Waikato Home Birth Association Inc. Newsmagazine 2003

Maggie Banks
Te Awa Rd
RD 3
HAMILTON Expiry:8/03

Disclaimer: Opinions expressed in this magazine are not necessarily those of the Waikato Home Birth Association Inc. Articles are intended for educational and informational purposes ONLY and are not intended to be a substitute for your health care providers consultation.

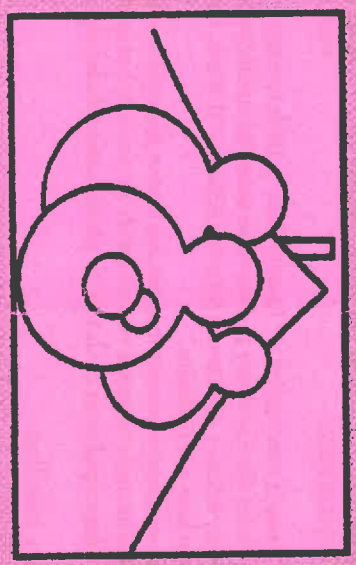
SENDER:
Waikato Home Birth Association Inc.
P O Box 15043
Hamilton

WHBA CORE GROUP MEETING
Monday 15th September 2003 at 7:00pm.
Unit 2- 8 Te Aroha Street, Hamilton
Contact Dianne De Estena on 07 854 9686
for details or agenda items.
*** ALL WELCOME***

Newsmagazine

SEPTEMBER 2003

Home Birth = A Safe Option



Waikato Home Birth Association Inc.

WAIKATO HOME BIRTH ASSOCIATION
P O Box 15043, Hamilton - http://www.homebirth.org.nz

CORE GROUP CONTACTS:

Name:	Phone:	e-mail:	Position:
Ruth Hungerford	855 2683	ruthh@clear.net.nz	Treasurer
Traceyann May	858 3494	traceyann_may@hotmail.com	Immunisation Awareness Support Group
Dianne De Estena	854 9686	unusual1@slingshot.co.nz	Newsmagazine Editor & Co-ordinator
Telisa Pearson-Collet	854 7585	t.pearson-collett@xtra.co.nz	(acting) Secretary Mailing List Co-ordinator
Jo Simpson	846 9226	jopiripiwiremu@xtra.co.nz	Birth Preparation Classes
Sheryl Wright	(07) 828 8226		Web Page

LIBRARY: The WHBA Library is now located at "Parents Place" 4 Little London Lane, Hamilton Ph: 838 2229. Parents Place is open for the toy library and therefore access to our library is also available. Tuesday 9:30am - 11:30am, Thursday 6:30pm - 8:30pm & Saturday 9:30am - 11:30am. Please phone Dianne De Estena Ph: 854 9686 if you have any problems.

NEWSMAGAZINE: We welcome your contributions but reserve the right to edit or decline at our discretion. Every effort will be made to ensure that all details are accurate but we accept no responsibility for errors or omissions. Please send your birth stories, photo's and articles to:

Dianne De Estena
Unit 2 - 8 Te Aroha Street, Hamilton
Ph: 854 9686
E-mail: unusual1@slingshot.co.nz

Advertising rates: Advertising space is available in our newsmagazine. Our rates are: $15 (full A5 page), $10 (1/2 A5 page), $8 (Business Card Size). We also offer a %10 discount for pre-paid runs of 6 months or more. For further information please contact Dianne ph 854 9686.

DEADLINE: Material for the next magazine is accepted up to midday on the 20th of the month. This also includes birth notices.

Waikato Home Birth Midwives Collective members		
Maggie Banks	(e-mail banks@ihug.co.nz)	856 4612
De Cleaver	Cell/pager - 027 224 0094	855 2081
Michelle Keen	Cell - 027 296 8630	834 4346
Karene Clark		07 871 9114
Hannah Mae		856 0221
Heather Muriwai		07 888 1178
Independent Midwives		
Ruth Kowalewicz		827 3553

All midwives listed underwrite to practice according to the College of Midwives Standards for Practice. You are free to choose your own midwife and to change your caregiver at any time. Before you decide who is going to look after you, ask questions eg. her basic beliefs about (home) birth, drugs in labour, alternative methods of pain relief, what her services include, level of post natal care/breastfeeding assistance, WHBA member? her back up system (eg. second midwife, access agreement with hospital(s) in case of transfer?), her epidural rate, her caesarean rate. It is important for you to feel at ease with your midwife and be confident of her ability to care for you.

"Have you considered a Home Birth?" Booklets
Free copies of these booklets are available for distribution by Midwives who are financial members. For non financial members of the WHBA there is a 50¢ charge per copy.

Please contact Telisa Ph: 854 7585

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 a s member of the association and entitles me to 11 issues of the newsmagazine and use of the library, located at "Parents Place", 4 Little london Lane, Hamilton, Ph: 838 2229.

POST TO:
Waikato Home Birth Association
P O Box 15043, Hamilton

Annual Subscription $20 (2 years $35) $ .....
Practising Midwife Professional Sub $50 (2 years $85) $ .....
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Cheque enclosed for $.....

Name: .....
Address: .....
.....
Phone: ..... E-mail: .....
ARE YOU A NEW MEMBER? Yes ☐ No ☐

THE LAST LAUGH CORNER ....

For all of us who feel only the deepest love and affection for the way computers have enhanced our lives, read on.

At a recent computer expo COMDEX), Bill Gates reportedly compared the computer industry with the auto industry and stated, "If GM had kept up with technology like the computer industry has, we would all be driving $25.00 cars that got 1,000 miles to the gallon".

In response to Bill's comments, General Motors issued a press release stating: If GM had developed technology like Microsoft, we would all be driving cars with the following characteristics:

1. For no reason whatsoever, your car would crash twice a day.

2. Every time they repainted the lines in the road, would have to buy a new car.

3. Occasionally your car would die on the freeway for no reason. You would have to pull over to the side of the road, close all of the windows, shut off the car, restart it, and reopen the windows before you could continue. For some reason you would simply accept this!!.

4. Occasionally, executing a manoeuvre such as a left turn would cause your car to shut down and refuse to restart, in which case you would have to reinstall the engine.

5. Macintosh would make a car that was powered by the sun, was reliable,five times as fast and twice as easy to drive - but would run on only five percent of the roads.

6. The oil, water temperature, and alternator warning lights would all be replaced by a single "This Car Has Performed An Illegal Operation" warning light.

7. The airbag system would ask "Are you sure?" before deploying.

8. Occasionally, for no reason whatsoever, your car would lock you out and refuse to let you in until you simultaneously lifted the door handle, turned the key and grabbed hold of the radio antenna.

