maternity action

SAVE THE MIDWIVES

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THE NEED FOR ONGOING DICUSSION AND DEBATE

A newsletter can serve a variety of functions but one of its prime objectives should be to disseminate information that will both inform and facilitate discussion and debate. Most women discover pretty quickly that views on maternity issues are many and varied. Experts abound and each one is absolutely convinced that their knowledge is the most profound, the only correct version and the information to be heeded.

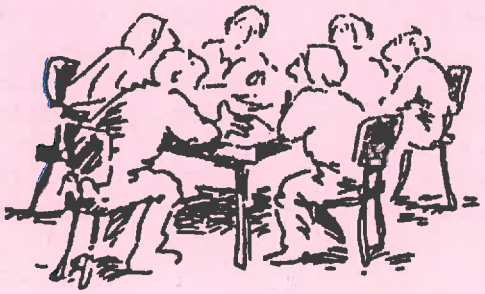
Women and midwives need to continue sharing experiences and knowledge in a way that contributes to ongoing discussion. By sharing and asking questions of each other we keep a positive focus on the value of women's experiences. Thank you to those who have contributed articles, letters, ideas and suggestions, and a plea to those of you who see an article, something of interest or have a good idea - please send it in.....and if there is something you disagree with or feel strongly about...do tell us.

The link between women and midwives is a strong one but like all partnerships it needs ongoing communication. The affirming and informing role of communication obviously also extends amongst women and amongst midwives.

Midwifery Education has continued to be a subject of considerable discussion as we await the processing of the Direct Entry Midwifery curricula. It is known that 5 curriculums have been submitted to the Nursing Council for professional approval. The Nursing Council must either approve or advise on how a curriculum can meet the established professional criteria. Following this step, the curriculum proceeds to the NZ Qualifications Authority where it is scrutinised to see that it meets educational requirements. Direct Entry Programmes are expected to be underway at the beginning of 1992.

The recent Vision 2000 Workshop on Midwifery and Nursing Education highlighted the fact that quite a number of nurses are still having difficulty with accepting midwifery as a profession in its own right. The need for education about midwifery, further discussion and enlightenment remains ongoing both in the community and amongst health professionals.

It is essential that we continue to listen to each other and keep the dialogue flowing on all fronts. Judi Strid



Midwifery and Women's Power

by Ina May Gaskin

Ina May Gaskin *is a midwife and founder and director of the Farm Midwifery Center. She is the author of* Spiritual Midwifery, Revised Edition *(1978) and* Babies, Breastfeeding and Bonding *(1988). She edits and publishes the quarterly journal,* The Birth Gazette. *She also produces video programs on childbirth issues. Ina May is one of the founding mothers of the Midwives Alliance of North America and lectures frequently throughout the world. She teaches English at the Farm High School in the Farm community. She can be reached at 41, The Farm, Summertown, TN, 38483.*

I am a midwife, storyteller, writer, teacher, and pathfinder. Perhaps in another time I would have learned my midwifery from one of my grandmothers, but that chain was broken the generation before that of my grandmothers, and I had to essentially re-discover what a midwife does and why she is so necessary a part of any society.

Because that chain of women's knowledge had already been interrupted by the time I came of age, I had to learn from bitter experience why pregnant and laboring women need protection around the time of birth. I don't mean the kind of protection symbolized by the high technology so many of my sisters have come to accept as necessary at birthing time, but rather the protection of other women, wise to the ways of birth, who understand that birth is a time of transformation and empowerment in women's lives. Birth is a rite of passage, and we need compassionate and wise guides to help us during this peak experience.

Candace Whitridge, a midwife friend of mine, tells about an African myth that illustrates that no matter what we do, we women are still essentially alone when we give birth. In the myth, a woman is on a narrow log in a shallow but very rapidly moving stream. Giving birth means getting from one shore line to the other. Villagers and loved ones can be on both sides of the log and accompany her downstream. They can pick her up if she falls off the log. People can cheer her on, and they can help her keep her balance and give her an idea of how close the other shore is, but they can't get on the log with her. Birth is like that.

At least from the time of the birth of my first child in 1966, I have been obsessed with the relation of women's power to the act of giving birth. Having come to that first birth with a faith that I was perfectly made to flow with its biological necessities, I was surprised when my obstetrician said there was a very real danger that my baby's brain could be damaged "by pounding against my perineum," as he put it, unless he intervened by giving me a spinal anesthetic and pulling my baby out with forceps. He advocated this approach for all first births.

Having spent much of my childhood around farmers, I knew that the female of the species was supposed to be protected from intrusions around the time of birth in order for the process to work well. My aunt, who raised animals all her life, kept me away from a mother dog and her newborn puppies lest I obliterate the scent cues on the pups that prompted her to know they were hers and to give them expert care.

Besides not believing that all first births had to be by forceps, I was afraid of being anesthetized and helpless among strangers. I could not believe that my own body could injure my baby. Despite my arguments, general stubbornness and my strategy of being unobtrusive while in labor so that they would leave me alone, I was surrounded by several nurses and the obstetrician when I was near full dilation, and they gave me the spinal. Straps were placed around my wrists and ankles, and the forceps were inserted. I felt as if I was in a medieval torture chamber. My daughter was carried away before I had a chance to look at her (I think the doctor didn't want me to see the forceps marks on her head). I was stitched up and told that I shouldn't try to raise my head for at least twelve hours if I didn't want a headache that might last for a month. I didn't get to have a real look at her until she was almost a day old. I wasn't sure she was mine.

Although by outward appearances I was an adequate mother, inside I knew that something very important was missing. I was full of fears that I had not known before; I didn't really feel like a mother, and, most importantly, I didn't know that my daughter was Somebody. It took me the rest of her life to catch up, but we finally did. She died of brain cancer at the age of twenty.

The story of how I became a midwife has been told in my book, *Spiritual Midwifery*,* excerpts of which are reproduced with this article. Suffice it to say that most of what I learned, I learned from other women. There were a few male doctors who provided me with instruction and reinforcement at critical times in my early midwifery training.

My husband and I and two hundred seventy other people began a community in 1971. Virtually everyone who was not a child was of childbearing age, and babies started happening fast, including my last three children. I trained midwives to help me, since none of the women in my community opted for birth inside the hospital. Some of the first babies to arrive were born to mothers who had had hospital births much like mine; their enthusiasm about a style of birth that put midwives at their service was contagious. The women who were having first babies also wanted to birth at home. The confidence of the women grew with each birth, and fear of

**Spiritual Midwifery*, rev. ed., by Ina May Gaskin (Summertown, TN: The Book Publishing Co., 1977). © 1977 Ina May Gaskin.

childbirth became less of a factor at our births. I was constantly amazed at the courage and beauty of the women, and I couldn't help but notice that my admiration of them seemed to help sustain them. Together we knew that pregnancy and birth were not medical emergencies.

In 1971, when I began my work as a midwife, the national cesarean rate was about 7%. Today it is 24% nationally. Then as now, the mother was not permitted to eat or drink once she was in labor. Our way was entirely different. I remembered the hunger and weakness I had felt during my own long labor, and I couldn't imagine denying my friends food and drink while they were working so hard. In my eighteen years of practice, no woman has had any problems related to eating or drinking in labor. The women in my community knew that we were doing something right. I tried to treat everyone the way I wished I had been treated when I had Sydney—like the most important being in the universe. The rule was that if anyone were to be around the laboring mother, she deserved their absolute attention, love and respect.

The men in the community had to stay away from birth, except when their own children were being born. My husband provided a positive example to the rest of the men by insisting that it was right for women to decide how they should be treated in childbirth. Once everyone saw how well this system worked, there were few arguments as to its essential rightness.

