Waikato Home Birth Association Inc. Newsmagazine 1995

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ADDRESS LETTERS CAREFULLY

new zealand 40c

Disclaimer: Opinions expressed in this magazine are not necessarily those of the Waikato Home Birth Association Inc.

HOME BIRTH AWARENESS WEEK
23 - 29 OCTOBER 1995
SEE INSIDE FOR CELEBRATIONS

SENDER:
Waikato Home Birth Association Inc.
P.O. Box 12099
HAMILTON

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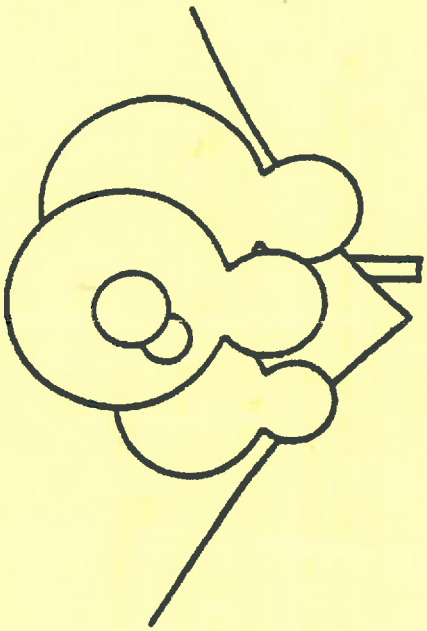
Newsmagazine
1995



OCTOBER

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Newsmagazine Editor
HBH Roster Coordinator

Home Birth House — **834-0682** — **8D Richmond Street**

Open: Wed	10am-2pm
Thur	10am-2pm, 5pm-7pm
Fri	10am-2pm
Sat	10am-12pm

Hi everyone,

I hope you are all well and I hope you have all remembered Home Birth Awareness Week. It is a very important date so please make a note of it.

There will be a fun day for all on the 29th October page 3 has all the details. I look forward to seeing you there.

I'm still in need of more articles and Birth stories so please keep sending them in. The more I get the bigger and better the magazine will be.

I'm sorry about the last article in this months magazine. Space was limited but if you can follow the numbers it should all make sense.

See you on the 29th - Christine

BIRTH NOTICES

On	these parents:	had a:	named:	where:	Midwife / s
11/9/95	Ineke & Frans Van Driel	daughter	Ella	Hamilton	Jane/Karene
11/9/95	Nadia Mason & Carey Monaghan	daughter	Amber	TeKuiti	Sally
12/9/95	Karen Reynolds & Arnie Gurau	daughter	Naia	Hamilton	Maggie/Paulette
13/9/95	Lisa Corston & Nigel Jackson	son	Ryan	Waitoa	Jane/Jenny
29/9/95	Brigid & John Devcich	daughter	Holly	Hamilton	Maggie/Penny
30/9/95	Karen & Kevin Benge	son	Elliot	Hamilton	Jane/Maggie
2/10/95	Barbara & John Marneth-Rust	daughter	Anna	Morrinsville	Maggie/Sharon
2/10/95	Kahren Bull & Foster Kalma	daughter	Grace	Ngarua	Maggie
3/10/95	Michelle & Norman Morris	daughter		Hamilton	Jane/Kerry

If your Birth Notice has been omitted contact Joanne Ridder ph 847-4987 for insertion in next newsmagazine.

The WHBA endorses the following sample of quotes taken from "Qualities we expect in a midwife" in the booklet "Have you considered a home birth?"

A midwife needs at all times to maintain a professional attitude, respecting the privacy of the woman she is caring for. She needs to be aware of the issues that are affecting women in today's society and to care for a woman sensitively, woman to woman, in the environment the woman chooses and in a way that will lead to greater feelings of self esteem and confidence for the woman.

A midwife should belong to her professional body, i.e. The New Zealand College of Midwives (Inc) and adhere to the standards of practice of such a body.

Midwifery Is a Women Centered Profession

Information and names of practicing Home Birth Midwives is available at Home Birth Resource Centre, 8D Richmond Street, or phone Debbie Stewart, 827-8202

SUBSCRIPTION FORM

If there is a GREEN spot on this form then it is time to renew your subscription.

No Green Spot? **Pass the form on to a friend**

The **$20 minimum fee** will list me as a member of the Association and entitles me to 11 issues of the Newsmagazine and use of the Library, located at Home Birth House, 8D Richmond Street, Hamilton.

POST TO:
Waikato Home Birth Association
P.O. Box 12-099
Hamilton.

Annual Subscription (your choice):
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Practicing Midwife
Professional Sub ($50) $.....
Cheque enclosed for $.....

NAME:.....

ADDRESS:.....

.....

PHONE:.....

HOME BIRTH AWARENESS WEEK

23rd October - 29th October.

Let's celebrate and promote the Home Birth option.

Sunday 29th October 11.00am - 2pm.

Home Birth Families and Midwives Picnic and Group Photo.