9. Every time a new car was introduced car buyers would have to learn how to drive all over again because none of the controls would operate in the same manner as the old car.

10.You'd have to press the "Start" button to turn the engine off.
Please share this with your friends who love - but sometimes hate - their computer

Editorial..

Hola

Well our sub-committee for home birth week has increased by double, which is awesome. More hands and minds make it light work. Our core group meeting on the 18th August was not well attended, as people could not get here, because of road closures. So that was out of our hands. I hope more people can come to the next Core Group meeting. ALL MEMBERS are welcome and we would love to see you there. Also a reminder the position of Secretary is still vacant and it would be good to get that filled, as it is people in our Core Group are doing two jobs at once, makes it hard to keep the passion for doing this when we are doing too much.

Thank you to Ruth for all your work. Look forward to Home Birth Week in October with a lot of great activities planned around it.

I hope all who have been sent out an evaluation of the classes form from the evaluation team has filled it in and sent it back. It is very exciting to get this professional assessment of how our classes have been and are doing. I will let you know in the magazine the results from it.

PLEASE PLEASE send me your birth stories I have run out, and I think it is one of the most popular features of the magazine. You will receive a FREE bumper sticker with the month your birth story is published. SO PLEASE this is a desperate call for you to send them in. I personally love to read all the wonderful stories, to cry, to laugh and share in the joy that is birth.

Chao
Dianne

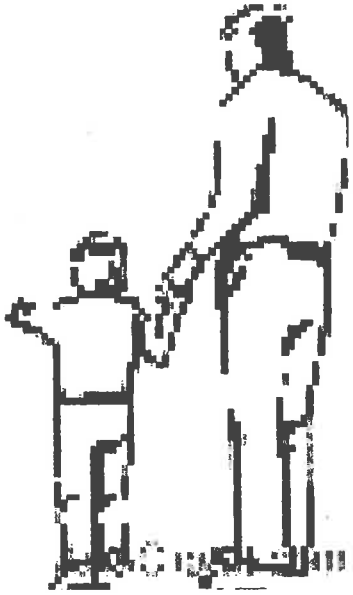
CONTENTS:

Your Newly Hatched!

On	These Parents	From	Had a	Named	Attended by
29/07/03	Dionne & Thomas	Ngaruawahia	Boy	Jacob	Michelle/De
30/07/03	Simone & Damien	Hamilton	Girl	Makaylah Whatuoterangi Te Aira	Michelle/Jo

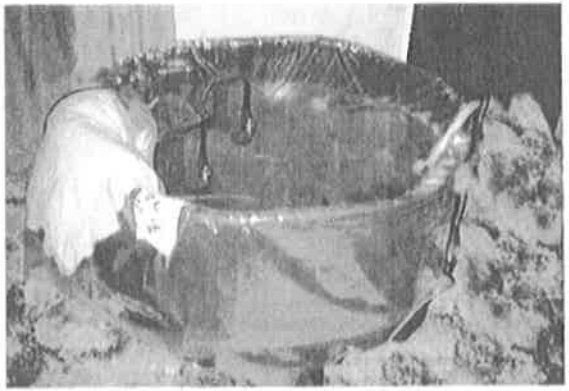
Happy Father's Day

To all the Home Birth Father's out there, we hope you have a great day. Enjoy this time with your family.



SERVICES FOR MEMBERS ....

BIRTH POOL FOR HIRE



- ♦ Safe and Natural
- ♦ Lightweight Construction - tubular plastic frame with vinyl liner
- ♦ Comes in carry bag - very easy to transport
- ♦ Pool Frame easily assembled in 10 minutes
- ♦ Comes with:
  - full instructions
  - your own disposable liner
  - hoses for filling / emptying
  - electric heating elements

Hirage of pool: $50
Gas Caliphonts: $25

BOND is $100

*****NOW** available Gas Caliphonts to heat the water without using your water cylinder! Instant hot water to fill the pool - Is really great fills it up quick!!!!!!!!!!***

For bookings or more information contact:
Glennise Head: 846 4925

BABY SLING FOR HIRE

A great way to try out a sling before deciding whether to buy one of your own. Available for Short Term Hire. $ 5 month. For bookings or more information please contact: Glennise Head 846 4925.

SIBLING KITS FOR HIRE

The ideal way to prepare your child for a new arrival! Kits include baby doll and basket, several children's books, the video "A sister for Hugo" and a parents preparation guide. Available for Short Term Hire - $2 fortnight. For bookings or more information please contact: Glennise Head 846 4925

W.H.B.A. FUNDRAISING MERCHANDISE

T-SHIRTS: **ADULTS: $15.00**
CHILDREN'S: $12.00

Quality adults 190 gram t-shirts in 100% cotton. Good sizing and of longer length. These are embroidered with the WHBA logo and "Home Birth Naturally".

Sizes L, XL, XXL & XXXL. **White, Grey and Black**
(no black available in L or XXXL)

Children's t-shirts are good quality cotton fabric and these are screen printed with the WHBA logo and "I was born at home" in large print.

Sizes 1 **Orange, Red, Lilac, Lime, Aqua and Royal Blue**
2 **Aqua, Lemon, Sky Blue, Natural and Red**

CALICO CARRY BAGS: **$10.00**
These are strong handmade calico bags which are screen printed on one side with the WHBA logo and "Home Birth Naturally".

PROPITS: **$4.00 (or 3 for $10.00)**
A really nifty gadget! Ideal for use near the computer, phone, desk, where-ever you have paper/bills/photos that need "propping" up. The are white with the WHBA logo and "A Safe Choice – Homebirth" printed the front.

BUMPER STICKERS: **$2.00**
As seen on great cars! White background with "Home Birth Naturally" in large purple printing.

Ordering Information - Please allow up to 21 days for delivery. Postage is 40 cents for bumper stickers and $1.00 for T-shirts, bags or propits. Please enclose a cheque for payment with your order.

WHBA MERCHANDISE ORDER FORM

Please post orders to: Waikato Home Birth Association,
P O Box 15-043, Dinsdale, Hamilton.

Name: .....

Address: .....

Phone:..... .....

Item Description:	Price	Colour	Size	Quantity	Total
Postage & Handling:					
Total Enclosed:					

Calendar of coming events

WHBA Core Group Meeting: Monday 15th September 2003 at 7:00pm at Unit 2-8 Te Aroha Street, Hamilton. Contact Dianne 854 9686 for agenda.

ALL MEMBERS INVITED TO ATTEND.