Some of my most important lessons in helping women give birth centered around showing their mates what kind of support to give during pregnancy, labor, and birth. Although my experience with birthing has involved male partners, the following experience should apply to the many women who have female labor and delivery coaches, such as female relatives and lovers.

When a woman's partner knew how to touch the mother during labor, the partner could alleviate a lot of her pain, and couples who cuddled and kissed during contractions were nice to be around: their babies seemed to slide out easily; they were in good condition, even when the labor was long. Many of the mothers seemed to experience very little pain, and it was not unusual to hear a woman say afterwards, "That was so nice! Let's have another one."

We midwives kept careful records on pregnancy and birth. We studied obstetrical texts and gathered all the knowledge we could about birth. I couldn't help but notice that we weren't experiencing the number of complications that were reported in most texts. One hundred and eighty-six babies were born before we needed a cesarean section. Another one hundred thirty-seven babies were born before we needed another cesarean.

I feel that we have unlocked the great riddle of birth and in doing so, we have found a way that women can live with men without being exploited. It seemed most relevant that someone figure out how this might be done, since half the babies being born are male, and we need to know how to raise them so we can live with them, too.

Breastfeeding worked as well as birthing. Every mother who gave birth was able to breastfeed, even those whose babies had been born prematurely. (Friends brought their babies by to help these mothers keep their milk supply up, and husbands drank the mother's milk to stimulate milk production until the premature baby was able to suckle.) Most of the women wanted to work at least part time outside the home, so in our community, babies got to go to work with their mothers. Baby beds and playpens were considered office furniture; as essential as desks.

To date, my partners and I have attended some 1,706 births, with a low mortality rate (the neonatality rate is 8.8/1000 births including all transfers, uterine deaths during pregnancy and congenital abnormalities), no babies permanently damaged by our way of childbirth, and a cesarean rate of 1.4%. I lecture regularly at medical schools and have recently begun to do Grand Rounds for family practice physicians and obstetricians. I show them videotapes of how birth should look. One of my basic tenets is that laboring women should look beautiful and powerful. If they don't, they're probably not being treated as well as they should be.

In the community where I live, we live with the knowledge that birth works. If it works for us, it can work for the rest of our species—provided that men move over and let women make the decisions about how we go about caring for women in childbirth. Obstetricians ought to be taught about birth by midwives who are independent of modern obstetrics, midwives who are versed in the true motherwit. Motherwit, or mother wisdom, includes knowing that every woman has the knowledge within her about how to give birth, and that for her to have access to this knowledge, she must be protected from fear, distraction, and abusive treatment. Obstetricians are taught to fear childbirth; all through their training, what can go wrong with childbirth is constantly before them. Obviously, since obstetricians necessarily must deal with the problems of childbirth, they must be trained in pathology, but before they are exposed to what is frightening about birth, they need a thorough grounding in what normal childbirth is and how to keep it normal.

I know that if we can bring about this change in how we treat women during pregnancy and birth, we can make important and far-reaching changes in society and how we relate with our environment. However, according to my calculations, the U.S. is about 250,000 midwives short of the number we truly need. We need to respect different educational routes to midwifery. While some midwives may enter the profession through nursing, we need to know that ultimately, nursing and midwifery are distinct professions. In many states, the laws permit only nurse-midwives to practice legally. The U.S., along with Canada, produces fewer (nurse) midwives per capita than the other industrialized countries, and this rate of production will not significantly increase until midwifery is viewed as its own self-regulating, independent profession. Only in this way can we have enough midwives with sufficient freedom of practice that all women who need and want midwifery care during labor and birth can enjoy this privilege. ∞

Excerpts from ***The Spiritual Midwife,*** *by Ina May Gaskin*

Pregnant and birthing mothers are elemental forces, in the same sense that gravity, thunderstorms, earthquakes, and hurricanes are elemental forces. In order to understand the laws of their energy flow, you have to love and respect them for their magnificence at the same time that you study them with the accuracy of a true scientist.

A midwife or obstetrician needs to understand about how the energy of childbirth flows—to not know is to be like a physicist who doesn't understand about gravity.

Every birth is Holy. I think that a midwife must be religious, because the energy she is dealing with is Holy. She needs to know that other people's energy is sacred.

Spiritual midwifery recognizes that each and every birth is the birth of a child of God. The midwife's job is to do her best to bring both the mother and the child through their passage alive and well and to see that the sacrament of birth is kept Holy. The Vow of the Midwife has to be that she will put out one hundred percent of her energy to the mother and to the child that she is delivering until she is certain that they have safely made the passage. This means that she must put the welfare of the mother and child first, before that of herself and her own family, if she has to make a choice of that kind.

A spiritual midwife has an obligation to put out the same love to all children in her care, regardless of size, shape, color, or parentage. We are all One.

The kid in front of you is just the same as your kid. We are all One.

By religious, I mean that compassion must be a way of life for her. Her religion has to come forth in her practice, in the way she makes her day-to-day, her moment-to-moment decisions. It cannot be just theory. Truly caring for people cannot be a part-time job.

During a birthing there may be fantastic physical changes that you can't call anything but miraculous. This daily acquaintance with miracles—not in the sense that it would be devalued by its commonness, but that its sacredness be recognized—this familiarity with miracles has to be part of the tools of the midwife's trade. Great changes can be brought about with the passing of a few words between people or by the midwife's touching the woman or the baby in such a way that great physical changes happen.

For this touch to carry the power that it must, the midwife must keep herself in a state of grace. She has to take spiritual vows just the same as a yogi or a monk or a nun takes inner vows that deal with how they carry out every aspect of their life. So must a midwife do this if she is to have touch that has any potency. A person who lives by a code that is congruent with life in compassion and truth actually keys in and agrees with the millions-of-years-old biological process of childbirth.

If the midwife finds habits in herself where she does not always behave as if we are all One, she must change these habits and replace them with better ones. A midwife must constantly put out effort to stay compassionate, open and clear in vision, for love and compassion and spiritual vision are the most important tools of her trade. She must know that she has free will and that she can change if she needs to. This is the spiritual discipline that she must maintain in order to be fit to do her work, just as an Olympian athlete must keep her or his physical and mental discipline to stay in top condition.

To one who understands the true body of *shakti*, or the female principle, it is obvious that she is very well-designed by God to be self-regulating. We are the perfect flower of eons of experiment—every single person alive has a perfectly unbroken line of ancestors who were able to have babies naturally, back for several millions of years. We are the hand-selected best at it. The spiritual midwife, therefore, is never without the real tools of her trade: she uses the millennia-old, God-given insights and intuition as her tools—in addition to, but often in place of, the hospital's technology, drugs, and equipment.

One of the midwife's most valuable tools is the same intimate knowledge of the subtle physiology of the human body that is the province of yoga. The spiritual midwife brings about states of consciousness in women that allow physical energy transformations of great power, great beauty and great utility.

In Zen Buddhism, they talk about your "original face." The Zen Master might say to a student: "Show me your original face." A midwife is an especially privileged person because she gets to see the original face of each child she helps to birth. The beauty and purity of the energy field that radiates from each child treated with proper respect is awesome and unforgettable. ∞

DISCUSSION PAPER ON CARE FOR PREGNANCY AND CHILDBIRTH

Department of Health
TE TARI ORA

SUMMARY OF RECOMMENDATIONS

1. The Working Group supports the proposal for women to carry their own health records.

2. The Working Group supports the option of planned early discharge but stresses that this must be backed up by community midwifery services and access to health professionals, nappy services, child care and home help. Area health boards must take the responsibility to [illegible] to implement the

3. Antenatal education is a basic right of all women. The quality of antenatal education must be of a high standard and should be provided by trained health educators. The Working Group considers that area health boards have an obligation to provide antenatal education free of charge.