Childrens Playground at Parana Park, River Rd.

Come and have a fun day and meet with other Home Birth Families.

Bring your own picnic fare, chairs and games eg Volley Ball and cricket.

Other entertainment includes: Clown, Face Painting, Lolly Scramble, Balloons.

Public display at the Hamilton Central Library

Come and see our new display boards that will be circulating around various venues.

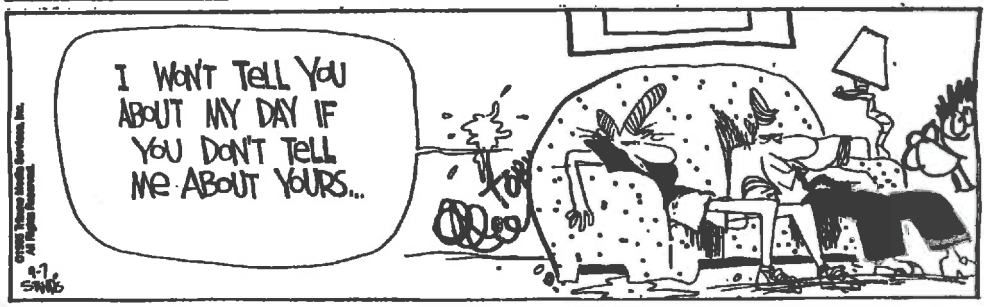
(Note change of venue - it is not being personed, they will be at the Central library all week)

Dessert and Coffee Evening Monday 30 October.

All Members invited to meet the Core Group at 4 Reynolds Drive 7.30pm.

Bring a dessert to share. Contact Libby Cooney 843-7664.

ine Buckets



Sharron Cole discusses the pros and cons of the vitamin K debate.

To give vitamin K or not to give it? If it is given, how to give it—by intramuscular injection or as an oral preparation? Does it help if the mother eats more vitamin K-rich foods in the weeks leading up to the birth? Are there satisfactory homeopathic or herbal alternatives that could be used? Do babies need vitamin K anyway?

Since the publication of the Golding studies in 1990 and 1992 which suggested that babies who received intramuscular injections of vitamin K following birth had a two to three times greater risk of developing childhood leukaemia, issues concerning the administration of vitamin K to the newborn have been debated by health professionals and consumers.

That three further studies in Sweden, the USA and Denmark did not find a link between intramuscular vitamin K and childhood cancer has been reassuring but the seeds of doubt and concern are still there in the minds of many.

Parents Centres New Zealand • No. 147 • June/July 1995

Part 1 ↑ Part 2 P.T.O

Part 3 ↓

What is vitamin K?

Vitamin K is a fat-soluble vitamin which is stored in the liver and plays a role in the complicated process of blood

of other conditions where HDN has occurred has indicated that vitamin K deficiency may not be either the prime or sole factor involved.

Parents of the newborn have a right

babies should be breastfed without any restrictions from birth

to information about the retrospective UK study published in 1990 and the later case-controlled study from the same researchers which suggest a possible link between intramuscular vitamin K and childhood cancer. Although the results of these studies have been termed "worrying but not certain", they showed that intramuscular vitamin K gave a 1:500 chance of subsequent childhood leukaemia. This compares to the risk of severe haemorrhage in HDN of being 1:10,000.

Following an injection of vitamin K, a baby's body may contain up to 5,000 times the normal level of the vitamin. It has been speculated that this may accelerate tumour producing activity and that the relative vitamin K deficiency was designed by nature to protect against the induction of genetic mutation at a time of rapid cell division. There is speculation too that phenol which is included in the injected preparation is a suspected cancer-causing agent.

Homeopathic and natural alternatives

Because of the elements of uncertainly surrounding both the oral and injected preparations, some parents may wish to learn more about natural alternatives. The recommended homeopathic preparations are Arnica and Aconite, with calc fluor being useful where cephalhaematoma is present.

It is essential, however, that any parent considering homeopathic alternatives should consult a registered homeopath as there are no specifics in homeopathy and every case needs to be considered individually.

The best natural source of vitamin K is alfalfa and a preparation that can be given to the baby is: crush 1 teaspoonful of alfalfa seeds, add kelp, steep in boiling water. Keep in the fridge and give the baby one teaspoonful of the liquid over the first few days, together with a little vitamin E. This should be accompanied by what might be termed "early and enthusiastic" breastfeeding!

Conclusion

Parents have a right to a clear explanation of the treatment proposed, including any risks and alternatives, before they agree to medical treatment for their child.

However, in the case of vitamin K, the information is confusing. Many of the problems might be overcome if the micellar oral form of the vitamin which is better absorbed were available in New Zealand. Properly conducted studies are necessary to find out what the real risks, if any, of a large dose of vitamin K at birth are.