Immunisation Awareness Support Group: Anyone with Immunisation Inquiries are welcome to the coffee mornings, or ring Dianne De Estena Ph: 854 9686. "For an Informed Choice" tapes - two copies are available to borrow from the WHBA Library.

Home Birther's Coffee Mornings: Thursday September 11th, 10am, bring a plate and share morning tea. Contact Traceyann ph 858 3494. Welcome to all members, pregnant women who are having a home birth or thinking about having one. Children are most welcome.

Cambridge Home Birth Support Group: Contact Tania Bullick ph 827 5165

Te Awamutu Home Birth Support Group: Small library available. Contact Karene Clark ph 07 871 9114.

Preparation for Birth Classes: The next series dates are in September to book in please contact Jo Simpson ph 846 9226 or leave a message with Dianne on 854 9686.

Pregnancy Yoga and Relaxation Classes - Monday 1:30pm or Thursday 5:30pm, at the St Andrews church centre, 6 Te Aroha Street. **Friday 5:30pm** at Parents Place, 4 Little London Lane, Hamilton. Contact Hannah Mae ph 856 0221

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

La Leche League monthly meetings - Chartwell Group: 3rd Friday,10am, Richmond St Plunket rooms, Annemarie ph: 856 6471. **Westside Group:** 2nd Thursday, 9:45am, Parents Place, Little London Lane, Hamilton, Lynn ph: 846 1013. **Hillcrest Group:** 3rd Thursday, 7:30pm, 51a Wellington St, Hamilton, Anne ph: 849 7675. **Cambridge Group:** 3rd Monday, 10am, Parents Centre, Taylor St Cambridge, Tracey ph: 823 2259. **Te Awamutu Group:** 2nd Wednesday, 10am, Kindergarten Room, St Andrews Hall, Mutu St TA, Mandy ph: 823 6522 (Ohaupo). **Morrinsville Group:** 1st Wednesday, 10am, Plunket Rooms, Anderson St, Morrinsville, Anne ph: 849 7675 (Hamilton). **Raglan Group:** 2nd Tuesday 10am contact Dianne for venue 854 9686.

Joan Donley

ORIGINALLY FROM CANADA, WHERE SHE WAS a maternity nurse, Joan Donley is the matriarch of the modern midwifery and homebirth movement in New Zealand. With global political aspirations, she has become a strong voice for independent midwifery internationally. Donley began her midwifery training in New Zealand in 1971 at the age of 55.

A life member of the New Zealand College of Midwives, Donley was instrumental in achieving an amendment to the Nurses Act of 1977, which restored autonomous practice to New Zealand midwives. New Zealand doctors were very resistant to this amendment, concerned about the erosion of a 50-year-old fee-for-service system. Negotiations established a new pay structure for both doctors and midwives. Numbers of New Zealand independent midwives grew from less than 100 in 1990 to more than 1,500 in 1995. Together they lobbied the government in 1989 to birth the certificate of midwifery, which grew into a diploma and in 1993 matured into a bachelor of health science degree in midwifery. In New Zealand today, more than 70 percent of births are attended by midwives, the highest rate in the world; nearly 10 percent of births occur at home.

At 81, Donley was the first to be awarded an honorary master of health science degree. As well as being a prolific author, Donley has been a speaker at many midwifery conferences throughout the world and has been a consultant to Canada's department of health in the implementation of its direct-entry registration of midwives. In 1990 Donley received an Order of the British Empire medal for services to midwifery and childbirth. She has also been awarded a Women's Suffrage Medal.

Her most significant achievements, however, are the 750 babies she has caught, including 4 of her 12 grandchildren.

Early Bedtime Means Better Baby Sleep

In their efforts to encourage their baby to sleep better, one approach that many parents use is to put their baby to bed *later* in the evening. They think, "If he's "really tired" he'll sleep better, right?" Wrong! This often backfires because Baby becomes overtired, and chronically sleep-deprived.

In the majority of cases, a baby's biological clock is preset for an early bedtime. When parents work with that time, a baby falls asleep more easily and stays asleep more peacefully. Most babies are primed to go to sleep for the night as early as 6:30 or 7:00 p.m. I often hear about how babies and toddlers have a "melt down" period at the end of the day, when they get fussy, whiny and out of sorts. I suspect that it's simply a sign of over-tired children longing for sleep.

Early to bed, early to rise?

For babies, early to bed does *not* mean early to rise! Most babies sleep *longer* with an earlier bedtime. Many parents are afraid to put their baby to bed so early, thinking that they will then face a 5 a.m. wake up call. But keeping your little one up too late backfires, and more often, a late night is the one followed by that early morning awakening.

My youngest child, two-year-old Coleton used to go to bed at 9:30, the time when my three older children went to bed, because it was convenient for me. At that time in the evening, it would take him a long time to get settled. I never connected his inability to settle with his late bedtime. When I started putting him to bed at 7:00, he fell asleep much more quickly and slept more soundly.

What About Working Parents?

If you are a working parent, and your evening with your little one *begins* at 6:30 or 7:00, you may find yourself torn between keeping your baby up for some playtime and getting him right to bed. You may find, though, that when your baby goes to sleep earlier, and sleeps better, he awakens in a pleasant mood, eager to play. Because you have gotten a good night's sleep, you can consider getting up earlier in the morning and saving some time before work to play with your baby, as an alternative to that late-evening play session. You'll both enjoy that special morning time. Later, when your baby is consistently sleeping all night, every night, you can move bedtime a little later and judge whether the difference affects your baby's sleep.

Finding Your Baby's Best Bedtime

It can take some experimentation to find your baby's best bedtime. If you have been putting your baby to bed too late in the evening, you can approach this adjustment in one of two different ways:

§1 Adjust your baby's bedtime to be earlier by fifteen to thirty minutes every two or three nights. Pay attention to how easily your baby falls asleep as well as his awakening time and mood to gauge the effectiveness of the changes until you settle on his best bedtime, or

§2 Beginning at around 6:30 p.m., watch your baby closely. As soon as he exhibits any signs of tiredness (fussing, losing interest in toys, looking glazed, yawning) put him right to bed, even if his previous bedtime has been 11:00 p.m. When you do this, keep your home quiet and the baby's room dark so that it resembles his usual environment in the middle of the night. If this bedtime is substantially earlier than usual, your baby may think he's going down for a nap and awaken after a short snooze. If he does this, respond very quickly so that he doesn't fully awaken. Follow your usual method for helping him fall back to sleep, such as rocking or nursing; keep the room dark and quiet as you do during the middle of the night.