4. The Working Group recommends that area health boards should provide up to 10 days postnatal midwifery care.

5. The Working Group supports the concept of the domino option and recommends that area health boards should investigate implementing this initiative.

6. The Working Group recommends that the Department of Health should review the benefit structure for domiciliary midwives in light of the proposed amendment to section 54 of the Nurses Act to ensure that women who choose a homebirth have access to the same services which medical practitioners provide free of charge.

7. It is recommended that area health boards establish a new committee, called the Childbirth Services Co-ordinating Committee, to co-ordinate pregnancy and childbirth services within each board and to ensure the establishment of childbirth quality assurance programmes.

8. It is recommended that the Obstetric Standards Review Committees should disbanded.

9. The Working Group supports the recommendation of the Board of Health Women's Health Committee that boards should appoint a senior advisor on women's health and that women should comprise a minimum of 50 per cent of all committees established by boards.

10. Area health boards should provide acceptable facilities for normal births, for example, family rooms. Consumers should be consulted as to their actual needs.

11. The Working Group supports the retention and establishment of small childbirth units in rural areas, for example, birthing units operating on a domino scheme.

12. The Working Group recommends that the training of health professionals should include a cross cultural education component, interaction and communication skills, and disability awareness.

13. The Working Group recommends that boards should provide trained health interpreters to ensure good communication between women and their health professional.

14. The Working Group recommends that the Department of Health should involve consumers in the development of Board contracts and performance indicators.

15. The Working Group recommends that the Department of Health should consider funding a pilot programme to establish the cost of continuity of care.

16. The Working Group supports direct entry midwifery training. This is seen by the group as another way of increasing the number of trained midwives. It also opens avenues for education for lay midwives.

17. The Working Group recommends that some sort of formal recognition be given to traditional birth attendants and lay midwives which will enable them to work within the health system subject to the checks and balances inherent in the health system, and subject to the requirements of the childbirth quality assurance programmes established by each board.

18. The Working Group recommends that all boards should review their existing policies on access to beds to ensure that barriers to choice of location and choice of health professional are removed. (Independent midwives will need access to beds in hospital.)

19. The Working Group recommends that separate written informed consent be obtained for ultrasound scanning.

20. The Working Group supports the establishment of a perinatal data base.

The Treaty

Te Tiriti o Waitangi

ENGLISH VERSION

ARTICLE THE FIRST: The chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation, cede to to Her Majesty the Queen of England, absolutely and without reservation, all the rights and power of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole Sovereigns thereof.

ARTICLE THE SECOND: her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof, the full exclusive possession of the Lands and Estates, Forest, Fisheries, and other properties which they may collectively or individually possess, so long as it is their wish and desire to maintain the same in their possession; but the Chiefs of the United tribes and the Individual Chiefs yield to Her Majesty the exclusive right of Pre-emption over such lands as the proprietors thereof may be disposed to alienate, at such prices as may be agreed upon between the respective proprietors and persons appointed by Her Majesty to treat with them in that behalf.

ARTICLE THE THIRD: In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her Royal Protection and imparts to them all the Rights and Privileges of British subjects.

ARTICLE THE FOURTH:The Governor says that the several faiths (beliefs) of England, of the Wesleyans, of Rome, and also Maori custom shall alike be protected by him.

MAORI VERSION

KO TE TUATAHI: Ko nga Rangatira o te Wakaminenga, me nga Rangatira katoa hoki, kihai i uru ki taua Wakaminenga, ka tuku rawa atu ki te Kuini o Ingarani ake tonu atu te Kawanatanga katoa o o ratou wenua.

KO TE TUARUA: Ko te Kuini o Ingarani ka wakarite ka wakaae ki nga Rangatira, ki nga Hapu, ki nga tangata katoa o Nu Tirani, te tino Rangatiratanga o o ratou wenua o ratou kainga me o ratou taonga katoa. Otiia ko nga Rangatira o te Wakaminenga, me nga Rangatira katoa atu, ka tuku ki te Kuini te hokonga o era wahi wenua e pai ai te tangata nona te wenua, ki te ritenga o te utu e wakaritea ai e ratou ko te kai hoko e meatia nei e te Kuini hei kai hoko mona.

KO TE TUATORU: Hei wakaritenga mai hoki tenei mo te wakaactanga ki te Kawanatanga o te Kuini. Ka tiakina e te Kuini o Ingarani nga tangata maori katoa o Nu Tirani. Ka tukua ki a nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani.

KO TE TUAWHA: E mea ana te Kawana ko nga whakapono katoa o Ingarani, o nga Weteriana, o Roma, me te ritenga Maori hoki e tiakina ngatahitia e ia.

[NOTE: the fourth article appears only in the Maori version of the Treaty. Two churchmen, the Catholic Bishop Pompallier and the Anglican Missionary William Colenso, recorded a discussion on what we would call religious freedom and customary law. In answer to a direct question from Pompallier, Hobson agreed to the following statement. It was read to the meeting before any of the chiefs had signed the Treaty.]

QUESTIONS

Which Treaty is the real one?

Both versions are genuine. There are 512 signatures but only 30 are on the English version. The rest are all on the Maori Treaty.

The Waitangi Tribunal is instructed to have regard to both Maori and English versions in interpreting the Treaty.

Is the Treaty legal?

Yes, but like other treaties, the Treaty of Waitangi is not directly enforceable by the courts unless Parliament has so directed in an Act of Parliament. This has happened in some but not all areas of law.

Parliament has set up the Waitangi Tribunal to hear and report on claims that the Treaty has been breached.

What happens when the two texts are interpreted differently?

In international law, in any ambiguity the *contra proferentum* principle applies. This means that where two parties are unable to agree on the meaning of a certain provision, the interpretation of the party which did not draft it takes precedence. The indigenous language text also takes precedence over the translation.

RACE RELATIONS OFFICE

Do you want more information about the Treaty and its significance? If so, please contact

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A midwife's thoughts on dignity

Preserving a patient's dignity is dinned into everyone during basic training. But what does dignity mean? Caroline Flint describes what it meant for one woman during labour

I delivered a baby this morning. It was so amusing when the baby, who only had her head out, began to cry; I kept telling her that she could not because she was not able to expand her lungs yet. But baby Joanna ignored what I was saying and went on crying until she was delivered.

Joanna's mother delivered on all fours, completely naked (she had suddenly hurled off her nightdress because she found it constricting), her bottom in the air. In fact for 45 minutes during the labour I never saw the mother's face, only her bottom. Joanna's mother was on all fours on a mat on the floor and she leant her face and arms on a large beanbag and a pile of pillows.

Joanna's mother had intended having an epidural, like she had in her first labour, but she could not persuade herself to get up off the floor and onto the bed because she knew how uncomfortable the bed would be and she would not be able to bear the pain, even for the short time it would take to administer an epidural. She could not get over how comfortable she was on her hands and knees.

After the labour, she sat on the floor with her husband and me, cuddling baby Joanna. She looked at me with shining eyes and said, 'Thank you, Caroline, that was so lovely, so dignified. I really felt in control of the whole thing'. Her words struck a chord in me and I thought about then. all day. Here was a woman who had been naked, in a position that can hardly be called dignified, feeling very positively that she had given birth with great dignity and control (which she had). I thought about her first labour which she had told me about. She had had an induction, an epidural, and she had been electronically monitored throughout the labour. She had had excellent pain relief from the epidural and had had a liftout forceps delivery. She had given birth on a bed and had kept her clothes on throughout the labour and delivery. In theory, that labour sounds as if it were much more dignified than this one; dressed instead of naked, no pain so no grunts, no groans or sounds of pushing, a covered woman sitting on a bed instead of a naked bottom with no face, and yet Joanna's mother was ecstatic about the delivery and labour this time. She obviously feels incredibly clever and has grown throughout the whole experience.

