Maggie Banks
Te Awa Rd
RD 3
HAMILTON

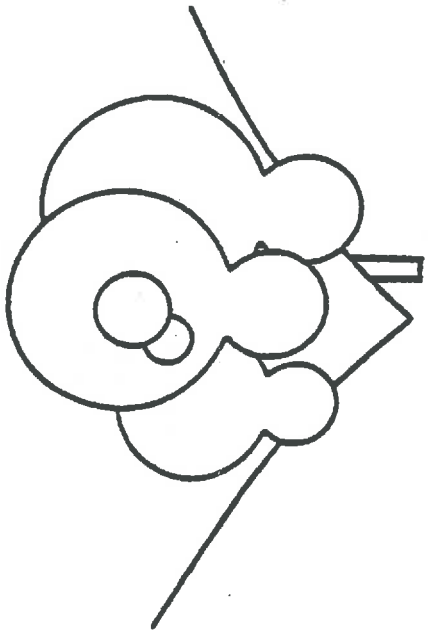
5431-v:7/99

WHBA CORE GROUP MEETING
MONDAY 17 AUGUST 7.30 PM
PHONE 846-4925

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

Waikato Home Birth Association Inc.

Newsmagazine 1998



AUGUST

PHONE NUMBERS:

Karen Benge	855-5003 Chairperson WHBA Inc.
Glennise Head	846-4925 Treasurer
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Karen Walker	825-5025 Newsmagazine Editor

Please post Birth Stories & articles to Karen
Old Mountain Rd, R.D. 1, Waitetuna Valley, Raglan

The **W.H.B.A. Library** is now located at
"Parents Place" 113 Rostrevor St, ph 838-2229 Hamilton.
Phone Joanne Ridder if you have any problems.

Greetings Home-Birthers

Hope this newsletter sees you well. I am having a particularly wonderful month fulled with many blessings. I am looking forward to going to the Midwifery Conference in Auckland next week and will bring back lots of exciting news to share with you.

A big Thank You for the families who have contributed photos and articles towards this publication and I hope to have our mural boards by the end of this month.

Please continue to send your photos and articles to me. - Karen Walker.

BIRTH NOTICES

On	these parents:	had a:	named:	where:	Midwife / s
7/7/98	Donna Clark & Chris McPike	daughter	Alex	Hamilton	Paulette/Julie
9/7/98	Clare & Rob Shallcross	son	Neethan	Hamilton	Lyn
15/7/98	Tania Phillips & Billy Rawiri	daughter	Reremoana	Hamilton	Paulette/Bet
18/7/98	Meegan & Scott Dunn	daughter	Ellie	Te Pahu	Maggie/Kerri
19/7/98	Carolyn & Avon Rosewarne	daughter	Ashleigh	Hamilton	Lyn
29/7/98	Marilyn Ruwhiu	son	Hamish	Hamilton	Maggie/Carena
29/7/98	Helen Ritchie & Tom Rudolph	son	Ernest	Hamilton	Liz
30/7/98	Aneta Timu & Hogie Hohua	son		Hamilton	Hannah/Adele/Betty

WAIKATO HOME BIRTH ASSOCIATION
BIRTH POOL FOR HIRE
FOR DETAILS PHONE
BELINDA BEETHAM 823-2902,
GLENNISE HEAD 846-4925

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 25 Roy St, Hamilton, ph 847-4987.

POST TO:
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P.O. Box 12-099
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Annual Subscription (your choice):
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Children

AND a woman who held a babe against her bosom said, Speak to us of Children.

And he said:

Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you yet they belong not to you.

You may give them your love but not your thoughts,
For they have their own thoughts.
You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow, which you cannot visit, not even in your dreams.
You may strive to be like them, but seek not to make them like you.
For life goes not backward nor tarries with yesterday.

You are the bows from which your children as living arrows are sent forth.
The Archer sees the mark upon the path of the infinite, and He bends you with His might that His arrows may go swift and far.
Let your bending in the Archer's hand be for gladness;
For even as He loves the arrow that flies, so He loves also the bow that is stable.

KAHLIL GIBRAN (1883 – 1931) from *The Prophet*

HOW TO WRAP A BABY'S MATTRESS FOR COT DEATH PREVENTION

The advice to wrap mattresses applies to every mattress on which a baby sleeps (except a BabeSafe mattress) and includes: adults' mattresses; mattresses of other children; and all mattresses made of or containing natural products such as sheepfleeces, goatskins, kapok, tree bark, coconut fibre, etc.

The most convenient way to wrap a baby's mattress is to use a *BabeSafe* mattress cover. These covers are available at babycare retail outlets throughout New Zealand. They are manufactured in six sizes and cost under $20.

Alternatively, parents can make their own mattress wraps. If they select this option, the following instructions apply:

1. Use thick, clear (not coloured) polythene sheeting, or alternatively surgical rubber sheeting. The thickness of polythene sheeting must be at least 125 microns. *On no account should PVC (polyvinyl chloride) be used for wrapping mattresses.*

2. Place the polythene or rubber over the top of the mattress and down the ends and sides, and then secure it firmly beneath the mattress with strong adhesive tape.

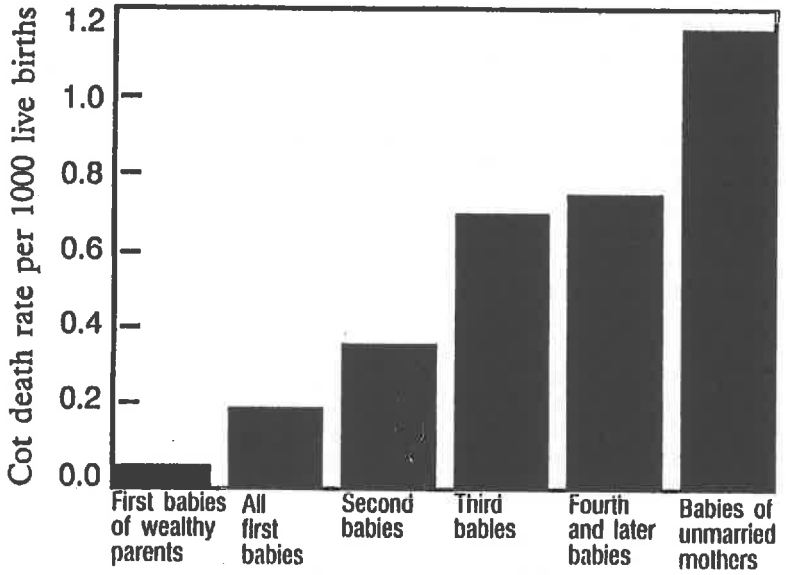
3. The polythene or rubber on the underside of the mattress should not be airtight. It must be airtight on the top and sides of the mattress.