Here's what Tammy, mother of seven-month-old Brooklyn had to say about changing her baby's bedtime, *"I had been waiting until 10:00 to put Brooklyn to bed because that's when I go to sleep. But your suggestion made so much sense that last night I put her down at 8:00. I loved having the evening to spend with my husband. We haven't spent that much time alone together in months! And the baby actually had a better night's sleep. I'm happy that all our needs can be met in such a pleasant way."*

It may take a week or more of adjustment to settle into a new bedtime, but once you do, you'll find that both you and your baby are happier.

Home Birth Aotearoa

ANNUAL REPORT - HOME BIRTH AOTEAROA
July 2003

The Home Birth Aotearoa contract has nearly completed its first year of a two-year contract. This contract is with the Ministry of Health and is administered by Community Birth Services in Palmerston North. Home Birth Aotearoa is comprised of representatives from Home Birth Associations around the country as well as Domiciliary Midwives Society. The group holds monthly teleconferences and communicates mainly via email with regular (approx 2 monthly) mailouts to Associations etc.

A summary of involvement and progress for the year:

WEBSITE: The home birth website was established in August last year and has proved to be a well visited site. There has been much positive feedback and has been a great tool for liaising and networking with people all over the country. There are currently approximately 20 active Home Birth Associations /Support Groups around the country. Some of these Home Birth Associations have feature pages on the website. There are also birth stories, information, merchandise and other areas of interest. The website address is www.homebirth.org.nz

MATERNAL AND NEWBORN INFORMATION SYSTEM PANEL: Home Birth Aotearoa continues to have input into these meetings and recently a meeting was held to discuss Home Birth statistics specifically. The meeting was very worthwhile and attended by various women from around the country as well as NZCOM and Nga Maia. Some long-term goals were established to ensure that accurate and meaningful information is collected and provided about Home Birth in New Zealand in the future. We are striving for some Home Birth statistics in the 2002 report.

NATIONAL IMMUNISATION REGISTER: This meeting was attended back in February and Home Birth Aotearoa continues to have input into resources and legislation regarding immunisation.

SUBMISSIONS: A submission was written with regard to the Public Health Legislation Review and circulated to Home Birth Associations and NZCOM.

LETTER TO NZ BREASTFEEDING AUTHORITY: A letter was sent to the NZBA AGM with regard to concerns about the lack of consumer involvement on assessment panels. Kirstie Le Quesne spoke to the letter at the meeting and was strongly supported by other consumer groups. This letter was circulated to Home Birth Associations, NZCOM and National Committee members. To date we have not received a formal response to the letter from the NZBA.

MORTALITY REVIEW COMMITTEE INPUT: There was considerable consultation with Alison Stewart of Otago University with regard to the Mortality Review Committee Review. Notes were compiled and these will be circulated within the next week or so.

HOME BIRTH CONFERENCE 2003: The Home Birth conference will be held in Palmerston North this year, Friday 10 – Sunday 12 October – hosted by both Manawatu Home Birth Association and Home Birth Aotearoa. There will be a Domiciliary Midwives meeting on the Friday evening, Saturday will comprise of a morning and an afternoon workshop and Sunday will be the Home Birth Aotearoa hui. Flyers will be circulated in the next week or so.

Home Birth Aotearoa has gifted some funds to Maori women and midwives through the local Nga Maia representative to provide an opportunity for a korero tautoko / wananga for Maori home birth women. This event will most likely coincide with this year's conference.

For any further information, please feel free to contact me:

Jeannette Lazet
Email: homebirthaotearoa@clear.net.nz
Ph: 06 – 367 9050

So those are the reasons why I choose not to have routine ultra-sound scans in my pregnancies and why I get frustrated about routine scanning. I would urge all women to make an informed and socially responsible decision about whether or not to have a scan (for anything other than a medical reason). Just because 'everyone else has one' is not a reason to – we are not sheep – we can choose to go a different way to the rest of the flock!
Ruth Hungerford
Disclaimer: these are totally my own views (although some supported by research and other authors of course!) and not necessarily those of the WHBA.
If you want to read more about this I would recommend The Tentative Pregnancy by Barbara Katz-Rothman

Ultrasound may change baby's cell growth
June 9, 1999 (from CNN.com) Web posted at: 3:10 PM EDT (1910 GMT)
LONDON (Reuters) -- Ultrasound scans, routinely used to look at internal organs and to monitor the growth of a developing fetus, can stop cells from dividing normally, Irish scientists said Wednesday.
Researchers at University College in Dublin told *New Scientist* magazine it is too early to tell if the changes they found in the cells of mice are harmless or what the implications of the findings could be for humans.
"It has been assumed for a long time that ultrasound has no effect on cells," said Patrick Brennan, who led the research team. "We now have grounds to question that assumption."
During the study, the rate of cell division in mice that were given an 8 megahertz scan lasting 15 minutes was 22 percent lower than normal, and the rate of cell death doubled.
Routine hospital scans use frequencies between 3 and 10 megahertz and can last up to 60 minutes.
Brennan said the sound waves of the scans could be damaging the DNA in cells, which could delay cell division and repair, or it might be switching on p53, a tumour suppressor gene that controls cell death.
Cancer occurs when damaged cells multiply uncontrollably and form tumours. Mutations in p53 are the commonest gene abnormalities seen in human cancers.
"Our results are preliminary and need further investigation," Brennan told the magazine.

Newnham, J.P., Evans, S.F., Michael, C.A., Stanley, F.J., & Landau, L.I. (1993). *Effects of Frequent Ultrasound During Pregnancy: A Randomised Controlled Trial.* The Lancet, 342(Oct.9), 887-891.

A study of over 1400 women in Perth, Western Australia compared pregnant mothers who had ultrasound only once during gestation with mothers who had five monthly ultrasounds from 18 weeks to 38 weeks. They found significantly higher intrauterine growth restriction in the intensive ultrasound group. These mothers gave birth to lower weight babies.
The researchers concluded that prenatal ultrasound imaging and Doppler flow exams should be restricted to clinically necessary situations. This recommendation comes at a time when ultrasound during prenatal visits has become increasingly popular and serves as a kind of entertainment feature of office check-up visits.

Campbell, J.D., Elford, R.W. & Brant, R.F. (1993). *Case-Controlled Study of Prenatal Ultrasound Exposure in Children with Delayed Speech.* Canadian Medical Association Journal, 149(10), 1435-1440.