Dignity. What is it? Is it keeping women's gowns on them when they feel hot and constricted, is it stopping them making noises that offend our sensibilities, is it sedating them so that they can stay motionless and 'dignified' throughout a hugely physical, abandoned, sweaty, steaming process, or is it giving them their head? Is it handing their labours over to them? Is it sitting back and keeping an eye on the fetal heart occasionally but otherwise trying to keep a low-profile?

We all sat on the floor, on a mat covered by a sheet, while I examined the baby. Parts of the sheet were covered with blood and amniotic fluid. Joanna's mother said to me, 'Isn't this cosy and relaxed?' We must have looked like a group at a rather bloody picnic party, but she was right; it was cosy, it was relaxed, but above all it was dignified.

IS THE NURSERY A POSITIVE EXPERIENCE?

Mothers whose babies stayed in the nursery at night did not sleep longer or better than mothers who kept their babies in the room with them during the night. While many mothers want to keep their babies with them at night, a common belief of health professionals is that mothers will have a more restful night's sleep if their babies stay in the nursery. Because of this conflict, a study was conducted to determine the impact of rooming-in on maternal sleep at night. Twenty-one healthy, full-term newborns and their mothers were included in the study. The infants of ten mothers remained in the nursery at night and were brought out to the mothers for feedings, if so requested. Eleven infants roomed-in with their mothers at night.

Maternal sleep data was collected during the first two consecutive nights following birth. Each mother was asked to estimate the number of hours she slept during the previous eight hour time period, from 11:00 p.m. to 7:00 a.m. Mothers also rated their quality of sleep on a seven point Likert scale, from "poor disrupted sleep" to "sound restful sleep." Seven out of ten mothers in the nursery group took sleep medication at least once during the nights of the study while none of the ten mothers in the rooming-in group took sleep medication. There was no significant difference in the amount or quality of sleep for mothers in either group. Mothers in the nursery group reported they slept an average of 5.35 hours during the eight hour period while mothers in the rooming-in group reported they slept an average of 5.55 hours. On the seven point Likert scale, the mean quality of sleep score was 4.78 for mothers in the nursery group and 5.23 for mothers in the rooming-in group. Mothers in both groups experienced marked sleep disruption and were dissatisfied with the amount and quality of sleep they had while in the hospital.

Keefe, M. R. 1988. The impact of infant rooming-in on maternal sleep at night. *J Ob Gynecol Neonatal Nurs* 17(2): 122-126.

THE FEMALE CRADLE

Rebeca Barroso has been a traditional midwife for fifteen years and is a member of the NAPSAC group, Genesis. She is also the proud owner of the smallest gynecoid pelvis she has ever encountered. During a workshop which she led in Minneapolis she had a volunteer measure the intertubular diameter of her pelvis. Rebeca then squatted while she talked and after several minutes demonstrated that she had increased her pelvic measurements by 2½ finger widths.

Rebeca then discussed the myth of the inadequate pelvis. According to the *medical model* pelvic inadequacy leads to the following: maternal death is 7 times greater; incidence of infection is 20% greater; 5-10% will sustain tears and lacerations; the baby will suffer inter-cranial hemorrhage and stillbirth 4 times more often than women with "normal" pelvises.

Rebeca countered. "In my fifteen years of working as a midwife, the only pelvises I have encountered that were inadequate to give birth were 2 or 3 that were crushed in car accidents. The bones had healed at funny angles. I have never encountered a woman whose pelvis was misshapen due to malnutrition, although I feel it could be possible."

Rebeca explained that all pelvises are movable. Women who are pregnant experience a softening of the cartilage in the pelvis. The joint in the back of the pelvis (the sacroiliac joint) is the strongest and most adjustable joint in the human body. Rebeca feels that there is a misconception that the pelvis is like a jail cell and that the iliac spines act to pierce the baby. "It's like holding an egg in an egg cup. The spines serve to keep the baby from falling out of the pelvis before it's time."

Rebeca does pelvimetry for many of the mothers that she helps, but it's not to diagnose an inadequate pelvis. She will make a sketch of each woman's pelvis to scale so that the woman can visualize how the baby will need to move to come out. "We all know from raising kids that if we can do something, the kids will follow." Rebeca feels that if the woman knows how she would need to move to exit her pelvis she can teach her baby to make those same moves.

Rebeca then discussed the varying types of pelvises and the advantages and potential problems of each. She emphasized, though, that there is no type of female pelvis that is incapable of birthing a baby. It's just that each woman has a unique pelvis, and she has to work with what she's been given.

50% of all women have "true female," or gynecoid, pelvises. The distinguishing feature is its round opening (figure 1), and the narrowest diameter is the anterior-posterior (AP diameter) or true conjugate. These women have wide, classical female hips and usually have a measurement of 14 inches or greater between their elbows and small finger tip. Rebeca often finds that these women have feelings of inferiority about their bodies. She remarked, "A lot of these women say, 'I always felt my hips were too broad,' and I reassure them. 'No, you have a wonderful pelvis'" Rebeca finds that this is the pelvis that most easily births babies.

5% of all women have a platypelloid or flat pelvis (figure 2). Most of these women are small in stature, although not every short woman has this type of pelvis. Rebeca has seen three women with this type of pelvis give birth—all with no problems. The front to back diameter is really tight, and these women tend to have problems with urination during the labor.

She has also seen women with an anthropoid or "apelike" pelvis (figure 3). These women have a classical swimmer's body. They have wide shoulders and narrow hips. This pelvis can be a little more problematic, but it works fine, too. The largest diameter here is not from side to side, but from front to back, so that sometimes the baby's head goes into the pelvis transverse; that is, the head of the baby faces 3:00 or 9:00. 25% of women have this kind of pelvis.

The android or male pelvis (figure 4) has a narrow pubic arch and not much in the way of anterior-posterior diameter. The "sits" bones (medically known as tuberosities) are next to each other. These women are always big women, and what they lack in shape, they usually make up for in size. The baby is often pushed to the back because of the narrow pubic arch. Rebeca finds that many of these women have a higher incidence of back labor, and there could be more likelihood of a tear, especially with a long perineum. 20% of all women have this kind of pelvis.

Rebeca finds that it doesn't matter so much what type of pelvis a woman has as much as her attitude toward it. "Some women have had traumatic sexual or obstetric experiences. You look at their hips, and you can see that they are not cold; they are frozen." Rebeca remarked that sometimes babies are posterior because the woman has so much tension in her pelvic floor, sacrum and lower back that baby doesn't have enough room to move around.

In order to open the pelvis and increase awareness and acceptance of that area, Rebeca recommends that pregnant moms spend time squatting during their pregnancies. She doesn't recommend any specific birth position, however. "It's really important for the midwife to let the woman get in touch with what she primaly knows and not confuse her with a lot of intellectual gibberish."

One thing that she has seen mothers do is spontaneously devise a routine or pattern of several positions over the course of labor. "It's almost like a dance." She finds that this happens a lot and is very effective for women birthing a posterior baby.

According to Rebecca one of the most destructive things a midwife can do is monitor the laboring woman's progress. Announcing, "You're still at 4," can have a harmful influence on the woman's progress. "If a woman asks me, 'How dilated am I?' I respond by asking her, 'How dilated do you think you are?'"

She carries a knitted cervix to births so that women can use that to picture their own dilation. Even announcing progress to a laboring woman can be harmful, according to Rebeca. If a woman is marking her progress and then finds the need to slow down, she may think something is seriously wrong with her labor.