Until then, parents will need to read all information available to them and together with a properly informed opinion from their caregiver, then make a decision which best suits them and their baby. ■

Sharron Cole
PCNZ National President

Part 2.

clotting. Vitamin K is obtained from food sources such as alfalfa (also containing vitamin E which promotes absorption of vitamin K), kelp, all green leafy vegetables, tomatoes, whole grain cereals and milk. Vitamin K is also produced within the body by the bacterial flora in the large intestine and it is thought that about 50% of the vitamin K in the blood of an adult is of bacterial origin. In the newborn however, the gut is sterile and it takes 5 to 7 days for it to become colonised by bacteria.

Haemorrhagic Disease of the Newborn

Babies are born with low levels of vitamin K—this has been referred to as a "deficiency" but more accurately, it is a "relative deficiency"—that is newborn babies' levels are low when compared with what is considered a normal level for an adult. Levels fall to day 3 and then begin a gradual rise to day 6. These relatively low levels have been linked to bleeding problems in some newborn babies—a condition called Haemorrhagic Disease of the Newborn (HDN).

HDN falls into three categories

1 Early HDN which occurs in the first 24 hours of life. It is rare and is associated with mothers on anticonvulsant therapy.

2 Classic HDN occurs between day 2 and 7. The incidence varies from minor haemorrhage in 1 in 400 births to serious haemorrhage occurring in 1 in 10,000 healthy newborn babies. The site of the bleeding varies and may include broken skin sites, navel, nose, gastrointestinal tract and bowel or occasionally, the brain.

3 Late HDN occurs after the first week of life and mainly involves bleeding into the brain, although it may also involve bleeding from the gut. The incidence is at least as common as that of Classic HDN.

Interestingly, it has been recognised from very early times that some newborn babies are prone to excessive bleeding and that is probably why the Jewish religion did not permit circumcision within the first week of life. As circumcision is a significant risk factor in Classic HDN, it is a very good reason why circumcision of the newborn should not be carried out today.

Are some babies more at risk?

It is debatable as to what determines the extent of a baby's vitamin K store at birth, how long these stores last and whether malabsorption of vitamin K is a major factor in causing HDN.

What is acknowledged is that babies most "at risk" are those where there are factors which reduce a baby's ability to absorb or utilise vitamin K. These include premature or low birthweight babies, babies who have a traumatic delivery, bruised or bleeding babies in the first few days of life, those requiring surgery, those taking inadequate feeds, babies with insufficient liver function, and those being treated with antibiotics.

It is also agreed that babies of mothers who have been on anticonvulsant drug therapy or who have been treated with anticoagulants during pregnancy are also at risk of bleeding. Exclusive breastfeeding has also been associated with a higher incidence of HDN.

Where do babies get vitamin K from?

Clearly newborn babies do not eat the foods that contain vitamin K. In the initial few days after birth, they obtain their vitamin K from stores in the liver, from vitamin K-fortified formula if babies are formula-fed and from breastmilk.

There is presently no evidence to show that increased consumption of vitamin K-rich foods by the mother preceding the birth has any affect on the foetal liver stores. However, in the days following birth, it is important to note that the concentration of fat-soluble vitamin K is greater in colostrum and hind milk and it has been found that vitamin K levels in breastmilk depend on maternal intake in the last stage of pregnancy.

Unfortunately, the practice that prevailed until very recently has been to restrict the baby's time at the breast in the first few days, thus ensuring the baby receives less than optimal amounts of vitamin K-rich colostrum and hind milk and also prolonging the times it has taken to establish the baby's intestinal bacteria which manufacture vitamin K.

For the many who do not believe "nature got it wrong" in allowing a fully breastfed infant to bleed to death, this goes some way to explaining the link between the higher incidence of HDN and breastfeeding. There may well be environmental factors involved but in any event, babies should be breastfed without any restrictions from birth.

Oral or intramuscular?

As Golding's studies showed no association between oral vitamin K and leukaemia, it has been widespread practice to give vitamin K in three doses by mouth. In New Zealand, this is the preferred option for healthy term infants.

However, there are problems associated with the oral route. The dose (which is designed by the manufacturer to be given by injection) may be spat out or vomited, it may be an irritant on the mucus lining of the mouth and throat and there are questions about how well it is absorbed.

Further, babies who do not receive the three recommended doses may have only partial protection from HDN and there are reported cases of late HDN in infants who have received only one or two oral doses.

Roche, the manufacturer of the vitamin K injection (Konakion) does not recommend the administration of the solution orally. Although there has been talk since 1992 about the introduction into New Zealand of a better absorbed form of the oral vitamin K (mixed Micelle) and it has apparently been in use in Germany for some time, it has yet to make an appearance here.

The Paediatric Society of New Zealand recommends that in infants regarded as high risk, the recommended route of administration is by intramuscular injection. There is no doubt that the high dose of vitamin K as an injection has been shown to prevent Classical and Late HDN although the existence

Parents have a right to a clear explanation of the treatment proposed including any risks and alternatives...

COMING EVENTS - October.