Delayed speech is not a pathological or organic syndrome but developmentally defined symptom complex. Clinicians have noted an increased incidence of delayed speech in paediatric patients.
This is a matched-case control study of 72 children 2 to 8 years old presenting with delayed speech of unknown cause. The children were measured for articulation, language comprehension, language production, meta-linguistic skills, and verbal memory. When checked for ultrasound exposure, the speech-delayed children were about twice as likely to have been exposed to ultrasound than the matched controls.
The authors believe that delayed speech is a sensitive measure reflecting sub-optimal conditions for development. If ultrasound can cause developmental delays, the authors are concerned about the routine use of ultrasound and they warn against it.

Ultrasound

Having a scan is so common nowadays that the second question you get asked after informing someone that you are pregnant is "do you know what it is?" (the first question being of course, "when is it due?" to which I always reply "on its birthday"). To the "do you know what it is ?" question I always reply (tongue-in-cheek) "a baby we hope!" This usually stems the tide of questions although the unusually persistent questioner may continue with "did you not want to know?" At this point I say "no" and usually add that "I've never had a scan." This always, without fail, comes as a surprise to the questioner. They cannot understand why a pregnant woman would not have at least one (and the average is three I believe) scan per pregnancy. There are actually some really good reasons for not having a scan. These are mine:

- ◊ **Safety** – the safety of ultrasound scanning has not been proven. We do not know what the long term effects on the baby (or mother) are. The reason we do not know this yet is because scanning has not been around long enough for us to measure the effects. Some research has shown some negative side (see the following articles). I have no desire to risk my baby's or my health just so I can 'have a look' at my baby inside.
- ◊ **Social responsibility** – ultrasound scanning costs money (about $130 per scan if you pay to have it done privately). That is $130 of our health dollars per scan that could be better spent (like on supporting home birth families for example). I cannot justify spending $130 (or $390 if I had the average 3 scans per pregnancy) just to 'have a look' at my baby when home-birthing families are not supported or when my 12 year old nephew has leukaemia and might die and needs that money to pay for his treatment or to support his family to support him. In my view, if a woman wants to have a scan so she can have a wee video or a picture for the photo album she should pay for it. I don't believe that my health dollars should be spent on baby portraits for expectant parents.
- ◊ **No medical need** - I have no medical need to have a scan. I am healthy. My pregnancy is normal. My baby is growing well (not that scans have ever been proven to make babies grow – but that's another argument).
- ◊ **I would not abort a different baby** – one reason women have scans is to find out if their baby is 'normal' or not. I do not have any reason to suspect that my baby is different (there is no history of particular disorders in my family for example) but I am also realistic enough to know that there is always a chance. Personally, I could not choose to abort a baby who had an 'abnormality'. Perhaps if I knew in advance that my baby was different I could get more prepared (i.e. finding support groups or reading up about the topic). But I would not know how the difference would affect my baby, so I would rather wait and see what my baby was like (after birth), then get the information and support I need.
- ◊ **False positives** – this is a research term which basically means that a test can say something is true when it is not (i.e. the test is wrong). Most tests have a certain amount of false positives. For example, a scan may indicate that your baby has Downs Syndrome, when in actual fact it does not. Or the scan may indicate that your baby is not growing ("small for dates" or "intra-uterine growth retardation") when in actual fact your baby is growing perfectly well. Or the scan may say your baby is perfectly fine when in actual fact it isn't. There is no sure way of knowing whether the result you have been given is a false positive or not often until it is too late. Sometimes further tests (i.e. amniocentesis) may say that the scan was wrong, but again these tests also have false positives, and they also have other risks (i.e. amniocentesis can cause miscarriage of what may be a perfectly healthy baby).
- ◊ **The cascade of intervention** – one of my friends can trace her forceps delivery of her first baby back to the first scan she had which 'diagnosed' her baby as not growing properly (intra-uterine growth retardation). This resulted in further scans and tests, close (medical not holistic) monitoring of her pregnancy, stress for her, and the decision to induce labour at 39 weeks, which didn't work very well thus requiring further intervention to 'speed up 'labour' more pain, drugs and an eventual episiotomy and forceps delivery of a 7lb 3oz baby. If this baby had been allowed to come out in her own time she, no doubt might have been even bigger than the healthy size she was.

Home Birth Story

Adi-Grace, born 17 May 2002 By Karen Mooar

My labour and delivery of Adi (my only baby, so far) was pretty much straight forward. The story is very special to me and my husband, and - one day - to Adi-Grace as well.

Initially, a lot of braxton hicks and 'pre-labour' had my midwife Jo and I thinking that baby might come early. So it was very disappointing to wait eight days past my due date. Labour started on the evening of May 16th - only a few hours after I finished sewing curtains for our lounge. I think I was waiting for that - I didn't want to birth baby with all of Raglan looking on.

Two strong braxton hicks (afterwards, I realised they were contractions) and a bloody show that let me know babe was on the move. I was VERY excited. Heck. I was almost hopping about the room. I wanted to ring EVERYONE. I felt like the only woman in the world who had ever been pregnant, and the only woman in the world to ever give birth.

I rang my sister, mother, midwife, and mother-in-law. I wanted them to be ready for later, when I'd need them. (Mum-in-law would ring back at 8am from America, just in time to hear me birth Adi). We tried to ring my brother-in-law in Japan but couldn't get through. That was all at about 11.30pm. Then, for reasons I can't now recall, I spent a bit of time trying to decide what to wear. I think I wanted to look nice when everyone came to see me and baby. Ha. I also didn't want anyone to see me in my pyjamas. Of course, everyone saw me in a lot less as the night wore on. I didn't get very far though. I got a few 'very ouchie' contractions and left the wardrobe.

1:30am saw Aaron call Jo again, asking her to come straight out. Contractions were getting nasty (or so I thought) and I wanted people with me. Also, being out in Raglan I wanted to give people enough time to get here. Jo was fast, and she came right in and knelt with me by the couch. We got through the first few hours: I vomited, cried, panicked, was scared, and giggled with Jo at Lord knows what. Jo was very comforting, and I had good breaks between contractions. But this stage was the most difficult of the whole labour, probably because I fought it. I couldn't seem to get on top of it all and 'accept' it. The notion seemed laughable.
Aaron had filled the birthing pool, so I got in. Incredible. It felt like a thick, soft, hot, comforting *thing*. It didn't feel like water. It felt like a living thing that was holding me. I relaxed. Contractions eased off long enough for me to regroup and surrender to the whole process. I felt weightless (a pregnant woman's dream), and floating made it so easy to change positions. I was ready for the second stage.