Reprinted with permission from the *North Dakota Midwives Alliance*, November 1988.

by Yvonne Kurtz, CNL

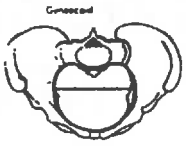


Figure 1

Figure 2

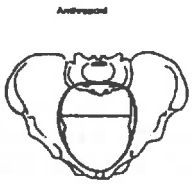


Figure 3

Figure 4

BABY DEATHS

Most baby deaths in Britain occur because of poor heart monitoring, misuse of forceps, and inadequate supervision by senior doctors, says a study published in Britain.

Research into 64 obstetric accidents, outlined in the *British Medical Journal*, shows that some doctors do not always recognise when foetal heart monitors indicate that a baby is in distress.

The authors of the study, from University College, London, said that five infant deaths were directly attributable to mismanaged forceps, and misused forceps indirectly caused one maternal death.

"Repeated attempts to use forceps by junior doctors is dangerous."

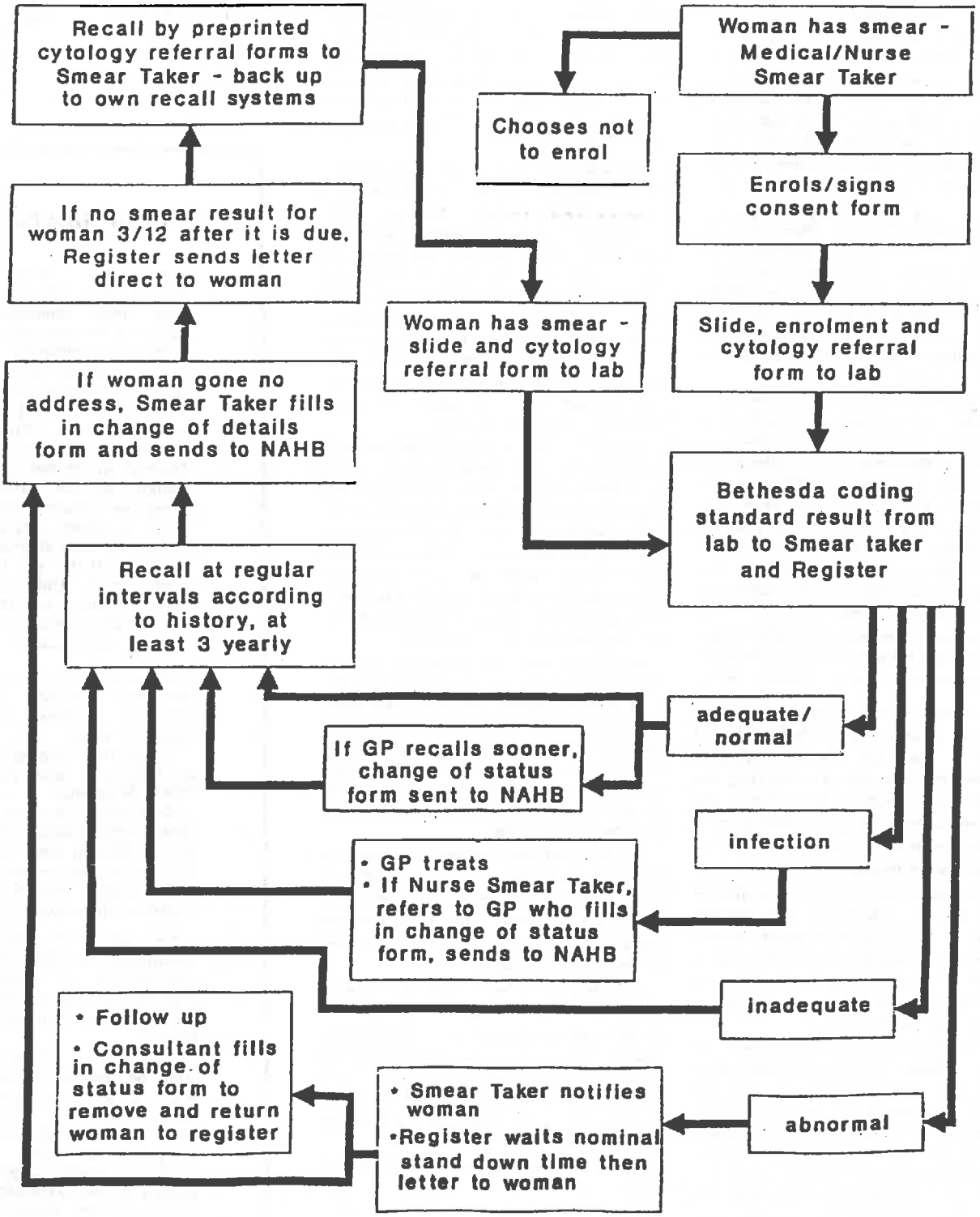
They added that many inexperienced junior doctors in Britain were left for long periods on labour wards without visits from registrars or consultants.

"In two cases where consultants doubted the competence of junior staff, they still did not visit the labour ward during 24 hours.

"The cases in this series could be dismissed as isolated incidents, but we believe that they reflect more general problems," the researchers said.

"Our results suggest there is a need to examine junior doctors' ability to use forceps and investigate the extent to which senior staff participate in running a labour ward."

CERVICAL SCREENING PROGRAMME REGISTER OVERVIEW



National Screening Program
The Register

The REGISTER is a tool of the NSP:

1. It ensures women with normal smears are recalled three yearly

2. It ensures that women with abnormal smears receive adequate follow-up and treatment

3. It measures the quantity and quality of smears (and determines the extent of overscreening)

4. It allows an estimate of the pop. who have an up-to-date (< 3yrs) smear, and the success of efforts to enrol the "at risk" women

% reduction in cum. incidence cervical cancer in women 35-64

EFFECTS OF DIFFERENT FREQUENCIES OF SCREENING

Interval between screening	% reduction in cumulative incidence	Number tests in lifetime
Yearly	93.5	30
2 years	92.5	15
3 years	90.8	10
5 years	83.6	6
10 years	64.1	3

WATER - HOW 8 GLASSES A DAY KEEPS FAT AWAY

Water is quite possibly the single most important catalyst in losing weight and keeping it off.

Here are some points worth considering about how water may help us:

- Water suppresses the appetite naturally and helps the body metabolise stored fat. Studies have shown that a decrease in water intake can actually reduce fat deposits, as the kidneys can't function properly without enough water. When they don't work to capacity, some of their load is dumped onto the liver. One of the main functions of the liver is to metabolise stored fat into usable energy for the body. If the liver is doing some of the kidneys work it can't operate properly.

- Drinking enough water is the best treatment for fluid retention. When the body gets less water it sees this as a threat for survival and begins to hold onto every drop.

- The best way to overcome the problem of water retention is to give your body what it needs - plenty of water. Only then will the stored water be released. If water retention is a constant problem, excess salt may be to blame.

- Water acts as a solvent in the body and the purer it is, the more body toxins can be let into it and the more organic nutrients it can carry to the body cells. Other fluids like coffee, tea, fruit juices, milk and other liquids don't count. Water regulates all body functions and is essential for the removal of wastes especially from the lymphatics.

- The overweight person needs more water than the thin one. Since we know that water is the key to fat metabolism, it follows that the overweight person needs more water. Water helps rid the body of waste.

- Water helps to maintain proper muscle tone by giving muscles their natural ability to contract by preventing dehydration. It also helps to prevent the sagging skin that usually follows weight loss - shrinking cells are buoyed by water, which pumps the skin and leaves it clear, healthy and resilient.

- Water can help relieve constipation. When the body gets too little water, it syphons what is needed from internal sources resulting in constipation.