Note these dates on your calender

WHBA Core Group Dessert and Coffee Evening
Monday 30 October, 7.30pm at 4 Reynolds Drive (off MacMurdo Ave).
Bring a scrummy dessert to share! Contact Libby Cooney ph 843-7664.
ALL MEMBERS INVITED TO ATTEND.

Home Birth Awareness Week 23 - 29 October
Sunday 29 October 11.00 - 2pm, Home birth families and Midwives Picnic and Group Photo at Parana Park, Childrens Playground.
Display Boards to be erected at Central Library as a static display.
Support the Home Birth Option - talk to your friends about home birth.

Preparation for Birth Classes
Series begins **Tuesday 14 November,** 7.30 - 9.30pm for 5 weeks.
Contact H.B.H. ph 834-0682 or Rachael Sorensen ph 856-3817.

Raglan Preparation for Birth Classes
Series begins **Wednesday 4 October,** 7.30pm for 6 weeks.
Ph 825-8052 for details.

Cambridge Home Birth Support Group
Monday 9 October, Pot luck lunch 12 midday at 166 Carlisle St Cambridge.
Contact Sandy Upton ph 827-8361.
Monday 30 October, Pot luck lunch at 12 midday at 51 Weld St Cambridge.
Contact Michelle Isaac ph 827-9263.

Baby Daze - at Home Birth House 8D Richmond St
Tuesday 17 October, 10am - 11.30am **Previous Birth Preparation Classes get together.** Please bring a plate for a shared morning tea. Other interested people also very welcome. Contact Belinda Beetham 843-8082.

Te Awamutu Home Birth Support Group
Contact Helleni Quirke 07-870-2622, small library available.

Morrinsville Home Birth Support Group
Contact Joanne Leask 07-889-6220.

Te Ahuru Mowai o Waikato - Whakawhanau ki te kainga. The Sheltered Haven Homebirth for Maori Women. Contact Rangimarie Hohaia 07-871-5858.

Immunisation Awareness Discussion Group
For information contact Belinda Beetham 843-8082 or Janet Young 854-7502.
"For an Informed Choice" tapes are available for purchase - $6 at H.B.H. Two copies are also available to borrow from the WHBA Library

any conclusions, more work is needed.

Regardless of what our own research will reveal, there already exists enough scientific information to justify rethinking the assumptions underlying current infant sleep research, as well as pediatric recommendations as to where and how all infants should sleep.

Especially needed are new studies which begin with the assumption that infant-parent co-sleeping is the normative pattern for the human species - and that our own recent departure from this universal pattern could have some negative effects on infants and children. We need to determine if unrealistic parental expectations, rather than infant pathology, play a role in creating parent-infant sleep struggles - one of the most ubiquitous pediatric problems in the country. It may well be that it is not in the biological best interest of all infants to sleep through the night, in a solitary environment, as early in life as we may wish, even though it is more convenient if they did so.

Co-sleeping is often discussed as if it were a discrete, all-or-nothing proposition (i.e., should baby sleep with parents?) Many parents fail to realize that infants sleeping in proximity alongside their bed, or with a caregiver in a rocking chair, or next to a parent on a couch, in a different room other that a bedroom, or in their caregiver's arms all constitute forms of infant co-sleeping. I studied the location of infants and parents in their homes between 6.00pm and 6.00am and found that more infant-parent contact than parents describe.

I prefer to conceptualize infant sleep arrangements in terms of a continuum ranging from same-bed contact to the point where infant-parent sensory exchanges are eliminated altogether, as, for example, infants sleeping alone in a distant room with the door closed. Nowadays, one-way monitors often broadcast infant stirrings to parents in these situations, compensating for the loss of sensory proximity.

I am amused by this baby monitor phenomenon, primarily because we Americans seem to have gotten it all backward. Rather than parents monitoring the infant, a great number of developmental studies suggest that it should be the other way around, with the infant processing parental stirrings (especially breathing sounds and vocalizations). Infant sleep, heart rate, breathing, and arousal levels are all affected by such stimuli, probably in adaptive ways to facilitate development and to maximize adjustment to environmental perturbations (Chisholm 1986). At the very least, monitors should be broadcasting sound in both directions!

Given the human infant's evolutionary past, where even brief separations from the parent could mean certain death, we might want to question why infants protest sleep isolation. they may be acting adaptively rather that pathologically. Perhaps these infant "signalers," as Tom Anders calls them, have unique needs and require parental contact more than do some other infants, who fail to protest. It's worth considering.

James J. McKenna, PhD
Professor of Anthropology
Pomona College
Claremont, CA
Breastfeeding Abstracts, February 1993, Vol, 12 No. 3.

Dear Christine,

Thanks for putting together an interesting and infomative newsletter each month. I especially love reading the birth stories, they are always such positive experiences and also very moving. To follow is ours.

I feel honoured to have had my second baby at home in exactly the way I had envisioned. But I am sad that so many women aren't getting the right information in order to make an informed choice about birthing at home. A few of my friends and acquaintances have asked me how it was, "was it very awful?". They can't understand my reaction of "it was wonderful". I honestly feel that - it was the most positive day of my life.