The second stage started. Big contractions. No, I wasn't ready at all, but we got through the next hour: I tried not to hit Jo; I made dying-animal sounds; I bit a hole in Jo's tee-shirt; I bit the pool-lining; I was given a face-cloth to chew; I cried; I asked is 'it' there yet? I was not behaving at all like the strong, Amazonian woman I had thought I was. Where were my deep, guttural lion-roars that were to push baby out? And, where was Aaron?
Earlier he'd said "I just have to go out for a bit" and he hadn't returned. Didn't he know I was having a baby? I thought I must have scared him and that it was all too much for him. It turned out that he'd neglected to make the birthing mat, and had gone off to whip one up. Good man. I

ception that our private lives have no relevance for our professional lives, and that our roles as "mothers" render us "unprofessional." Women can make a statement by breastfeeding their children wherever they happen to be, whatever they happen to be doing, to show others that breastfeeding is important and can be accomplished by normal women living in the real world. Women can continue to lobby for realistic maternity/nursing leave, and employment opportunities that allow them to care for their children at the same time. All women, whether breastfeeding or not, whether mothers or not, as well as all men, need to understand the importance, for all members of society, of nurturing child rearing practices.

This isn't a male versus female issue; most of the outspoken critics of breastfeeding in public, and breastfeeding older children, are women, just as women are the ones clamouring for their right to have their breast size increased through surgery. Likewise, some researchers have suggested that breastfeeding advocacy represents a call for women to return to their "traditional," circumscribed roles as housewives and mothers. In this chapter, I explicitly reject this interpretation. Women should not have to choose between nurturing their children in the best possible way and pursuing other interests outside the home. Just as an earlier generation of women thought that they had to choose between having a family and having a career, today's generation of working mothers often think they must choose between breastfeeding their children and having a career, but it doesn't have to be that way. It is up to us to change the cultural context of breastfeeding, and of work, in the United States, so that breastfeeding is compatible with the modern workplace. Rather than concluding that an advocacy of breastfeeding means a return to the days of "a woman's place is in the home," one can argue that an advocacy of breastfeeding means a change in a culture's valuation of child rearing as an activity, and a change in the valuation of the important contributions that only women can make to the social reproduction of a society. We can teach fathers other ways to nurture and care for their children besides giving them a bottle. We can show them that their cultural beliefs about the sexual nature of women's breasts are cultural beliefs, not biological givens. Men need to know that, however much sexual pleasure they may derive from women's breasts, breasts were designed, first and foremost, to feed children. Every father can be taught that the long-term health of his spouse and children should overshadow his culturally-taught sexual desires for access to his wife's breasts. We can teach our sons that they should not judge a woman's character or sexual attractiveness on the basis of her breast size. We can teach our daughters to value their bodies, to have confidence in their bodies, and to not be ashamed of using their bodies as they were designed. We can make sure that children have many opportunities to see women breastfeeding, in many different contexts. We can answer our children's questions about breasts and breastfeeding in a forthright, practical, straightforward manner. Finally, we can continue to combat the "culture of misinformation" that surrounds breastfeeding among medical professionals and the lay public. Medical students and other health professionals need general nutrition education, as well as specific classroom and clinic education in breastfeeding (Freed, 1993; Stanfield, 1984). If doctors don't know how to effectively treat a particular problem, they can refer their patients to the experts--La Leche League International, lactation consultants, or other local women who have experience breastfeeding--rather than just recommending weaning. Women need to have their problems with breastfeeding met with serious concern and treatment, from knowledgeable, experienced people. Women's and new parents' magazines can make available objective, accurate information about breastfeeding, not bow to the power of the infant formula industry.
I realise that what I am calling for constitutes nothing less than a cultural revolution. Just as women have held rallies and marches to "Take Back the Night," we can "Take Back Our Breasts." We can restore our breasts to their rightful place as the most important point of contact between mother and child after birth. We can do as much as possible to facilitate breastfeeding for all women, and to make sure that women have all the information they need to make informed choices about infant feeding. No child should have to settle for bottle-feeding because his mother thought it was "just as good." No child should have to settle for bottle-feeding because his mother thought she "didn't have enough milk." No child should have to settle for bottle-feeding because his mother thought breastfeeding would be painful, or could only be done in private. No child should have to settle for bottle-feeding because his mother wasn't allowed enough maternity leave, and/or couldn't find child care near her workplace. No child should have to settle for bottle-feeding because her father wants her mother's breasts all to himself. The path to a "Breastfeeding Friendly" society is open before us. We have only to take the first steps. Prepared August 3, 1995.

all times. It is inappropriate to let the very Western cultural idea that breasts are for men overshadow their primary biological function for feeding children, just as it was inappropriate for people in Chinese society to let the cultural idea that deformed feet were sexually stimulating overshadow their primary biological function for walking. Women and children are harmed by Western beliefs about breasts, both directly and indirectly, both physically and emotionally.

I am not suggesting that it is wrong or immoral or perverted to experience sexual pleasure from manual or oral manipulation of the breasts as part of sexual behaviour. I am insisting, however, that we recognise this as learned behaviour, learned in a particular cultural context. I am not suggesting that men and women in any culture should give up this aspect of their sexuality; I am suggesting that they should recognise this role of the breasts as a very distant, secondary lagniappe. Can't we "have our cake and eat it, too?" one may ask. Perhaps, I would respond, but with caution. Perhaps, but only to the extent that using our breasts for these purposes doesn't lead to the excesses represented by female mammary mutilation, widespread dissatisfaction among women with the way their bodies look, men who judge a woman's value on the size of her breasts, and widespread misunderstanding of the primary function of women's breasts, which leads to breastfeeding being defined as sexual behaviour. The costs of these cultural beliefs, in terms of women's physical health and self-esteem, and children's health, are, it seems to me, too high a price to pay. Women deserve to have their bodies accepted as they are, and not feel compelled to submit to the knife in pursuit of the perfect body. The size of a woman's breasts is not related to her ability to produce breast milk. We can teach our daughters that whatever the size of their breasts, they will be able to sustain and nurture their children through their breastmilk. If we can teach our children that breasts are for feeding children, then the phenomenon of female mammary mutilation and the issue of breast implant safety will simply fade away, as the desire and demand for artificially inflated breasts disappears. We can educate ourselves, and others, about all the different roles that breastfeeding plays in normal, healthy child development. Breastfeeding is more than just the transfer of nutrients from mother to child. Not only nutritionally, but immunologically, physically, cognitively, and emotionally, breastmilk is vastly superior to artificial infant feeding products, and breastfeeding is much more than just a way to feed a child, much more than just a "lifestyle choice." Women need to know about the advantages of breast milk and breastfeeding; they need to know that breast milk protects children against a variety of illnesses and parasites as long as they are ingesting it, and that an early diet of breast milk sets the stage for life-long health advantages through a strengthened immune system. Women also need to know about the very real "risks" of bottle-feeding, including higher morbidity and mortality during childhood, higher rates of cancer and diabetes in adulthood, and poorer cognitive development. Women need to know that infant formula is not "almost as good" as breast milk. They need to have realistic expectations about how often and for how long human children need to nurse, so that they will nurse often enough to produce enough milk, of sufficiently high fat content, to satisfy their child's needs. They need to know that breastmilk continues to be an important source of clean, cheap and convenient nutrition for their children as long as they are producing milk, and that breast milk can be a critical source of nutrients for a sick child. They need to know that breastfeeding releases a flood of hormones that promote maternal behaviour and that will help them cope with the many demands of child rearing. Women need to know that breastfeeding quiets a noisy or fussy child, relaxes an anxious child, comforts a sick, injured, or frightened child, and conveys unequivocally that the child is safe and loved. They need to know that a child who has the "safe haven" of her mother's arms is a secure, independent child, or who has the self-confidence to reach out and explore the world. Finally, women need to know that meeting their children's needs through breastfeeding, as long as children express those needs, is both normal and appropriate.

