent visits	$66.00
Delivery fee to doctor	$88.00
5 days stay in hospital	$705.00
Post-natal check	$19.50
	$890.00

HOSPITAL

Hardly "getting it all for nothing!"

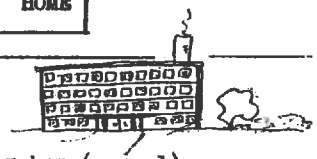
NORMAL HOME BIRTH - EXAMPLE 2

Susan's situation was exactly the same as Ann's, except that she elected to give birth at home. Her costs were as follows;

Antenatal visits; 1st visit	$11.50
11 subsequent visits	$66.00
Antenatal visit by midwife	$4.25
Delivery fee to doctor	$88.00
Delivery fee to midwife	$36.00
Postnatal care:14 visits from midwife	$101.50
Post-natal check	$19.50
	$326.75

HOME

SPECIALIST CARE FOR NORMAL BIRTH - EXAMPLE 3



Robin chose the care of a specialist obstetrician for her (normal) pregnancy and birth, for which she paid $300.00 directly to the specialist, in addition to the following costs:

Antenatal visits: 1st visit	$11.50
11 subsequent visits	$66.00
Delivery fee to specialist	$88.00
5 days stay in hospital	$705.00
Post-natal check	$19.50
and	
Fee to specialist	$300.00
	$1190.00

SPECIALIST

Who is it that makes the rules? - the Hospital Board, the Medical Superintendant, the staff members at the hospital ? ? ?
Why is the policy of National Women's Hospital and Waitakere Hospital more positive and understanding than either North Shore or St. Helens?

We parents must not be intimidated by austere hospital staff. We need to know our rights, and be prepared to go to the "top" if we have to.
Our births are too precious to be thwarted by someone else's whims!

Cathi Sadler.

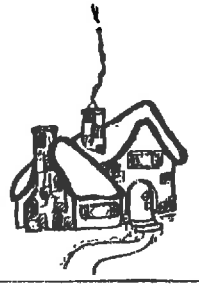
HOW DO YOU DO IT?

If you have been refused a reasonable request by hospital staff, first contact the Medical Superintendent (in writing). If you still receive an unfavourable response, write to the chief executive of your local hospital board. (A list of hospital boards is included in this newsletter) In your letter to the chief executive, include copies of your letter to the medical superintendent, and his/her response.Ask for clarifiation of the issue.
If you still receive an unsatisfactory answer, write to the Office of the Ombudsman, 5th floor,Southern Cross Building,High Street, Auckland, enclosing $2.If a decision is urgently required,as above, be sure to mention it. The Ombudsmans job is to ensure that the ordinary citizen is able to exercise her rights, and he will take up, on your behalf, any case in which you feel you have been unfairly treated.

Oh, and take a copy of the Ombudsmans letter with you when you go in to hospital - who knows, you may never need it but it's very handy to have if you do.

CO-OPERATIVE PARENTING NETWORK

Save The Midwives, Parent's Centre,La Leche League , the Home Birth Assoc., the Downs Assoc., Contact and Parent-to-Parent are still looking for premises to share for office space and meeting rooms.
Phone Judy Larkin, 602 301, if you know of anything.



BABY BLUES

Two years ago the Mental Health Foundation published a booklet on Post Natal Depression. It contains a great deal of information on the subject of new motherhood, and is available from the Foundation, P.O.Box 37-438, Parnell, Auckland 1, for $1.50. The following has been excerpted from the booklet.

DEPRESSION IN MOTHERS - BIRTH AND PRESCHOOL YEARS

Depression in mothers following the birth of babies and during the preschool years is of epidemic proportions in this country, an epidemic which, although widespread, is largely hidden.
Three subtypes are often distinguished, namely "maternity blues", puerperal psychosis and post natal depression.