It is imperative to use the correct bedding on a *BabeSafe* mattress or on a mattress covered with polythene or surgical rubber. Use a fleecy pure cotton (flannelette, winceyette) underblanket and tuck this in securely. Then make the bed using cot sheets and a pure woollen blanket. *Do not use any form of moisture-resistant mattress protector, sheepskin, acrylic underblanket or sleeping bag.*

The cover on a mattress should be cleaned by wiping with pure soap and water. *Do not use chemical bleaches or sterilants.*

Proprietary mattress covers should not be used unless they carry the *Campaign Against Cot Death* logo or are accompanied by a certificate of analysis showing that they contain no detectable phosphorus, arsenic or antimony (lower limit of detection 0.001% = 10mg/kg = 10ppm).

COT DEATH RATES FOR FIRST & LATER BABIES AND BABIES OF UNMARRIED MOTHERS: BRITAIN, 1992



Data: Official statistics

This graph is arguably the most important piece of epidemiology relating to the cause of cot death. The range of cot death risk from the lowest group (first babies of wealthy parents) to the highest group (babies of unmarried mothers) is 1:22.

This data is part of the overwhelming proof that there is only one cause of cot death and it destroys any argument that cot death has a medical cause.

The more times a mattress is used from one baby to the next, the greater is the risk of cot death. This accounts for the higher cot death rates in less well-off families, who are more likely to use second-hand mattresses. If a mattress contains any of the elements phosphorus, arsenic and antimony, and the common household fungus *Scopulariopsis brevicaulis* has become established in the mattress during prior use, the output of toxic gas commences sooner and is greater in volume.

ALL women become like their mothers.

That is their tragedy.

No man does. That is his.

OSCAR WILDE from *The Importance of Being Earnest*

may be little incentive for change. Not only does pregnancy occur within a social context, so also does medical care and the politics and social divisions of maternal medical care are highly significant in its development (Witz, 1990).

THE INTERNATIONAL ASSOCIATION OF INFANT MASSAGE

The I.A.I.M. is a non-profit organisation, formed in 1981 largely as the result of the pioneering work of Vimala Schneider McClure. Vimala (an American) spent time living and working in India and was deeply affected by what she observed and experienced of the use of traditional massage (particularly for babies).
The vision of the I.A.I.M. is as follows "We believe that by fostering and encouraging Infant Massage and other cultural traditions which enhance the parent-baby bond, and by helping create more family-centred values in our cultures, we will begin to see whole generations expressing more compassion toward and responsibility for their fellow human beings."

I am a home-educating mother of two children (13 & 6) and enjoyed massaging my daughter as a baby (I understand now, how much more we both could have benefited if I had the understanding then that I now have of theory and techniques of infant massage).
I heard about I.A.I.M. and its instructor training as a result of my Health Massage course in 1997, and decided to attend the 6 day intensive training in June of this year.
To complete the requirements for the Instructor's Certificate I need to finish a comprehensive written assignment and to lead 12 massage sessions with parents and babies.
If your group is interested, I would be pleased to provide 3-5 (weekly) sessions of 1-1½ hours (from August 10th - September 30th)
During the 3-5 sessions we will cover

- *a) Massage - theory and techniques*
- *b) Relaxation techniques*
- *c) Infant development as related to massage*
- *d) Massage for particular conditions eg colicky or high-need babies*
- *e) Massaging the growing child*

There will also be scope for discussion of many parenting issues. I will appreciate a small koha from participants to cover my costs.

Ann Chapman (07 856 6523) July 1998

Note: This may be a good opportunity to have a Birth Preparation Series Class get-together.

Our love is extended to our dear friend and midwife, Lyn McCroskery, her care and support through this pregnancy and birth (and the last) has been just wonderful.
We look forward to utilising her talents again in the future and promise to write the "Autumn" and "Summer baby" birth stories for the magazine as we add to our family in the future!!!
Love and blessings to all homebirthers and their families.

Clare Shallcross.

SITA RAHM ORGANICS

BABIES SPECIAL OINTMENT: Excellent for nappy rash.	65gm	$4.50
FIRST AID OINTMENT: All purpose first aid ointment.	65gm	$4.00
PLANTAIN OINTMENT: For skin irritations; haemorrhoids.	65gm	$4.00
CALENDULA OINTMENT: For wounds, burns.	65gm	$4.00
BABIES CHEST RUB: For winter sniffles, (has calendula oil)	65gm	$5.50
LACTO TEA: Great for aiding your milk supply.		$5.00
WIND AWAY: Helps to ease wind and colic (mum or baby to drink)		$5.00
SCALP CLEANSER: For removal of cradle cap (lavender)		$3.50
BABIES MASSAGE OIL: (Lavender)	200ml	$7.50
LIP BALME: Unscented, great for dry cracked lips.	15ml	$2.75
GARLIC HONEY ELIXIR: For coughs and colds. (very strong)	200ml	$6.50
GARLIC HONEY AND CIDER VINEGAR: Also good for weight loss.	200ml	$5.50
GARLIC HONEY AND ECHINACEA: Great for colds and flu.	200ml	$10.00
FLU TONIC: Mucous reducing vinegar (May reduce your milk supply.)	200ml	$7.50
ROSE MOISTURISING CREAM: Pamper yourself.	65gm	$14.00

HERBS:

OATSTRAW:	50gm	$2.00
RASPBERRY LEAF:	35gm	$2.00
NETTLE:	35gm	$2.00
PEPPERMINT:	35gm	$2.00

Post is $2.50 for under 500gm.