- How much water do we need?

The water should be cold and we need to drink 8 250ml glasses every day. However, the overweight person needs one additional glass for every 12 kilograms of excess weight. The amount of water consumed should also be increased if you exercise briskly or if the weather is hot and dry.

- To utilize water most efficiently follow this schedule:

Morning - approximately 650ml consumed over 30 minutes

Noon - approximstely 650ml consumed over 30 minutes

Evening - approximately 650ml consumed over 30 minutes

If possible don't drink the water with meals. Drink it up to half an hour before a meal or more than one hour after the meal.

- The benefits of drinking more water?

When the body gets the fluids it needs to function optimally its fluids are perfectly balanced - when this happens you have reached the breakthrough point.

- Endocrine gland function improves
- Fluid retention is helped as stored water is lost
- But remember, if you eat a poison (junk food) nutritional stress, hurt yourself (physical stress) or get angry (mental stress) you create shock at cell level and will need water to replace the water loss from Blood Stream being held as fluid retention.
- More fat is used as fuel because the liver is free to mobilise stored fat.
- Natural thirst returns.
- There is a loss of hunger almost overnight

COMING EVENTS

* **Australian 12th National Homebirth Conference** - Melbourne July 12 - 16 1991 - " Homebirth Reborn "
Enquiries: Homebirth'91, PO Box 298, North Carlton, Vic.3054

* **XIV Soroptomist International Convention:** 28 July - 1 August The Health Workshop will be devoted to Safe Motherhood.
Enquiries: 87 Glisson Rd, Cambridge CB1 2HG: ph.44-223-311833

* **NZ College Of Midwives AGM** - 2nd August 1991, 6pm, Wellington Polytechnic School of Nursing and Health Education, Staff Resource Room. Remits to reach BOM by 12th July. Election of President and Selection of Region to be the BOM from 1992.
Enquiries: Board of Management, PO Box 7063, Wellington South phone Beryl Davies (04) 887-403

* **Spiritual Midwifery Seminar Series** - with Shivam Rachana
" To awaken the spirit of midwifery and recover its art "
August/September Seminars in Taupo and Nelson.
Enquiries: Lydia Millar, 38 Rimu St, Taupo
Karyn Patterson - Nelson, ph. 80172

* **NZ Health Promotion Forum** presents Public Purpose Marketing a workshop with Dr Richard Steckel on assisting organisations to develop projects which generate income for themselves.
August 12-13 1991, Dental Association Rms, Remuera, Auckland
Enquiries: HPF, c/- Dept. of Community Health, Auckland Univ. Private Bag, Auckland. Ph.(09)795780 x 6354: Fax.(09)770956

* **ICEA 1991 International Convention** - Aug 16-18, Denver, USA
Key Speakers: Shelia Kitzinger, Donna Ewy, Jeanne Altendorf
Enquiries: PO Box 20048, Minneapolis, Minnesota 55420, USA

* **Australian College Of Midwives 7th Biennial Conference**- Perth 16-18 September 1991 Theme: " Birthdays, Birthways " Focus on ethics, innovative practice, quality assurance, the environment, research, education and the childbearing team. Enquiries: ACMI 91 Conference, PO Box 553, Subiaco 6008, Western Australia. Ph. Australia (09) 279 7328

* **Symposium On Professional Training For Safe Motherhood At 13th World Congress Of Gynaecology & Obstetrics** (FIGO) Enquiries: Congress Secretariat, c/- Dept. of O&G, National University Hosp,Lower Kent Ridge Rd,Singapore 0511, Singapore ph. 65 777 0313: Fax. 65 777 3121 September 15 - 20 1991

* **California Association Of Midwives** (CAM) - 1991 Conference " Growing Together, Growing Wiser " September 27 - 29 1991
Enquiries: 1821 27th Street, Sacramento, California 95816

* **Midwives Alliance Of North America** (MANA) 1991 Conference " Sisters on a Journey " October 10-13 El Paso, Texas, USA
Enquiries: MANA, 2715 San Diego Ave, El Paso, TX 79930, USA

* **1st International Congress Of Perinatal Medicine** (ICPM) 5-8 November 1991 on "Care of the Mother, Fetus and Neonate"
Enquiries: ICPM, c/-Japan Convention Services, Nippon Press Ctre Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan Ph. 813 508 1213

* **10th International Congress Of Psychosomatic Obstetrics And Gynaecology** - on " Reproductive Life " 14-17 June 1992
Enquiries: Congrex, International Society of Psychosomatic O & G (SPOG) - 92, PO Box 5619, S-114 86, Stockholm, Sweden Ph. 46 8 32 69 00: Fax. 46 8 32 62 92

* **2nd International Homebirth Conference** - 4-7 Oct'1992 Sydney " Reclaiming our Heritage; Creating Our Future "
Enquiries: GPO Box 2609, Sydney, NSW 2001, Australia Ph. (02) 241-1478: Fax. (02) 251-3552

* **International Confederation Of Midwives 23rd International Congress:** 9-14 May 1993, Vancouver, British Columbia, Canada

BREASTFEEDING

AWARENESS WEEK: July 8th 1991

Mothers & Breastfeeding Matter

La leche League are hosting a session with **Maureen Minchin** on Saturday July 13th; Ellerslie War Memorial Community Hall, Main Highway, Ellerslie, Auck. $20 postal registration for the whole day or $23 at the door. $15 postal registration for the 9.30 - 12 noon session ($18 on the day). The afternoon session goes from 1-2.15pm.

Soup & bread for lunch will be available for $1. Send postal registrations to LLL Workshop, Barbara McCardle,105 Grange Rd, Mt. Eden, Auck.3: ph (09)686286

Maureen Minchin will also speak in Hamilton on Tuesday July 9th at Waikato Women's Hospital.

MASSEY UNIVERSITY

PRELIMINARY NOTICE
OF

A WORKSHOP

ON

THE MAINTENANCE OF BREASTFEEDING

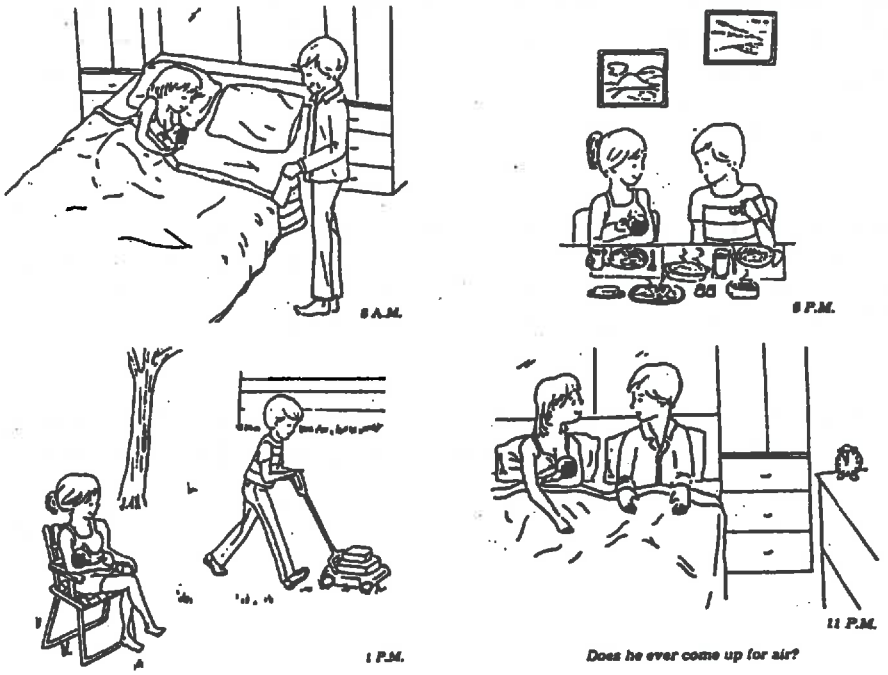
4-5 NOVEMBER 1991
QUALITY INN
PALMERSTON NORTH

To bring together, for purposes of continuing education, health professionals, research workers and educators to exchange knowledge and ideas concerning breastfeeding.