MATERNITY BLUES

50% - 80% of women experience maternity blues sometime between the third and tenth day after the birth. Symptoms vary from mild to moderate in severity and include: tiredness, low spirits, tearfulness, anxiety, poor concentration and memory difficulties. Problems in establishing breastfeeding often accompany these changes.
The causes are uncertain. Some studies conclude that the problem is probably a reaction to a change in hormone levels, while others determine that the incidence is higher when there is a high level of technological intervention during birth (i.e. forceps delivery, dissatisfaction with 2nd stage, the use of epidural anaesthesia).

PUERPERAL PSYCHOSIS

Psychoses are serious disorders of thought and emotion which greatly disrupt the sufferers ability to go about her usual life activities. Puerperal psychoses occur in about 1 in 500 pregnancies. Psychoses which develop following childbirth frequently have a sudden onset. In addition, feelings of hostility experienced as fears of harming child and husband are common. Themes of delusion often include feelings of inability to care for the new baby or not having enough love for either the father or child. Guilt associated with these thoughts is also typical.

When the first 6 months post partum are considered surveys indicate one half occur in the first two weeks after the birth, one sixth occur in the next two weeks, and the balance develop during the next 5 months. Although rare, these severe psychiatric conditions are much more likely

SCALE OF FEES - ANAESTHESTISTS

One scale of fees applies to both general and epidural anaesthesia.
(Anaesthetists are not paid these fees if they are employed by a Hospital Board. In such cases the $141 per day would cover these costs.)

- NORMAL BASIC FEE (1st half hour).....$33.00 _____
- SPECIAL BASIC FEE (nights, weekends and public holidays) (1st half hour).....$47.00 _____
- SPECIAL ADDITIONAL BASIC FEE FOR CAESAREAN (1st half hour).....$11.00 _____
- ADDITIONAL FEE FOR EACH HALF HOUR BEYOND THE FIRST HALF HOUR.....$13.00 _____

Where an anaesthetist is engaged and attends, but her/his services are not ultimately required, the normal basic fee of $33.00 is payable.

SCALE OF FEES - MIDWIVES

Of the approximately 1000 midwives working in N.Z., most work in hospitals. They are paid by the relevant Hospital Board. Domiciliary (home birth) midwives work in the community and are reimbursed for the maternity services they have provided by the Health Department as follows;

- ANTENATAL VISIT.....$4.25 (one only)
- DAY OR DAYS OF LABOUR.....$36.00
- SUCEEDING DAYS, VISITING.....$7.25 (14 at 1 per day)
  LIVING IN.....$24.50(" " " " ")

It is possible, using the above information, to calculate the approximate cost of your baby's birth. Following are three examples for your guidance.

NORMAL HOSPITAL BIRTH - EXAMPLE 1

Ann had a normal birth in hospital, stayed in 5 days, and 6 weeks later saw her G.P. for the usual post natal check-up. She calculated the approximate cost of her maternity care as follows:

nursing services,although the A.H.B. does not reduce the figure if the birth is attended by a G.P. or obstetrician in private practice. The charge made by the Hospital Board in your area can be ascertained by simply writing to them - a list of Hospital Boards can be found at the end of this newsletter.

SCALE OF FEES - DOCTORS

G.P.'s are self-employed, and apply to the Department of Health for reimbursement for the maternity care that they have provided.They are paid according to the following scale of fees,which also applies to obstetricians working in private practice. Obstetricians,however,are permitted to charge additional fees while G.P.'s are not.

▪ FIRST ANTENATAL VISIT	$11.50
▪ EACH SUBSEQUENT ANTENATAL VISIT	$6.00
▪ LABOUR AND DELIVERY (NORMAL)	$88.00
▪ EACH VISIT TO MOTHER AND BABY DURING THE FIRST 14 DAYS AFTER THE BIRTH	$6.00
▪ POST NATAL EXAM (MOTHER)	$12.50
(BABY)	$7.00
▪ PROLONGED ATTENDANCE;for each half hour in excess of 1½ hours	$19.75
▪ LABOUR AND DELIVERY, CAESAREAN SECTION	$146.00
If the Caesarean section is performed by a second doctor called in consultation,that doctor may claim $146, while the first doctor may claim $88.	
▪ FOR DELIVERY OF 2 OR MORE BABIES in addition to the fee specified above	$22.00
▪ SECOND OPINION PROVIDED BY ANOTHER DOCTOR DURING PREGNANCY	$24.00
▪ ASSISTANCE (OPINION OR ACTION) PROVIDED BY A SECOND DOCTOR DURING LABOUR AND DELIVERY	$88.00