For more product info. (Ingredients etc).
Please call Claire on 825-6769.

BANANA CAKE

100gm butter
2 eggs
2c self raising flour
½ c milk
1c sugar
2tsp vanilla
2 mashed bananas

- gently melt butter
- add sugar, eggs and vanilla
- beat well with a wooden spoon until smooth
- sift in flour, do not stir yet
- add milk and mashed bananas, stir until just mixed
- spread evenly into a tin
- bake for 30 minutes at 180C

FRIED NOODLE

1 ¼c Water
2tsp oil
1 diced onion
2 grated carrots
2 pkts Oriental 2 Minute Noodles
2tbs oil
½c red/green pepper
2c mung beans/bean sprouts

Optional: Mushrooms, celery, ham, cooked meats, 2-3 spring onions, cashew nuts.

Method: Cook noodles in water for 2 minutes until the water is absorbed. Stir in 2tsp oil.

Heat 2tbs oil in frying pan, add onion, then meat, vegetables. Add the noodles and cook for 3-4 minutes.

I often do this in the microwave - cooking the noodles in a large casserole dish then adding the raw vegetables and cooked meats and heating until cooked.

If you have favourite recipes that you would like to share please send to Karen.

women and their obstetricians generally left the consultant in charge and prevented many women from voicing their questions and anxieties (Oakley, 1993).

A factor seen as important in restricting the possibility of women articulating their criticism is that of the power and authority of obstetricians. Indeed Romalis (1985) suggests that there is little evidence of disagreement with the medical model for the later stages of pregnancy – many women have come to accept that birth should be in a hospital and that technology is desirable. McIntosh (1989) sees this as determined more by class than simply gender and professionalization. Whereas studies of middle-class women tended to find marked dissatisfaction with the medicalized aspects of pregnancy and birth, e.g. Oakley (1990), McIntosh's study of 68 working-class pregnant women in Scotland in 1982 found that the great majority accepted the medicalization of birth and tended to accept the system they were given on the basis that the prevailing system must be the best. Nevertheless the 1980s saw considerable change in women's acceptance of the medicalization of childbirth and the medical profession has had to respond to a strong consumer movement in maternity care, and listen to the demands of women for greater participation in the management of pregnancy (Oakley, 1993).

The subsequent changes have largely been in relation to the care of women during the early and middle stages of pregnancy rather than affecting childbirth and technological surveillance at that stage. One example of an attempt to give some power back to women in the management of pregnancy and to increase their satisfaction has been in the amount of information that they are given during early visits to hospital. Lovell and colleagues (1986) report on such an innovation at St Thomas's hospital in London where half of a group of 246 mothers were given responsibility for looking after their maternity case notes between clinics, the rest simply holding less informative maternity 'co-operation' cards. Having the notes did appear to increase information sharing between mother and hospital staff, and maternal participation in decision-making. There was also some evidence that husbands and partners who read the notes, were better at providing companionship during labour and were more positive about involvement with the baby following birth. Similar benefits for mothers have been found in studies by Flint and Poulengeris and by Oakley. Flint and Poulengeris (1987) studied the effectiveness of providing continuous personal support from a midwife throughout pregnancy, Oakley (1992) studied the effectiveness of providing social support to women at risk of delivering low weight babies. In both studies women who received social support and increased information from midwives felt more in control during labour after this support, had slightly bigger babies and experienced better psychological health post partum.

The goal of maintaining a high level of information for mothers may be something that many women from all classes want and from which they and their babies would benefit. Unfortunately, despite the growth in the consumer movement in medical care, extending such care through pregnancy and especially extending it to choices about childbirth may prove to be more difficult. The St Thomas' innovation was successful because it had considerable support from the consultant and medical staff. Where such support is lacking the effects might not be so positive. Obstetrician's status depends on far more than patient satisfaction and as there are continual pressures on them to measure up in other scales, there

Medicalization of pregnancy

The medicalization of pregnancy is characterized by changing relationships of power between pregnant women and their professional carers during pregnancy and is marked by its potential for change. Medicalization has occurred as medical understanding of the biological process of pregnancy has increased along with its ability to intervene in the process. Widespread surveillance of pregnancy and childbirth now exists in industrialized societies. Nearly all women in such societies attend for prenatal care and are subject to medical monitoring and support throughout their pregnancy; the majority give birth in hospitals where obstetric technologies and medical interventions have increased massively over the last 30 years. The history of these changes, however, is a chequered one and highlights the social nature of science with inter-professional conflicts and the social and political nature of health care being as apparent as the claim of a neutral scientific approach to pregnancy (Stacey, 1988; Oakley, 1993). Sociologists, and feminists in particular, have been concerned to examine this feature of medical understanding of pregnancy, and how it has affected the social organization of obstetric care, its impact on women's experience of pregnancy and the varied ways in which women and health professionals have responded to the changes (Graham and Oakley, 1986; Oakley, 1984; Oakley, 1993; McIntosh, 1989; Romalis, 1985).

The medical model of pregnancy tends to claim a neutral scientific approach. It views pregnancy and childbirth as inherently problematic, requiring medical intervention and control in order to be accomplished successfully. Oakley (1993) argues that it is only by this transformation of the 'normal' to the 'potentially abnormal' that doctors have legitimized obstetrics as a medical speciality. As obstetrics and the medical model have gained credibility, alternative views of pregnancy as a natural event have declined, as has women's control over pregnancy. The dominance of the medical model leads to a dominant mechanical image of pregnant women and an assessment of pregnancy outcomes largely in terms of infant or maternal mortality rather than in terms of satisfaction or measures of positive health.