Registration will cost $210 and will include lunches, morning & afternoon refreshments plus the dinner on Monday evening. It is restricted to the first 150 to register.

Keynote Speaker will be Dr Audrey Naylor Co-Founder of Wellstart, an organisation that runs a successful breastfeeding clinic in San Diego for women with breastfeeding problems.

Enquiries: DDS Mackenzie, Workshop on Breastfeeding, Dept. of Animal Science, Massey Univ, PN



Canberra Times, 11 July, 1990

Medical textbooks 'outdated, sexist'

SYDNEY, Outdated, sexist and unscientific theories about women are being taught to medical students, according to an analysis of textbooks recommended by universities.

The study of gynaecological and obstetric textbooks has found they are often sexist and patriarchal, and reinforce the notion of "normal" women as being passive and subordinate.

They also assume that all women aspired to marriage & motherhood, some texts suggesting feminine achievement was attained by having a uterus.

"Unmarried, separated, divorced, widowed and lesbian women are largely unmentioned," a La Trobe University researcher Glenda Koutroulis reports.

"...The authors still generally believe the traditional roles to be husband as provider and the wife as homemaker and mother."

"The textbooks are preoccupied with women as virgins, reinforcing the image of "pure" and "fallen" women in which men are the controllers of women's sexuality.

Writing in the journal Communty Health Studies, Ms Koutroulis notes that one text describes the vagina's main function as a "receptacle for the male penis during coitus".

In the text, the function of vagina as a passageway for menstrual fluid is not mentioned and its function as a birth canal is given little importance."

Ms Koutroulis, a postgraduate sociology student, says many of the textbooks' statements about women are unsubstantiated, and are prejudice and opinion disguised as scientific fact.

"The assumptions and opinions that obstetricians and gynaecologists have made about women are transmitted....to students under the guise of objective science," she says.

Ms Koutroulis analysed textbooks recommended at Melbourne, Monash, Flinders and Newcastle Universities.

CHILDBIRTH AS A MEDICAL EVENT
(From Shelia Kitzinger)

The modern obstetric view of birth in our society is based on the assumption that childbirth is a medical event which should be conducted in an intensive care setting. The whole of pregnancy is seen as a pathological condition terminated only by delivery. The modern high-tech obstetrician actively manages labour with all the technology of ultrasound, continuous electronic monitoring and an oxytocin intravenous drip. Many obstetricians have never had the opportunity to see a truly natural birth.

To turn the process of bringing new life into the world into one in which a woman becomes simply the body on the delivery table rather than an active birth giver is a degradation of the mothers role in childbirth.

Safer Childbirth?

ICEA 1991 INTERNATIONAL CONVENTION

DENVER

DENVER MARRIOTT CITY CENTER

AUGUST 16, 17, 18

A CRITICAL HISTORY OF MATERNITY CARE

Marjorie Tew

In all developed countries the last fifty years have seen a dramatic decline in the deaths of mothers and babies in childbirth. What is it that has made birth safer?

The medical profession has propagated the belief that the increased safety is due to the increased management of birth in hospital by obstetricians. This is a hypothesis which can be tested against actual experience. Contrary to all expectations, however, impartial investigation of the accumulated evidence, observational, biological and statistical, points clearly to the reverse conclusion, that on balance obstetric care has made a negative contribution to safer childbirth.

Marjorie Tew has brought together this evidence which discredits the obstetricians' case but supports the alternative hypothesis, that safety in childbirth depends primarily on the good health of mothers which rising standards of living and nutrition have increasingly made possible.

This well researched book provides material of vital concern, not only to all professionals involved in organizing and delivering maternity care and to all women who use it, but also to the wider public, in Britain and abroad, who ought to know how policies for this basic community service have evolved.

Chapman and Hall

Second International Homebirth Conference

Reclaiming Our Heritage - Creating Our Future

4-7 October 1992,

Sydney, Australia

Conference Secretariat:

GPO Box 2609

Sydney NSW 2001

Ph (02)241 1478

(02)247 6940

Fax (02)251 3552

12th National Homebirth Conference

HOMEBIRTH REBORN

HOMEBIRTH REBORN

EXRACTS FROM

REFLECTION ON MIDWIFERY PRACTICE FROM THE MOTHER'S PERSPECTIVE

A. SLEDZIK

Midwives are caring practitioners who have been working at the mother's side during labour since antiquity. The midwifery profession continuously strives to improve practitioner performance.Therefore, a search for further knowledge through research by midwives is desirable.

Therefore, reflecting on research which includes responses of mothers through their own birthing experiences, from their psychological and emotional perspectives, forms an essential component for personal and professional evaluation of midwives. To achieve such aims requires from midwives honest reflection on their own clinical practice. Therefore, for the purpose of this paper, reflective practice will be operationally defined as 'honest self assessment of personal and perceived professional performance'.

Aspects of currently conducted qualitative research findings will be discussed from a perspective of feelings of mothers, emphasis will be placed on their emotional and psychological responses as experienced by them during the birthing process. Although, the major focus of this research is on practitioner effectiveness as extrapolated through the process of role perception, it was nevertheless felt that these research findings on emotional experiences of mothers, during the birthing process, are so profound and enlightening that they do have important implications for midwifery practice and are therefore shared with you .

Analytical summaries and verbatim statements made by mothers will be utilized to provide illustrative illuminative examples your critical scrutiny. Through the process of communication based on your experience and on experiences of mothers of their birthing process, it is hoped to create a surrogate experience for you which can facilitate evaluation of mothers responses for clinical application. Thus, by "telling it to you as it is ", that is, as mothers express their innermost feelings during birth it is hoped to create the interviewee's responses without bias.

Therefore, to avoid bias by influencing mothers responses and to elicit non standardized, and, or , singular information the unstructured or 'elite' interview was the method selected for this study. The actual interviews with mothers followed their experiences with the birthing process, including their personal experiences with midwives.

Philosophical stance

The philosophical stance which influenced the selection of a qualitative research approach includes assumptions that:

1. mothers' possess a special knowledge about labour which needs to be studied;
2. the intertwined feelings, fears, and other emotions experienced by mothers are founded in the mothers very own personal birthing and life experiences;
3. the midwifery care which mothers received during this critical period of their life has a profound effect on their emotions and makes a deep impression on their psyche;
4. the effectiveness of midwifery practitioners is enhanced by gaining insight into mothers emotional and psychological experiences from their perspective during this critical phase of their life.

Mothers' most profound feelings

The unstructured interview approach elicited profound rich information which only mothers through personal experiences can provide for midwives. Although, initially the aim was to solicit knowledge from mothers on their recent experience with midwives. It was of great interest to find that mothers, as well as those , fathers who requested to be interviewed spontaneously described their experiences with midwives through the birthing process, as they had experienced it for each birth. Mothers did this with with great clarity, irrespective of the time interval for each birth . To them the previous birthing experiences were just as relevant as the experience with the birth of their last baby. The emotional impact of previous birthing experiences were just as profound even though years may have passed. Mothers also clearly remembered the midwife who they perceived was closest to them during their labour. Many mothers also emphasized that they would not forget:

1. their labour experiences;
2. the midwife who cared for them during labour and birth;
3. the profound emotions they experienced during this period;
4. how vulnerable they felt;
5. the concern they felt about being able to cope;
6. the emotional impact they experienced when they looked at this new life.
7. the degree of anxious self pre - occupation they experienced during labour and birth. (a frequent finding)

The degree of self pre - occupation and the degree of anxiety felt clearly surprised many mothers, and according to two mothers statements these feelings of anxiety and self pre - occupation may be owed to a perceived helplessness at that time. The conclusions of these mothers made are similar to Sarason 1989 cognitive view on anxiety.