Doctors are paid even if they did not attend the birth, provided that "the doctor was prevented for reasons beyond his control from arriving in time".[2]

to develop during the post partum period than at any other time during a mothers child-bearing years.

POST NATAL DEPRESSION

Community surveys show that more than 10% of mothers suffer from an episode of depression lasting longer than a month in the year following childbirth.Ranging in severity it is at least partially disabling and significantly impairs the womans quality of life.

Symptoms include: extreme and persisting tiredness, tearfulness, depressed mood, anxiety, insomnia, lack of concentration, poor appetite, loss of interest in sexual activity, difficulty in coping with the demands of baby care, irritability, guilt, and negative feelings towards the father and baby.

Nearly one half (40%) of mothers who develop this form of depression have these symptoms for more than one year.The majority do not seek (or do not receive) psychological or medical treatment. Most do not know what is wrong and many feel that they are the only ones not basking in the supposed "joys of motherhood".

Studies have revealed a number of factors which increase the likelihood of post natal depression.Vulnerability factors include:undesirable life events before and during pregnancy (e.g. unplanned pregnancy, housing problems), younger age, previous psychiatric history,moderate to severe maternity blues,little or no prior experience with babies, the prescence of other young children in the household, the absence of part-time or full-time paid employment, & poor marital relations - that is, communication problems and little support with baby care and household tasks.

The great majority of mothers, however, do NOT have previous psychiatric histories, and unlike those with puerperal psychosis, are NOT more liable to depression at other times.This suggests that this group of women is comprised, in the main, of normal people who are overwhelmed by the stresses that accompany childbirth and the care of babies.

While there has been little research into the effects of the birth experience on the incidence of post-natal depression, there is one small study of Cardiff, U.K. mothers, which shows that 64% of 107 women delivered in hospital experienced depression, compared with 19% of 86 women delivered at home.

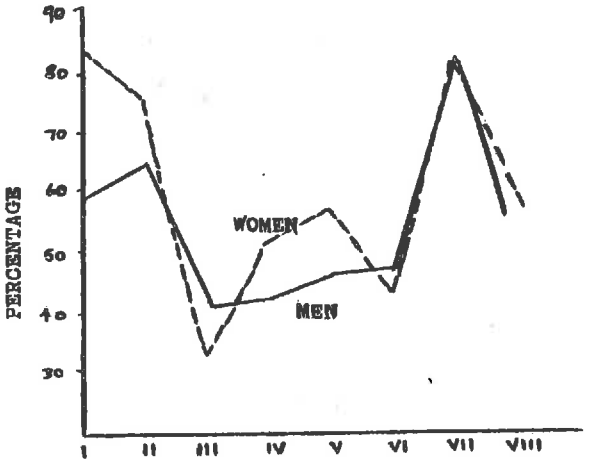
(In N.Z., the Auckland Branch of the Home Birth Association states that the post-natal depression rate in a sample of 1157 births was 0.8% (over a period of 10 years.))

DEPRESSION IN MOTHERS OF PRESCHOOLERS

Symptoms described for post-natal depression are common throughout the period that mothers care for preschool children; indeed community surveys indicate depression is even more widespread at this time. Prevalence of depression reaches 70% when the child has a behaviour problem and there is marital disharmony. Solo mothers and married women with more than 3 children are also at risk. Inadequate housing and low income appear to be contributing factors. However, 20% - 30% of mothers with normal preschool children and "good" marital relationships suffer from disabling levels of depression.