A number of writers have shown that women's assessment of pregnancy and childbirth often conflict with this 'neutral' view of doctors. Using evidence from samples of mothers in York and London, Graham and Oakley (1986) showed that the frames of reference of obstetricians and of women differed both as to the nature of childbearing and its context. Their studies showed that obstetricians use a relatively limited view of 'woman as patient' throughout pregnancy whereas women tended to view pregnancy not as an isolated episode but as integral with the rest of their lives. Such differences were seen by the mothers to lead to conflict at times. Oakley points out that the typical encounter between pregnant

Cot Life 2,000

No fancy names for the New Zealand campaign against cot death, no anodyne euphorisms or acronyms. They call their society the Cot Life Society.

Their message is simple. Cover your baby's mattress with polythene. Sudden infant death is usually caused by cot mattresses or the sheepskins often used for babies to sleep on in New Zealand.

Common household fungi can convert normally inert or harmless chemicals, man-made plasticisers and fire retardants, into the poisonous gases arsine, stibine and phosphine which are highly toxic, interfering with the enzyme anticholinesterase, essential for normal nerve function.

Some regions of New Zealand have arsenic rich soil which shows up in the wool, just as it does in human hair (remember Dorothy Sayer's heroine, Harriet Vane, falsely accused of poisoning her lover?) so the problem is not just caused by our twentieth century passion for safety and convenience and the resulting unsafe materials. Having said that, it is odd how reluctant the British and New Zealand governments have been to admit to the probable cause of cot death and to endorse the simple solution - isolate these harmful chemicals from your baby by sealing the mattress in polythene. The main British charity has also remained oddly silent on the subject of mattresses.

The SIDs rate has been falling in recent years, both in Britain and in New Zealand. The toxic gas theory is getting through to the public if not to the rest, but I still see second hand mattresses advertised in the local press and shudder to think of the consequences.

Second hand mattresses are particularly dangerous because the fungi will have had a good chance to form large well established colonies capable of excreting quantities of poisonous gases that could build up quickly and become lethal to a new baby.

A Scottish case control study reported an increased risk of cot death for infants who slept at night on a mattress previously used by another infant or adult (BMJ, 314, 1,516-1,520). Furniture regulations require that mattresses be fireproofed, so co-sleeping is not necessarily safer. However, good ventilation should help reduce the risk.

LOGO COURTESEY OF BARRY RICHARDSON

HOW TO AVOID COT DEATH

Cot death is caused by gaseous poisoning, the gases being phosphine, arsine and stibine (and/or derivative gases). The poisonous gas/es arise from the mattress where the baby sleeps. They are formed by the action of a common household fungus, *Scopulariopsis brevicaulis*, on (respectively) compounds of the elements phosphorus, arsenic and antimony within the mattress. The danger increases as a mattress is re-used from one baby to the next.

The risk of cot death can be virtually eliminated by ensuring that babies sleep on mattresses known to be free from the elements phosphorus, arsenic and antimony. In New Zealand the ***BabeSafe*** range of mattresses complies with this requirement.

All other types of cot mattress (and any other mattress on which a baby sleeps, including sheepskins) must be wrapped in thick, clear polythene (not PVC) sheeting, minimum thickness 125 microns. Polythene of this type is available from garden centres. Polythene does not contain phosphorus, arsenic or antimony and it inhibits both flow of gas and growth of the fungus.

BabeSafe slip-on cot mattress covers, available at babycare retail outlets, also meet the above requirements.

Surgical rubber may be used to wrap mattresses but it is expensive and difficult to obtain. Only the best quality surgical rubber is suitable.

For instructions on how to wrap a mattress correctly, see the next page.

Babies must not be put down to sleep on sheepskin unless the sheepskin is enclosed in polythene or a ***BabeSafe*** cover. This is because sheepskins can contain phosphorus, arsenic and antimony.

For the correct bedding to use on a covered mattress or a ***BabeSafe*** mattress, see the next page.

Research in Britain has shown that babies are safer and healthier if their mattress is covered with a smooth plastic surface which can be easily cleaned. The claim that sleeping on polythene will cause a baby to become overheated is wrong. Likewise, there is no risk of suffocation.

BIRTH IS NOT AN ILLNESS !

15 Recommendations of the World Health Organization

The Recommendations are based on the principle that each woman has a fundamental right to receive proper prenatal care; that the woman has a central role in all aspects of this care, including participation in the planning, carrying out and evaluation of the care and that social emotional and psychological factors are decisive in the understanding and implementation of proper prenatal care.

- The whole community should be informed about the various procedures in birth care, to enable each woman to choose the type of birth care she prefers.
- Information about birth practices in hospitals (rates of Caesarean section etc) should be given to the public served by the hospitals.
- There is no indication for pubic shaving or a predelivery enema.
- Birth should not be induced for convenience. No geographic region should have rates of induced labour over 10%.
- Artificial early rupture of the membranes, as a routine process, is not scientifically justified.
- There is no evidence that routine intrapartum electronic foetal monitoring has a positive effect on the outcome of pregnancy. Electronic foetal monitoring should be carried out only in carefully selected medical cases (related to high perinatal mortality rates) and in induced labour. Countries should carry out investigations to select specific groups of pregnant women who might benefit from electronic foetal monitoring. Until such time as results are known, national health care services should abstain from purchasing new monitoring equipment.
- Pregnant women should not be put in an lithotomy position during labour or delivery. They should be encouraged to walk about during labour and each woman must freely decide which position to adopt during delivery.
- The systematic use of episiotomy is not justified.
- There is no justification in any specific geographic region to have more than 10-15% caesarean section births.
- There is no evidence that a casearean section is required after a previous transverse low segment casearean section birth. Vaginal deliveries after a casearean should normally be encouraged wherever emergency surgical capacity is available.
- The immediate beginning of breastfeeding should be promoted, even before the mother leaves the delivery room.
- The healthy newborn must remain with the mother, whenever both their conditions permit it. No process of observation of the healthy newborn justifies a separation from the mother.
- Governments should consider developing regulations to permit the use of new birth technology only after adequate evaluation.
- Technology assessment should be multi-disciplinary and involve all types of providers who use the technology. The women on whom the technology is used should be involved in planning the assessment as well as evaluating and disseminating the results. The results of the assessment should be fed back to all those involved in the research as well as to the communities where the research was conducted.