Everyone, from doctors and lactation consultants down to the youngest school children, needs to know that breastfeeding is not only for newborn infants. All of the evidence from our closest living relatives in the animal kingdom, the non-human primates, suggests a natural weaning age between two and seven years of age. Cross-cultural evidence from around the world suggests that two to four years of breastfeeding is typical of modern humans. The question "Is that child still nursing?" needs to be stricken from our conversations. Parents and health professionals need to recognise that the benefits of breastfeeding (nutritional, immunological, cognitive, emotional) continue as long as breastfeeding itself does, and that there never comes a point when you can replace breast milk with infant formula or cows' milk, or breastfeeding with a pacifier or teddy bear, without some costs to the child.

We can work to counter the artificial separation of private and public domains, the cultural per-

hadn't actually wanted him close to me till the end of the labour anyway. There was something about the strength and comfort and understanding of another woman that I much preferred while I was labouring. Jo was so calm and stable.

Our second midwife Hannah arrived, and my sister and mum. After Hannah and Jo helped me to work out some surrendering, we got through the rest of the labour. I concentrated on lowering my voice and using the energy behind it to push baby down. I focused. I got bloody determined. I squatted in the pool, and squeezed the life out of Aaron's arms. I felt ferocious. I probably looked ferocious. I felt like I had so much burning energy in me that my eyeballs would melt whatever they looked at. (I had finally managed to surrender to the birthing process. I was so proud).

Then: Ring of fire. Oh my Lord. The pain wasn't easing between contractions. I was stinging, burning ALL THE TIME. Surely baby must be here now? Whenever I asked (after each contraction) 'Is it here yet?' I was told 'You're doing really well, Karen.' Everyone avoided the question. I was furious. How could baby not be here after all this work and PAIN? And, no one would give me a time to expect baby. I really, really just wanted to be told 'It'll be here at 7:30' or something. I really believed they all *knew* and they were all holding out on me.

My pushing stage lasted three hours: I spat water at Aaron. My sister dropped boiling water which splashed on Aaron, and my mother made the annoying joke that 'the waters have broken'. I was unimpressed. I glowered at her. My sentences were now single words: 'Water.' 'Hands.' 'Contraction.' 'Cloth.' 'F...k' (only once!) People read my birthing affirmations out for me - just right for that stage of labour.

When baby finally came (at 8:08am) I didn't realise it. I birthed her head, which felt soft to my touch. It then took a few more pushes to birth her body. I was waiting for the next contraction when someone said 'There's your baby Karen.' I looked down into the water (I'd stayed in the pool because getting out was physically impossible) but only saw a light coloured blob because I'd taken my glasses off hours earlier. I reached down and picked her up, not sure which way round she was. I cuddled her to my chest and tummy. Someone put my glasses on me and I could see her.

She wasn't breathing and her eyes stared straight ahead. It was scary, but I knew she would be okay. Breathing on her face didn't work, so Jo and Hannah used oxygen to help her. She made noises. She breathed. Her eyes moved. She wanted my milk! The first woman in the world to feed her baby! We checked various bits and found we had a daughter. So amazing. My baby girl.

I'd been squatting for hours and my right leg had been numb and useless since just before Adi was born, so I was helped out onto the birth-mat (cheers Aaron). Adi-Grace suckled away. I was given chocolate and towels, and I birthed the placenta. Anyone who says that doesn't hurt is lying.

On our birth video, there is no record of anyone saying 'There's your baby Karen'. I think I just knew Adi had arrived, and those words were in my head, letting me know. But I can remember them, clear as day, as if someone spoke them out loud. Perhaps the thoughts about the biggest event in your life just sound extra loud and real.

PS. She was 8 pounds, 6 ounces. The biggest baby ever born.

The Cultural Context of Breastfeeding by Katherine Dettwyler, PhD Department of Anthropology, Texas A and M University. Excerpt from the conclusions of Katherine A. Dettwyler's *Beauty and the Breast: The Cultural Context of Breastfeeding in the United States,* to be published in Breastfeeding: Biocultural Perspectives, edited by Patricia Stuart-Macadam and Katherine A. Dettwyler, Aldine de Gruyter, October 1995.
Cause for Optimism? Unlike Kennell and Klaus (1983), I do believe that an understanding of the evolutionary background of the human species carries clear implications for cultural change in the United States. Nevertheless, I would be pessimistic about the potential for cultural change in the United States concerning attitudes towards breastfeeding were it not for the major changes I have witnessed in my own lifetime with respect to tobacco smoking. Like artificial infant feeding, the risks of tobacco smoking were difficult to pin down epidemiologically, and were not accepted by the medical establishment for many years. Like artificial infant feeding, an extremely powerful financial lobby worked very hard to counter the medical and public acceptance of the growing scientific literature on the health risks of tobacco smoking (see Fredrickson, 1993 for the genesis of this idea that there are striking similarities between the two issues). Despite these difficulties, public attitudes towards tobacco smoking have changed radically I the past twenty years. The number of people who smoke has dropped sharply during this time; many restaurants, including McDonald's, department stores, hospitals, public buildings, and work places have voluntarily banned smoking. Smoking is no longer allowed on most airplanes. Because of studies documenting the detrimental effects of second-hand smoke on non-smoking bystanders, especially children, President Clinton is currently considering legislation that would outlaw smoking in all public buildings, and the Food and Drug Administration is considering whether or not to classify nicotine as a drug. Because I have lived through this radical shift in public opinion, beliefs, and behaviours concerning smoking, I can imagine the same thing happening with bottle-feeding.