The following figure is informative:

PERCENTAGE OF WOMEN AND MEN AT EACH STAGE OF THE FAMILY LIFE CYCLE REPORTING THE PRESENT STAGE AS VERY SATISFYING.



FAMILY LIFE CYCLE

1 before children arrive
2 stage until oldest child is two.
3 stage until oldest child is 5.
4 stage until oldest child is 13;children at school.
5 stage until oldest child is 20;having teenagers.
6 stage when oldest child has left home.
7 stage when youngest child has left home;grandparenting.
8 stage of retirement.

3. Clinic / Hospital Birth

The mother can attend a maternity hospital's antenatal clinic for all her prenatal checks, then give birth in the hospital attended by the doctor who happens to be on duty when she delivers her baby.The hospital staff, including the doctor, are all paid by the Hospital Board.

4. Shared Care

The mother can see her G.P. for her antenatal care, then go to a maternity hospital for the birth where she is attended by whichever doctor happens to be on duty.The G.P. does not attend the birth, but is reimbursed by the Department for the antenatal care.The duty doctor who attends the birth is paid by the Hospital Board for which s/he works.

5. Early Discharge

If the birth is normal the mother can eschew the hospital stay and go home 1 to 2 hours later , where she transfers to the care of a domiciliary midwife or a nurse-midwife employed by the Health Dept.

6. Midwife / Home Birth

The mother can see a G.P. who attends home births for her antenatal care, see a domiciliary midwife for one antenatal check, and then give birth at home attended by the midwife and the doctor.Postnatal care is provided by the midwife for 14 days after the birth, and both the doctor and the midwife are reimbursed by the Health Department.

COSTS $ $ $ $

The relevant scale of fees to doctors is quite complex, and full information can be obtained from the Clinical Services Letter No 202.[2]
The information in this article has been compiled from this document and from data kindly supplied by the Auckland Hospital Board.

The costs quoted here for reimbursement to midwives and doctors are exact;the figure of $141 per day for a hospital stay was supplied by the Auckland Hospital Board as the charge currently made to non-residents of N.Z. who use maternity units, and as such can realistically be expected to reflect actual costs.The $141 per day includes medical and

FREE DELIVERY ?!

With the battle raging within government departments over the relative costs of services to the taxpayer,I thought it pertinent to investigate the cost of giving birth in New Zealand today. In the field of health care, as in all others, we are becoming sharply aware of the enormous amount of money paid in taxes and are beginning to ask how the dollars are distributed.The question deserves an answer, particularly since belts are being tightened anyway - informed parents can better do their bit towards ensuring that the belts are tightened appropriately.

TYPES OF CARE

All maternity care in N.Z. is "free" to the mother- that is, there is no direct charge made to the mother by any of the professionals or institutions involved.Rather, parents pay for maternity care indirectly, through their taxes.This makes it difficult,if not impossible, to ascertain the exact cost of such care,but a reasonable approximation can be made by combining fees paid to doctors &midwives and the cost of a hospital stay.

The cost of maternity care varies somewhat according to the arrangement chosen by the parents, to whom six options are open;

1. G.P./ Hospital Birth.

The mother can see her family doctor, a general practitioner,for all her antenatal care.She will be booked into a maternity hospital where the baby's birth will be attended by the G.P.,after which the mother may stay in hospital for up to 14 days, although the usual length of stay is 5 days. The G.P. is reimbursed by the Department of Health, and the midwives who attend the mother and baby in hospital are paid by the relevant Hospital Board. About 60% of N.Z. mothers make this choice.(1)

2. Obstetrician / Hospital Birth.

If the pregnancy is normal but the mother wants the care of an obstetric specialist,she can employ one working in private practice who will provide her antenatal care and attend the birth. Currently in Auckland the parents pay the obstetrician about $ 300 for this,with the obstetrician being further reimbursed by the Health Department (at the same rate as for G.P.s).