However - that wasn't to last very long Within the next ten minutes the contractions were coming hard and fast. Rob was now sitting on the sofa rubbing my lower back as I knelt in front of him with my head resting in his lap. I had handfuls of his jeans gripped in both hands through each contraction (which was far less painful than the handfuls of skin I'd gripped during Keenan's birth!!). Soon the really powerful contractions and the feelings of being completely overwhelmed hit me and I knew that I must be in transition. Lyn reminded me that I might be sick and the words had hardly passed her lips when I performed on cue (lucky the bucket was at the ready!). For me, the vomiting is the worst part of labour, but while feeling pretty dreadful, I was glad that this part of labour would soon be over.

Quite suddenly, I felt the need to have a wee (and maybe another pooh too!!), Lyn asked if I was sure I wasn't just feeling pressure from the baby's head moving down - but I was certain it wasn't baby and we were both surprised at the huge wee I did do!

Afterwards we came back into the lounge and before I knew it I was back into the really powerful contractions again and another session of vomiting. It was now that I began to feel quite concerned - I thought I'd been through all this and that transition was over - I'd expected to come back from the loo and begin pushing!! I felt a bit scared that I'd lost track of where I was in labour and although I wanted to ask Lyn where I was at, I was worried I may not like her reply so I just kept quiet and thought to myself - "you've got to get through this, no matter what - just trust your body".

Eventually, the contractions seemed to change a little and the urge to push began to take over at the end of each contraction. (With Keenan, there had been a "rest phase" between the opening contractions and the pushing contractions). Suddenly I felt baby move and almost "kick off" my ribs and the pushing seemed to take on a life of its own. I complained of pain at my tailbone and Lyn put some pressure there with her hands and the relief was immediate - baby was on the way down now for sure.

After about 5 minutes of pushing Lyn said that she would go and wake my Mum and Keenan to come and see the baby being born, (Keenan had said many times during the pregnancy that if he was asleep, he wanted to be woken to see the birth). I thought Lyn may be waking them too soon, but she said the baby would be here in about 3 or 4 more contractions.

Ten minutes later, Neethan Charles emerged, with the bag of waters preceding him. It was most strange to reach down and feel a squashy bag of waters emerging and not a furry wee head. Neethan's arrival was slow and gentle and the "stretched to the maximum" feeling lasted for longer than with Keenan's birth (he arrived facing my thigh and just shot out really leaving a slight tear). However Neethan's "textbook" arrival left no tears or grazing - just some swelling and tenderness which disappeared quite quickly.

The whole labour took around 3 hours and was an awesome experience from start to finish. We were overjoyed to discover we had a wee boy as I'd spent the whole pregnancy thinking I was carrying a girl. Keenan's experience of the birth was very laid back - he'd seen lots of birth videos and it was nothing new to him at all!

25 June 1998

Waikato Home Birth Association
Preparation for Birth Classes

I took over the co-ordinators role during June last year, the second session was already running with a small group of 5 women. Stephanie visited me with the box of "stuff" and ran through the method of record keeping and tasks. At that time the role was to field inquiries from women, record their details, send information about a series that would suit with a reply section to complete and return in the postage paid envelope, collect and pass on monies received, give a list of participants to the facilitator running the classes, send a letter to the midwives involved confirming their attendance, photocopy handouts and evaluation forms, post out a second evaluation about 3 months after baby is born and hopefully receive these evaluations back.

The next series began with 8 women in attendance, one dropped out after the first night and another woman joined the group for sessions 2 and 3.

The November series began with 8 women from the 11 that booked and one did not return after the first session and another attended only the first and second session. The six women that completed the series all verbalised their satisfaction with the classes although none have returned an evaluation. I appreciate how a mother has to juggle her time and understand how such things can be overlooked.

Major changes to the classes are still happening and I have become aware of many areas that require attention. WHBA has acquired (through members' hard work) THA financial assistance and the format of the classes has been adapted to fit the requirements of the contract.

At a WHBA core group meeting on Sunday morning 25th January details for the next series were confirmed - beginning 12th February, this meant the series was not advertised and midwives and consumers would need to be informed of the changes.

The information sheet sent with a booking confirmation letter was not suitable at all and I had to rewrite the sheet for that series. The sheet is printed with WHBA logo which I did not have a disk for so left it off. Using a friend's computer it took a few days to complete as it was a particularly busy time.

On the Monday of the week the series started we had a Child Birth Educator to facilitate, a WHBA consumer representative to assist, a home birth father to run a men's session, a venue and information to share and only 4 women booked from 6 inquiries.

We required 6 women to attend to meet our contract requirement and to run this series. I contacted all the midwives I had telephone numbers for, to let them know that the series was up and running and to ask if they had clients interested but not yet booked. Many were not aware what was on offer and had not made particular mention of the series to clients. The comments expressed cover a large range of feelings about the classes and I spoke to 25 midwives in two days. I have lots of ideas but not much time right now to improve the "status" of the classes within our community. Suggestions are welcome too.

Two days before the start and there are 7 women booked. Six women begin the series, and except for illness and travel difficulties, and despite a couple of backstage mix-ups the series was enjoyed and valued by the participants

Series 2 for 1998 began 7th May and there were 9 women booked (from 15 inquiries). Included in the group were 2 student midwives, both mothers who added lots of value to the group and also helped in a practical way. The May series went really well, Murray Head took the men's session and was well appreciated with lots of favourable comments from the men.
We are very lucky that Murray has agreed to do the next series as well.
The next series begins in August, we have 6 women registered so far.
I have to re-write the evaluation form to accommodate the different structure of class topics. We now have "Labour Support" on a fifth night after the four series nights. This is a change made because of the requirements we have to fulfill to meet the contract.
I would be glad of input from this group to help shape the evaluation form.
i.e. What is it that the WHBA wants to have reviewed by participants?
A current evaluation form is attached. What changes would be made to this?
I would like to thank Glennise Head, Joanne Ridder, Sam Shultz, Karen Benge. Jane Cairns and Clare Shallcross, especially for help and encouragement with this role.

Vanessa McColl.