" Anxious self- preoccupation consists of heightened concern over one's inadequacies and shortcomings. The anxious person is concerned about present or potential dangers and threats, and the inability to cope with them."

The preliminary research findings of this study supports the assumption that mothers do have a very special knowledge about labour, especially, from an emotional perspective. Furthermore, knowledge of mothers about labour and psychological aspects in labour are further enhanced by sensitive intuitive midwives who have the ability to recognize and clearly explain intertwined emotional aspects of labour .

Mothers feelings and their profound impact felt are illustrated by the following *verbatim* accounts.

Two mothers' stated that " during labour you go through the whole gamut of emotions within the total period of labour".

One mother clearly stated " in labour you go through every possible emotion a human being can experience".

Two mothers described their labour and made this identical statement

" labour was the most excruciating, exhilarating, profoundly taxing emotional experience I have ever had."

One of these mothers also added:

" I went through every human emotion known within a very short time of labour" .....
" labour it is the biggest sign post in life, no emotion can ever equal the experience I went through during my labour."
This particular mother was *alone* , she had no support person present during labour. She said " the only person there was my midwife, but even so, I felt so a*lone*, ... when my baby was born I wanted to scream on top of my voice - look what I have done - isn't it wonderful - I have given life. But there was no one there I could scream it to, however, my midwife must have felt that I experienced enormous emotions and she just held me." How wonderful". Nevertheless, I do not wish that experience on anybody, I was so lonely so terribly *alone*."

It is of interest that although this mother appreciated the midwife's support , she nevertheless felt so *alone*. She did not consider this midwife the appropriate person for sharing her innermost emotions .Thus, from such a statement it may be assumed , that, for this mother the midwife could not fill that gap, nor could she be able to reduce the mother's distress of loneliness, only her family or significant others can fill such a gap. Such a statement demands from midwives deep reflection on how such traumatic experiences could be minimized without being intrusive or cause further distress. It is not difficult to see that such experience truly demands from midwives

deep understanding of the emotional aspects of labour and loneliness.

Another mother described her labour in these terms:

" labour is the most growth facilitating life experience I ever had, during my labour I went from the highest most euphoric experience through the lowest levels of despair. From feeling most capable to feeling most desperate. During my labour I felt the happiest to the loneliest in my life I have ever felt."

After a pause she said

" I have felt the most excruciating pain of my life in labour, nothing can ever describe it, and I believe therein lies the bond between women especially in labour. Only a midwife that has had a baby can ever know what I am talking about."....

" It took me days to return to my normal self, I experienced emotional highs and lows".

Most pleasurable and most stress producing situations

A mother described her second pregnancy and labour like this:

" In the initial stages of my pregnancy I was focussing on what was happening to my body, noticing especially the immense pleasurable sensory experiences and emotions that occur within your body during the growth of this baby. It was like a river of strength flowing through you. When I first heard the baby I felt powerful, elated like being on top of the highest mountain, like the surf and its rhythmical movement giving me strength. ..... What a feeling."

This mother also described her labour contractions like letting yourself go with the rhythmical contractions flowing like a river through you and knowing that these painful contractions will go away . So in my mind I let them flow away . During the rest period I watched a golden leaf float on a gentle still pond getting ready for my baby.....When I had the baby I felt such self respect - look- I did this, and I did this really well,I alone did this , this is my baby . ....is this little thing really part of me unbelievable, how lovely , how tremendous."

These emotions expressed by mothers could be likened to self actualization and to the human motives.

"Satisfaction and Stimulation (abundancy motives): attaining a feeling of self - respect and self confidence; expressing oneself; feeling a sense of achievement; feeling challenged; establishing moral and other values; discovering a meaningful place of self in the universe."

One mother expressed aspects her labour as follows:

" labour to me was like traveling to a valley of fear not knowing what the outcome will be, will my baby be all right? ..... will I be all right ? ..will I be able to care for my baby as I should? Will I be able to cope with the pain? .....I was so lonely and it was strange because everybody tells you labour is normal , and yet in the same breath they say you have to go to the hospital , just in case something goes wrong, what a contradiction, and you know they do this all the time."

This lady came into labour with a posterior position and had extremely painful contractions which caused her great distress. She also frequently said,

"I had the need to be able to go into myself to be able to gain inner strength, ... and to be able to cope, .. to be able to deal with labour and be able to maintain my dignity."

From the responses of mothers spontaneously recalling their feelings during labour, it appears that childbearing is for many a self- actualizing experience, a growth process.

From the preliminary findings it appears that there may be many aspects of labour which can, and do, enhance personal growth it is equally important to reflect on aspects of labour which are truly extremely traumatic to mothers emotional well being, as well as, their husbands and other support person/s.

Thus, it may be desirable to reflect on this statement, which was made by four mothers, and this included two midwives; these mothers had to have a forceps delivery and they were placed in stirrups for this procedure.

" I had a forceps delivery and was put up into stirrups, I felt abused"
and two responses from mothers included, " I felt as if I was raped."

Midwifery practice and education

From these accounts it is obvious that midwives need to be well educated in all aspects of midwifery care, and in addition possess proficient counselling skills. Therefore, a reflection of the desirable characteristics of a midwife as one mother perceived them is of informative value and could form a useful framework for education from the mothers perspective.

Sensitivity, the ability to listen with an open mind and intuition were aspects of midwives' characteristics which mothers perceived to be most valuable. Honesty, trust, understanding, gentleness, and firmness when appropriate, as well as the ability of midwives to adapt to mothers and their families needs and idiosyncrasies were considered essential characteristics of midwives.

" One mother described what the characteristics of midwives should be according to her perception, recorded *verbatim* here: (and these may be a useful guide)

"First of all a midwife should be able to :

1. develop a rapport with a woman in labour.;
2. competently discuss issues which are of importance to you and your husband, because there is no time to do so in labour;
3. establish a trusting and respectful relationship, one in which the midwife can hear what the woman wants, and one in which the woman can hear what the midwife wants as well;
4. listen that is most important; even if people can not express themselves well;
5. honestly explain to you any worries she may have;
6. know when to intervene and when to sensitively withdraw, and yet be there;
7. be caring to all people not just the ones they , that is the midwives can identify with, or with mothers who can help themselves.

I suppose I expect them to be just perfect, however I know that is not possible."

Other expectations of midwives included :

- the ability to be able to tune in to a woman in labour and be able to take cues from her;
- that they have sensitivity and know just when to intrude, and when to withdraw.

Mothers expectations of midwifery educators and education included :

1. that midwives be educated to a high level of competency in the skills of:
   i) education throughout the total period of pregnancy, labour, birth, and postpartum period;
   ii) counselling, and that these counselling skills extend from the normal midwifery care advice giving, as well as, to be able to assist parents with the grieving process;
2. that midwives develop the skills of intuition;
3. that midwives learn to accept responsibility and acquire the ability for complex decision making.

Thus, it is of the outmost importance that midwifery experts share their knowledge with student midwives, and that they recognise their own teaching potential and the power of role modelling.

Finally, it is important that midwives are willing to record their knowledge for posterity. That midwives through educational sharing enhance the quality of midwifery care, professionalism, autonomy, and ensure professional survival without causing alienation from midwifery's traditional colleagues.