The figure comes from a community survey of N.Z. men and women at different stages in the family cycle.A number of points emerge. The first is that while there is a slight drop in ratings of life satisfaction for women in the two years following the birth of their first child, (remembering however that more than 10% are severely depressed) satisfaction ratings drop considerably when there are preschool children at home.This is also the period when surveys reveal that rates of depression are at their highest.

It is significant that for women, the happiest periods are before children arrive and after they leave.

compiled by Jenni Churton.

N.Z. BIRTH STATISTICS

for 1982, the most recent year for which figures are available, the statistics are as follows;

total number of births ; 50025

number of caesareans : 4913 ——— 10%

number of forceps deliveries : 6880 — 13.5%

THIS MEANS THAT NEARLY ONE MOTHER IN FOUR EXPERIENCED AN OPERATIVE DELIVERY IN 1982!!! NOT SOMETHING FOR N.Z.'s MATERNITY SERVICES TO BE PROUD OF!

POTPOURRI

From ICEA News, official publication of the International Childbirth Education Association;

"In Brazil, the traditional upper class, private medical care clients, often have their babies by caesarean. Vaginal birth is thought by some to be so traumatic for the baby as to constitute a form of child abuse. There is also the belief that vaginal birthing destroys future sexual pleasure for a couple. Pelvic floor exercises are generally unknown. Some 80-90% of private medical care clients have caesarean births. To emulate the upper class, women in the upwardly mobile segment of society will seek out a doctor who will promise a caesarean birth".

From Mothering magazine (USA);

Natural remedies for morning sickness include: increase vitamin B 6 intake to 20 to 40 mg each day, drink fluids between rather than with meals, avoid greasy foods, keep crackers or dry cereal at bedside to snack on during night, have frequent snacks rather than three large meals, apply pressure to the "neikuans", accupressure points situated about three fingerwidths up from the cresse of the wrist, toward the elbow, and remember that the nauses of pregnancy is self limiting.

From the article "From Home Birth to Active Birth: The British Midwife", Winter 1984, Mothering magazine,

"Many younger midwives working in maternity units today have seen few home births (if any) and have become accustomed to the "medical model" of birth.....Overall our induction rate now stands at 36%. In hospital women are likely, too, to receive a routine shave and enema, internal or external fetal monitors (or both) and an episiotomy. Caesarean rates are lower than in the United States, currently about 10%, while forceps deliveries account for another 13% of all births."

From the article "Staying in Charge", Winter 1984 issue; Mothering,

When a mother tries to take charge of her child's development, she is confronted with two kinds of pressure: She has difficulty trusting her own perceptions when they are contradicted by those who are considered experts. Also those who believe THEY should be in charge often attach too little importance to a mother's point of view. The mother's differing perception becomes an obstacle to overcome, and if she persists she is labelled a "difficult" mother.

cope like this for a long time." She made me feel as if I was on top of the world. I felt very pleased that I had achieved a natural birth, it was the most wonderful sensation...because I knew I'd missed out the first time...

DID YOU HAVE AN EPISIOTOMY?

No episiotomy, just two slight tears on the labia...there's all sorts of things you can do so you don't need one, massage the perineum, use heat...
They gave us a phone and a cup of tea immediately after the birth. They took Lucy away just to sponge her down, that's all, then they brought her back...I saw the placenta this time too, they just whipped it away the first time, I never saw it.....you never forget, do you?

DID YOU GET AS MUCH REST AS YOU EXPECTED IN HOSPITAL?

I stayed in hospital to have a rest. I came out after 4 days because I reckoned I'd get more rest at home. I kept thinking of Woodside Road, it's so lovely and quiet, and it's so peaceful here.
One night I didn't sleep at all, my room was next to the nursery - there was a baby in the nursesry that cried all night. One night I couldn't stand it and I went and said to the nurse, "Can't I just go in and sing to that baby, rock it maybe?". She shot me a terrible look, flounced into the nursery, slammed the door shut, and then hissed SHUT UP at the babies. It was awful. Lucy was only in the nursery one night. But apart from that they were excellent. Ward 4 was really great. The Polynesian nurses would go in at night and talk to the babies, hold them, really cuddle them...they seem so much more maternal.