This report was presented at the Core group meeting held on Monday 20th July as it was not able to be presented at the AGM on Thursday 25th June.

Our Winter Baby

It's hard to believe that it is nearly three years ago that I sat down to write the birth story of our first baby for the Home Birth Association Magazine. For any of those readers who remember it was titled "Our Spring Baby" and described a magical first birth experience - an enjoyable six hour labour which gave us our beautiful son Keenan Everton (a planned home birth of course!). Well ..... this is the sequel to that story .... The birth of baby Shallcross number two!
"Due date" for baby's arrival was July 1st (however we all know how little credit to give that "exact" calculation, don't we?!). But as July 1 got closer I began to notice a number of what I thought were clear signs of an impending labour, (lots of lower abdominal pains, loose bowel movements and a general feeling of discomfort!). So I began to feel certain that the baby would arrive very close to this date, and as the days in July passed and I began to feel really good again (these "signs" seemed to disappear) I decided that I'd been a bit of a pratt to try and predict the unpredictable.
Anyway, I decided to let go of any pre-conceived ideas of when the baby would come and just wait until he/she was ready. The only thing that remained in my mind was that my husband Rob had said whatever happens, don't have the baby Wednesday night/Thursday morning of July 8th/9th. Hah!! (Thursday was going to be a busy day at work and he needed to be there).
It was 2.34am when I awoke on the morning of Thursday 9th July to a call of nature. Although I was used to waking up a few times a night for a wee - this visit to the toilet was for number twos! When I got back to bed I began to feel what I thought were contraction like pains (or was it just an irritable bowel??).
I watched the clock to see if there was any pattern to the pains and they came regularly at 4 minutes apart. I told Rob that I thought labour was starting and that I thought I would go and call our midwife, Lyn. I'd had strict instructions to contact her at the very first signs of labour to make sure she would make it to me in time for the birth, (although I hardly wanted to make her come out in the wee hours to announce I had an upset bowel!! Funnily enough, I'd thought I had an upset tummy when I was actually in labour with our first baby, and this time I was a little worried I wasn't actually in labour again - for a fairly similar reason!!).
However, I called Lyn at 3.20am and she was convinced I was in labour. I thought that Lyn sounded very coherent at such an awful hour of the morning and she told me later that she was actually awake, half expecting me to call!!! She said she'd be with us in half an hour and I told her I was heading for our shub (the wee bath under our shower).
When Lyn arrived I was still in the shub kneeling up and the contractions were fairly easy to cope with. As they began to intensify, the space between them seemed to increase and I leaned over on my hands and closed my eyes through each one repeating over and over in my head "relax and open, relax and open".
It got to the stage where I felt I needed to sit on the loo again, so I climbed out of the bath and did some more "emptying out"! It was now around 4.45am and I decided to move into the lounge where Rob had set up the birth mat in front of our couch. He had also lit lots of candles and put on some beautiful relaxing music. I knelt down on the birth mat thinking how good it was that the contractions were still fairly easy to cope with.

she pees. With such gloomy prospects from the doctor, it was difficult for this mom-to-be to face the next contractions. She agreed to the Pitocin and epidural.

During the time we were waiting for the anesthesiologist, her contractions became more frequent and incredibly powerful. I recommended to the woman that she ask to be checked once again. The doctor refused, saying that it had only been forty minutes since the last check. Within a short time of the epidural administration the mom was fully dilated, which the doctor attributed to the "help" that was given. The mother said later that she felt betrayed: had she known she was moving that quickly, she would have "done her labor."

I was at another birth where the woman did ask several questions. The OB had come in several times to recommend Pit and an epidural. My client wanted to know if there were any adverse effects on the baby from either of these. The attending labor and delivery nurse said, "Absolutely none." I almost fainted. When I stated that there was substantial research about many common and concerning side effects, I was asked to leave. "We do not discuss these things in front of our mothers," I was reprimanded. "We do not want to upset them." "I discuss everything in front of *my* mothers," I replied, as I was whisked out the door. I consider them intelligent, strong individuals, able to make decisions about their lives and their births.

When the women in my class went on tour of the local hospitals, they inquired as to how many of the nurses on staff had given birth naturally. In most of the hospitals, there was not one nurse who had had a natural birth. They heard comments like, "Why do women feel as if they have to have a natural birth? What's the big deal?"; "I had forceps and my kids are very smart!"; "I'm a big chicken, myself." A midwife in a local hospital practice commented to me that she thought it was actually a shame some women were so committed to natural childbirth, that they were being set up for disappointment.

One female obstetrician told my client that she herself had two children and had begged for an epidural at one centimeter with both of them. Considered an expert on birth, this obstetrician hasn't even experienced birth!

There are many women who think that by choosing a birth center they will not have to endure unnecessary interventions or ridiculous protocol. They sometimes choose centers only if their insurance companies will cover the cost. But here in my area, at least, even at birth centers, almost everything is routine. Everyone gets their glucose tolerance tests and their AFPs and their beta streps. There are drugs to take the edge off and drugs to help us sleep. Everyone gets monitored, the babies all get Vitamin K and eye goop and hepatitis shots. There is little that can be done at a birth center that cannot be done at home—but there are many things that are not routine at a homebirth, and that helps parents maintain true responsibility, control, and safety of the experience. Several dedicated but dispirited midwives have left the centers they had created. One said, "I realized I could not stay when it became apparent to me that due to regulations and bureaucratic policies, the dream of an autonomous center was not even within reach of my fingertips."

Women begin to believe that frequent testing constitutes good care. In a paper entitled "Private Screening," which discusses the acceptance rates of a number of prenatal genetic tests, we are reminded that we can get any pregnant woman to comply to any test whatsoever, even if the test is inaccurate, unnecessary, unpredictive, and costly—just by the way that test is packaged and presented to the woman. Conversely, we can get women to refuse certain tests, even when the test is inexpensive and the results would be of value, just by the manner and tone in which the information is introduced. We use the woman's natural, mammalian instincts to protect her unborn and add the elements of concern and fear. Have you ever noticed in our culture how eager people are to tell pregnant women horror stories, filling them with apprehension and self-doubt?