BIRTH OF BETHANY

On the morning of the 28th of June I felt I had a heavy stomach with mild period like pain every now and again. I had organised with my mum to come and look after our 16 month old son Kieran, so I rang her to let her know she might be needed as she had to come from Auckland. Unfortunately Mum got an emergency call from Gran just after and ended up in an ambulance with her on her way to North Shore Hospital. She rang back to let me know and by that time I knew today was the day. Thinking she wouldn't make it we just figured we would cope between Russell and our support person Gay Tye.

During the morning the contractions were very mild with an occasional good one thrown in. The day was glorious, Kieran and I pottered round the house and garden thinking about Gran and this new life inside me. When Russ got home we walked up to the cowshed where Kieran enjoyed being with his father. I used the bails in the cowshed to squat holding on and found them a really good height. After a few odd jobs at a relaxed pace and lunch Kieran went to sleep and Russ and I walked around the farm. I felt I needed him close by now and sometimes I leant on him for a contraction or used a gate to squat by. Most of the contractions I needed to stop for but they were still a long way apart.

Back home and Kieran woke up, I did some last minute organising - candles, Rescue Remedy etc. A neighbour called in with her son and Russell invited them in! I was surprised about that but every time I had a contraction I would just kneel or squat as I was starting to have to concentrate! Gay arrived, Yay! The contractions got closer but weaker and I decided on another walk. Gay and I walked together with everyone else tootling along behind. It was nice for Kieran to have another little boy over. I used fence posts and Gay to lean on, also the cowshed to squat in. I even hung off the front end loader! Some I could still talk and walk through. When I hung onto Russell Kieran would get in between for a cuddle.

Back home again and I knelt into cushions. Mum arrived! we were all so happy she had made it as it took the pressure off knowing Kieran would have his caregiver and I would have my two. The contractions took all my energy and

concentration at this point. I decided on a bath, it was so lovely and deep and of course Kieran had to get in too. Hilary my midwife arrived just before I hopped in, with Jenny the student midwife we had agreed to have. Both had been doing all our antenatal care, and Jenny and I had attended some of Gay's classes together, so it was a great team. After a while with Russ rubbing my back I found I needed to be on my knees, Kieran got out and Russ sat at the end of the bath and I leaned over a board across the middle. We turned out the light and used candles. It was very peaceful with steam and lovely smelling oil.

Hilary, Gay or Jenny would pop in from time to time to see how we were doing. I found the contractions very easy to handle I had started to groan quite a bit. Russ started to think I was too relaxed and things might be slowing down. About ten minutes later I realised I needed to get out. I had a great contraction leaning over the bath standing and another where my knees buckled and I had to get more grounded. One more in the bathroom squatting and a red show then. I guess it was about 6.00 - 6.30 when I again knelt into cushions in the dining room. Again we used candlelight and the fire was glowing red. I found the going tougher and Russ sat on the couch with me leaning into him, pushing with most of the contractions. my waters broke here on the birth mat. The contractions were stormy and lots of opening pain while I felt I needed to push. Hilary quietly told me to trust my body. I had a little break here for a minute or two. At this stage Gay was doing a wonderful job with hot towels on my lower back. she reminded me a couple of times to let go and go with it, she was spot on recognising when to remind me! I used words here to help me, open open open, baby baby baby, and nearly nearly nearly. When my perineum was stretching Gay used towels on that - what a blessed relief! I would let her know when a contraction was coming and she would warn me just before the next towel went on.

I pushed Beth out with her hand up by her head and didn't feel much relief when her head was out, so I kept on pushing and breathing her out with that contraction. I felt Hilary manoeuvring her, I guess the hand made it a little harder. I gathered her up from between my legs and lay her on my knee just loving and touching her, feeling overwhelming joy to have her finally. I didn't bother looking to see if she was a boy or a girl. The cord was very short and I felt quite uncomfortable, Beth was crying, what a shame. Hilary then asked if we would like her to look for us and we discovered we had a beautiful little daughter. What joy! When I got more comfy I put her to my breast and shortly after delivered the placenta. She was a great little sucker right from the start. Then I was allowed a celebratory glass of champagne. Kieran needed a cuddle from his mummy before he went to bed that night. And he is getting to know his little sister. Her birth was witnessed by Kieran and my mother which I think is very special. Our wonderful friend Gay cut the cord as Kieran was with his daddy then. We just look back on that day and think WOW!

One of the best things to come out of it is the turn around I've seen in my mother. When we first asked her to be present and help care for Kieran she was happy but concerned by our "risky decision to birth at home". She continued to

Rethinking "Healthy" Infant Sleep

Mother-infant co-sleeping often accompanies nighttime breastfeeding. New research suggests that co-sleeping affects infant physiology and patterns of arousal, raising questions about currently accepted norms for "healthy" infant sleep.