In the early 1990s, one can find evidence that we have reason to be optimistic that public attitudes toward breastfeeding are changing in the direction of more direct support. Two well-publicised cases in 1994 involved breastfeeding mothers being ejected from public buildings and even threatened with arrest for breastfeeding in public. They made the national news because the mothers did not slink home, embarrassed. The first case involved a New York shopping mall, where a woman breastfeeding her three-month-old son was asked to leave by a security guard because she was "exposing herself" (AP wire story, 1994). The next day, more than 40 women gathered at the mall and staged a "nurse-in" to protest against the mall's attitude toward public breastfeeding. Similarly, in Texas, a woman was asked by a security guard to leave Houston's Museum of Natural Science because she was nursing her six-month-old infant. The next day, more than 150 women and children gathered across the street from the museum and staged a "nurse-in" to protest against the museum's application to nursing infants of their policy prohibiting "eating" in the exhibits. The museum's response was that nursing mothers should go to the restroom to nurse their children. The fact that more and more women are standing up for their right to breastfeed their children in public, and finding widespread support from other people, is a cause for optimism. In addition, thousands of instances of women nursing their children in public without being harassed go unreported, and therefore, unnoticed.
There are other reasons for optimism as well. Laws in most states have vague indecent exposure statutes that often define any exposure of the nipple and areola in public as "indecent exposure." Although breastfeeding in public is not against the law in any state, hypothetically, the indecent exposure laws could be used to characterise breastfeeding as indecent exposure. Beginning as long ago as the 1980s, in a quiet effort to clarify the issues, a number of states and local jurisdictions have been amending their indecent exposure statutes to explicitly exclude breastfeeding. As of 1995, New York, Florida, North Carolina, Michigan, Texas, Nevada, and Virginia were among the few states to specifically protect women who breastfeed in public. Technically, all women have a constitutional right to breastfeed, and there are no laws anywhere in the United States that prohibit breastfeeding or limit the length of time a mother can nurse her child. The New York state law passed in 1994 defines any attempt to prevent a woman from breastfeeding a child, in any location where the woman has a right to be, as a violation of her civil rights, and includes stiff penalties for violation of the law (Baldwin, pers. comm., 1994). In New Jersey, as this book went to press, legislation was being written to protect women's rights to breastfeed their children in public.
More and more official bodies are recognising that breastfeeding is not just a "lifestyle choice" for women, but a health choice for both mothers and children. In Florida, state law requires medical professionals to go beyond providing information and education about breastfeeding and to "actively encourage" mothers to breastfeed. In Dade County, Florida, local ordinances provide incentive programs which allow hospitals to advertise themselves as "Baby Friendly" if they meet the guidelines of the "Baby Friendly Hospital Initiative" at the 80% level of compliance. Hopefully this will encourage other hospitals to take responsibility for this issue, rather than waiting for it to be mandated.

In the past several years, over two dozen large corporations have provided pumping breaks, breast pumps, private pumping rooms, and breast milk storage facilities for mothers who are breastfeeding their children. The World Alliance for Breastfeeding Action's (WABA) theme for 1993 was the promotion of a "Mother-Friendly Workplace." In the mid-1990s, the trend is for more and more companies to support the working mother, a change that has come about because society is recognising that breastfeeding is a positive health choice for both mothers and children. Once again, Florida is leading the way with legislation pending to designate the entire state as a supporter of WABA's "Mother-Friendly Workplace" initiative. Because of these shifts in public, corporate, and legislative attitudes and policies, I am optimistic for the future of the cultural context of breastfeeding in the United States. In the not too distant future, I can imagine a day when a young couple enters a restaurant with an infant or young child, and notes the sign on the front door: "This is a Breastfeeding Friendly Establishment." I can imagine a day when all fifty states have legislation guaranteeing a mother's right to breastfeed her child in public. I can imagine a day when all cans of infant formula carry a series of rotating warning labels from the Surgeon General that clearly state: "Use of infant formula may be hazardous to your infant's health. Infant formula is known to be a contributing factor in many cases of infant illness and death, including cancer and Sudden Infant Death Syndrome. The use of infant formula is known to reduce children's IQ as much as lead poisoning does, and hinders the development of strong affective bonds between mother and child." I can imagine a day when parents would have to sign a release when they buy infant formula, relieving the formula company of responsibility for causing higher rates of infant morbidity and mortality.12 I can imagine a day when heavy taxes are levied on the sale of every can of infant formula, both to discourage its use and to help offset the enormous medical costs incurred by those who use it. I can imagine a day when insurance companies charge higher life-long premiums for health care coverage of bottle-fed children. I can imagine a day when all pregnant women are fully informed of the costs of bottle-feeding, in terms of both their own health, and their children's health. I can imagine a day when doctors no longer worry about "making mothers feel guilty for choosing not to breastfeed," any more than they worry today about "making mothers feel guilty for choosing not to use an infant car seat." I can imagine a day when women who work outside the home can take their children to work with them; a day when every employer has on-site child care, and women can have their children with them as they work, or can go to a nearby location to breastfeed their children as often as thy like. I can imagine a day when women in the United States can choose to take a year or more of maternity/nursing leave, with a guarantee that their job will be waiting for them when they return. On good days, I can even imagine that this maternity/nursing leave will be paid leave, as it is already in some European countries! I can imagine a day when children are so used to seeing women nursing their children in public, including at work, that they just assume that's the way things have always been. I can imagine a day when movies, television shows, and children's books portray mothers, including non-human animal mothers, nursing their children as a matter of course, instead of giving them bottles.13 I can imagine a day when anthropology students will learn about "the great breast implant debacle of the late 20th century" as yet another example, along with Chinese foot-binding and female genital mutilation, of cultural beliefs gone astray to the detriment of women and children. I can imagine a day when children grow up appreciating women's breasts for the wondrous, amazing, life-sustaining organs that they are. I can imagine a day when all the world's children, including those in the United States, start out breastfeeding, and are allowed to breastfeed for as long as they need.

What can we do to make these imaginations become reality? Among the first steps might be the following: We can speak out against the prevailing cultural view that breasts are "naturally" sex objects, and that 'breast-mouth' contact is, by definition, sexually charged. It is inappropriate to take the very Western cultural idea that breasts are sexual organs and turn it into a "Law of Nature," applicable to all people, at