The high point of it all for me was the birth...because it was a team effort...you get a feeling of confidence from the midwife having confidence in you...in fact I felt so confident that I wanted to give birth before my G.P. arrived and we birthed the head just as he walked in...he was happy everything went well too,
in fact he was beaming from ear to ear...this time
I really trusted my instincts, I didn't worry,
I stayed in control.

rician disappointed me. She came in and all she said was "No dear. Haven't started. Go home." That's when I cried.Now I've been and controlled my own labour next time I'd do it myself, with the help of my husband, a competent midwife and my G.P.

This time we got an English midwife, Shuna...we sent her a present afterwards. She gave us her address in England where we could send a photo of the baby..she kept a book of photos of "her" babies. She broke the waters when I went in, she told me before she did anything, she let us know what was happening. I decided I was going to be in control this time. I said "I don't want to be critical but..." and she said " I want you to be honest, tell me just what it was like the last time".
The first time I was more or less hoodwinked into the epidural...I couldn't manage to push.I didn't really know what pushing was like till I felt it the second time.The first time the epidural was presented to us as an institutional routine , we had it to fit in, we didn't want to hold things up.They said if you want an epidural it takes half-an-hour to set one up and if you want it you have to say so now,,. we had the impression the anaesthetist had just done one, and ours was next, and then he was going on to the next one, and we didn't want to stop the flow.But I think I could have done that first birth without an epidural, I could have done it myself if I'd had the support and the encouragement.

HOW WAS THIS MIDWIFE DIFFERENT?

Shuna worked on what I wanted, she really listened to what I said. Although we had a dispute over the birth position.I wanted to be on all fours, but she said it would be a lot easier for her if I was propped up, or at least on my side. But I was sure of what I wanted.All fours is a great position, you're not pushing uphill, there's no weight on your spine, you've got gravity on your side. Anyway she let me stay on my hands and knees until the last push, when she told me to turn on my side, and I did, and one push and Lucy was out.She kept it to the last minute and she knew I only had one more push to do when she said turn over.

So Lucy was born at 6.30 that morning, it was really quick, I was fresh from a night's sleep.I was very high afterwards, I felt really powerful and I felt in control.The midwife was wonderful. She kept saying, "oh, you're doing wonderfully well - I haven't seen someone

From BIRTH. (U.S.A.), Spring 1984 issue,

IUD INSERTION DURING BREASTFEEDING LINKED TO UTERINE PERFORATION

Women who have an IUD inserted while they are lactating run an increased risk that the IUD will perforate the uterus.This conclusion comes from a report of the Women's Health Study, a large project started in 1976 by the National Institute of Child Health and Development.
The type of IUD did not influence the risk of perforation.For women who started using IUD's following childbirth, the timing of insertion did not change the risk of perforation.
Two main factors are thought to increase the risk of perforation in lactating women. First, the walls of the uterus remain thin in breastfeeding women because lactation keeps estrogen levels low.Secondly, breastfeeding stimulates the uterus to contract rapidly to its pre-pregnancy size, thus making it easier for an IUD to perforate the uterine wall. In addition to perforation, lactating users were more likely to have the IUD become embedded in the uterine wall.
More information can be found in Vol 61, No1 of OBSTETRICS AND GYNAECOLOGY.

From BIRTH, (U.S.A.), Spring 1984 issue,

CAUTION URGED IN USE OF LECITHIN BY PREGNANT WOMEN

A popular health food supplement, lecithin, may cause neurological damage to the developing foetus.Researchers at Duke University have found that lecithin may produce defects in the development of unborn children at doses even slightly higher than normal.Though they have reached no definitive conclusions, the scientists have raised serious questions about the use of lecithin diet aids by women during their childbearing years.