Judging from the infant's biology and evolutionary history, proximity to parental sounds, smells, gases, heat and movement during the night is precisely what the human infant's developing system "expects," since these stimuli were reliably present throughout the evolution of the infant's sleep physiology. The human infant is born with only 25 percent of its adult brain volume, is the least neurologically mature primate at birth, develops the most slowly, and while at birth is prepared to adapt, is not yet adapted. In our enthusiasm to push for infant independence (a recent cultural value), I sometimes think we forget that the infant's biology cannot change quite as quickly as can cultural child care patterns.

Infants sleeping for long periods in social isolation from parents constitutes an extremely recent cultural experiment, the biological and psychological consequences of which have never been evaluated. Most Americans assume that solitary sleep is "normal," the healthiest and safest form of infant sleep. Psychologists as well as parents assume that this practice promotes infantile physiological and social autonomy. Recent studies challenge the validity of these assumptions and provide many reasons for postulating potential benefits to infants sleeping in close proximity to their parents - benefits which would not seem likely with solitary sleeping infants. Since infant-parent co-sleeping represents a species-wide pattern, and is practiced by the vast majority of contemporary peoples, the accepted clinical model of the "ontogeny" of infant sleep is probably not accurate, but rather reflects only how infants sleep under solitary conditions. I wonder whether our cultural preferences as to how we want infants to sleep push some infants beyond their adaptive limits.

To explore this possibility further Dr. Sarah Mosko and I are studying the physiological effects of mothers and infants sleeping, apart and together (same bed) over consecutive nights in a sleep lab. Our two pilot studies conducted at the University of California, Irvine School of Medicine, showed that the sleep, breathing, and arousal patterns of co-sleeping mothers and infants are entwined in potentially important ways. Solitary sleeping infants have a very different experience than social sleeping infants - although we do not know yet what our data means.

Funded by the National Institutes of Child Health and Human Development, this research will help us to evaluate the idea that infant-parent co-sleeping may change the physiological status of the infant in ways that, theoretically, could help some (but not all) SIDS-prone infants resist a SIDS event (McKenna et al., in press). One of the suspected deficits involved in some SIDS deaths is the apparent inability of the infant to arouse to reinitiate breathing during a prolonged breathing pause. Our preliminary studies show that mothers induce small transient arousals in their co-sleeping infants at times in their sleep when, had the infant been sleeping alone, arousal might not have occurred. We have suggested that perhaps co-sleeping provides the infant with practice in arousing. Before we can draw

complete and total awe, elation and ecstasy. They never knew that because the birth was stolen from them. It was the doctor who "delivered" the baby. Much like the Jews who were "delivered" from Egypt, it was presumed that the passage was frightening, painful and even fraught with evil.

When the mothers of the fifties and early sixties "lost birth," they lost the emotional bridge between pregnancy and motherhood. An entire generation of children grew up feeling that they were always searching for love — the love generation. What they were searching for was their mothers' arms the moment after birth, and their mothers' breasts to suckle and their mothers' intuition and their grandmothers' wisdom.

It was out of that generation of love-ins that the midwife reappeared. In searching for that love the children of the '60s began to seek their own way of bringing their children into the world; they were looking for a way to bring love back into birth. They had no wise women to turn to, no mothers who knew birth or breastfeeding or natural mothering. They only had one another. And the only way they could have one another was at home. (Hospital birth at that time precluded any and all support persons from attendance at birth.) In order to give birth with the assurance of love, they chose to give up all of the medical assurances of safety in the hospital. They read everything the could about birth and their closest friends who had had the experience of giving birth themselves would be asked to come to help. If several women in a community were pregnant at the same time, they would get together to talk about birth, what they had heard and what they had read. And they would, once again, invite those who were more experienced (who had had several babies themselves) to share the wisdom of their experiences. Eventually one woman in the community would become known as the one who knew — the one who knew how to help, the one who knew what to do, the one who knew how to mother the mother. And the midwife was reborn. All across America a new kind of caregiver appeared... the kind who wanted to bring love back into birth; the kind who drew upon the wisdom of the elders — the elders of many cultures, of many generations ago, of many generations to come.

When the mothers of the fifties and early sixties "lost birth," they lost the emotional bridge between pregnancy and motherhood.

Today midwives assist women all around the world. Some of those midwives have only the knowledge which has been passed down to them. Many in the United States have gone on to blend the wisdom of the elders with the science of medicine. Midwives are still generally unrecognized by the medical community, and are likely to remain so unless an entire revolution in health care breaks the egotistical paternalism which dominates women's health care. However, the women who choose the care of midwives know for themselves the invaluable service their midwife has provided for them. The quality of care, the quality of kindness, the quality of love blended with the medical advice — meeting the needs of the mother, mothering the mother so that she can mother her baby — these are the qualities which midwifery care provides.