I have worked with thousands of VBAC women. I coined the term in the 1970s and have had twenty-five years experience assisting women to birth normally after having been cut. Recently, a consent form for VBAC was sent to me. Women who "attempt" to deliver normally are reminded that they do have the option of a repeat cesarean. The form states that there is a risk of uterine rupture with a VBAC. The fact that there may be associated risk with the use of Pitocin is listed—but way down on the bottom of the list. There is no mention whether the use of Pitocin was factored in as a possible statistical cause for rupture. And then we are told that the use of oxytocin (Pitocin) may be "necessary" to assist in a vaginal delivery. Women are then asked to sign on one of two lines: "I have read the information and I choose a VBAC," or "I want a repeat cesarean." I want a different consent form.

I love the magic and the mystery of birth. I love the scent of it; I love laboring women; I want babies to have a fair shake as they enter this crazy world. I don't want them to be delivered, I want mothers to give birth. Raising one's birth I.Q., of course, has nothing to do with being able to memorize the bones of the pelvis, or being able to pronounce pubococcygeus, or even understanding the mechanism of labor. By dramatically reducing the fear we have about birth and death, we raise our birth I.Q.s. We increase our I.Q.s by trusting our bodies, by educating those around us, by going into preschools and kindergartens and elementary schools—junior high and high school

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Low Birth I.Q.

by Nancy Wainer Cohen

I am a homebirth midwife—a birth preserver. I believe that natural childbirth is important. I don't want women to be delivered: I want them to give birth. I am sometimes hired to be a birth assistant (doula, labor support person) by women who plan to deliver in a hospital. I go to the woman's home when she is in active labor and help her stay as peaceful, relaxed and confident as possible. I then go with her to the hospital, and stay with her until after her baby is born. I do not leave when the shifts change. I wouldn't want to leave. I have either already fallen in love with her or I am in the process of doing so: I believe that love helps a baby to be born. I do my best to bring a sense of wonder, excitement, and celebration to her birth experience, along with many years of experience working with pregnant and birthing women. During labor, I breathe with my mothers, massage them, feed them, walk with them, hold them, and encourage them. How many times have I uttered words such as: Good job!; Stay with it, you are almost there; It's just the Life Force, that's what it is; You are safe; Just let it flow right through you; That's right, that's it. Hundreds of times? No, thousands.

There are many advantages for a pregnant woman who has personal labor support. In most other cultures, when a woman gives birth, she is surrounded by familiar faces—women who themselves have given birth and who assist at her delivery. In our culture, many laboring women are surrounded by strangers, people whom they have never met, many of whom have never even been pregnant before and have never actively or consciously given birth. I bring with me the belief that women are capable human beings who are, in most circumstances, fully able to meet the task of giving birth without tools, tubes, chemicals, drugs, machines or doctors.

I love my work. I don't mind being awakened in the middle of the night with an excited, somewhat tenuous, "I'm sorry to call at this hour, Nancy, but I think I might be in labor." Sorry? Sorry?? This is the wonderful time we have all been waiting for! If I didn't want to be awakened at these preposterous hours I would have chosen a nine-to-five job. Yet, in spite of my love for this work, I have vowed on several occasions never to do labor support again. This week, I remember why: I am wondering how so many bright, articulate, intelligent, worldly-wise women in our culture end up sporting such "low birth I.Q.s" by the time they are nine months pregnant.

I began using the term "low birth I.Q." after a conversation with my husband, who is a dentist. A while back, he was pondering why a number of educated, sharp, friendly, socially aware, and otherwise well-groomed patients of his seemed either disinterested or clueless when it came to taking good care of their teeth. "They are intelligent individuals with low dental I.Q.s," he commented. I realized at that moment that the concept of "low birth I.Q." was exactly what I had been trying to articulate for so long. Sadly, I have met many women over the years who, in my opinion, fit this label.

I have a labor support client who hired me because she wanted to have a natural birth. Why, then, did she reluctantly traipse to the hospital every time her doctor wanted her to have an ultrasound or a glucose tolerance test? Why did she not trust nature—that is, her body and the process of birth? Despite all the interventions we foist on today's laboring women, the United States ranks an embarrassing 28th in the world in maternal and fetal outcome. I had another woman who wanted to avoid a second cesarean. Why did she then use the same obstetrician who sectioned her the first time? Why did she think that if the same circumstances presented themselves he'd respond differently and help her avoid another unnecessary section?

Childbirth educator Kathy Gray Farthing wrote to me: "I haven't run a BirthWorks series in a year, because women here don't want to take 6-8 weeks to do a class. Twenty minutes is too far to drive; $95 is too much to pay when the hospital class is only $40. I worked with a woman who had a failure to progress [FT], cephalo pelvic disproportion [CPD], cesarean and is now "planning" a VBAC. She's a school principal and she seemed very interested. That was five months ago. She is due in four weeks and has never called, attended an International Cesarean Awareness Network (ICAN) meeting, asked about classes or doulas. I want to help so much, but I can't."

I was hired by a woman who wanted a natural birth. Her sisters were all overdue and had perfectly healthy babies. Her obstetricians—five in the practice—began doing vaginal exams at 36 weeks. Permitting these men access to her genitals—is that *natural*? She was informed that she would most certainly be early. At 40 weeks exactly,

they began to frighten her. Decisions made out of fear are not decisions at all—they are forced reactions. Rather than consider natural approaches to encourage the labor to begin, she went to the hospital, had her water broken and then a Pitocin induction. She told me her doctor insisted that she come in.

Another woman who hired me had just had her fifth ultrasound. Although the baby passed the biophysical profile, the OB told her to high-tail it over to the hospital for an induction. The OB said the baby was on the small side and it was "time for it to be born." I suggested that the mother up her protein, drink more water, and so forth—a la Dr. Tom Brewer. The induction did not take and the OB gave up and sent the woman home. The next day, the OB tried again. As we know, more babies are induced on a Friday before a long weekend—and this was one of those. The obstetrician—an older woman with nary a smile on her face, commented that she wanted this baby born so she could enjoy the long weekend ahead. The mother-to-be was pressured to agree to Pitocin, an epidural, an episiotomy, which she had sworn she would avoid at all costs, and a vacuum extraction. The baby, 7 pounds, 14 ounces, was born with enough vernix for me to shine my car.