From BIRTH (U.S.A.), Spring 1984 issue,

STANFORD O&G CHAIRMAN RESIGNS
The Chairman of the Obstetrics Department at Stanford University, California, resigned January 5, 1984, after coming under intense criticism for reprimanding a resident doctor for becoming pregnant.The Chairman reportedly stated in a public memo that the cheif resident's pregnancy was "presumptuous and a disservice to oneself and one's colleagues" and warned that some faculty were advising him to appoint no more women to the obstetrics department.

birth story

Lucy was born to Sue and Bill almostthree months ago at National Women's Hospital.Their first child, Annie, was born there nearly three years ago, with an epidural and forceps. This time Sue acheived a totally natural birth, which she recounts here in an interview with Judy Larkin.

WHY DID YOU CHOOSE NATIONAL WOMEN'S HOSPITAL?

"I wanted a woman as an obstetrician. I didn't want a man - what does a man know about giving birth? I liked this obstetrician. Her attitude was "birth is birth", a spade is a spade, she's not misty-eyed, she's a no-fuss woman but she's gentle at the same time, and she wasn't patronising, not like a man might have been.She answered all my questions, I wrote down all my questions before I went and she sat and answered them all, sometimes the sessions would take 20 minutes. And she didn't mind Annie coming along either.

AND SHE DELIVERED AT NATIONAL WOMEN'S?

That's right, she could only deliver at National Women's Hospital. Well, it's close to where she lives and she can get there really quickly,she never misses a birth. But she's very straight, that's what I like about her, she's direct, and when I first went along, I was about a month pregnant I guess, she checked her diary and she could tell then that she wouldn't be there when the baby was due. She was going to go on holiday. She had someone else to do her births then and I accepted that. But at 6 months I swapped.

YOU SWAPPED DOCTORS?

Yes, I swapped to my G.P. I decided I didn't want a locum, someone I didn't know turning up when I was in labour, someone who didn't know my sense of humour.....I went to my G.P., who was recommended to me as a fantastic doctor with children. He said delivering babies was the best part of his practice.So she sent all the notes to him - he wanted to see me every week for the last 13 - 14 weeks, it's one of his conditions and he 's very careful. If anything goes wrong he picks it up very early. I didn't realise until 2 months before the birth that I didn't have to pay. We'd paid the obstetrician for the first birth,

we paid her $200 I think it was, and I thought you had to pay. So I said to the nurse, "I'd much rather pay each visit rather than have to pay in one lot " and she said "what do you mean, you don't pay us! It's free."

YOU PAY QUITE A BIT THROUGH YOUR TAXES

Oh yes well I know that.

YOU THOUGHT YOU HAD TO PAY THE G.P.?

Yes, well, we'd just come back from the States , where friends of ours had just paid $16,000 for the birth of their child. They didn't have insurance and it was a difficult birth. It pays to have insurance in the States.

HOW DID THE MIDWIFE GREET YOU?

The person who came down was very friendly, she took me straight away to be prepped. I was 7 cms when I went in.I don't know how they treated Bill....how did they treat you, Bill?

I had to go the window to ask where you were. They didn't go out of their way to do anything special, but they weren't hostile either. I don't have any negative or positive feelings about it.....they just did what they can be expected to do.

Sue: It seems to me that your experience in hospital depends TOTALLY on the midwife you get.You have problems if you have a long labour and the shift changes inbetween and you start with a nice one and end up with a grumpy one.When Annie was born we went to National Women's too and our midwife was Harriet, she was Scottish, very competent, it was a party atmosphere really.The anaesthetist was a jogger, and Bill's a runner, so they were laughing and joking....Harriet made the birth, even though I had forceps and an epidural.....she was totally open... I quite wanted to call the baby Harriet but Bill wasn't keen.

HOW LONG WAS YOUR LABOUR?

We got in at 10 past 5. I woke at 4 in the morning,with period like cramps every 4 minutes.I didn't want to go to the hospital because I'd had false labour the first time and they'd sent me home.It was a bad experience, I felt a failure...it was humiliating. The obstet-