■ *Lynn Baptisti Richards, LM, is Secretary for the Arizona Association of Midwives.*

voice her opinion for most of my pregnancy, until I explained that for me a good birth is 90% mental and I needed her to trust that we were aware of, and had discussed all possibilities and outcomes with Hilary. The day after Beth was born I asked her how she felt about homebirth now. "Great, wonderful" was her reply. Hearing her talk about her 10 day enforced stays in hospital - the drugs and the limits on seeing, touching, bathing and feeding her babies (and the subsequent failure of breastfeeding) has been healing for her and brought a closer understanding between us.

So Hooray for homebirths and all the work from the many people dedicated to promoting it as a safe and viable choice.

Diane Simmons.

WANTED - FACILITATORS FOR BIRTH PREPARATION SERIES 1996

Home Birth Association Consumer Representatives and Midwives required to facilitate future "Preparation for Birth" Series.

Contact Rachel Sorenson ph856-3817 if you are interested.

BIRTH PREPARATION SERIES REUNION

All people who have been involved in previous Birth Preparation series are invited to a shared morning tea.

WHEN: Tuesday 17 October.

TIME: 10am -11.30am.

WHERE: Home Birth House, 8d Richmond St.

CONTACT: Belinda Beetham 843-8082.

Please bring a plate.

Home Birth House Roster - Volunteers required.

Due to other committments the number of volunteers have declined.
Can you spare 2 hours a month to help person Home Birth House?
Opening Hours - Wed 10am-2pm
- Thurs 10am-2pm, 5pm-7pm
- Fri 10am-2pm
-Sat 10am 12pm

Contact Robyn Parker 856 3247 for more details if you are interested.
Thanks to everyone who is helping keep Home Birth House open the advertised hours. Please continue to put your name on the following months roster at HBH.

In my opinion

Midwifery — The Second Oldest Profession

by Lynn Baptisti Richards

The "profession" serving the sexual needs of the man is often credited as being "the oldest profession." Who, then, serves the needs of the woman? What might those needs be? A woman's time of greatest sexual need is, not surprisingly, her time of giving birth to her babies. And it is at this time that she most naturally turns to another woman in her family or community with the experience, knowledge and skills needed to help her. A woman who has helped many in their times of need. A woman who intimately knows from her own life experience as mother and grandmother, and finally as midwife and community healer, what women need in order to bring life into the world.

For thousands of years midwives have been the professionals called upon to help women in childbirth. So important were midwives to the life of a people, that they are described in the Old Testament as examples of strength and faith in God. Midwives were the "medicine women" of most indigenous peoples. They were the wise women who knew about the passages of life — birth and death, the transitions of menarche and menopause, about herbs as healers, about foods as life sustainers, about marriage as the source of family strength and about family as the essence of culture. Not only were they called upon to assist at births, they assisted families and mothers throughout their lives. They were often called upon to preside over a coming death, to assist the dying in their transitions into the "afterlife." Midwives were once the nutritionists, herbalists, doctors, ministers and counselors all rolled into one "profession." They were the first wholistic practitioners. For thousands of years midwives practiced their healing arts with knowledge that had been passed down from generation to generation.

During medieval times, however, the male-dominated Church feared the knowledge of the midwife. Her ability to predict whether or not a labor might be long and painful or short and easy (probably based upon her examination and counseling skills) was considered evidence that the midwife was a witch whose power had come from the very source of evil — the devil. The midwife's knowledge of healing with herbs further substantiated the midwife's "obvious connection with the devil." Thus, many midwives whose only crime was the art of birthing and healing were tortured and burned as witches during this very dark time in the history of midwifery. Unfortunately this deeply held belief that midwives are somehow unclean, occult and unfit to be present at the birth of a baby has continued to be promoted by male-dominated institutions and has continued to haunt midwives ever since those darkened times.

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For example, late in the nineteenth century, forceps were invented. Forceps were the secret tool of the male physician, who kept them hidden from view at all times. Forceps were the "saviors" of difficult births and the secrecy elevated the physician to a godlike position. This marked the beginning of male intervention in what had always been a woman-centered process. It was the beginning of the end of honoring the power of the birthing mother bringing life into the world.

Shortly after forceps came hospital birth. Touted as a place of health and safety for the mother and her baby, the actual motivation was simply the convenience of the physician. If the physician could convince all of "his" mothers to have their babies in the hospital, then he wouldn't need to be bothered traveling long distances through the night to the homes of the poor for even poorer compensation. He could do all births in the same convenient location and be paid "top dollar" as well. Care by a physician in a hospital became a status symbol. Midwifery care then became relegated to the poor; it was poo-poohed and demeaned.