Another of my clients who wanted to have a natural birth learned that her baby was breech. I suggested exercises to turn the baby. She said that she tried them once, but is "too uncomfortable" doing them. While I applaud women standing up for themselves and setting limits, I wonder how "comfortable" she thinks a cesarean section would be. She refused to see one of the local chiropractors who has had great success in assisting breech babies to turn, and she "forgot" to take the homeopathic remedy that might help turn the baby. I told her that in many circumstances, especially with a relaxed, experienced attendant, it is definitely possible for breech babies to be born safely.

I noticed that her feet were quite swollen. I asked her how long she had shown signs of swelling, and she replied "for several weeks." I asked her what her doctor said about this. "Oh, he said not to worry unless it spreads to my hands and face." I told her that swelling is often a sign of problems that can and must be corrected. There are several simple dietary things she can do that will almost certainly eliminate the swelling. She said she would call me for the information but never did. I wanted to follow her home and scramble her up some eggs! I have seen edema disappear and blood pressure return to normal in less than three days. Five days later, she had an emergency section for high blood pressure and "toxemia." Doctors who tell women that nutrition has nothing to do with healthy babies and births ought to be tarred and feathered.

Another client is ambivalent. She wanted to "try" for a natural birth. I told her that unless she was committed to a natural birth, it is unlikely that she would have one. "If it gets too hard," she told me, "I want to know that you will support an epidural." I support women, not epidurals. Epidurals don't need support. She doesn't think she is brave enough to have a natural birth. Personally, I think it takes more guts to go under someone's knife. I asked her what she could do to begin feeling strong and brave in the next few weeks, before the baby was born. She couldn't think of anything.

Next in line was a VBAC mom who wanted to hire me not as her midwife, but as her labor support. She knew that I helped turn her friend's posterior baby. But that was at a homebirth, I reminded her. "Well, if I have a posterior baby, you can turn it at home before we go to the hospital," she said. "I don't want another cesarean." Then why did she go to a hospital that has a 23 percent section rate? She had almost a one in four chance that she would be cut again. She wanted me as an insurance policy, but this policy has many flaws. I told her that assisting in rotating a baby is not a labor support skill, but a midwifery skill. Why hire caregivers who don't have the skills you may need? "We don't have to tell anyone," she said to me. "We can do it at home before we go to the hospital." I will not "play" midwife with her when she has chosen others as her primary care providers. Her primary providers are being paid to do the primary work with her at her birth. If she buys their ticket, she goes on their ride.

I did some of my midwifery training in another country. The understaffed and overworked midwives there had few instruments, little money for suturing equipment, and no extra time to be stitching up women. "Allowing" one of your birthing mothers to tear was practically considered a disgrace. There was no extra pay for suturing, and no extra prestige for being able to suture. These midwives stood over their students' shoulders, giving explicit instructions for how to prevent injury to the perineum during delivery, and continually reminding us, "Don't let your mama tear." How proud we were to have intact mothers! Why do women in this country still believe that having one's genitals cut or mutilated is necessary at birth? One of my mothers was insistent that she not have an episiotomy, and then circumcised her son a few days after his birth. You cannot cut my genitals, but you can cut my baby's?

Women don't realize that in most hospitals, I will not be allowed to do much of anything. I watch as perineum after perineum splits open unnecessarily because of poor or non-existent support. I will have to hold their hands as they are rolled into a fetal position to have a needle that they never wanted inserted into their backs. I may have to bite my

Continued on next page

tongue as they are convinced that they are not strong enough or powerful enough to birth without drugs. I may have to sit on my hands so that I don't grab back a baby that is being taken away and subjected to an unnecessary procedure or treatment. I have heard from several couples who were told that if they did not comply with the hospital's recommendations for their baby, their infants would be made wards of the state.

Once I was with a woman whose obstetrician walked into the room and announced, "You are forty-two years old. You don't really expect to have a natural childbirth, now, do you?" If the woman's body knew how to conceive and grow this baby—as it obviously did—then I, for one, believe it knows how to birth the baby as well. When the OB did a yoni exam and found the woman to be four centimeters, I was very excited—it had only been three hours since she was at no dilation at all. She was definitely progressing and at the beginning of active labor! "You are only four centimeters," the doctor announced impatiently. Then she sighed, as if the woman was ruining her whole day.

"Only four?" the woman cried out. Her bubble burst. I told her that four is remarkable! It was a first baby and "look at how much more frequent and stronger the contractions are coming. It generally takes much more time to get from zero to four or five then it does to get from five to ten—" she was really cooking! The questions in my mind were: How stretchy is the cervix—maybe she was beginning to really move! Has the baby come down any lower? How about we feed the mom at this point to give her some additional energy for the next leg of this run? All the questions that I teach coupl in my childbirth classes to consid and ask—none of these are asked the hospital-taught clients.

When I began to discuss this, was told by the OB, in effect, to bu out. "Lets do Pit and an epidural," sl cheerfully but emphatically ordere

The woman managed to ask or question: "How much longer does th doctor think the labor will be?" It coul be eight or ten more hours, at least," sh answered. "There is no predicting. With far less experience than this Ol and with much less arrogance, I hav been able to make some predictions i the past with my clients. There ar many factors which provide us wit "clues" into the timing of a birth—th position of the baby, the strength an frequency of the contractions, the sup port given the mother, her beliefs, he ability to eat and drink and wall around during labor, and how ofter

First Trimester Blues
by Jennifer Boire

Where is the time or space alone
to breathe, let skin rest from touch
too constant,
and him climbing over my body
like a lion cub over lioness:
I roam tranquil in my room,
vastness inside is rest enough
wild enough, soothes my longing
for peace, space. lost in twilight zone
between feeding, changing, paying
constant attention to his small but
mighty
needs and deeds.

I would sleep for two whole days.