Then, a strange thing began to happen. Women died of puerperal fever. A week or two after giving birth to healthy babies, the mothers were dying. While a great deal of fuss was made about these deaths and blame was somehow shifted to midwives and home birth, a Vienna physician named Ignaz Semmelweiss became determined to understand the cause of these deaths. Through his study he observed that the physicians who had so cleverly moved birth to the hospital for their convenience were actually the cause of the dreaded puerperal fever. How could this be? Physicians had been busily examining corpses in one area of the hospital. Then, without washing their hands, they were examining laboring women. Thus, they were transmitting all of the deleterious bacteria from dead bodies into the warm, wet medium of the woman's vagina and uterus. Within two weeks the bacteria would multiply and spread. The woman would die of septicemia (infection throughout the body). Semmelweiss's solution, which he presented to his colleagues, was very simply—to wash their hands thoroughly before each examination. For this presentation, Semmelweiss was rewarded with banishment from the medical profession and he was placed in a mental institution. The idea of aseptic

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technique would take many years to reappear in the practice of medicine. Of course the news of Semmelweiss's discovery never reached the public via satellite television, and so the midwife and home birth continued to receive the "bad rap" for death in the birthplace. Thus, the promotion of fear of childbirth escalated.

In the 1920s a new political group called the American Medical Association (AMA) was formed in the US. The purpose of the group was to destroy all practitioners who were not "medical" (allopathic) doctors. Prior to this, there had been, in addition to midwives, many diverse healers: chiropractors, naturopaths, homeopaths, osteopaths, herbalists and spiritual healers. There were no licenses to practice healing of any sort — no medical licenses, no midwifery licenses, no "anything" licenses. All healers were free to attain their knowledge in any manner they deemed suitable. All were free to practice their healing arts. There were schools of all types scattered throughout the country. Then, the AMA hired a man named Flexner to develop a report to "prove" the safety of allopathic medicine and to destroy the credibility of all other types of healing practices. The result of this report was to:

1. Close almost all of the healing schools in the United States that were not ascribing to the philosophy of allopathic medicine.
2. Criminalize the practice of almost all non-allopathic healing.
3. Destroy the credibility of almost all non-allopathic healers.

In addition to the destruction of non-allopathic medicine, the AMA had made a striking publicity campaign to elevate the practice of surgery as a healing technique. "Going under the knife" had originally been greatly feared because no anesthetics were available. But with the development of anesthetics and "painless surgery," came a strange turn in the history of women's health. Women themselves began to lobby the doctors to be permitted access during childbirth to the anesthetics used in surgery. This was considered to be a "patient's right." And why did these women need this anesthetic? Because ever since midwife-attended, woman-centered empowered birth had been reduced to physician attended, physician-centered, physician empowered birth, laboring women had been at the mercy of their physicians.

By the thirties most births in this country had shifted from a home setting attended by a midwife (wisewoman) to a hospital setting attended by the physician. Only in a few isolated areas such as the Tennessee hills, or the Bayou, or the back country of the deep South, or the tenements of immigrants, did the midwife continue to exist. These "granny midwives" continued to carry on the traditions of birth. These grannies who carried the wisdom of the ancients, served the poor, the hungry, the downtrodden. They were often unpaid servants who had little to no equipment or training. But they knew from the experience of years and years and years how to help a mother or how to breathe life into a child. They were the unsung heroes of woman-centered women's health care. Most of them died unrecognized and unpaid. But, if we search long and hard enough, we can still find a few grannies out there who have a lot to teach us if we have enough respect to ask them.

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By the fifties most births were heavily medicated with both analgesia and anesthesia. Most women knew nothing about labor or birth because the doctors told them not to listen to the wisdom of their elders (their own mothers and grandmothers). The only acceptable person to answer a new mother's questions was her doctor. And his advice was simple, "Trust me, little girl. Just do what you're told, and everything will be all right." The woman about to give birth had no woman wisdom within her to trust. She knew nothing of the process which she was about to endure. She didn't need to know anything. She was just going to walk into the hospital and "god the doctor" would take care of the rest. He would give her drugs.

The most popular drug given during the '50s and early '60s was scopolamine, an amnesiac and hallucinogen. It was placed in the IV which was routinely started. The woman would be strapped to the bed. Women on this drug were completely out of control. They would have no idea where they were, who they were, or what they were doing. They would completely lose sight of the fact that they were in labor having a baby. The drug was so powerful that the woman would writhe and twist and fight the straps. Some women were permanently damaged by their own fight while under the influence of this drug. The nurses knew that scopolamine made women unpredictable and untrustable with their babies. Nurses were ordered not to bring the babies to their mothers until the woman could correctly read the clock on the wall. This supposedly indicated that the effect of the drug had worn off and mothers could then be trusted not to harm their own newborn babies.

The saddest part of these "revolutionary practices" to save women from the "pain of childbirth" was that it destroyed the intuitive mothering process for an entire generation of mothers. For although women were told that the drugs would take away their pain, what actually happened was that the drugs took away their memory of childbirth. Mothers would have only occasional "flashbacks" of their labors, much like a scene of a torture chamber from a horror movie, but would never know the process of giving birth. They would imagine that these torture chamber scenes were the pain of childbirth. They were eternally grateful for being rescued by the "god" in the white coat. Women never knew that the process of giving birth, although difficult and at times even agonizing, would end in